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The Development Process for a Self-Sustainable School-Based Health Center for a School District in Western Arkansas

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THE DEVELOPMENT PROCESS OF A SELF-SUSTAINABLE SCHOOL-BASED HEALTH CENTER FOR A SCHOOL DISTRICT IN WESTERN ARKANSAS

by

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DEDICATION

This dissertation is dedicated to the two people who have influenced my life the most, my late brother, Jason Cleveland, and my wife, Cristi Cleveland. Jason died when we were teenagers but established for me the understanding that excellence does not mean perfect, it means having the courage to display your absolute best effort. Cristi continues to model excellence for me. She is an excellent mother, wife, partner, cheerleader, comforter, confidant and trusted friend. She has always encouraged and supported me to strive for excellence in all aspects of life God has provided. Her devotion in every area of life is a constant blessing to our family and a wonderful example for others.

ABSTRACT

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Title: The Development Process for a Self-Sustainable School-Based Health Center for a School District in Western Arkansas (Under the direction of Dr. Keith Williams)

This qualitative case study examined the development and implementation process of a school-based health center (SBHC) in a school district in Western Arkansas. Researchers and health professionals agree that children who are in good health are in a better position to learn (Allensworth & Kolbe, 1987). Little (2009) noted student health, being an underlying factor in educational achievement, is garnering educator focus to improve academic success.

SBHCs are developing across the country as potential solutions to improve children's access to quality health care (Allison et al., 2007). SBHCs provide opportunities to remove barriers like geography, transportation, and cost for impoverished families to access quality health care. Addressing student healthcare needs provides opportunity for students to reach their full academic potential.

Data instruments used in this study were focus group interviews with the researcher acting as moderator of the focus group interviews. The focus group interviews with the participants involved in the establishment of the SBHC provided rich data to describe the process from developmental policy through daily operations of the SBHC.

This qualitative study described the circumstances surrounding the state policy makers, state agencies, and advocacy groups working together to allow the establishment of SBHCs in Arkansas. Additionally, the study describes how the local school board, school administration, and community leadership identified the need to improve student, staff, and community health and chose to work together to provide access to quality healthcare on the school campus.

The research findings indicate that the SBHC model established in the school district in Western Arkansas can be replicated provided stakeholders work together with fidelity to meet the needs of the school district children, staff, and families in the community. Reducing the barriers to academic achievement improves the opportunity for academic success and ultimately the potential for an improved life.

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CHAPTER 1

INTRODUCTION

With the accountability standards in No Child Left Behind (NCLB, 2002), public school districts are diligently working to find effective ways to increase student achievement to meet federal standards. A recognized purpose of NCLB is to ensure all children have a fair, equal, and significant opportunity to obtain a high-quality education and reach, at a minimum, proficiency on challenging State academic achievement standards and state academic assessments. NCLB identifies a need to meet the educational needs of low-achieving children in the nation's highest-poverty schools, limited English proficient children, migratory children, children with disabilities, children of American-Indian descent, neglected or delinquent children, and young children in need of reading assistance. Additionally, NCLB focuses on closing the achievement gap between impoverished children and their more advantaged peers. Children who can be classified into these categories are likely to be children who have limited access to quality healthcare.

Researchers and health professionals agree that children who are in good health are in a better position to learn (Allensworth & Kolbe, 1987). Little (2009) noted student health, being an underlying factor in educational achievement, is garnering educator focus to improve academic success. The author, Little, continued by stating if students are absent from class due to an untreated medical condition, they miss valuable

instruction time with the teacher and classmates that can potentially lead to weak test scores and poor grades. If no intervention takes place for students with health needs, deeper problems can occur, ultimately leading to early dropout from the academic arena.

School based healthcare centers (SBHCs) are developing as a potential solution to improve children's access to quality health care. Allison et al., (2007) believed SBHCs provide opportunity for access for children who are minority, low-income, underinsured or uninsured, or lacking a usual source of health care. Allison et al., affirmed that there is a disparity in health care access to services for school age children and access to quality health care is a significant barrier for students across the country, especially for children living in rural areas where health care providers may not exist.

For impoverished families, geography and transportation costs could hinder opportunity for access to quality health care. For employed parents, missing work potentially means missing income. Employed parents have the difficult choice of continuing to work to earn money or taking off work and potentially losing valuable income in order to attend to their child's health care needs by taking them to the doctor for a costly visit.

All too often, student health care needs must be addressed for academic opportunities to be successful. To meet these basic core student needs, school systems are reaching out to health care professionals for help (Little, 2009). A movement to establish SBHCs in school districts across the country began in the late 1970s with the first centers opening in Dallas, Texas and St. Paul, Minnesota (National Assembly on School-Based Health Care [NASBHC], 2012). The NASBHC identified that, today, there are over 1,700 centers in 45 states plus the District of Columbia. They argued, currently, these

centers nationally serve over 2 million young people. Amaral, Geierstanger, Mansour, and Walters (2004) recognized school health programs have a positive influence on academic performance, and healthy children make better students. In addition, SBHCs place medical service providers in the school setting to help students avoid health-related absences, thereby supporting opportunities for student academic success (NASBHC, 2012).

Large numbers of children and youth in the United States go without any health care services due to lack of access and means that families have to find the means to pay for medical services (Alexander, Nystrom, & Zimmer-Gembeck, 1997). These services range from prevention services to critical care. This lack of care could create barriers for academic success and potentially reduce opportunities for a successful and productive life for children (NASBHC, 2012). Further, the NASBHC (2012) argued that children not having access to health care will likely experience health and social problems, which compromise academic success, result in missed instructional time and poor academic performance, and lead to greatly increased potential for school dropout.

Overall, poor health appears to have a negative effect on student success (Amaral et al., 2004). Every missed academic opportunity for students due to untreated medical condition can lead to weak academic scores and can be a direct barrier to learning (Little, 2009). Without adult intervention, student potential can decline and cause additional problems beyond academic failure. Little (2009) also noted that neglecting physical and mental health care needs may result in chronic or severe conditions eventually leading to potential premature death.

Statement of the Problem

It is increasingly difficult for teachers to provide high quality instruction and learning when students with an untreated medical condition or behavioral problem do not attend class or disrupt the learning environment when in attendance. Most school leaders now view education as service of the whole child, not just the academic portion. The holistic community and school approach has been embraced by school leaders seeking to improve educational experiences of all students. One such approach has been applied in a public school system in Western Arkansas. Thus, the purpose of this qualitative case study was to describe the development process of a self-sustainable School-Based Health Center for a school district in Western Arkansas.

Background

SBHCs were established in an attempt to improve health care access for students and potentially improve overall student academic success (Little, 2009). Little (2009) further noted that school districts with SBHCs across the country attempt to transform overall student health and educational outcomes by uniting health and education systems under one roof. SBHCs integrate comprehensive medical, mental health, and social services on the school campus to optimize learning readiness (Amaral, Geierstanger, Soleimanpour, & Brindis, 2011). SBHCs are opening across the country in school districts where students are consistently present. Little (2009) contended these SBHCs are playing a vital role in improving student health, and likely, positively influencing student academic achievement. Little reported that children better reach full educational potential and lifelong well-being when schools provide the student access to high-quality healthcare. This opportunity can create additional pathways to support student success.

There are approximately 2,000 SBHCs in 44 states, Washington DC, the Virgin Islands, and Puerto Rico, serving approximately 1.7 million students (Little, 2009). Even though SBHCs provide a quality service for students on campuses where they are established, there are still significant numbers of children who are underserved or not served. To emphasize this idea, Little pointed out there are 8 million uninsured children in the United States representing 11% of the population under 18 years of age.

SBHCs deliver medical care to help students with chronic and acute conditions cope with disease, to get them back to the classroom faster, and to promote their readiness to learn. Beyond student physical health conditions, SBHCs have components to address student mental health, as well. These mental health services focus on improving students' emotional well-being and decreasing high-risk, health-compromising behaviors such as drug, alcohol, and tobacco use (Little, 2009).

Role and Effect of School Based Health Center Access

The vast majority of SBHCs provide primary healthcare services, mental health and counseling services, family outreach, and chronic illness management. Most SBHCs generally operate without concern for a student's ability to pay. SBHCs vary based on specific needs of a community and school and availability of funding resources (Little, 2009).

The NASBHC (2012) identified common characteristics of the majority of SBHCs. They include:

- Located in schools or on school grounds
- Work cooperatively within the school to be an integral part of the school

- Provide a comprehensive range of services that meet the specific physical and behavioral health needs of the young people in the community
- Employ a multidisciplinary team of providers to care for the students that includes nurse practitioners, registered nurses, physician assistants, social workers, physicians, alcohol and drug counselors, and other health professionals
- Provide clinical services through a qualified health provider such as a hospital, health department, or medical practice
- Require parents to sign written consents for their children to receive the full scope of services provided at the SBHC
- Have an advisory board consisting of community representatives, parents, youth, and family organizations to provide planning and oversight

SBHCs are primarily designed to meet the health care needs of students and are considered one of the most effective strategies for delivering high-quality, comprehensive, and culturally-competent primary and preventive care to adolescents—a population that can be difficult to reach (Amaral et al., 2004). Qualified health professionals like doctors, nurses, and mental health therapists at SBHCs provide developmentally appropriate health services. They incorporate the principles and practices of pediatric and adolescent health care recommended by the American Medical Association, the American Academy of Pediatrics, and the American Association of Family Physicians (Ammerman, 2010b).

Due to its physical location on the school site, SBHC staff members are first-hand witnesses to factors that affect student health and academic achievement. These factors

include bullying, school violence, depression, stress, and poor eating habits, among others (Ammerman, 2010a). A SBHC staff generally has the time and resources to address these and other challenges influencing student health

A multi-site study of SBHCs across the country conducted by Mathmatica Policy Research found a significant increase in health care access by students who used SBHCs (Ammerman, 2010b). Of the students in the study, Ammerman noted 71% of students reported having a health care visit in the previous year as compared to 59% of students who lacked access to a SBHC. Ammerman asserted that Dr. John S. Santelli, Heilbrunn Professor of Clinical Population and Family Health Chair at Columbia University, found that young people with access to a SBHC are more likely to be seen for primary care and more likely to receive counseling and other preventative services. Linda Juszczak, Executive Director of NASBHC, encouraged leaders to establish SBHCs in areas identified as high need or for hard-to-reach populations (NASBHC, 2012). Ammerman (2010b) concluded SBHCs do an exemplary job of increasing access to services to those affected by health disparities.

Improvement of Health and Academic Achievement

Educators are constantly looking for new ways to improve student academic achievement because of the national accountability system of NCLB (2002). The NCLB Act of 2001 holds schools accountable for academic achievement. The Whole Child initiative, Arkansas Department of Education Coordinated School Health Unit, Arkansas' Act 1220 (2003), and Michelle Obama's *Let's Move* campaign, focus on student health and nutrition (U.S. Department of Health and Human Services, 2010). These initiatives

address student health at the district and school levels to produce healthier students who are more successful and ready to learn on a consistent basis.

The Journal of School Health, The Journal of Adolescent Health, and the NASBHC have published articles establishing positive relationships between SBHCs and student academic outcomes. SBHCs deliver results for students in school in the areas of decreasing tardiness, reducing absenteeism, curbing the dropout rate, and slowing discipline referrals to the office (Ammerman, 2010a). It is logical that students need to be present and engaged in the academic classroom in order for the learning process to take place on a school campus.

The Oregon Department of Human Services Public Health Division's (2009) annual Patient Satisfaction Survey noted that 92% of students reported they are likely to follow the advice given to them at the SBHC. Of the students surveyed, 61% reported their health has improved because of the SBHC. Additionally, the survey reported that 62% of students indicated they were unlikely to receive care if SBHCs were not located at their school.

Physical and mental health status is an important predictor of attendance for students, especially high-risk students. High-risk students are often underserved by public and private healthcare systems. These students live in high-poverty communities, have no health insurance coverage, and belong to an ethnic minority (Bruns, Cosgrove, Kerns, Lyon, & Walker, 2009). Veda Johnson, Assistant Professor of Pediatrics at Emory University School of Medicine reported in 2006 that SBHCs are the best model of health care in this country for at-risk populations because they increase access to health care,

eliminate barriers and improve health outcomes for essentially every patient enrolled (Ammerman, 2010a).

SBHCs are popular with providers, with parents, with students, and with educators due to improved health and academic success for the students that are served. These health centers assure equal access for all children and adolescents to critical health care services, which lead to opportunities for success in school and life (Ammerman, 2010b).

Student Health Focus

The Center for Disease Control promotes a coordinated school health program that is an eight-component program (Centers for Disease Control and Prevention, 2013). A coordinated school health program is widespread across the country. In Texas, the Texas Department of State Health Services (2008) in the Annual Report on School-Based Health Centers identified that state legislation requires all elementary, middle, and junior high schools to implement a coordinated school health program. Arkansas adopted the model in 2003 and provided funding through ACT 1220 (2003). The funding comes through a partnership with the Arkansas Department of Health, Arkansas Department of Education, and Arkansas Children's Hospital.

Arkansas ACT 1220 of 2003 (2003), was designed to address the growing problem of obesity among Arkansas children. Act 1220 included these key components:

- Annual measurement of BMI for all children attending public schools and report of the BMI and associated health risks to parents.
- Elimination of student access to vending machines during the school day in elementary schools.

- Specification of funding to hire Community Health Promotion Specialists with expertise in community health promotion to work with schools and communities.
- Establishment of a statewide Child Health Advisory Committee with membership from specified groups (including academic units from the University of Arkansas for Medical Sciences) to develop regulations for schools in a variety of specified areas, based on scientific evidence related to nutrition and physical activity.
- Public reporting of vending contracts.
- Establishment of school nutrition and physical activity advisory committees with broad membership.

The Arkansas Child Health Advisory Committee provided a series of evidence-based regulations enacted by the State Board of Education and phased in over the next few years (Raczynski, Thompson, Phillips, Ryan, & Cleveland, 2009). Additional changes in school policies and practices were recommended by some local advisory committees and adopted by local school districts. Thus, the Act established mechanisms for both immediate and longer-term initiatives to be established at both the statewide and local levels.

Health programs across the country have shown success in improving academic success. One such program is SPARK, a comprehensive curriculum and professional development program designed to promote physical activity in and out of school (Sallis et al., 1999). Ratey (2008), in SPARK, suggests that schools in Naperville, Illinois and Titusville, Pennsylvania have increased academic achievement due to focusing on student

health. Since implementing the programs, Titusville has experienced an increase in test scores as well as beneficial psychosocial changes in student behavior (Ratey, 2008). Titusville did not implement a SBHC but focused on healthy activities for students and improved food service programming.

School-Based Health Center Funding

SBHCs are cost-effective investments of public funding sources (Ammerman, 2010b). Veda Johnson, Assistant Professor of Pediatrics at Emory University School of Medicine has studied the effectiveness of SBHCs in lowering the cost to Medicaid and third-party payer systems in reducing hospitalization and inappropriate emergency room use. Johnson's studies revealed that SBHCs not only are effective in reducing Medicaid and third-party payer system hospitalization costs, but are also effective in reducing the cost of medication costs and nonessential drug use. These costs are better controlled due to additional collaboration among stakeholders and focus on overall student health.

The National School-Based Health Care Census has collected trend data on demographics, staffing, operations, prevention activities, clinical services, and policies of SBHCs nationally (Strozer, Juszczak, & Ammerman, 2010). The collection efforts revealed that, of the organizations that serve as the primary administrative home to SBHCs, most are typically a local health care organization. Community health centers administer 28% of SBHCs while 25% are administered by hospitals. Local health departments administer 15% of the SBHCs. The other remaining partners include mental health centers, nonprofit organizations, higher education institutions and school districts. School systems directly sponsor 12% of the SBHCs. SBHCs generally receive in-kind support from schools in the form of space to operate and extended services available. The

medical centers generally do not have financial responsibility for construction and renovation, utilities, rent, or cleaning services. The sponsoring agency generally meets those obligations (NASBHC, 2012).

For an income revenue stream, SBHCs bill Medicaid, Medicare, private insurance, and accept cash for services (Ammerman, 2010b). Medicaid is billed by 81% of SBHCs, 68% bill The Children's Health Insurance Program, and 41% bill Tri-Care. Tri-Care is a health care program serving active duty military service members, National Guard, Reserve members, retirees, their families, and survivors. Over half of the SBHCs, 51%, bill private insurance. Additionally, 38% of the centers bill students or families directly. The majority of SBHCs, 85%, offer assistance to students and families enrolling children in some form of public insurance programs. This service is critical for sustainability of SBHCs in insuring a pay source remains available.

SBHCs also report receiving support from a variety of revenue sources not related to billing for services. Reports indicate that state governments, private foundations, sponsor organizations, and school or school districts provide direct financial support to SBHCs. The federal government overall provides 39% of the SBHC funding (Ammerman, 2010b).

The federal and state governments support SBHCs through a menagerie of state and federal programs (Ammerman, 2010a). Of these programs, 23% of SBHCs receive Section 330 monies through the Public Health Service Act for community, migrant, and rural health centers. These SBHCs are directly sponsored by Community Health Centers. State Departments of Health are the most common source of state funds–almost half of SBHCs report receiving funds from these state entities– while the departments of human

or social services and education fund about 11% of programs. In 21 states, the state funds or sponsors a grant program specifically dedicated to SBHCs.

The 2010 NASBHC Census discovered that SBHCs across the country are serving the community where the centers are located along with the students at school. Only 36% of SBHCs reported serving only children who attend the school serviced by the SBHC (Ammerman, 2010a). The current difficult economic climate has many SBHCs starving for additional financial support due to increasing workload and operating costs. The centers have a growing enrollment of eligible students and community members requiring services, yet a continual reduction of federal and state funds for operation.

Currently, the NASBHC is working on advancing SBHCs as a vital component of health care reform. Signed into law by President Obama in March of 2010, The Patient Protection and Affordable Care Act (P.L.111-148) includes a federal authorization for SBHCs in Section 4101(b). A second provision in the law was developed to require $200 million over a 4-year period for capital projects (Sec. 4101(a)). The provision is for capital improvements and equipment purchases, with expenditures for health-care services. Specifically excluded was a provision for personnel.

According to NASBHC's 2007-08 Census, 72% of the nation's SBHCs are 5 years or older, up from 4% in 1998 (Ammerman, 2010b). In addition, 287 SBHCs opened in the past 4 years. These numbers attest to a continued community support of and demand for SBHCs.

Policymakers are also increasingly recognizing the value in supporting SBHCs. Congressman Sarbanes (D-MD), an advocate for SBHCs, consistently promotes implementing a SBHC in every school. He advocates the initial investment will save

millions over the long term by improving overall student health and by teaching healthy habits (NASBHC, 2012).

Research Questions

Central Question

What was the development process of a self-sustainable school-based health center in a school district located in Western Arkansas?

Subquestions

- What circumstances prompted the development of the school-based health center?
- What legislation aided the development of the school based health center?
- What funding sources were used to help establish the school-based health center?
- How did the development process unfold in the school district?
- Who were the people involved and what roles did they play in the process?
- What structures in the school and community influenced the decisions made both positively and negatively?
- What structures in the community influenced the decisions made both positively and negatively?
- What were the outcomes from the process for school personnel, students, and community?
- What was the satisfaction level for the stakeholders with the outcome?

Description of Terms

Absenteeism. USLegal (2012) defined absenteeism in employment law as the state of not being present that occurs when an employee is absent or not present at work during a normally scheduled work period. For students, absenteeism is the state of not being present at school or in class during the scheduled day or period. Absences fall into two categories including, scheduled and unscheduled. USLegal noted absences are considered unscheduled for such events as illness, family emergencies, transportation emergencies, family member illness and/or death, and household emergencies such as flooding.

Achievement gap. The achievement gap in education refers to the disparity in academic performance between ethnic groups of students. The achievement gap is revealed through grades, standardized-test scores, course selection, dropout rates, and college-completion rates, among other success measures. It is most often used to describe the troubling performance gaps between African-American and Hispanic students, at the lower end of the performance scale, and their non-Hispanic white peers, and the similar academic disparity between students from low-income families and those who are better off (ED Data Express, 2012).

Coordinated School Health (CSH). Coordinated School Health is an effective system designed to connect health (physical, emotional, and social) with education. This coordinated approach improves students' health and their capacity to learn through the support of families, communities, and schools working together. The Coordinated School Health (CSH) model is a method of connecting health and learning that consists of eight inter-related components. This approach constitutes a system's change by improving

students' health and their capacity to learn through personal responsibility, and the support of families, communities, and school (NASBHC, 2012).

Medicaid. The Medicare.gov website (2012), retrieved September 24, 2012, defines Medicaid as a joint federal and state program that helps with medical costs for some people with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if one qualifies for both Medicare and Medicaid ("Medicaid definition," 2012).

Medicare. The Medicare.gov website (2012), retrieved September 24, 2012, defines Medicare is the federal health insurance program for people who are age 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease, which is permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD ("Medicare definition," 2012).

School-Based Health Center (SBHC). A SBHC is a partnership created by schools and community health organizations to provide on-site medical, mental health, and/or oral health services that promote the health and educational success of school-aged children and adolescents. Medical services typically offered in SBHCs are age appropriate and address the most important health needs of children and youth. These services may include but are not limited to: primary care for acute and chronic health conditions, mental health services, substance abuse services, case management, dental health services, reproductive health care, nutrition education, health education and health promotion (NASBHC, 2012).

Significance

Research Gap

This study sought to expand the knowledge base regarding the development and implementation of a self-sustainable school- based health center serving students, staff, and community in Arkansas. The services provided in the health center include physical health, mental health, dental health, optometric health, audiological health, and nutrition. All of these services are located at school, where there is convenient student access.

Providing necessary medical services where students are, at low to no cost, removes common barriers normally associated with student health. With the barriers removed, students that use the services are healthier and likely to be absent from school less, consequently more likely to graduate.

Instructional staff who make an appointment visit a doctor must take off work and miss valuable instruction time. This lost instructional time, regardless of the quality of the substitute teacher, is detrimental to the learning process for students they serve. Having health care services on campus for teachers to use during non-instruction time can reduce the need for the teacher to be absent while seeking health care and increase the time the regular teacher is in the classroom.

Allowing a SBHC to serve people outside of the school system provides an outside revenue stream to support services for students and staff. State and federal funding, generally in the form of grants, are used to provide seed money to begin SBHCs. After these funding sources are depleted, SBHCs must seek revenue to be solvent financially or run the risk of ceasing to exist. Sustainability of a SBHC is vital to keeping services viable for students and staff, ultimately improving student achievement.

Potential Implications for Practice

The research findings of this study provided additional information regarding how to begin, implement, and sustain a SBHC on a school campus in rural Arkansas. In the future, researchers may build on the information from this study to help the academic community, the business community, and medical community collaborate to improve student and teacher performance along with improving overall health of communities that are served by SBHCs.

Process to Accomplish

The design of this research was a qualitative case study that explored and described the development and implementation process of a self-sustainable SBHC in a rural school district located in the River Valley of Western Arkansas. Qualitative researchers must rely on an inductive model of the scientific method with the major objective of this type of research being exploration or discovery (Johnson & Christensen, 2008). The researcher explored the process used to establish the only self-sustainable SBHC in Western Arkansas. In this study, participants in the process described their experiences by citing and explaining factors effecting the establishment of a SBHC in the school district.

Qualitative case study research was the best design for the researcher to interact with participants, gain information, and establish best practice for establishing a SBHC. The study explored the developmental history of the SBHC from inception to operation. A qualitative case study was appropriate for this research study.

Sample

The researcher chose a school district located in Western Arkansas, specifically the Arkansas River Valley. The small rural school district was the first to establish a fully functional SBHC in Arkansas in 2011. The SBHC opened in January of 2011. The SBHC was the only center in Arkansas to serve students, staff, and community members on a public school campus. The researcher used an intensity sampling in selection of participants. The sample of sources of data was useful in understanding the historical background and process that transpired in the establishment of the SBHC.

Participants involved in the establishment of the SBHC were contacted by telephone and email requesting participation by the researcher. Those individuals willing to participate were sent a follow-up letter of acceptance into the study. The participants chosen were stakeholders in the SBHC. The participants include Arkansas Department of Education representatives, Arkansas Department of Health representatives, members of the local school board, city officials, health care professionals, and school staff members that played a role in the establishment of the SBHC. The perspective of the stakeholders provided insight into the achieved success and challenges faced in establishing the SBHC. The stakeholders in the process were the participants as the study was conducted.

Instrumentation

The researcher obtained data from stakeholders of the SBHC by conducting interviews and interactive discussions along with email communication for questions and answers. The researcher facilitated the interviews and questions. The researcher's role was to serve as moderator as the primary instrument for collecting data, an appropriate instrument according to Creswell (1994). The questions were asked to the participants.

As the questions were answered, the researcher subjectively made judgments about the information noted and made field notes both during and after the interview. The researcher used technology to video and audio record the interviews for analysis when focus group interviews were conducted.

The researcher designed a guide for the purpose of including all questions and sequencing them in the most appropriate order. The researchers used open-ended questions from general to specific to address the research topics. The guide was used to keep the communication focused, and to provide consistency in interviews.

As the researcher conducted the interviews, participants identified perspective of the roles and responsibilities each had in the development and later establishment of the SBHC. For content validity, the researcher asked participants for clarification of comments, for verification of statements and for additional areas of discussion they thought should have been included in the discussion. The researcher documented many comments from participants who questioned the relevancy of any of the questions asked in the interview.

The researcher contacted the participants and sent a written agreement form for the individuals who accepted the opportunity for the interview. The researcher video recorded interviews for those that agreed. Every participant agreed to be videotaped and audio recorded for the purpose of focus group sessions. The researcher met face-to-face in a comfortable setting to conduct the interviews. Interviews were conversational in nature as questions were asked. From the interviews conducted, notes taken, and written responses from email interviews, the researcher compiled data for use in the study.

Data Analysis

The researcher took substantial and accurate field notes during the interviews to reflect the responses from the participants. The reviewed field notes along with the transcripts of the discussions added to the understanding of the participants' comments. The recordings were reviewed with data as well as the field notes and emailed responses. All were analyzed and organized by historical sequence in a written document. Data must be selected, focused, simplified, abstracted, and transformed (Miles & Huberman, 1994).

The research questions for the study directed the analysis. The researcher analyzed all information by arranging it in chronological order as events unfolded in the establishment and implementation of the self-sustainable SBHC located in a school district in Western Arkansas.

The findings of the study are based on the analysis of the data provided by the stakeholders who participated. A discovery was completed concerning how stakeholders participated in the establishment and implementation of the SBHC. The results revert to the original research question and connect to the purpose of the qualitative case study that was to describe the establishment and implementation of a SBHC located on a school district campus in Western Arkansas.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

The origins of SBHCs date back to the early 1900s when the public health nursing movement began. Student absenteeism during the period was high due to communicable diseases like whooping cough, tuberculosis, scarlet fever, and measles (Vessy & McGowan, 2006). Nurse Lina Rogers, considered the first school nurse, helped organize treatment protocols and provided care to children in New York City schools. She and other nurses began the practice of home visits and provided health education about hygiene and methods for disease control to families. Due to her efforts, the student absentee rate in New York City decreased by almost 90% in 1 year and the need for school nurses became nationally recognized (Vessy & McGowan, 2006). The school nurse program has evolved since to include aspects of primary health care, immunizations, health screenings, and referrals (Gustafson, 2005).

SBHCs currently reach beyond the original concept of the school nurse program. However, the goal of improving the health of children remains constant. SBHCs across the country exist where primary health care, mental health care and education come together to maximize readiness for student learning. The combination allows vital resources to be readily available where children are housed at school. SBHCs place medical service providers in the school setting to help students avoid health-related absences, therefore, supporting opportunities for student academic success (NASBHC,

2012). A real movement to establish SBHCs in school districts across the country began in the late 1970s with the first centers opening in Dallas, Texas and St. Paul, Minnesota. According to The NASBHC (2012), there are over 1,900 centers in 45 states plus the District of Columbia. The SBHCs serve over two million young people nationally. The NASBHC (2008) conducted a census for 2007-2008 requesting data from all SBHCs for the purpose of providing a better understanding of the role of SBHCs in meeting the needs of underserved children and adolescents, collecting trend data among programs, and creating a national data base of programs. The Census identified clinics and programs connected with schools nationwide including three types of programs: school-based programs, mobile programs, and school-linked programs.

The NASBHC (2008) report identified that the 96% of SBHCs are located in a school building, 3% are in a separate facility on school property, and 1% are mobile in some manner. SBHCs are located in geographically-diverse communities, with 57% of the centers located in urban communities and 27% located in rural areas. The remaining 16% of SBHCs are reported to be located in suburban areas.

The setting for a SBHC varies across the nation concerning the location within a school. A majority (80%) of the programs serve adolescents in the sixth grade or higher while 17.3% report to serve in a K-12 setting (NASBHC, 2012). The various combinations of grade configurations of schools across the country create category-reporting problems. An additional category of other represents 20% of the settings for SBHCs across the country.

The students in schools with SBHCs are predominantly members of minority or ethnic populations who experience being underinsured, uninsured, or having other health

care disparities. Of the students served nationally, 36.6% are Latino, 29.5% are white, 26.2% are black, 4.4% are Asian/Pacific Islander, 1.7% are Native American/Alaskan, and 1.4% are identified as other (NASBHC, 2012).

Of the SBHCs, 365 report serving only children who attend the school(s) they serve, which is a decrease from 45% from the 2004-2005 NASBHC (2012) Census. The trend indicates SBHCs are expanding their ability to provide access to care to others in the community where the SBHC is located. Additional factors that may have influenced the trend include increased budgetary constraints and a weak economy combined with an expanded need for affordable health care. Patient populations served by SBHCs that serve beyond the student population in the school include students from other schools in the community (58%), out-of-school youth (34%), faculty and school personnel (42%), family members of students (42%), and other community members (24%).

SBHCs generally have sponsor organizations that serve as the primary administrative home. Typical sponsors for SBHCs are local health care organizations such as a community health center, local hospital, or local health department. Other sponsors include mental health agencies or nonprofit organizations. The NASBHC (2012) report that 12% of the SBHCs receive sponsorship directly from the school system.

Schools and school districts primarily support SBHCs through in-kind donations of space and services. In general, SBHCs do not have fiscal responsibility for construction and renovation (66%), maintenance and/or janitorial services (77%), uses (82%), or rent (93%) (NASBHC, 2012). The 2007-2008 NASBHC Census data identifies that 78% of schools in which SBHCs are located have a school nurse paid for by the

school district. Where both are present, 40% are located in separate facilities while 38% are co-located within the same health suite.

Mental health services in SBHCs are critical services offered for students. Of schools in which SBHCs are located, 82% have a school-employed mental health provider in the building–of these 67% are separate from the health center, and 15% are co-located with the health center (NASBHC, 2012). Additionally, 37% of SBHCs collaborate with the school to support students with health issues that influence the ability to learn and/or attend school. SBHCs support the academic success of these students by monitoring medication, reviewing medical records, assisting in implementing the Individualized Health Plan (IHP), and serving on the Individualized Education Plan (IEP) development committee.

SBHCs vary in hours of operation reported on the 2007-2008 NASBHC (2012) Census. The majority of SBHCs (95%) are open during normal school hours. The census shows that 60% keep the doors open after school, 49% before school, and 36% during the summer when school is not in session. SBHCs are typically open for more than 30 hours per week. Of these SBHCs, 67% report a pre-arranged source of after-hours care to assist students outside of normal SBHCs operating hours through an on-call service or referral to another health center.

Health Aspects of SBHCs in the U.S.

SBHCs across the country provide primary on-site care. Services include comprehensive health assessments, anticipatory guidance, vision and hearing screenings, immunizations, treatment of acute illness, laboratory services, and prescription services (NASBHC, 2008). Additionally, the census reported a variety of staffing models ranging

from a health care provider two hours per week up to seven full-time staff members operating daily. Regardless of the chosen model, a primary care physician was reported in all census responders. Of the staffing models reported in the 2008 Census, the most common models were broken down into three major types consisting of Primary Care (PC), Primary Care-Mental Health (PCMH), and Primary Care-Mental Health PLUS (PCMH+).

For the primary care model, the staff is composed of a nurse practitioner or physician assistant under the medical supervision of a physician. Other partners in the model may include dentists, audiologists, and optometrists. This model makes up roughly 25% of the models reporting to the NASBHC (2008) 2007-2008 Census. The majority of SBHCs are PCMH, making up 61% of the total clinics that reported. Mental health providers and primary care providers within one clinic staff the PCMH clinics. The final model is the PCMH+. This model is considered the most comprehensive considering the number of possible partnerships associated with the SBHC. The most common additions to the team makeup are health educator, social services manager, and nutritionist.

Mental health services play a significant role in SBHCs. Mental health and counseling services include mental health assessments, crisis intervention, brief and long-term therapy, family therapy, teacher consultation, and case management (NASBHC, 2008). These services provide quick response to students having crisis events or in need of mental health care services at school. A significant goal for mental health services for students is to shorten the duration of crisis events and increase learning time opportunities and overall academic achievement. Mental health services provided in elementary settings enable early identification of mental health needs of children with

behavioral issues and emotional needs. The opportunity for referral and treatment early on would include counseling interventions to children with behavior problems or dispensing and monitoring medication with behavior plans (Hutcherson & Johnson, 2006).

For middle and high school environments, mental health needs of students are addressed in much the same way as elementary environments but go farther because students can initiate mental health services. Mental health is a key area in the development of adolescent health for students who may deal with depression, suicide, or ongoing exposure to violence from multiple sources. A utilization study of SBHCs conducted in Baltimore, Maryland in 1996 identified other than general medical examinations, the most common reasons for a student to visit a SBHC was for mental health services or reproductive health matters (Borenstein, Harvilchuck, Rosenthal, & Santelli, 1996).

Oral health is a key component of general health and well-being for children and youth. Nationally, majorities of the SBHCs reportedly provide oral health education and dental screenings but are not able to address general or specialty dental care for students. The NASBHC (2008) National Census for 2007-2008 identified that 12% of the SBHCs report having a dental service provider on staff. Many SBHCs address student dental needs by contracting with practitioners for specific services like dental exams, cleanings, and sealants. Fewer than 10% of SBHCs provide general dentistry and less than 5% are able to provide specialty dental care to students.

Tooth decay is the single most common chronic childhood disease with over 50% of 5 to 9 year old children having at least one cavity or filling. Professional care is

necessary for maintaining oral health, yet 25% of poor children have not seen a dentist before entering kindergarten (U.S. Department of Health and Human Services, 2000b).

Almost 93% of the SBHCs across the country provide vision and hearing screenings to students. In many states, schools are required to provide vision and hearing screenings at specific ages for students. The Arkansas Department of Education (2006) Rules Governing Eye and Vision Screening Report in Arkansas Public Schools state in Rule 4.01 that beginning with the 2006-2007 school year, all children in pre-kindergarten (PK), kindergarten (K), Grades 1, 2, 4, 6, and 8, and all transfer students shall receive eye and vision screening.

Access to Care

Of the few studies conducted focused on SBHCs, common findings suggest that SBHCs can be an effective manner for health care systems to improve access to care and quality of care for underserved children. Children who have limited to no access to quality healthcare are considered a vulnerable population. The Agency of Healthcare Research and Quality identifies individuals who are vulnerable due to financial circumstances, place of residence, health, age, personal characteristics, functional status, developmental status, ability to communicate effectively, and presence of chronic illness or disability (Dorsey & Murdaugh, 2003). The Agency of Healthcare Research and Quality contends vulnerable populations are less likely to care for themselves and may incur different health outcomes related to unwanted disparities and barriers to care (Dorsey et al., 2003).

Defining vulnerable populations in terms of health disparity, the National Institutes of Health state there are populations where significant differences are identified

in the overall rate of disease incidence, prevalence, morbidity, mortality, and survival rates among specific population groups as compared to health status of the general population (Thompson, Mitchell, & Williams, 2006). Vulnerable populations are social groups who experience health disparities because of a lack of resources and increased exposure to risk (Flaskerud & Winslow, 1998; Flaskerud, Eesser, Dixon, Anderson, Conde, Kim,… & Verzemnieks, 2002). These groups also include high-risk mothers and children, non-English speaking individuals, people with AIDS, and homeless families (Aday, 1997).

SBHCs can be an excellent opportunity to provide a medical home for children who would otherwise have limited or no opportunity for health care access. Historically, a medical home is determined by the presence of a usual or primary source of care, such as a pediatrician or a family physician. However, The American Academy of Pediatrics emphasizes that a medical home is the best form of health care delivery for children and adolescents (Bethell, Read, & Brockwood, 2004). SBHCs at school where children are located provide easy access and opportunity for a potential medical home. With the recent healthcare expansion nationally, the definition of medical home has been expanded to include seven dimensions and 37 discrete concepts for determining the presence of a medical home for children (Bethall et al., 2004). A true medical home is a system of care that is accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective (American Academy of Pediatrics, 2002). Having a true medical home is important for children because research indicates there is a lower rate of hospitalization and emergency department use due to having access to better

preventive care and illness management (Cooley, McAllister, Sherrieb, & Kuhithau, 2009).

Children of poverty frequently have unmet physical and mental health care needs and are at the highest risk of not having regular health care maintenance or preventative care visits (Allison et al., 2007). SBHCs focus on meeting the health care needs of children by increasing access to sensitive and appropriate care. This whole-child approach includes mental health care as well as physical care. Increased accessibility and continuity of health care on the school campus makes the SBHC primed to diminish or eliminate health care disparities for impoverished children who attend school where SBHCs are located. Creating a familiar, consistent medical home for poverty students can help to eliminate potential barriers to success for students socially, emotionally, physically, and academically.

Benefits of SBHCs

Children and adolescents who have no health insurance coverage or are underinsured face a high risk of not having their medical needs met. This lack of opportunity for preventative health maintenance physically and mentally creates a difficult situation for poverty children, regardless of race. The majority of SBHCs in the United States work to provide the necessary services to combat the barriers of poverty on adolescent health. The SBHC services include comprehensive health assessments, vision, hearing, and other screening services along with immunizations. Additionally, mental health services are a key component of SBHCs across the country. For student mental health concerns, SBHCs are able to attract students with serious mental health issues.

SBHCs can play a significant role in meeting mental health needs that might otherwise go unmet (Amaral et al., 2011).

Health promotion and illness prevention are major targets for SBHCs for all students served by the schools where SBHCs are located. Great examples of illness prevention in SBHCs are the efforts to immunize students, staff, and families for influenza, tetanus, and hepatitis B. SBHCs participate with outside agencies such as State Health Departments to vaccinate children and adults often times at no cost.

SBHCs work to control dental disease, asthma, and obesity through effective counseling and health education programs. Oral health problems, like dental disease, account for an estimated 52 million missed school hours per year in the U.S. (U.S. Department of Health and Human Services, 2000b). Since most dental diseases are preventable, preventative visits with a dentist are essential for increased class time, improved oral health, and reduced expense for crisis dental visits.

With an estimated 10% of children in the U.S. diagnosed with asthma, SBHCs can play a major role in reducing absences by providing closer monitoring of the students with asthma, providing additional health education regarding asthma, and by having clinical care in close proximity to asthmatic children (U.S. Department of Health and Human Services, 2000a). Additionally, SBHCs have the expertise to provide health information to parents of students with chronic conditions to collaborate in the efforts for wellbeing of the children.

Obesity is becoming an epidemic among school-aged children, with one-third of youth in the U.S. being overweight, and rates are higher among minority youth (Ogden, Carroll, Curtin, Lamb, & Flegal, 2010). Of SBHCs across the country, 90% offer

nutrition, fitness, and weight management services to students, families, and staff members (Ammerman, 2010b). SBHCs are encouraged by results from the obesity prevention and treatment programs for overweight children. In addition to educational interventions and programs, SBHCs can offer medical evaluation and management of coexisting conditions, such as diabetes, dyslipidemia, and hypertension, which now appear to be affecting many of the youth today.

The Federal Maternal and Child Health Bureau define children with special heath care needs as having chronic physical, developmental, behavioral, or emotional conditions or run an increased risk for each. These children may also require health and related services beyond that required for children in general (Arango et al., 1998). SBHCs are ideal for servicing children with special health care needs who are mainstreamed into the regular public school setting due to the long-term care needed.

The conversation that develops over reproductive health of children is often met with passionate people who have opposite viewpoints. These political and regulatory differences have led to many different models within the SBHCs across the country. However, comprehensive reproductive health education is essential, especially in the middle and high school settings due to reproductive health visits being among the most common reason adolescents seek care at SBHCs (Allison et al., 2007). The availability of confidential services is attractive to teens using SBHCs (Barkauskas et al., 2007). Even with a majority of SBHCs being prohibited from dispensing contraceptives, almost 70% offer sexually transmitted disease diagnosis and treatment. Most SBHCs offer opportunities for preventive counseling to teens regarding sexually transmitted diseases

regardless of the policy on dispensing of contraceptives (Brindis, Geierstanger, Kaller, McCarter, & Soleimanpour, 2010).

Mental health is a significant service component of SBHCs across the country. A recognized gap in access for mental health services has been identified for children and adolescents. An estimated 20% of children and adolescents meet the diagnostic criteria for mental disorders, yet of those students, only one-third receive any treatment (Avenevoli et al., 2011). Children of poverty and minority students run a high risk for psychiatric issues, but are less likely to access care due to barriers such as no insurance or underinsurance for mental health services (Alegria, Pumariega, & Vallas, 2010). Children whose families qualify for public assistance or have no means to pay for treatment are two-thirds more likely than those who are privately insured to request mental health treatment from a SBHC. It is likely that these children would have no other alternative access to mental health services (Avenevoli et al., 2011).

With alcohol, tobacco, and drug abuse being a serious problem across the country, SBHCs can provide educational supports to arm students with knowledge to potentially prevent participation in these dangerous behaviors. The 2009 National Youth Risk Behavior Survey reported that approximately 26% of youth in Grades 9 through 12 reported current tobacco use (Jiang, Kolbe, Seo, Kay, & Brindis, 2011). More than 41% of students who took part in the survey admitted to current alcohol use, and 24% reported binge drinking. The report further stated that marijuana use was at almost 21% among the teens. Additionally, more than 22% of students reported being offered, sold, or given an illegal drug by someone on school property in the past 12 months. It is important to point out that the Center for Disease Control and Prevention's 2010 National Adolescent

Health Objectives must continue to address outcomes and identify additional avenues to reach the youth of today with effective intervention.

Tobacco and substance abuse counseling services are offered by more than 80% of the SBHCs mental health providers across the country as reported in the 2007-2008 National School-Based Health Care Census (Strozer et al., 2010). However, little research has been conducted on the implementation of alcohol and substance abuse treatment and counseling in SBHCs. This opportunity of counseling for at-risk children reinforces the potential impact that SBHCs could have on vulnerable populations whose access to these services would be restricted had the SBHCs not been easily accessible. SBHCs have the educational component to address counseling services as students have need.

Academic Performance/Outcomes

Since the NCLB (2002), academic accountability in K-12 education has dramatically increased. With the increased accountability, school districts have diligently sought increased academic performance of students. Recognizing that many outside influences greatly affect student academic achievement, school professionals continue to work toward eliminating barriers to student learning. These barriers include the basic health needs of the children that may be unmet, ultimately hindering academic performance.

Questions arise from across the country regarding academic success of students served in SBHCs and the contributions to support learning and academic outcomes. Some short-term measurable outcomes known to be positive for students served by SBHCs are an increased grade point average, reduced absenteeism, and reduced tardy rates (Gall,

Pagano, Desmond, Perrin, & Murphy, 2000). Additionally, comparisons of SBHC medical users and nonusers show that SBHC users attend school at higher rates than nonusers (Bruns et al., 2009).

A student being in class more often does not always translate into increased academic performance. However, it is logical that a student who spends quality time engaged in classroom learning activities has a better chance of academic success due to exposure than a student who is not present in the classroom. A study conducted in an urban district in Seattle, Washington, found that low to moderate use of services in a SBHC was related to one-third lower likelihood of high school students dropping out of school. The same study found that students not using the SBHC services lost three times the amount of time available for students to learn known as *seat time*, as students who utilized the SBHC services (Van Cura, 2010). These findings of the study suggest SBHCs have a direct impact on educational outcomes for students who use the SBHC.

Supporting learning is a goal for SBHCs beyond improved health related services to children. SBHCs support students by providing health related curricula to classrooms; conducting health fairs for students, staff and community; providing consultation to teachers and other school staff who support and address students' needs in the classroom (Brindis, Keeton, & Solimanpour, 2012).

Student Development

Not only do SBHCs impact student health and academics, but SBHCs also provide opportunities to expose students to healthy youth development and empowerment. The concept of youth development revolves around the ongoing growth process where youth are engaged in attempting to meet their basic personal and social

needs of feeling safe, cared for, valued, useful, and spiritually grounded. Additionally, youth look to build skills and competencies that allow them to function and contribute in their daily lives (Pittman, O'Brien, & Kimball, 1993). Youth advisory boards are one example of youth development where students are empowered to make recommendations on issues of program and policy development. For students, these opportunities provide a platform for meaningful conversation to take place about student health and school programs designed for student success. Identifying where students perceive services to be lacking or underutilized helps provide meaningful feedback to providers to define the true health needs of the students.

Other youth development opportunities that are offered by some SBHCs include peer health education and youth-led research programs (Brindis et al., 2012). These opportunities provide exposure for students to leadership and advocacy opportunities along with firsthand knowledge of health care careers being modeled by SBHC staff.

Funding Mechanisms and Sustainability

One of the biggest challenges beyond finding the right people to serve in a SBHC is securing the funding to develop, operate, and sustain a center. A financial study from Oregon regarding SBHCs identified the median initial start-up capital needed ranged from $49,750 to $128,250 (Nystrom & Prata, 2008). Center cost depends largely on construction and/or renovation variables. Additionally, the median annual operation budget ranged from over $90,000 up to $210,000, mainly to differences in services provided and the hours of operation of the SBHCs. The Oregon study identified that a fully functioning, year-round, SBHCs had an operating budget that exceeded $400,000 (Nystrom & Prata, 2008). In Colorado, SBHCs operate on average annual revenue of

roughly $287,000, which includes in-kind support and general revenue dollars (Colorado Association for School-Based Health Centers, 2011). Factors that affect costs include geographic location of the centers, types of schools where the centers are located, and depth of services offered in the centers. According to NASBHC's (2008) national census, SBHC clinics reported non-patient billing revenue sources: state government (76% of SBHCs), private foundations (50%), sponsoring organizations (49%), school or school district (46%), and federal government (39%). The 2008 census further reported that the majority of SBHCs bill public insurance programs, including Medicaid (81%) and the State Children's Health Insurance Program (SCHIP) (68%), private insurance (59%), and students or families directly (38%).

SBHCs appear to be popular and successful in the schools and area locations across the country. However, the centers face financial issues directly related to sustainability. The challenges stem from efforts to serve all students regardless of pay source and additional services provided that are not billable to insurance or Medicaid. Perceived sustainability issues could be a detractor for schools and health care providers from establishing new SBHCs. Roughly 1900 SBHCs exist across the United States supporting roughly 2% of the total number of schools (Strozer et al., 2010).

Many SBHCs student users have no insurance or medical coverage currently. Undocumented immigrant students and families served by SBHCs, not included in the US health care reform movement, will likely continue to use SBHCs as a primary source of health care. The SBHCs will have no pay source for these students and families creating a financial drain for the centers. Some insurance providers will not reimburse SBHCs for health services since the centers were not designated as a primary care

provider. Additionally, SBHCs often find it problematic to bill insurance because patients may have multiple public and private health care plans causing collections on billable services to be delayed. With billing sources being limited for reimbursement, the lack of cash flow often causes needed billing services to be too costly to employ. The SBHCs may find business office staff may not be adequately trained to pursue payment sources for the billable services. This inefficiency further reduces the SBHC ability to collect much-needed funds for sustainability.

SBHCs provide patient services beyond direct health care. These beneficial but non-billable services include case management, health education, and teacher consultation. If any reimbursement for treatment can be obtained, it is rare for the reimbursement to cover the actual costs of the provider (California School Health Centers Association, 2011). For financial security and sustainability for SBHCs, reimbursement from a pay source for health services provided is critical for future availability. SBHCs look for partners willing to provide alternative revenue streams outside of the regular medical billing of services. Successful SBHCs have diverse bases of benefactors in the public and private sectors willing to invest revenue to offset costs of the centers. For the SBHCs to find benefactors, the leadership must concentrate on the mission of supporting the whole-child. Additionally, SBHCs must keep copious records of services, provide quality communication to sponsors and benefactors, concentrate on confidentiality procedures and quality assurance, and build support for a state association devoted to networking and support. Working to support the efforts for seeking sponsors and benefactors will provide potential revenue streams outside of the SBHC normal stream of funding (Silberberg, 2002).

The new federal health care system expected for full implementation in 2014 is expected to change the dynamics of sustainability for SBHCs. Accountable Care Organizations will focus on management of chronic health conditions for individuals and the families they are responsible for serving. Health providers will receive payment for "bundled care" and disease management of illnesses, such as heart disease, asthma, and diabetes (Brindis et al., 2012). Providers will likely receive one payment for managing all aspects of a health care condition, from patient education through treatment. Incentives for improving service delivery may contribute to incorporating SBHCs as part of integrated care (California School Health Centers Association, 2011). If SBHCs become a recognized part of an ACO where documented delivery of care is focused on maintaining the health and well-being of participants, reimbursement from the health system may be a reality. SBHCs may seek funding from the Center for Disease Control and Prevention for preventative health set aside for reduction occurrences of tobacco use, diabetes, and teenage pregnancy (California School Health Centers Association, 2011).

In the changing arena of insurance coverage for medical care in the Health Information Exchange, health providers will be accountable for health outcomes of the patients they serve. Healthcare providers may opt for using electronic health records for participation in the Health Information Exchange. SBHCs may be able to use the information technology for collection and reporting of data for services and student-patient outcomes that use the SBHC as a medical home (California School Health Centers Association, 2011).

Sustainability of SBHCs is not only an obstacle for SBHCs, it is critical for long-term continued student services. Even with SBHC sustainability being questionable,

additional SBHC numbers have increased nationwide. The latest national census identified that over 50% of the SBHCs were 10 years or older. Additionally, 22% have been in operation between 5 to 10 years (Ammerman, 2010a). Even under difficult financial and social circumstances, SBHCs have continued to survive by supporting students and communities.

Medicaid accounts for roughly 41%, of health care coverage for low-income children while private insurance covers 34%. Unfortunately, an estimated 25% of low-income children have no health coverage. SBHCs are cost beneficial to both the Medicaid system and society and may close health care disparity gaps (Guo, Wade, Pan, & Keller, 2010).

For sustainability of SBHCs, effective billing practices must be a priority. Of the SBHCs that reported to the NASBHC (2012) 2011 Census, 87.9% reported billing at least one insurance program. Over 81% reported billing a state Medicaid agency, and 71% reported billing a Medicaid managed care organization. The Children's Health Insurance Program was billed by 63% of SBHCs that reported while only 64% billed private insurance companies. Of SBHCs, 40% bill Tri-Care, the health care program serving active duty, National Guard, Reserve, and retired military, their families, and survivors (NASBHC, 2012).

Managed Care Organizations are important regarding potential reimbursement opportunities for SBHCs. Of the SBHCs that reported to the 2011 NASBHC (2012) census, 47% are recognized as primary care providers or preferred providers. Being a primary care provider provides an opportunity for children with no medical home to have critical access to one.

Nationally, SBHCs receive revenue from sources that include some form of state government funds 74.7%, the federal government 53.4%, private foundations 40.4%, school districts 33.1%, hospitals 32.6%, city or county governments, 32.3%, managed care organizations or private insurers 27.4%, businesses 18.4%, NASBHC 6.6%, state networks or associations 5.1%, and tribal governments 1.1% (NASBHC, 2012). Without billing opportunities for services provided to a pay source and outside funding beyond those services, sustainability of the SBHCs may be in question. Little published data exist on Medicaid funding of SBHCs, with even less related to mental health billing in schools.

SBHCs face significant barriers that could affect the potential success of the partnership necessary between Medicaid funding and SBHC existence. The relationship between pay sources and services that can be offered at a SBHC is significant. SBHCs offering mental health services may not be able to access reimbursement through Medicaid or to bill private insurance due to licensing complications. However, SBHCs can receive Medicaid funds by providing health-related services intended for special education under IDEA.

For low-income children, private insurance covers approximately 34%; 25% are underinsured, and 41% are covered by Medicaid (Robinson, Barrett, & Tunkelrott, 2000). For mental health programs in SBHCs, the federal government is a substantial funding resource. One of the most significant funding opportunities through the federal government was the Safe Schools/Healthy Students initiative. It began in the late 1990s due to a national response for preventing school violence.

The U.S. Department of Education, the Department of Health and Human Services, and the Department of Justice collaborated to provide grants to establish mental

health programs, with emphases on violence prevention, healthy childhood development, and resilience. In the first decade of the program, the federal government invested more than $600 million in the Safe Schools/Healthy Students Program (Weist et al., 2003). The Healthy Schools, Healthy Communities Program, administered by the Health Resources and Services Administration, is the second source for SBHC funding. Healthy Schools, Healthy Communities began in 1994 from a grant through the Bureau of Primary Health Care to encourage the development of comprehensive, full-time, school-based primary care programs that serve high-risk children (Weist et al., 2003). It was the initial federal program to financially support creating SBHCs and now is the primary source of funding for SBHCs with $17 million allocated to support the centers in 2001 (Weist et al., 2003). SBHC funding is used to support a wide range of programs with most including prevention-oriented topics such as fitness programs, violence prevention, wellness promotion, parenting groups, and self-esteem enhancement.

Federal funding for mental health programs in SBHCs include Title V Maternal and Child Health Block grant, Title XI funds for disadvantaged youth, the Title XX Social Services block grant, and the Preventive Health and Health Services block grant (Allison et al., 2007). The federal block grants for SBHCs allow for discretion at the state level for addressing the documented need in the state (Allison et al., 2007).

Several states use state general revenue to provide financial support for SBHCs. In Arizona, Massachusetts, Florida, and Louisiana, tobacco taxes, and funds from tobacco settlements provide funding for SBHCs while some other states have used a supplemental sales tax to help support SBHCs (Weist et al., 2003). Beyond federal and state funding, private and local funds are an important source of funds for SBHCs.

Private funding is important for the growth and development of SBHCs across the country. Foundations are the most significant private funding source of school mental health programs. The Annenberg Foundation gave a large grant to the Coalition of Essential Schools through the Los Angeles Unified School Districts while the Duke Endowment has financed planning and start-up costs for SBHCs in North Carolina (Pachter, 1994). The Robert Wood Johnson Foundation has played an important role in financing SBHCs across the country. The Robert Wood Johnson Foundation's early funding program called *Making the Grade* in the 1990s focused on assisting states to develop financial and development strategies to foster replication of SBHCs. The program provided funding for SBHCs (Lear, 2002). Even though the program no longer exists, the fundamental elements still exist within the Robert Wood Johnson Foundation. Another foundation that has national prominence in support of SBHCs is the Kellogg Foundation. This foundation has provided significant support to SBHCs through its support of the NASBHC. The NASBHC (2008) is a membership association that focuses on advocacy, training, and technical assistance to advance school-based health care. These private sources of funding, while important, provide no long-term solution for financial sustainability.

SBHCs in Arkansas are supported by grants made available through the Arkansas School-Based Health Center Grant made possible and supported by Arkansas' Governor Mike Beebe and the Arkansas Tobacco Excise Tax created by Arkansas Act 180 of 2009. The grant funds are to be used to promote health, wellness, and academic achievement in Arkansas' public schools. The Arkansas Department of Education Office of Coordinated School Health, Arkansas Department of Health, Arkansas Department of Human

Services, Arkansas Center for Health Improvement, Arkansas Children's Hospital, and Arkansas Medicaid In the Schools all collaborate to provide a funding stream to schools to support student health. These funds are used to support student health that may otherwise not be addressed due to lack of resources or isolated location of the students served by the SBHC.

All Arkansas public and charter schools are eligible to apply for the Arkansas Department of Education grant. The Arkansas Department of Education grant operates on a 5-year funding cycle. The Arkansas Department of Education may fund only one SBHC per district during the initial 5 year funding cycle. The grant funds $150,000 over a 5-year period. The SBHC grant recipients will receive an annual distribution of funds for a 5-year period, decreasing amounts each year. Annual renewal is based on a review of annual progress and appropriation of Tobacco Excise Tax funding (Arkansas Department of Education Office of Coordinated School Health, 2013).

Partnerships

Throughout the United States, SBHCs are seen as key strategic partners for providing vital access to health care for children. In order for the SBHCs to be a success, multiple partners are needed to have the opportunity to attain sustainability. It takes a collective assortment of committed people to maneuver the difficult aspects of the establishment of a SBHC. In Arkansas, SBHCs provide basic physical, mental, dental, or other services as needed. In order for these services to be offered, medical providers must be willing to serve in some capacity within the SBHC. Arkansas SBHCs are required to maintain working relationships with physicians of children with medical homes. This

relationship ensures that individual patient health plans are executed effectively and efficiently (Arkansas Office of Coordinated School Health, 2013).

School boards and school administrators must be willing to invite medical providers to partner and serve students on a school campus. All stakeholders must work cooperatively within the school setting to become an integral part of the school. The SBHCs may employ a multidisciplinary team of providers to care for the students: nurse practitioners, registered nurses, physician assistants, social workers, physicians, alcohol and drug counselors, and other health professionals (Arkansas Office of Coordinated School Health, 2013).

Future Implications and Policy

SBHCs provide access to physical and mental health services for children, affecting their ability to succeed physically, emotionally, socially, and academically. SBHCs are operating in a critical time in history with the implementation of the Affordable Care Act. If the SBHC model is to meet the full potential and promise, all stakeholders must come together to support the expansion, enhancement, and sustainability to serve students at the highest level.

The role of SBHCs is to improve health and social outcomes directly for children and to reduce health inequities overall. Throughout the country, SBHCs are a key strategic partner in providing critical access to health care for youth. There are chronic conditions affecting many students that may negatively influence academic performance. The SBHCs provide prevention education, screening, diagnoses, and disease management. SBHCs may create an ideal environment to educate students on a comprehensive level in which medical, mental health, and school professionals can all

work together to prevent or manage these difficult medical conditions (Brindis et al., 2012).

SBHCs provide a special platform for program and policy development considering the blended location within a school. Developing prevention and early intervention systems to serve students, families, and the school-based workforce is important for overall improvement of the community down to the individual. There are opportunities for increasing outreach through SBHCs for prevention education, early screening and detection, as well as continuity of care to include chronic care disease management (Brindis et al., 2012).

CHAPTER III

METHODOLOGY

SBHCs across the United States may not all look the same, have the exact same functions, or have the same funding mechanisms, but each strives to meet the health care needs of the students served. Students need must be an important piece of determining the overall health for students to be offered an optimal learning environment.

Central Question

What was the development process of the self-sustainable school-based health center for a school district located in Western Arkansas?

Subquestions

- What circumstances prompted the development of the school-based health center?
- What legislation aided the development of the school-based health center?
- What funding sources were used to help establish the school-based health center?
- How did the development process unfold in the school district?
- Who were the people involved and what roles did they play in the process?
- What structures in the school influenced the decisions made both positively and negatively?

- What structures in the community influenced the decisions made both positively and negatively?
- What were the outcomes from the process for school personnel, students, and community?
- What was the satisfaction level for the stakeholders with the outcome?

This chapter presents the methods and procedures used in the study, divided into six sections: research design, sample, instrumentation, data collection procedures, analytical methods, and limitations.

Research Design

Qualitative research was used for the study of the development process of a self-sustainable SBHC for a school district located in Western Arkansas. Qualitative research uses an inquiry process that provides the researcher understanding of social or human problems accurately (Creswell, 1994). The participants in the development process of the SBHC described their role, responsibilities, and experience through the development and implementation of the medical clinic. Qualitative research relies heavily on the inductive model of the scientific method, with the major objectives being exploration or discovery (Johnson & Christensen, 2008). The research revealed the process that led to the establishment of the self-sustaining SBHC in Western Arkansas.

A case study was used to create an understanding of what factors affected the development of the SBHC in Western Arkansas. The study design helps to describe an object or picture using words taken from details provided by participants. This design is a proven way to create understanding of the research (Creswell, 1994). When using multiple subjects, descriptive research is important (Bogdan & Biklen, 2007).

A qualitative case study approach was useful because the interaction with participants enabled the capture of quality information (Creswell, 1994). Inductive investigation enabled the emergence of common themes through the information shared. The inductive process is useful in exploring topics not fully known (Piccardi, 2005). The historical review and timeline emerged through the interviews conducted with the participants helped simplify the complexities of the investigation.

Interviews of Participants

Interviews were conducted with participants face-to-face and through email correspondence. The interviews were focused on the role the participant and how he or she assisted in the establishment and ultimate implementation of the SBHC in a school district in Western Arkansas. The researcher used the interview data to examine the beliefs, attitudes, and inner experiences of the respondents (Gall, Gall, & Borg, 2003). Additionally, two focus group interview sessions were conducted. The focus group interviews were segmented into two distinct groups: state SBHC officials comprised of Arkansas Department of Education and Arkansas Department of Education Health employees, and local SBHC officials comprised of local school district representatives, local city government officials, and the local medical providers. The use of focus groups in research has increased over time to gather in-depth information in a relatively short period (Johnson & Christensen, 2008). Focus groups allow participants to state perceptions more freely than one-to-one interviews due to the stimulation of interactive dialogue (Gall et al., 2003).

Interview guides were developed for the face-to-face interviews and focus group interviews (Appendix A), along with a checklist that helped to define the role each

participant aided in the development of the SBHC (Appendix B). The researcher asked the participants to explain all responses.

Sample

In the selection of the participants, the researcher focused on participants identified by a stakeholder who was a member of the local school board, as the key participants in the development and implementation process of the SBHC. As employed in this study, a single-category focus group picks information-rich participants to the extent that they have a significant degree of knowledge in the topic (Krueger & Casey, 2009). In this case study, the participants chosen were separated into two specific groups: Arkansas SBHC officials charged with funding and oversight of SBHCs in the state, local city officials, school district policy makers, school administrators, and the health care providers involved in the implementation of the SBHC at the local level.

The researcher emailed and telephoned potential participants to invite them to participate in the study. The researchers invited each participant to participate in individual interviews along with the categorized focus group interviews. A follow-up letter was mailed inviting the participants to confirm the date, time, and location of the scheduled group interviews and times for the individual interviews (see appendix D). As an incentive to participate in the study, a copy of the forthcoming summary was promised along with eligibility to win a $25 gift card.

One week before each interview, a follow-up calendar invitation was sent by an Internet Gmail System for the participants to accept or decline. If declined, an email was sent to reschedule the interview for a better time for the participant. One day prior to the interview or focus group interview and on the day of the interview, the Internet Gmail

System sent an alert reminder to each participant. Before joining focus group discussions and individual interviews, participants signed voluntary informed consent forms (see Appendix C.)

Instrumentation

Before data could be collected, the researcher designed a question protocol (see Appendix A). The question protocol provided direction and alignment to the research questions. General questions were asked early in the interview protocol with more specific questions placed in the later sequence. The tactic of question placement is recommended for improved consistency and clarity for data analysis (Johnson & Christensen, 2008). The question protocol was used to assist the discussion process for focus and clarity. For purposes of validity, the researcher listened and documented participant remarks seeking clarification when responses were unclear. At the end of each interview and focus group, the researcher asked each participant to summarize his or her comments (Krueger & Casey, 2009).

The researcher followed accepted protocol by using a checklist of individual interviews and focus group interviews. Krueger & Casey developed the checklist for obtaining trustworthy and accurate results. Giving advance notice of focus group sessions, developing and practicing questions, planning and scheduling of logistics, practicing moderator skills, and debriefing after each session were included in the protocol (Kruger & Casey, 2009).

Data Collection Procedures

Data were secured from two focus group interviews and individual interviews of participants. The researcher was the moderator of group and individual interviews.

Additionally, the researcher was the primary instrument for collecting data and the avenue kept individuals in the group focused on the topic. In the interviews, the researcher collected information regarding the participant's thoughts, beliefs, knowledge, reasoning, motivations, and feelings concerning the topic (Johnson & Christensen, 2008). Participants were encouraged to share their insights regarding the role they played in the establishment of the SBHC. For the focus group interviews, the researcher encouraged participants to describe their individual experiences, listen to others, and respond to each other to maximize data collection by the researcher. The format of questioning helped the researcher have control in obtaining detailed answers (Creswell, 1994).

During the question and answer process, the researcher made judgments about significant points in the information and made field notes during each interview session. Each focus group session was documented in a similar manner with reflective follow-up notes being scribed following the session (Patton, 1990).

The interviews and group discussions took place at times and locations convenient for participants. The researcher was responsible for locating a meeting place suitable for discussions (Krueger & Casey, 2009). Additionally, Krueger and Casey (2009) identified a recommended group size of five to eight participants. For this study, the focus group size was six, eight, and five participants. All participants were interviewed individually face-to-face or by email prior to focus group discussions.

Each of the focus group discussions were videotaped. All participants were strategically placed in the room to maximize the capacity of the audio and video equipment to pick up responses clearly. The participants were assured that the audio and video of the interviews were to strictly be used to accurately document each individual

response. All participants were assured that the audio and video were confidential (Krueger & Casey, 2009).

Questions from the moderator's protocol were asked by the researcher to the participants in a conversational manner. As participants shared thoughts, discussion flowed in a natural manner. However, the moderator kept the discussion focused using probes and pauses as appropriate. The moderator kept the group progressing from question to question until the completion of the focus group discussion (Krueger & Casey, 2009).

For data accuracy in the collection process, the moderator provided a summary of the discussion at the close of each focus group session (Krueger & Casey, 2009). Validity of the content was ensured by allowing the participants to clarify or verify the data collected by the moderator.

Analytical Methods

An assistant moderator took field notes during the two focus group meetings. The field notes and video recordings were reviewed for analysis by the researcher. During the review process, the field notes were compared to the video recordings for accuracy. The researcher analyzed the responses into identifiable, concrete, historical data suitable for reporting (Krueger & Casey, 2009).

The central research question and subquestions guided the analysis for the qualitative research study. The researcher systematically arranged the data collected. In sorting the information from the interviews, a description of steps to establish a fully functional SBHC emerged. The descriptive information was converted to a narrative format with the use of a data display to connect the two focus groups' questions to the

research questions. This systematic conversion to a visual format helps the researcher draw valid conclusions and take needed action (Miles & Huberman, 1994).

A written report was organized and developed by conceptual coherence of the data gathered for the central research question and subquestions to properly report the data, using strategies that stated the analysis clearly and effectively (Krueger & Casey, 2009; Miles & Huberman, 1994). For the purpose of the study, the researcher presented and communicated revealed data (Patton, 1990). The resulting descriptive narrative for the case study identified the historical process for developing and implementing the self-sustainable SBHC in a rural school district in Western Arkansas (Krueger & Casey, 2009; Miles & Huberman, 1994).

Limitations

There are limitations to this qualitative case study. The researcher was the former superintendent at the school district where the SBHC was developed and implemented was a threat to the internal validity of the study. Assurances of no harm to the participants from the researcher may not have rested the apprehension of the participants to answer openly and without reserve during the interview process. The researcher recognizes the participants' desire for the SBHC to be a success and a model for others to follow.

Unintended assumptions by the researcher are an additional limitation of the study. The researcher made a conscious effort to refrain from making assumptions, but professional relationships to each of the participants and deeply imbedded determination to develop a sustainable SBHC model in the school district in Western Arkansas may have influenced the researcher to make certain unintentional assumptions. The

unintentional assumptions could be based on the knowledge of the school district, local governance, and the Arkansas Department of Education SBHC funding mechanism.

The small sample of participants could be considered a limitation of the study due to the specific nature of the roles each participant had in establishing the SBHC. Furthermore, the bias of the researcher that basic health needs must be met first for children to fulfill their potential and promise academically could be considered a limitation.

Finally, it must be acknowledged this study was a historical narrative of how the SBHC was developed and implemented to meet the needs of the school district and the community in Western Arkansas. Other communities and school districts could have additional needs or resources creating a different SBHC model to be most appropriate for application.

CHAPTER IV

RESULTS

This qualitative study focused on describing the development process of a self-sustainable SBHC for a school district in Western Arkansas. Focus group interviews with the participants involved in the establishment of the SBHC in a school district in Western Arkansas provided rich qualitative data to describe the process from developmental policy through daily operations of the SBHC. This research addressed one central question and nine subquestions.

Central Question

What was the development process of the self-sustainable school-based health center for a school district in Western Arkansas?

Subquestions

- What circumstances prompted the development of the school-based health center?
- What legislation aided the development of the school based health center?
- What funding sources were used to help establish the school-based health center?
- How did the development process unfold in the school district?
- Who were the people involved and what roles did they play in the process?

- What structures in the school influenced the decisions made both positively and negatively?
- What structures in the community influenced the decisions made both positively and negatively?
- What were the outcomes from the process for school personnel, students, and community?
- What was the satisfaction level for the stakeholders with the outcome?

The research question and the nine subquestions were developed to identify important details regarding the development and implementation of the SBHC located in a school district in Western Arkansas. The informants supplied detailed information that created an accurate historical description of the development and implementation process.

Data Collection

The data for this research were gathered from participants involved in the development and implementation process of a SBHC in a rural school district in Western Arkansas. Two focus group interview sessions were conducted. The focus group interview sessions were segmented into two distinct groups: state SBHC officials comprised of employees from the Arkansas Department of Education, Arkansas Department of Health, and local SBHC participants, comprised of local school district administrators and school board members, local city government officials, and the local medical providers practicing within the SBHC. A standard protocol which elicited rich qualitative data from the participants was used for each group (see Appendix A).

The questions asked in each focus group were designed to elicit thoughtful responses from participants involved with the formation of the SBHC in a school district in Western Arkansas. The open-ended questions addressed the central research question and nine subquestions of this study. Participants were able to answer the questions, decline to answer the questions, elaborate on other's responses, have differences of opinions, and share any opinions. It was explained to participants there were no right or wrong answers.

Characteristics of Sample

All participants in the focus groups were all directly involved in the establishment of the SBHC in a school district in Western Arkansas. Two focus group meetings were held with a total of 17 participants. The participants were from two distinct groups who were instrumental in the establishment of the SBHC in a school district in Western Arkansas. Eight females and nine males participated in the interviews. All participants had a direct interest in the successful founding of the SBHC in a school district in Western Arkansas.

Results

Research Subquestion 1: What circumstances prompted the development of the SBHC?

Responses to focus group Questions 1, 2, 3, and 5 indicate that multiple circumstances were evident that prompted the development of the SBHC in a school district in Western Arkansas. Factors that participants in this study perceived as affecting the development of the SBHC include:

- Legislative policy makers, committed advocacy groups, and state agencies worked collectively to provide an opportunity through permissive legislation for guidance and funding to establish and support SBHCs.
- The local school board, school administration, and community leadership recognized the need to improve student, staff, and community health and worked together to provide on-campus access to high quality healthcare.

Circumstance 1: State policy makers, state agencies, and advocacy groups worked to formulate policy to allow for the establishment of SBHCs in Arkansas. As the state office of Coordinated School Health within the Arkansas Department of Education grew stronger statewide, the relationships with internal and external partnerships also became stronger. As a state collaborative, the Arkansas Department of Education office of Coordinated School Health assisted school districts by implementing the eight components of Coordinated School Health. The Arkansas Department of Education office of Coordinated School Health was designed to promote overall student health from physical education to health curriculum and culminated in offering competitive grant opportunities for school districts to establish SBHCs.

As a state collaborative, the Office of Coordinated School Health joined together to begin seeking areas where school districts could improve. One state level participant stated, "The Office of Coordinated School Health initiative brought forward for the state the eight components of Coordinated School Health which are: Health Education, Physical Education, Health Services, Nutrition Services, Counseling, Psychological, Physical Services, Healthy and Safe School Environment, Health Promotion for Staff,

and Family Community Involvement. SBHCs play a significant role in each of the eight components with the primary focus on health services."

Participants from the state-level focus group commented Arkansas has a low number of children receiving yearly well-child checkups with many having no medical home. The only medical services many children receive are when they encounter a more serious illness causing their family to have a more costly emergency room visit. Recognizing the inefficiency and need to improve the system, the Office of Coordinated School Health, Arkansas Advocates for Children and Families, Arkansas Children's Hospital, Arkansas Departments of Health, and Arkansas Department of Human Service, Child Health Advisory Council, and other groups collaborated to address this concern. The premise was to improve the whole child through education, advocacy, and health services. Study participants viewed SBHCs as a win-win for students, families, schools, and communities. The SBHC provide high-quality medical access to populations who have been historically underserved. With SBHCs being established in schools, a trusted location within a community, the medical centers almost have instant credibility among community members.

Circumstance 2: The local school board, school administration, and community leadership recognized the need to improve student, staff, and community health and chose to work together to provide access to high quality healthcare on school campuses. The school board, focused on improving opportunities for the whole-child, amended board policy to incorporate additional aspects to focus on meeting the health needs of children. The vision of the school board and superintendent revolved around positive influence of the factors that support the whole-child, whole

family, and whole-community health initiative. To begin the process, the school board passed a resolution to become a Coordinated School Health district and align policy to meet or exceed the criteria set forth by the Arkansas Department of Education regarding student health. The board passed a water only vending policy, encouraged the school district food service director to pursue the Healthy US Challenge Bronze Award for the child nutrition program, and challenged the superintendent to improve student achievement, student and staff health and wellness, and to create an avenue for the district to become the central focus of the community. Each of these efforts supported the focus of the board, which was to improve overall student achievement.

The school district formed a district wellness committee and assessed the community regarding health services available. The committee found the community was underserved regarding medical access. The ideology of meeting the needs of the whole-child evolved to meeting the needs of the whole family and whole community. Coordinated School Health was a catalyst to improve student achievement and the school district sought to establish additional supports by providing services to those that cared for children, parents, and community.

One participant viewed the school district as proactive in searching for ways to provide students additional opportunities for success both in and out of the classroom. The participant stated, "The school worked for grants and awards of excellence in nutrition and also worked to provide an increased amount of physical activity for the students." The participant also stated, "When an opportunity arose for the potential to have access to medical care in the school, there was never any hesitation by the school board."

Research Subquestion 2: What legislation aided the development of the SBHC?

Responses to focus group Question 1, 2, 3, and 4 indicate multiple circumstances were evident that prompted the development of the SBHC in a school district in Western Arkansas. The most significant factor that allowed the establishment of the SBHC came directly from legislation with support of the Governor of Arkansas in providing financial resources. The state and local participants in this study perceived legislation affecting the development of the SBHC to include:

- A legislative focus on student health from ACT 1220 of 2003 that began the impetus for adopting the eight components of Coordinated School Health.
- The Governor provided funding from ACT 180, otherwise known at the Tobacco Excise Tax, making funding available for SBHCs. The Arkansas Department of Education used the Office of Coordinated School Health to promote health and wellness in public schools across the state.
- The office for Joint Use Agreements was created within the Arkansas Department of Education to distribute tobacco excise tax funds in the form of grants for schools to begin and establish a SBHC in their district.
- Due to the implications of NCLB (2002) and the reauthorization of Elementary and Secondary Education Act (ESEA), school boards and administrators across the state became motivated to look for creative ways to improve student achievement. This motivation identified student health as a significant indicator in student achievement. If students do not come to school ready to learn, achievement could be limited.

Question 2 describes legislation that aided in the development of the SBHC. The participants analyzed the sequence and importance of the legislation in Arkansas that provided the foundation for the self-sustainable SBHC in a rural school district in Western Arkansas.

Legislation 1: Arkansas ACT 1220 of 2003, was the original force to improve student health across the state. Participants reported Arkansas legislation provided the impetus for the Arkansas Department of Education and school leaders to focus on overall student health across the state to address the whole child. In April of 2003, Act 1220 was passed by the Arkansas General Assembly and signed into law. The Act created a comprehensive plan to combat childhood obesity in the state. The Act called for an annual body mass index (BMI) screen for all public school students, with the resulting reports sent to parents. Additionally, the Act restricted access to vending machines in public elementary schools and required disclosure of any vending contracts with food and beverage companies. One of the most important aspects of the Act for local school districts was the creation of the advisory committees made up of parents, teachers, and local community leaders focused on improving student health.

Prior to the establishment of the SBHC in the rural school district in Western Arkansas, the small community offered no local medical services. A SBHC was perceived as meeting a true need for the children, staff, and community patrons of the district. As part of the overall plan to follow school board policy, improve academic achievement, and address the whole child health needs of the students of the school district, the school board directed the school administration to find state and local partners to meet the challenge.

Legislation 2: Arkansas ACT 180 made funding available for SBHCs. The Arkansas SBHC grant is a competitive application process made possible and supported by the Arkansas Governor and the Arkansas Tobacco Excise Tax created by Arkansas Act 180 of 2009. The grant funds are for promotion of health, wellness, and academic achievement in Arkansas' public schools. The program is a collaboration of the Arkansas Department of Education Office of Coordinated School Health, Arkansas Department of Health, Arkansas Department of Human Services, Arkansas Center for Health Improvement, Arkansas Children's Hospital, and Medicaid in the Schools. All Arkansas public and charter schools are eligible to apply for funding as available. School districts are limited to one SBHC grant every 5 years. Applicants intending to create a new health center on school campus currently may apply for up to $500,000.

SBHCs grant recipients receive an annual distribution of funds over a 5-year period with decreasing amounts paid to the district each year. To have annual renewal, a school district must meet annual progress goals established by grantor. Additionally, the legislature must appropriate funds from the Tobacco Excise Tax for grant funding. Grantees must adhere to the School-Based Health Center Grant Guidelines, the Arkansas School-Based Health Center recommendations, and the Arkansas School-Based Mental Health Manual.

Legislation 3: Federal legislation: No Child Left Behind (NCLB) or Elementary and Secondary Education Act (ESEA). Searching for ways to improve academic achievement to meet the federal educational achievement mandates known as NCLB or ESEA, school administrators identified a potential link between student health and student achievement, especially among poverty students. Due to the implications of

the federal mandate, school administrators across the state began to look for creative ways to improve student achievement. School leaders recognized the significance that student health was a featured role in whether students came to school ready to learn on a daily basis. School administrators and school board members recognized health disparities influence student academic achievement. School administrators recognized student access to health care was a significant barrier to maintenance of student overall health.

Research Subquestion 3: What funding sources were used to help establish the SBHC?

The state officials who took part in the focus group identified that within ACT 180, Arkansas SBHCs were included in general revenue as a line item to receive monies through a competitive grant process. These grants were dispensed to school districts for implementation of SBHCs on a school campus. The funds granted are for promoting health, wellness, and academic achievement in Arkansas public schools. The program is a collaboration of the Arkansas Department of Education, Office of Joint Use Agreements, Office of Coordinated School Health, Arkansas Department of Health, Arkansas Department of Human Services, Arkansas Center for Health Improvement, Arkansas Children's Hospital, and Medicaid in the Schools. All Arkansas public and charter school districts are eligible to apply unless the district has an active SBHC grant. Question 4 describes the importance of funding sources for establishing the self-sustainable SBHC in a school district in Western Arkansas.

Funding Source 1: ARSBHC Grant. The school district accessed the original Arkansas SBHC pilot 3-year grant of $525,000. The original grant was distributed in

equal installments of $175,000 per year over a period of 3 years to assist in the establishment of the SBHC. The grant required specific aspects to be addressed with the grant funds. The approved expenditures of grant funding included employing a fulltime Coordinated School Health Coordinator, a full-time SBHC Registered Nurse, and employ or contract with a full-time licensed Mental Health Professional. Allowable expenses from grant funding for purchasing or upgrading equipment to support a SBHC along with providing in-state travel expenses for training and workshops and basic remodeling expenditures. The grant funds would not allow for construction of standalone projects that were considered brick and mortar expenditures. If a school district has a specialized need, a request could be submitted to the SBHC team for approval. At the end of a fiscal year, if SBHC funds were not fully expended, carryover funds had to be justified for approval and fully budgeted in the next fiscal year budget.

Funding Source 2: ARSBHC Sustainability Grant. At the culmination of the original grant, the district was awarded a $250,000 sustainability grant to expand the services of the SBHC. The sustainability grant was funded for $100,000 in Year 1, $80,000 in Year 2, and $70,000 in Year 3.

The school district in Western Arkansas was originally only able to offer three medical services to the students and community members of the district. The focus for the students was mental health, physical health, and dental health. The sustainability grant allowed the district to expand the facility to incorporate space for an optometrist and improve the space for the mental health therapists.

Funding Source 3: Delta Dental Grant. The district applied for a Delta Dental grant to expand services for the dental provider. According to school district officials, the

grant provided $26,000 to purchase dental equipment for a dental office. The district collected a total of $801,000 in grant funding for the establishment of the SBHC. However, even though the amount of grant funds was significant, the district opted to use local building funds for much of the renovation costs that were not allowed as qualified expenses of the grant. During the initial 3-year implementation, the school district in Western Arkansas expended funds of approximately $50,000 from the operating fund.

Funding Source 4: Donations. A tax-exempt, non-profit corporation designed for charitable purposes provided medical equipment and supplies to the school district at no cost. The estimated donation of equipment and materials exceeded $100,000 value.

Funding Source 5: Third party reimbursement for provider sustainability. The medical providers rely on third party reimbursement for most medical services and expenses. The third party providers include Medicaid, Medicare, and most insurance network carriers. The school district grant does not reimburse medical providers for services rendered to any patient.

Research Subquestion 4: How did the development process unfold in the school district?

Each school district under Act 1220 of 2003 was required to have a wellness committee to begin building capacity and to create a strong foundation within the district. The wellness committees are to incorporate administrators, school board members, teachers, parents, school nurses, and community members. The wellness committees are charged to use the School Health Index, a Center for Disease Control assessment tool, in all school buildings, which would be reported to the wellness committee. The

committee's role was to evaluate the district's strengths and weaknesses associated with each of the components of the eight components of Coordinated School Health.

A school district's wellness committee was to meet regularly and review the district's progress toward meeting the eight health components. According to school district officials, significant improvements were made to the policy, practice, curriculum, and the nutrition program. These improvements were directly linked to the recommendations made from the work of the local school district wellness committee.

A participant of the focus group who also served on the district wellness committee recalled that the committee was successful in helping overall to mold school district policy toward improving student health. However, the participant expressed the committee could do more to support students at the level of the individual child. Another participant in the study who served on the CSH Wellness Committee stated, "The school was doing all it could do at the time to address the needs of the children while they are at school, but the real needs result from when the children are not at school… this is a parental issue. The real issue is the disparity between the students that have access to quality healthcare with those that have no access to any kind of healthcare." Question 4 describes the development process that unfolded in the district for the establishment of the SBHC in a school district in Western Arkansas.

Development 1: The district wellness committee recognized that the students of the district had health disparities. The local district wellness committee discussed ideas and developed a plan for the school and community partners to improve the quality of life for the students served in the district. The group branched out to include representatives from the county health department, health advocacy groups, and state and

local policy makers. Bringing in experts from the field together with local policy makers provided opportunities to have authentic discussions about issues schools and families face in educating children to meet their full potential and promise. These discussions provided the catalyst for the district leadership, community leadership, and state-level leadership to act to improve vital offerings for children and families.

According to the local community focus group, the district in Western Arkansas moved to set up opportunities to screen student vision and hearing beyond the state required screenings along with having dental exams and sealants for students. During these partnership opportunities, the medical providers were able to address the needs of the students who were not receiving medical services that was beyond their control. These partnerships with medical providers identified a large number of the children in the district who were not receiving the basic medical services necessary to maintain minimum student health needs. Students belonging to families with financial means were receiving the necessary health services, but those from poverty were not, except for the occasional health crisis event.

Development 2: The superintendent proposed to the school board that the district apply for the SBHC grant to attempt to address the unmet health needs of students identified by the Coordinated School Health and Wellness Committee. The Arkansas Department of Education Office of Coordinated School Health issued a formal request for proposal regarding the grant opportunity to implement a SBHC. School districts that were current Coordinated School Health schools were invited to submit an application to create a SBHC in the late Winter of 2009 for funding in the Spring of 2010. The superintendent proposed to the school board that the district apply for the grant. The

school board readily agreed and directed the superintendent to apply and take whatever steps necessary to meet the qualifications of the grant.

Development 3: The superintendent worked to educate the city leaders and local leaders on the potential and promise of the grant to the students, staff, and community. The superintendent of the district in Western Arkansas met with the city leadership and city council through public meetings to promote and educate patrons about the efforts of the School Wellness Committee and the school board regarding the opportunity for the grant. The superintendent conveyed the vision of the SBHC as serving the students, staff, and community with a fully-functional medical clinic, which did not exist in the community at the time. The city leaders agreed that a clinic would be a valuable asset to the community and agreed to communicate with local patrons positively regarding the effort of the district. The mayor took a special interest in supporting the grant proposal and agreed to accompany the superintendent to meet individually with community leaders to build a strong base of support. The mayor brought additional credibility to the endeavor with community members who had no connection to the school other than their property tax supporting the district. All the participants in the local district focus group agreed the work that the superintendent and mayor did to build community support for the clinic publicly and privately was instrumental in general community acceptance.

Development 4: The superintendent secured medical service providers for the SBHC for the potential grant award. The superintendent began the search for a medical provider to collaborate with the school district. The superintendent met a local nurse practitioner and discussed the possibility of having a clinic in the school setting.

After discussion, the nurse practitioner agreed to provide the name to the superintendent of a hospital administrator who had the potential to collaborate with the school district. The goal of the superintendent was to explore the possibility of enticing a medical service provider to collaborate with the school district in establishing a clinic at the school and allow the nurse practitioner to be the service provider under the direction of a doctor from the provider. Ultimately, the superintendent was successful in securing a medical service provider to collaborate with the school district if the grant funding became available. The superintendent was able to connect with a dentist from the area that was looking to expand his practice to additional locations. The dentist agreed to become a partner with the school district and participate in providing part-time services for the SBHC if the grant was approved.

The final partner necessary to meet the components required of the grant was a mental health service provider. The superintendent secured a memorandum of understanding with the largest mental health provider in the region. The agreement was the mental health provider would provide service to students who were in need of mental health services regardless of pay source. If no pay source were available, the provider would serve at no charge to the student, family, or district. However, no adults would be served through the SBHC for mental health services.

Development 5: The superintendent and school board worked to educate the students, staff, and parents regarding the potential SBHC. The superintendent and central office staff began the process of educating the stakeholders in the school, city, and community. The education process initially began by creating an educational pamphlet strategically placed at receptive businesses, the city offices, and the United States Post

Office. Additionally, the school used social media, district email, and the district informational communication calling system to announce the grant and SBHC implementation plan.

The information shared by the district with the community-generated conversation among patrons and staff as to what extent the SBHC would serve the stakeholders. Several patrons questioned the superintendent and school board members publicly and privately regarding what services would be available at the clinic. The superintendent had to clarify misconceptions several patrons had regarding contraception offered to students. No contraceptive aids would be readily available nor be sponsored by the school district. Another misconception addressed revolved around the safety of the students. Early in the process, many patrons of the district were concerned about the placement of the clinic in the building. The district addressed the concerns by creating a dedicated exterior for community access to the clinic. With the design of the clinic, the clinic community patrons would not have the ability to access any spaces within the school through the clinic. In essence, the clinic was isolated from student spaces. Additionally, a security system was added to the clinic to ensure safety and security of the students.

Development 6: The school district was awarded the $525,000 pilot SBHC grant award. The superintendent was notified by telephone the ADE awarded the SBHC grant to the district with the award being fully funded. A follow-up letter formally notified the district of the grant award. The SBHC grant was designed to have a 3-year funding cycle of $175,000 each year for 3 years for a total of $525,000. Additionally, the

district would be eligible for writing for a sustainability grant worth $225,000 at the end of the 3-year funding cycle.

Development 7: The district constructed the facility to house the SBHC. Once the superintendent received confirmation the SBHC would be funded by the state grant, funding was dedicated to beginning the renovation of a middle school building to house the SBHC. The superintendent, maintenance director, medical service provider, and consultants from the district's construction management firm developed the design of the facility.

The final design of the clinic incorporated two adjacent 950 square foot classrooms converted into a fully functional medical clinic. One classroom was converted into five exam rooms and functioning laboratory complete with bathroom. The second classroom was converted into office space for the medical staff, record storage, and reception area. Both classrooms originally had a large area of inefficient windows that had to be removed and replaced with an attractive brick exterior.

In the converted reception area, an exterior door was constructed for a dedicated community entrance. The exterior entrance served as a main entrance for the outside public to have access to the clinic. This simple design element alleviated community concern with student safety that arose in numerous conversations prior to construction. The designated entrance prevented clinic patrons from having to enter the building through any other school entrance.

Development 8: Partnerships with medical providers were executed culminating with final memorandums of understanding and lease agreements with each provider. As the construction process was underway, the superintendent was

notified the medical provider under agreement elected not to participate in the partnership due to political and financial issues within the provider administration. The CEO of the medical provider who agreed to collaborate with the school district was terminated leaving no contact person willing to continue the partnership.

The superintendent began the process of seeking a new partner to serve as a medical provider. A physician who lived in the community of the school district heard about the hospital severing the partnership and approached the superintendent about a possible collaboration with the district. Through numerous meetings and countless conversations, the superintendent and physician ultimately agreed to form a new agreement for the SBHC to continue as a public-private partnership.

The circumstances of the memorandum of understanding agreed upon by the school board and the physician allowed the clinic to be owned by the physician, operating rent-free until the culmination of the SBHC grant. At the conclusion of the grant, the physician agreed to pay $9,000 yearly as rent. In essence, the school district leased space to the medical service provider. For the protection of both parties, the agreement called for a six-month notification in writing prior to any severance of the contract.

The superintendent developed a similar agreement with a dental provider much like the memorandum of understanding with the physician. However, at the end of the grant, the dentist paid $500 per month due to having one converted classroom for an office and offering a part-time service. The dentist served in the clinic one or two days per week.

The superintendent secured a mental health provider in the region to collaborate with the clinic. The mental health provider agreed to serve all students, regardless of pay

source. The memorandum of understanding with a mental health provider secured vital access to students with identified mental health needs and appropriate space for them to be served. No rent was collected from the mental health provider due to the provider only serving students of the district. However, a lease agreement was executed requiring a minimum of six months notification prior to exiting the lease.

Development 9: The district hired the appropriate staff necessary for successful implementation of the SBHC and reassigned internal personnel to support the SBHC. The district advertised for and ultimately hired a credentialed Registered Nurse (RN) and appointed the school district Coordinated School Health Coordinator as the SBHC Director. The RN duties were to be the liaison between the medical clinic service provider, dental service provider, mental health service provider, and school. However, the main responsibility of the nurse was to be the first step in accessing any of the medical providers in the SBHC. The school RN would initially evaluate if a child needed advanced services beyond what she could provide. If the RN determined a child indeed needed advanced care, she would contact the parents of the child for permission for the child to be served by the clinic. If the parents approved services, the school RN would escort the student to the clinic for immediate attention. As a condition of the memorandum of understanding with the medical providers, a child's health needs would trump any community member at any time. The health care providers agreed in the memorandum of understanding to serve children immediately.

The SBHC director responsibilities were to administer the financial aspects of the grant and served as the contact with the Arkansas Department of Education SBHC leaders. Additionally, the SBHC director served as a liaison between the school board,

superintendent, and health service providers and as the direct supervisor of the SBHC RN.

Development 10: The district developed policies and procedures for students to gain access to the medical offerings of the SBHC. The district leadership, in conjunction with the SBHC grant leadership, developed an internal process for parent approval for children to be served in the clinic. The school board ratified the internal procedures and had the guidelines incorporated in the school district handbook. The decision by the board to add the SBHC policies and procedures along with the appropriate forms to the handbook ensured each student's parent and/or guardian had all the information necessary to access the SBHC. One participant noted, "Adding the information to the handbook meant that the school board had given full support and the stamp of approval for the clinic." All local participants agreed the school board desired to be transparent regarding the services the clinic would provide.

The procedure the district relied upon for students to receive services began with the parents or guardians having executed the appropriate consent paperwork to agree for their child to receive services in the SBHC. The next step happened at the time a student was deemed in need of medical attention by the SBHC RN. All students who need medical attention must visit the school nurse prior to receiving clinic services during school hours. Any child deemed in need of services was scheduled for a visit based on the acuity of the need. One example of this priority would be a child with a fever of 104 degrees would take priority over a rash that had been present for a week. If the school RN determined a student was in need of services beyond the initial level of care a school nurse can provide, the nurse must contact the parent or guardian prior to any delivery of

services from the SBHC providers. If a student were to seek any confidential medical services, the parents or guardians may not be contacted as permitted by law. However, no student is ever to be sent directly to the clinic during school hours without an assessment from the school nurse. Student and staff services are scheduled as soon as possible based upon acuity.

Research Subquestion 5: Who were the people involved and what role did they accept during the implementation process?

Many people served a role in the development process of the self-sustainable SBHC in Western Arkansas school district. However, some individuals were vital to the outcomes. Without any one individual working diligently for the same cause, the SBHC implementation may not have been realized. Question 5 describes the important people at the state and local level who were instrumental in the development and ultimate establishment of the self-sustainable SBHC in the Western Arkansas school district.

Important Participant 1: The school district superintendent. The superintendent was a driving force behind the establishment of the SBHC creating contacts of support at the state level, building partnerships with medical providers, and guiding policy development at the local level. The superintendent was the primary public relations outlet. The school superintendent contacted the media outlets to tour the facilities as construction moved forward and provided quality and accurate information for the media to report. Numerous television and newspaper articles were written and reported to the regional public providing positive news from the school district. The media attention helped educate the public concerning the unique opportunity for the

students, staff, and community members of the school district and created a sense of security for the public.

Important Participant 2: School Board members. The school board members were important participants because they were able to determine if the efforts would be a priority for the district in Western Arkansas. The school board created the opportunity for the circumstances of the SBHC to come together. The school board and superintendent worked collectively to seek innovative ways to increase opportunities for student achievement. The vision for increased achievement ultimately led the board to seek the SBHC grant. Through appropriate policy and community support, the board ultimately provided the opportunity to establish the SBHC.

Important Participant 3: City Mayor. The mayor of the city was a lifelong resident of the community, served as a past school board member, and considered a pillar of the community. He led by example and constantly sought to improve opportunities for the residents of the city and students of the district. Without the approval and support of the mayor, the community may not have been as readily accepting of the SBHC in the school district. Additionally, the mayor provided the superintendent access to community members who assisted with political influence. His presence in the one-on-one conversations with these influential people and the superintendent proved to be vital in the acceptance of the SBHC in the school. Any community fears or misunderstandings of intent were able to be averted due to the time and effort of the mayor.

Important Participant 4: The medical service providers. The medical service providers were the critical participants in the success of the SBHC. Providers risked their professional careers and financial stability to venture into a unique partnership with the

school district. The community would not have been accepted the SBHC without highly skilled medical providers with excellent character to serve. The medical providers had to build trust by establishing good relationships and quality care with the community. Without community patronage, the medical service providers would not generate enough revenue for financial stability. The SBHC needed billable visits beyond serving students and staff of the school district alone. However, the medical service providers agreed to serve children whose parents had no means to pay for medical care. Providing care for children without a pay source highlighted the dedication to serve, which built the trust the community valued.

Important Participant 5: The SBHC/CSH Coordinator. The SBHC/CSH Coordinator was an important participant since the coordinator wrote and administered the grant for the SBHC. The coordinator was responsible for ensured compliance with the SBHC grant requirements and acted as a liaison between the state SBHC officials and the school, in addition to the liaison between the school and community. The coordinator gathered and reported data vital in reporting to the Arkansas Department of Education to ensure the state investment made a positive difference in the lives of the children and the community. Data was used to make local decisions in concert with the school district wellness committee. The coordinator provided regular reports to the wellness committee at monthly meetings and orchestrated professional development opportunities for district staff. A special interest of the SBHC director was bringing in the community stakeholders for health-awareness opportunities. These opportunities ranged from district-wide health fairs to professional speakers who conducted seminars on healthy lifestyles. The SBHC Director worked to promote fun opportunities for all students and staff to improve their

individual health. These opportunities slowly improved the culture of the district into one that valued healthy lifestyles and promoted healthy environments.

Important Participant 6: State leaders and members of the state SBHC team. Many people at the state level were responsible for the successful implementation of the self-sustainable SBHC in the school district in Western Arkansas. The state leaders at the Arkansas Department of Health, Arkansas Department of Education, Department of Human Services, Arkansas Medicaid in the Schools and Arkansas Center for Health Improvement were all an integral part of the allocation of the dollars from Arkansas ACT 180 to the Arkansas Department of Education for SBHCs. The state leadership recognized Arkansas lagged behind forty-three other states had comprehensive health services offered on school campuses as well as mental health services. The vision of state leaders went beyond the Tobacco Excise Tax. The SBHC Director from the Arkansas Department of Education summed up the state level collaboration and support as follows:

> The Arkansas Department of Health included SBHC in several disease prevention initiatives, devoted staff, and resources from other funding sources to promote SBHCs. The Department of Human Services worked with the SBHC team to assist school in applying for Medicaid billing authorization. Arkansas Center for Health Improvement dedicated staff time to assist in planning and to implement SBHCs on a state level. The Office of Coordinated School Health team worked together to begin the program, while the state SBHC was being formed. The Arkansas SBHC team works with schools to establish a SBHC. This group writes and releases the request for applications, provides guidance via trainings and site visits, and collects and reports data.

The members of the state SBHC team are important for many reasons. Even though each member of the team is a state employee from the Arkansas Department of Education, the Arkansas Department of Health or employed by Medicaid in the Schools (MITS), all are true partners to the school districts involved in establishing a SBHC. Each state team member worked as a collective unit to provide high quality guidance and support throughout the entire process. The team was readily available for support when problems arose that threatened to inhibit the success of the SBHC implementation. Each team member personally invested time and talent into the planning and implementation of the SBHC.

The initial vision at the state level came from a collaborative of agency leaders composed of the Arkansas Department of Education Assistant Commissioner of Learning Services, Arkansas Department of Education Coordinated School Health Director, Arkansas Department of Education SBHC Coordinator, Arkansas Department of Education Grants Coordinator, Arkansas Department of Education Mental Health Director, and Director of Medicaid in the Schools. This group worked to establish a platform that ultimately allowed SBHCs to be operational in Arkansas school districts.

Research Subquestion 6: What structures in the school influenced the decisions made both positively and negatively?

Question 6 describes the structures in the school that positively and negatively influenced the decisions made by the school leaders that eventually led to the establishment of the self-sustainable SBHC in a school district in Western Arkansas.

Important Structure in the School District 1: The school board policy. The single structure that was most vital for the successful implementation of the SBHC in the

district revolved around the governing board. The school board worked diligently to provide a structure of permissive policy for a SBHC to work effectively and efficiently within the regular operations of the school district. Prior to the establishment of the SBHC, district policy would not have allowed such a public-private partnership. The district had strict policy on facility use by outside groups, which would have denied the opportunity for a SBHC to be developed. The policy structure was rewritten and submitted through the proper channels to meet Arkansas Law and Arkansas Department of Education Rules. This policy process took time to develop and needed to meet the needs of the school district.

Important Structure in the School District 2: School district personnel.

Beyond policy, the district needed the personnel to create internal structures to support a fully functional SBHC. The SBHC director and the SBHC school nurse worked seamlessly with one another, state leaders, and individual parents for the SBHC model to be effective. With the SBHC in Western Arkansas being the first to start in the state, everything that needed to be done had to be completed without precedence. The SBHC Director stated,

> There were not other school districts out there that had experience we could call on and ask how to do something or if we could use their policies as a guide. That is why our relationship with our state SBHC team was so important. Without their guidance and experience having studied the structure of SBHCs in other states, we would have been further behind in implementation than we already were. With our superintendent pushing hard for full implementation within six months of

being awarded the grant, we had no time for failure. It was a truly stressful time but so well worth the effort.

The SBHC director and SBHC nurse created the internal structure and internal procedures for students to be served by the various services of the SBHC. Creating the procedures and specific forms for students and parents were vital for services to take place. Additionally, the SBHC director and SBHC nurse created informational pamphlets for students, parents, staff, and community patrons to review prior to the opening of the SBHC.

Important Structure in the School District 3: Arkansas Department of Education eight components of Coordinated School Health. The local participants and state participants all agreed the Arkansas Department of Education eight components of Coordinated School Health were the single most important structure for successful implementation of the SBHC. A state participant stated, "The framework provided a way for the stakeholders within the district to truly evaluate the needs of the students and overall community." A local participant commented, "Using the eight components of coordinated school health as a guide to measure the health of our district, we realized that we were doing the right thing for our children." Another local participant stated, "The structure gave us the confidence to know that we were doing the right thing for our kiddos."

The school district had a strong physical education program established. The Western Arkansas school district was distinguished as a Spark Showcase School by the Arkansas Department of Education for excellence in physical education. School districts from across the state were invited to observe the high-quality Spark curriculum delivery.

Other important structures the participants offered toward improved student health included a redesigned school nutrition program, offering of mental health therapy, and the hiring of a student safety and security officer.

Research Subquestion 7: What structures in the community influenced the decisions made both positively and negatively?

Question 7 described the positive and negative structures in the community that led to the establishment of a self-sustainable SBHC in a school district in Western Arkansas.

Important Structure in the Community 1: City government. The local participant focus group answers were collated into four main themes. The first theme centered on the mayor and city council. The outstanding support from the city leaders influenced the community to accept and support the SBHC established within the school district. One local participant said, "Our little town hasn't changed in 50 years by design of our city government leadership. If they wanted to kill it (the SBHC project), they could have." Another local participant stated, "The relationship the superintendent built with the city and the time he spent up there made the difference for our kids." With the strength of the city council and mayor, their support was vital to the acceptance of the SBHC by the community.

Important Structure in the Community 2: Student and community poverty. The second theme that surfaced centered on the poverty of the district. The free and reduced lunch rate for the district increased each year. This increase indicated the community overall was slowly becoming impoverished. When parents decide whether to feed their family, pay for an expensive well-child checkup, or have their children's teeth

cleaned, most likely feeding the family will take precedence over medical care. Poverty impacts parent's ability to meet the basic health needs of their children. With the only access to medical services located in a community many miles away, the cost to transport children could prohibit parents from meeting those needs as well.

Poverty negatively effects families and communities as a whole. However, establishing a SBHC to meet the needs of children and families created a strong partnership between the school, families, and community. The partnership ultimately slows the negative effects of poverty and improves future opportunities of all stakeholders. A participant summed up the second theme by stating, "Having the SBHC right there on campus where their children are every day, it takes the hard decisions of eating versus check-ups away from the parent and makes it a no-brainer." Another participant stated, "It de-escalates the parents' stress by knowing that their children will be taken care of in the right way, because the school cares for their children too." These factors make it easier for parents to collaborate with the school and have their children served through the SBHC.

Important Structure in the Community 3: Community make-up. The third theme concerns the makeup of the community who reside in the school district. The city and surrounding school district territory is a bedroom community to a much larger city located twenty miles away. Locally, the school district is the largest employer in the community. For parents who must travel to work outside the community, they travel to the larger city or beyond. The larger city historically has been the source of many manufacturing jobs; however, in recent years those jobs have declined in number. The city experienced a loss of hundreds of jobs due to the larger manufacturers relocating or

closing. When parents do have one of the scarce jobs they want to do everything to keep their job. Taking off work to take their child to a medical checkup of some kind could potentially jeopardize the parent-worker from remaining employed. This real circumstance was a negative for a family prior to the establishment of the SBHC. Today, the parents who find themselves in that circumstance can have the SBHC serve their child without missing work, travel to pick up their child, and travel back to the larger city for medical services. The SBHC saves the lost work time, the expense of traveling seeking medical services, and overall stress on the child and parents. The center helped to change this perspective into a positive for all stakeholders.

Important Structure in the Community 4: Student instruction. The fourth and final theme with the deepest impact for children is the reduction of missed class time for students who are served in the SBHC. Provided the appropriate procedures are followed, a child can be seen by the medical service provider and back to class within twenty minutes, reducing the loss of instructional time. As described by the SBHC RN, "Often times, the only service needed is a temperature taken and a good hug, and then off back to class they go."

Research Subquestion 8: What were the outcomes from the process for school personnel, students, and community?

Question 8 describes the outcomes of the establishment process on staff, students, and the community.

Outcome 1: School personnel. School personnel have accepted and appreciated the services offered to children especially when it reduces the amount of class time missed by the students. A local participant stated simply, "You can't provide adequate

instruction to a child if he isn't in class." The statement was made in an attempt to infuse humor by the participant, but in reality, sums up the comments of the group regarding missed instruction time for students.

School personnel slowly began to use the SBHC for personal health care. By the end of the first semester the SBHC was in operation, staff absences were down 18% as compared to the previous semester without an operational SBHC. By the end of the second semester of operation, staff absences were lowered by a collective 22% when compared to the previous two semesters without the operation of SBHC. The reduction of staff absences resulted in a school district financial savings in cost of substitutes for the 2 semester period of just under $30,000. This is a substantial saving to the district. A local participant familiar with the financial implications of the district stated:

> I cannot confirm that the SBHC was the primary reason we were down in substitute cost, but it had to play a part. Our teachers are young with young children. They like the convenience of the clinic on campus for themselves and for their own children. It just makes good sense and is seen as a real benefit to working here especially when the district doesn't make you count the time you spend at the SBHC against your sick time.

Students appear to be pleased with the SBHC being on site. Many of the athletes frequent the clinic portion of the SBHC due to athletic-related injuries. A participant involved in the delivery of medical services to students stated,

> I try to build good relationships with all the students by getting to know them outside of the clinic. I attend all the sporting events that I can and speak to the health and PE classes when there is an opportunity. The way I see it, if the kids

know me and trust me, I can provide them with a better health care experience at a much higher level. Besides being the right thing to do, it builds my business and keeps the clinic employees paid. It is a win for everyone, especially the kids.

The medical providers work to create relationships with students, parents, staff, and community patrons of trust. The medical providers identified trust among SBHC patrons as a key to success for all involved.

Outcome 2: Student attendance. Student absenteeism across the district increased in the first two months the SBHC opened. The clinic officials attributed the increased absences to the flu virus that across the state the late winter and early spring of 2011. However, overall as a district, student absences declined the first two semesters of SBHC operation when compared to the previous two semesters without an operational SBHC.

A local participant knowledgeable of student medical services indicated many of the Medicaid eligible students had no medical home prior to the implementation of the SBHC. The barriers reported by the parents that were most difficult to overcome were addressed by allowing access to people who knew them, cared for them, and were willing to help them. A local participant reported parents were able to receive guidance in completing the Medicaid renewal paperwork to ensure no break in service coverage for their child. Building relationships with parents outside of the classroom solidified the opportunity for many of the children from poverty to improve and potentially seek a new standard of living for their family.

Outcome 3: Community acceptance. The community embraced and trusted the district to develop the clinic with appropriate service providers. When the SBHC opened

in January of 2011, the majority of patients served were students. The medical providers in the clinic reported to the SBHC Director in the first month of operation that the majority of the billable medical encounters were student encounters. The billed medical incidents included 60% students and 40% adult community patrons. This number shifted over time to 20-30% students and 70-80% adults. The medical provider stated, "The lion's share of our business comes from the adult community. This helps pay the bills and keeps access to services for students here on campus." The local participants shared in the first year of operation, the medical clinic generated approximately 5,000 billable encounters. In Year 2, the clinic generated 6,500 billable encounters. The medical clinic is on track to exceed 7,500 encounters in Year 3 if the pace of service remains at the same level each month. The medical service provider attributes the success to the expanded laboratory services to include allergy testing. He expects to expand further to offer radiology or X-ray services soon. This expansion would likely better meet the expressed needs of the community at this time, but would require additional space within the school district facility.

Research Question 9: What was the satisfaction level for the stakeholders with the outcome?

Question 9 describes the satisfaction level of the community with the self-sustainable SBHC established in the school district.

Satisfaction Level 1: School board and administration. The school board and district administration expressed extreme pleasure with the success of the SBHC to this point. There have been several student lives saved by the quick medical attention offered by the clinic. Parents are pleased with the quality of services that are offered to their

children and for the positive economic impact the SBHC provides in reducing lost revenue from missing work.

Satisfaction Level 2: School staff. The school district staff were pleased with the SBHC in a variety of ways. The staff members who used the service for their child or for themselves reported they are of high quality. The morale of the staff remained high because the SBHC was viewed as a low-cost benefit to the staff due to the convenient location of the facility. Additionally, the school district was supportive of staff members improving their personal health. The SBHC staff offered opportunities for weight loss challenges and the district offered fitness equipment for use by the staff.

Satisfaction Level 3: Community. The establishment of the SBHC by the district leaders addressed a portion of the community not traditionally influenced or supportive of the school district. The retired community in the school district might traditionally be reluctant to financially support any referendum to increase property taxes. One retired community patron who was a vocal opposition in the most recent referendum approached a school leader about the implementation of the SBHC. He relayed to the school leader the SBHC was the best thing that could have been started to serve not only the kids, but also the whole community. The retired patron stated,

> I've been seeing that doctor down at that clinic and I like him. When you walk into the clinic, you can't tell you are not in some fancy hospital. I think you've finally done something right down there. Just so you know, I didn't care what happened with that schoolhouse up until this point. I didn't care if it was knocked down, plowed up, and sowed in corn rows. But now, I'd consider voting for that

blamed millage if it meant you were taking my doctor away from me, but don't you get any ideas…

Overall, the satisfaction of the stakeholders has been high. The outcomes exceeded the initial expectations for the SBHC by the local school district patrons and the state-level leaders. The medical services, dental services, and mental health services have improved the medical condition of the students, staff, and community they serve. The SBHC helped to solidify the school district as the heartbeat of the community at all levels. The SBHC is a great success in the eyes of all the stakeholders who contributed to the focus group interviews.

Summary

The data in this chapter reflect a sampling of thought among participants involved in the establishment of the SBHC in a school district in Western Arkansas. The data were collected through a case study investigation to form a descriptive and conceptual representation of the development and implementation process of a SBHC in a school district in Western Arkansas.

The individuals that participated in this qualitative case study provided important information that constructed the details that identified circumstances that allowed the overall process of the SBHC to develop at the state and local levels. The state level participants described the legislation that made allowance for SBHCs in Arkansas to be developed along with the grant funding mechanisms. Local school district and community leader participants described their efforts to create a structure for understanding and acceptance of the need for a SBHC by the community. Identifying the

need and potential impact the SBHC could have on all stakeholders was key in the initial establishment phase.

After the establishment of the SBHC, participants described their perspective of outcomes and satisfaction of the community, parents, staff, and students that used the center. Both focus groups who worked to make provision to establish the SBHC were pleased with the outcomes of the SBHC on all stakeholders but especially the children of the school district. These perspectives were critical to understand the whole story of the establishment and implementation of the SBHC in a school district in Western Arkansas.

CHAPTER V

DISCUSSION

In the previous chapter, participants shared their involvement in development of the self-sustainable SBHC for a school district in Western Arkansas. The qualitative study approach allowed a structured analysis of the data to inform the investigation. Using this qualitative research model, this chapter further explores the establishment process as it connects the data and discussion of the findings.

This investigation provided rich qualitative data to describe the process from developmental policy through daily operations of the self-sustainable SBHC in a school district in Western Arkansas. Additionally, the investigation provided detail from all participants to construct a comprehensive story from inception to completion of the self-sustainable SBHC for a school district in Western Arkansas.

Finally, this chapter provides a concluding analysis of findings, recommendations, and implications. The findings, recommendations, and implications should provide an invitation to consider the possibilities of additional investigation that may probe further into the complexities of establishing SBHCs in the diverse school districts across Arkansas.

Conclusion

Using prior research as a foundation, this qualitative study attempted to examine the central question as to how the development process of the self-sustainable SBHC for

a school district located in Western Arkansas resulted in a successful working model for the school, community and beyond. The findings emerged from the data collected through participant focus group interviews suggest that the State executive and legislative branches support the establishment of SBHCs by providing opportunities for competitive grant funding through the Arkansas Department of Education. School districts that desire to create a SBHC must have full support from the governing board, school administration, and community leadership for successful implementation. This chapter will discuss the findings as they relate to the research questions.

Subquestion 1

The participants of the focus groups indicated that multiple circumstances were evident to prompt the development of the SBHC in a school district in Western Arkansas. The first circumstance necessary was for state policy makers, state agencies, and advocacy groups to formulate permissive policy for the establishment of SBHCs in Arkansas. The Arkansas Department of Education through the Office of Coordinated School Health in collaboration with the Arkansas Department of Health assisted school districts in improving health curriculum and additional components of Coordinated School Health. The Arkansas Department of Education Office of Coordinated School Health facilitated the offering of competitive grants for school districts to establish SBHCs.

Participants from the state-level focus group commented that within the state of Arkansas there is a low number of children receiving yearly well-child checkups with many children having no medical home. SBHCs address health services for students, families, schools, and communities. The SBHC provides high-quality medical access to

populations who have been underserved. Schools are a trusted entity within a community and, SBHCs have credibility among community patrons.

The local school board, school administration, and community leadership recognized the need to improve student, staff, and community health and chose to work together to provide access to high-quality healthcare on school campuses. The school board, focused on improving opportunities for the whole-child, amended board policy to incorporate additional aspects to focus on meeting the health needs of children. The vision of the school board and superintendent revolved around positively influencing the factors that support the whole-child, whole-family and whole-community. Each of these efforts supported the main focus of the school board to improve overall student achievement.

Subquestion 2

As identified by the focus group participants, the three significant legislative developments that aided the development of the SBHC in the school district in Western Arkansas were Federal legislation, NCLB or ESEA, Arkansas ACT 1220 of 2003, and Arkansas ACT 180 of 2009.

The school board and administrators were motivated to improve student achievement due to NCLB and the reauthorization of ESEA. The motivation identified student health as a significant indicator in student achievement. Arkansas ACT 1220 of 2003 was the original force to improve student health across Arkansas. The Act created a comprehensive program to combat childhood obesity in the state. Act 1220 of 2003 called for annual body mass index (BMI) screening for all public school students and restricted access to vending machines in public schools. One of the most important

aspects of Arkansas Act 1220 for local school districts was the creation of the advisory committees made up of parents, teachers and local community leaders. The advisory committee focused on improving student health. Finally, the governor of Arkansas provided funding from ACT 180, otherwise known at the Tobacco Excise Tax, to make funding available to establish SBHCs, which could positively impact student achievement by addressing student health needs.

Subquestion 3

The participants in the focus groups identified Arkansas ACT 180 of 2009 as the primary funding source for the establishment of Arkansas SBHCs. The health centers were included in general revenue as a line item to receive monies through a competitive grant process. The funds granted were for promoting health, wellness, and academic achievement in Arkansas public schools. All Arkansas public and charter school districts are eligible to apply unless the district has an active SBHC grant.

The school district accessed the original Arkansas SBHC pilot 3-year grant of $525,000 dispersed equally over 3 years. The approved expenditures of grant funding included employing a full-time Coordinated School Health Coordinator, a full-time SBHC Registered Nurse, and a contract with a full-time licensed Mental Health Professional. Allowable expenses from grant funding were used for purchasing or upgrading equipment to support a SBHC, provide funds for in-state travel expenses for training and workshops, as well as covering costs associated for basic remodeling expenditures. The grant funds did not allow for construction of standalone construction projects that were considered brick and mortar expenditures.

The second funding source was an Arkansas SBHC sustainability grant of $250,000, which was accessed at the culmination of the initial 3-year start-up grant. The purpose of the grant was to expand the services of the SBHC. The sustainability grant was funded for $100,000 in Year 1, $80,000 in Year 2, and $70,000 in Year 3.

The third funding source for the SBHC was a Delta Dental Grant accessed by the school district in Western Arkansas to expand services for the dental provider. The grant provided $26,000 to purchase dental equipment for the dental office.

The fourth funding source was received as donations of medical equipment by a tax-exempt, non-profit corporation designed to provide medical equipment and supplies to the school district at no cost. The estimated donation of equipment and materials exceeded $100,000 in value.

The fifth funding source for the SBHC came from a third-party reimbursement for medical provider services. The medical providers relied on third-party reimbursement for most medical services and expenses. The third-party providers included Medicaid, Medicare, and most insurance network carriers. The school district grant did not reimburse medical providers for services rendered to any patient.

Even though a significant amount of grant funding was provided to establish the SBHC, the district opted to use local building funds for much of the renovation costs that were not allowed as qualified expenses of the grants. During the initial 3-year implementation, the school district in Western Arkansas expended funds of approximately $50,000 from the operating fund. Overall, the district collected a total of $801,000 in grant funding for the establishment of the SBHC.

Subquestion 4

How did the development process unfold in the school district? This question describes the development process that unfolded in the district for the establishment of the SBHC in a school district in Western Arkansas. The first action was the establishment of a district wellness committee. Under Act 1220 of 2003, the district formed a district wellness committee composed of administrators, school board members, teachers, parents, school nurses, and community members. Significant improvements were made to policy, practice, curriculum, and the nutrition program due to the work of the committee.

The work of the wellness committee identified the students of the district had health disparities and sought assistance from community health professional for help in reducing these gap. Representatives from the county health department, health advocacy groups, and state and local policy makers became partners to reduce the health disparities for the children. Authentic discussions about issues schools and families face in educating children to meet their full potential and promise were facilitated. The discussions provided the catalyst for the district leadership, community leadership, and state-level leadership to act to improve vital offerings for children and families.

The second development came when the superintendent proposed to the school board that the district apply for the SBHC grant to attempt to address the unmet health needs of students in the district. After thorough review, the school board readily agreed and directed the superintendent to apply and take whatever steps necessary to meet the qualifications of the grant.

The third development revolved around the actions the superintendent took to educate the city and local leaders on the potential and promise of the grant to the

students, staff, and community of the district. The superintendent met with the city leadership and the city council privately and at public meetings to promote opportunity for the grant. The superintendent readily conveyed the vision of the SBHC as serving the students, staff, and community with a functional medical clinic, which did not exist in the community at the time.

Development 4 came when the superintendent secured the medical service providers for the SBHC for the potential grant award. The goal of the superintendent was to explore the possibility of enticing medical service providers to collaborate with the school district in establishing a clinic at the school. Ultimately, the superintendent was successful in securing medical service providers in the form of a family medical practitioner, a dentist, and a mental health provider to collaborate with the school district.

The fifth development revolved around the superintendent and school board educating the students, staff, and parents regarding the potential SBHC. The district used social media, district email, district mail, and provided educational pamphlets to patrons to announce the grant, services, and SBHC implementation plan.

Development six was the acceptance by the school district of the $525,000 pilot SBHC grant. The Arkansas Department of Education notified the superintendent that the school district was awarded the SBHC grant to be funded over a 3-year period of $175,000 each year for a total of $525,000.

The renovation of district facilities to house the SBHC was the seventh important development. The superintendent, maintenance director, medical service provider, and consultants from the district's construction management firm developed the design of the

facility housed in a district owned facility. District employees performed all aspects of the work for the conversion of the classrooms to the medical clinic.

The eighth development was the executing of the memorandum of understandings between the school district and the medical service providers culminating with final memorandums of understanding and lease agreements with each provider. The circumstances of the memorandum of understanding agreed upon by the school board and the medical service providers provided operational space rent-free for each provider until the culmination of the SBHC grant. At the conclusion of the 3 year grant, the providers paid rent each year. This allowed the school district to lease space to the medical service provider. For protection of both parties, the agreement called for a six-month notification in writing prior to any severance of the contract.

Development 9 was the hiring of the appropriate staff necessary for successful implementation of the SBHC and reassigned internal personnel to support the SBHC. The district hired a credentialed RN and appointed RN as the school district SBHC Coordinator. Additionally, the CSH Coordinator also operated as the SBHC Director to administer the grant funds. The SBHC could not operate efficiently without the necessary personnel to support student medical services in the school.

The development of district policies and procedures for students to gain access to the medical offerings of the SBHC was the final development. The district leadership, in conjunction with the SBHC grant leadership, developed internal processes for parent approval for children to have access to clinic services. The school board ratified the internal procedures and guidelines to incorporate in the school district handbook.

Subquestion 5

The self-sustainable SBHC in a Western Arkansas school district had a collective core of individuals who worked as a team to strategically plan and implement the SBHC to serve the students, staff, and community. The important stakeholders at the state and local level were instrumental in the development and ultimate establishment of the self-sustainable SBHC.

The superintendent, school board, city mayor and medical service provider team worked together to identify the need, create the circumstances to act, and ultimately establish the SBHC designed to serve students, staff and community of the district. The superintendent provided the primary leadership in the establishment of the SBHC, creating contacts of support at the state level, building partnerships with medical providers, guiding policy development within the district, and acting as primary outlet for communications for the district.

The second important participant was the school board. Each member of the board understood and advocated for the establishment of the SBHC to serve the stakeholders of the district. The board supported appropriate permissive policy to garner community support for the SBHC.

The mayor of the city, a lifelong resident and valued leader of the community, understood the need for high-quality medical services in the community. Seeking to improve opportunities for the residents of the city and students of the district, the mayor facilitated opportunities for the superintendent to communicate with influential community members regarding the concepts of the SBHC. The mayor helped to calm any

community fears or misunderstanding of the intent of the SBHC and encouraged acceptance.

The medical service providers were vital in the success of the SBHC. Taking a risk professionally, the health professionals offered high-quality services to students who were not receiving acceptable medical services. As a condition of the agreement with the school, the providers agreed to serve children whose pay source was fragile. This aspect alone indicated the high quality of character the providers possessed to agree to meet such a need.

The Coordinated School Health Coordinator, also serving as the SBHC Director, was an important participant in the process to coordinate the grant for the school district. The coordinator ensured state Arkansas Department of Education grant compliance and acted as the liaison between the state, SBHC, parents, and community. By collecting and reporting valuable information to the school board and Arkansas Department of Education, the SBHC Coordinator provided evidence that the pilot SBHC was making a positive difference in the lives of the children and the community.

The members of the state SBHC team were important in the successful implementation of the SBHC by providing quality guidance to the local implementation team. Through the vision of state leaders at the Arkansas Department of Health, Arkansas Department of Education, Department of Human Services, Arkansas Medicaid in the Schools and Arkansas Center for Health Improvement, the SBHC pilot grant program became a reality through the work of the collaborative SBHC state team. These state team members were all an integral part of the implementation process by working passionately as a collective unit to provide high quality guidance and support to grantees.

Each team member personally invested time and talent into the planning and implementation of the SBHC.

Subquestion 6

The public school structure of the school district in Western Arkansas influenced decisions made by school leaders positively and negatively led to the successful establishment of the self-sustainable SBHC in the district. The first essential structure was school board policy. The school board established permissive policy to allow for the special public-private partnership and established guidelines for the SBHC to work effectively and efficiently within the regular operations of the school district. The policy structure was rewritten and submitted through the proper channels to meet Arkansas Law and Arkansas Department of Education Rules.

The second identified important structure was school district personnel employed by the district to create internal structures to support the SBHC. The SBHC director and the SBHC school nurse worked together with state leaders and individual parents for the SBHC model to be effective. With the SBHC in Western Arkansas being the first to start in the state, all aspects of the implementation process had to be created without an example from within the state. The pilot project created a strong relationship with the state SBHC team for the desire of successful implementation. The guidance of the state team from their study of different structures of SBHC from other states was valuable information during the implementation.

The third important structure identified as highly valuable to the district with implementation of the SBHC was the Arkansas Department of Education's eight components of Coordinated School Health. The local participants and state participants

unanimously agreed the Arkansas Department of Education eight components of Coordinated School Health were the single most important structure for successful implementation of the SBHC. The framework provided tools to evaluate the needs of the students and overall community within the school district. The eight components of coordinated school health provided a guide to measure the health of the stakeholders of the district. The structure provided the participants with the confidence necessary to risk establishing a SBHC in a public school in Western Arkansas.

The eight components of Coordinated School Health established an accepted culture in the school district focused on aspects of student and staff health. The school district improved the physical education program and was recognized by the Arkansas Department of Education as a Spark Showcase School for excellence in physical education. Other important aspects stemming from the eight components of coordinated school health redesigned the school nutrition program, offered mental health therapy, and a student safety and security officer for the district.

Subquestion 7

Four aspects of the community structure provided reason to establish a SBHC in the school district. The structures created the community support to establish the SBHC in a school district in Western Arkansas. The city government, primarily the mayor and city council, provided public support for the school district leadership, school board, and medical service providers for the establishment of the SBHC. The city leaders understood the SBHC was to meet the needs and ultimately strengthen the community as a whole. With the school as a trusted partner, establishing a medical clinic would better serve the

community. The strength of the city council and mayor who provided full support for the school allowed the SBHC to be acceptable to the patrons of the district.

The second aspect of the community centered on the overall poverty of the school district. The free and reduced lunch rate for the district had steadily increased each year. The increase indicated the community was becoming increasingly impoverished. Poverty influences parents' ability to meet the basic health needs of their children.

Access to medical services located in a community many miles away created an additional barrier for parents to provide health services for their child. This structure was a negative for the community as a whole, but was seen as a positive by parents when the district implemented a medical clinic to serve their child. With the SBHC located on campus near children, economic barriers families face were reduced.

Parents who traveled to work outside the community and whose children attend the local school district were forced to travel to a larger city or beyond to secure medical services. Parents took off work to take their child to a medical checkup could have potentially jeopardized their employment. This real circumstance was a negative for families prior to the establishment of the SBHC. Parents have the option to allow the SBHC to serve their child without missing work. The SBHC saved the lost work time, the expense of traveling to obtain medical services, and the stress on the family. The center helped to change this perspective to a positive for all stakeholders.

The final aspect of the SBHC that is a positive for families is the reduction of missed class time for students. When procedures are followed properly, a child could be seen by the medical service provider and be back in class within twenty minutes, reducing the loss of instructional time. Prior to the establishment of the clinic, a child

who was ill and in need of medical attention might miss a large portion of the academic day.

Subquestion 8

School personnel have accepted and appreciated the services offered to children when those services reduced the amount of class time missed by the child. School personnel also used the services of the SBHC for personal health care. Within the first semester of SBHC operation, the district experienced a reduction of school personnel absences by 18% over the previous semester. The first year of SBHC operation, the district experienced a 22% reduction of staff absences. This reduction in missed workdays resulted in a financial savings to the district of just under $30,000. It cannot be confirmed that the SBHC is the primary reason the attendance of school personnel increased; however, it was determined the SBHC was at least a positive variable in contributing to the lower percentage of absenteeism.

Students report being pleased with the SBHC being on site. Many high school students visited frequently the SBHC for athletic physicals and athletic-related injuries. Along with being relatively pleased with the SBHC services, student absences declined the first two semesters of SBHC operation when compared to the previous two semesters without an operational SBHC. Additionally, Medicaid eligible students who had no medical home prior to the implementation of the SBHC now have a primary care physician at the SBHC.

School-based medical clinic and school district staff provided support for students and parents by assisting them through the Medicaid renewal paperwork, to ensure no break in service coverage for their child. A climate of trust supported the quality

relationships with parents outside the classroom and ensured opportunities for many children of poverty to change the medical access for their family.

Considered one of the most important outcomes of the creation of the SBHC was the trust developed with the services providers and the school district. Over time, the patients who use the clinic went primarily from student patrons to adult patrons of the community. The increase of adult patients helped to ensure the sustainability of the SBHC. The student population is stable and another way to increase revenue for the SBHC was to increase the number of adult patients using the services. A physician in the SBHC stated, "This helps pay the bills and keeps access to services for students here on campus."

The SBHC reported the medical clinic portion of the SBHC generated approximately 5,000 billable encounters in the first year of operation. In Year 2, the clinic generated 6,500 billable encounters. For the third year, the medical clinic expects to exceed 7,500 encounters. Expanded health services within the clinic were credited for the patient increase. Further expansions, which could likely broaden the patient base, are planned in the area of radiology or X-ray services.

Subquestion 9

In review of the satisfaction level of the community with the self-sustainable SBHC, many positive aspects were evident among the patrons of the district. The school board and district administration expressed extreme pleasure with the success of the SBHC. The SBHC was credited with having potentially saved several student lives from the quick, highly skilled, medical attention offered by the clinic. Parents were pleased

with the quality of services offered to their child and appreciated the positive personal economic impact the SBHC provided from their not missing work.

The school district staff who used the services for their child or themselves expressed pleasure for the high quality of the services offered by the SBHC. The morale of the staff remained high because the SBHC was viewed as a low-cost benefit to the staff for the facility location. Additionally, the school district was supportive of staff members improving their personal health. The SBHC staff offered opportunities for weight loss challenges and the district offered fitness equipment for use by the staff.

Finally, the community expressed extreme satisfaction with the SBHC considering the medical services met a need that had gone unmet in the community for 35 years. The SBHC addressed a portion of the community not traditionally influenced or supportive of the school district. The elderly population who used the SBHC appreciated the school district in a different manner prior to the establishment of the SBHC.

Collectively, the satisfaction of the stakeholders was positive. The outcomes exceeded the initial expectations for the SBHC by the local school district patrons and the state-level leaders. The medical services, dental services, and mental health services improved the medical condition of the students, staff, and community they serve. The SBHC solidified the school district as the heartbeat of the community at all levels. The SBHC was a great success from the point of view of the participating stakeholders in the community who contributed to the focus group interviews.

Limitations

There are specific limitations that could affect the reporting and analysis of the data from this study. Among the limitations was the fact that the researcher was the

superintendent at the school district where the SBHC was developed and implemented. This fact alone is a threat to the internal validity of the study. Assurances of no harm to the participants from the researcher may not have rested the apprehension of the participants to answer openly and without reserve during the interview process. The researcher recognizes the participants' desire for the SBHC to be a success and a model for others to follow.

Unintended assumptions by the researcher were an additional limitation of the study. The researcher made a conscious effort to refrain from making assumptions, but professional relationships to each of the participants and the deeply imbedded determination to develop a sustainable SBHC model in the school district in Western Arkansas may have influenced the researcher to make certain unintentional assumptions. The unintentional assumptions could be based on the knowledge of the school district, local governance, and the Arkansas Department of Education SBHC funding mechanism.

The small sample of participants could be considered a limitation of the study due to the specific nature of the roles each participant played in establishing the SBHC. Furthermore, the bias of the researcher that basic health needs must be met first for children to fulfill their potential and promise academically could be considered a limitation.

Finally, it must be acknowledged this study was a historical narrative of how the SBHC was developed and implemented to meet the needs of the school district and the community in Western Arkansas. Other communities and school districts could have additional needs or differing resources to create a different SBHC model to be most appropriate for application.

Recommendations

Because of this study, the story has unfolded of the development and implementation of a fully functioning, self-sustainable SBHC in a school district in Western Arkansas. The following recommendations are based upon the findings of this study. Local school boards, administrators, and school district staff should evaluate whether the students in their local district might benefit from establishing a SBHC. Implementing the eight components of Coordinated School Health is a first step in seeking to improve the overall health of the students, staff, and community served. If the stakeholders of the district value a SBHC, the investment of time, talent, and treasure will be part of the work to progress towards the establishment of the center.

Implications

Significance

The findings of this study expanded the knowledge base for school district leaders regarding what it takes to plan for, develop, and implement a fully functional SBHC in Arkansas. Identifying the challenges encountered by the school district leadership, governing board, community government, and medical service providers in the story provides other interested stakeholders an insight into what could be expected if they decide to begin the journey to establish a SBHC.

Many factors influence whether a community will accept a SBHC in the local school district. By describing the details of the process and the barriers that had to be overcome within the school, community, and with state requirements, the reader will be able to anticipate potential issues with implementation. In order to describe accurately the events of the development and implementation of the SBHC in the school district in

Western Arkansas, it was crucial to identify the barriers to implementation. The identified barriers hampered the efforts of the district leadership to achieve full implementation.

The challenges and success described in this study can be shared with other interested school officials and policy makers to promote student, staff, and community health in other school districts. In the process of this study, successful leadership examples were identified that could support school and community leaders in their efforts to develop and implement a SBHC in their school. It is important to understand that each school district and community was unique with particular needs and circumstances. No single model of development is ideal for all schools.

Unexpected Results

Three unexpected results of the study emerged over the course of the focus group interviews. The first unexpected result centered on the acceptance of the SBHC by the community patrons without direct involvement with the school. Within the first 12 months of operation, the SBHC documented serving more adults than students did. The adults who accepted and took advantage of the SBHC immediately without apparent reservation were the senior adults in the community. The focus group could only surmise the efforts of the superintendent and SBHC physician to communicate with the senior population at the senior citizens center that all in the community were welcome and needed to patronize the clinic. The medical provider proved quickly to be a trusted physician and is attributed to the success with communicating well and gaining trust of the senior adults.

The second unexpected result came in the form of the number of students who were not covered by some form of insurance or Medicaid. The original expectation by the

district leadership and medical service providers was that many children not covered would take advantage of the opportunity to have no-cost medical services. Of the students served in the district, parental insurance or Medicaid covered the vast majority of students.

The final unexpected result was the number of mental health occurrences that were necessary for students as young as the Kindergarten grade level. A second school-based mental health service provider was employed by the external supplier to serve the increased population of student needs that emerged.

Expanding New Knowledge Bases

SBHCs in Arkansas were a relatively new concept for school leaders, school board members, and community patrons to accept as realistic service school districts could provide. Employing a school nurse was an accepted practice for school districts, but having a fully staffed medical clinic to support student, staff, and community health was a foreign concept.

The SBHC proved to be a success in the school and community by meeting the medical needs of those that chose to be served. The school and SBHC served as an example for many other schools and communities who expressed a similar need for student and community services. The SBHC served as a demonstration site for those expressing interest in exploring a public-private partnership in their own community. The superintendent presented the model developed at the school district in Western Arkansas at the state level to state legislators in a formal hearing and at the national level at the Clinton School of Public Service. Additionally, the superintendent served as keynote

speaker at national conferences describing the development and implementation of this SBHC.

State leaders in partnership with local school district leaders promote quality student health care as necessary for all students to have the opportunity to obtain a quality education. The basic premise was that students would not be able to learn at the highest level if their basic needs were not met. High quality health services through SBHCs along with the implementation of the eight components of Coordinated School Health would provide children with the best opportunity for optimum learning. From this study, it is recognized the students, staff, and families of the community were satisfied and experienced positive results from the partnership.

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APPENDICES

APPENDIX A

Moderator's Guide for Focus Groups

I. Introduction: the research questions, the focus group process

II. Ice breaker: Getting To Know You Activity

III. Develop a shared operational definition of School-Based Health Center

IV. Questions:

1. What was your initial role in the planning of the SBHC?
2. What was your role in the development process?
3. What was your role in the implementation process?
4. How do you see your role and your influence as stakeholder in the development and sustainability process of the SBHC?
5. Who were the important participants in the planning, development, and implementation of the SBHC? How did they participate?
6. For the school leaders, what policies were necessary to develop to aid in the successful implementation of the SBHC?
7. For the SBHC, what policies were necessary for successful implementation?
8. In what ways did the school district support the SBHC?
9. What obstacles were encountered that threatened a successful implementation? How were they overcome?
10. Once the SBHC was opened, was it accepted by students, parents, staff, and community? If yes, why? If not, why?

11. What were the initial health services of the SBHC? What additional services have been developed?
12. What data are collected by the SBHC regarding those served?
13. How are the data used?
14. What can be gleaned from the data collected to date?
15. What have you learned from your experience?
16. From your individual experience, what would you do differently if you had it to do over again?
17. From your experience, what were the keys to successful implementation of the SBHC?

APPENDIX B

Follow-up Invitation to Focus Group

Dear Mr./Mrs. Stakeholder,

Thank you for accepting my invitation to participate in a focus group to identify the development process of a self-sustainable school-based health center (SBHC) for a school district in Western Arkansas. Your input is vital and will contribute to a better understanding of how the SBHC was planned, develop, and implemented.

The afternoon promises to be interesting. There will be several stakeholders in the development process attending each meeting. We will have refreshments for you to share and a comfortable environment for the discussion. Additionally, your name will be placed in a drawing for a gift card to be drawn at the end of each meeting.

The focus group for state officials will be held on:

Thursday, October 24th
12:00-1:30 p.m.
Arkansas Department of Education
105-C Conference Room
#4 Capitol Mall
Little Rock, AR 72201

The focus group for school district officials will be held on:

Friday, October 25th
12:00-1:30 p.m.
XXX Central Office

Please let me know as soon as possible if you cannot make it. My contact numbers are: XXX (Cell) and XX (work).

I have enclosed a list of questions that will be asked at the meeting for your review. This list will be what I will refer to throughout our discussion. We will discuss the history, difficulties, and successes in the development of the SBHC at the state and local level. Additionally, we will discuss the role each of you played in the SBHC story. Please be prepared to be open and honest about our experience.

I look forward to seeing all of you at the meeting. Thank you for your time and the work you do for the children of this state.
Sincerely,

Jared A. Cleveland
Doctoral Candidate

APPENDIX C

Informed Consent Form

Doctoral Program in Educational Leadership, Harding University Consent Forms for *The Development Process of a School-Based Health Center in a School District in Western Arkansas*

Dear Participant,

You are being asked to participate in the study described below. You should feel free to ask any questions about the research you wish. If you have questions now or at a later time, you may contact Jared Cleveland at XXX, or at XXX.

This study will attempt to discover the development process of a school-based health center in a school district in Western Arkansas. By understanding and documenting the process used to develop the School-based health center in Western Arkansas, potentially others can replicate the valuable work across the state that you have done to serve the students, staff, and community.

You are being asked to participate in a focus group interview. In the focus group, you will be asked to participate in discussion with the researcher and other participants who were involved in the development of the SBHC. This interview should take approximately 90 minutes.

For participating in this study, I will send you a summary of my findings by mail or email. The summary information, as well as the discussion itself, may be of benefit to you.

Although you will be known by the other participants in your focus group, your identity will remain confidential in any and all research reports. All data collected will remain secured and accessible only to the researcher. After a 3 year period, the data will be destroyed. Until that time, the transcribed data will be password secured in a laptop database. The video or audio recordings will be secured in a locked, fireproof filing cabinet in my home office.

Your participation in this study is completely voluntary. You may choose not to participate and discontinue your participation at any time with no penalty and without loss of benefits to which you would otherwise be entitled. If you are not satisfied with the way this study is conducted, you may express your concerns to my university advisor, Dr. Keith Williams at XXXor the Harding University Institutional Review Board at 501-279-4315.

Sincerely,

Jared A. Cleveland
Doctoral Candidate

I have read the consent form. My questions have been answered. My signature below indicates that I understand the information and that I consent to participate in the study.

_____	_____	____
Name of Participant	Signature of Participant	Date

_____	_____	____
Name of Researcher	Signature of Researcher	Date

Additional Consent For Audiotaping, Videotaping, And Transcription

This study involves audiotaping and videotaping of the focus group interviews. No name or identifying information about you will be associated with the tape or transcript. Only the researcher (or someone to whom the speakers' identifies are unknown) will listen to the tape. The researcher (or someone to whom the speakers' identities are unknown) will transcribe the tape. Once the transcript is checked for accuracy, the tape will be erased. Some of the transcripts may be reproduced in the presentations or reports on this research; however, no name or identifying information about will be used.

Please check one of each of these pairs of options:

Audio tape recording:

- □ I consent to having my interview audiotaped and videotaped.
- □ I do not consent to having my interview audiotaped and videotaped.

Transcription of focus group:

- □ I consent to having my taped interview transcribed into written form.
- □ I do not consent to having my taped interview transcribed into written form.

Use of transcript:

- □ I consent to the use of the written transcription of my interview in presentations and written documents resulting from the study if neither my name nor other identifying information will be associated with the transcript.
- □ I do not consent to the use of the written transcription of my interview in presentations and written documents resulting from the study.

Signature of Participant_____Date_____

I hereby agree to abide by the participant's instructions as indicated above.

Signature of Researcher_____Date_____

APPENDIX D

Status of Request for Exemption from IRB Review

HARDING UNIVERSITY
INSTITUTIONAL REVIEW BOARD

Status of Request for Exemption from IRB Review

(For Board Use Only)

Date: January 3, 2013

Proposal Number: 2013 – 001

Title of Project: The Development Process of Self-Sustainable School-based Health Center (SBHC) for a School District in Western Arkansas

Name and Contact information for the Principal Investigator: Jared A. Cleveland, Jared.Cleveland@arkansas.gov

■ Research exempted from IRB review.

☐ Research requires IRB review.

☐ More information is needed before a determination can be made. (See attachment.)

I have reviewed the proposal referenced above and have rendered the decision noted above. This study has been found to fall under the following exemption(s):

1 ■ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐

In the event that, after this exemption is granted, this research proposal is changed, it may require a review by the full IRB. In such case, a ***Request for Amendment to Approved Research*** form must be completed and submitted.

This exemption is granted for one year from the date of this letter. Renewals will need to be reviewed and granted before expiration.

The IRB reserves the right to observe, review and evaluate this study and its procedures during the course of the study.

Rebecca O. Weaver

Chair
Harding University Institutional Review Board