

**Health Care for Special Populations:  
Examining the Role for School-Based Health Centers  
in Supporting Children with Special Health Care Needs**

**The National Assembly on School-Based Health Care**

**Meeting Proceedings  
Washington, DC  
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In October 2006, the National Assembly on School-Based Health Care (NASBHC) convened representatives from education, special education, school nursing, school mental health, school-based health care, parent communities, and health education policy sectors [see appendix C for roster] to discuss how school-based health centers (SBHCs) can work with schools to support the education and health of children with special health care needs (CSHCN).

Children with Special Health Care Needs are defined by the Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) as “those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally” (McPherson, et al, 1998).

For CSHCN there are many barriers to engaging fully in the learning process. Over the last three decades, federal education and civil rights laws have been enacted to protect access to education for all children regardless of disability requiring schools to provide for specific accommodations to meet their needs [see appendix A for brief description]. The result is that today’s public schools have become a critical mechanism for assessment, coordination, and delivery of medical, nursing, mental health, and therapeutic services to students with a broad range of acute and chronic physical, developmental, behavioral, and emotional disabilities.

Simultaneously, yet separately, as school systems endeavored to meet the increasingly diverse and complex health care needs of its students, a movement to bring primary care and mental health services into schools emerged. SBHCs as the model is known today, have a thirty-year history of improving access to health care for low-income children and adolescents and supporting school success [see appendix B for description]. However, unlike special education-related services typically provided in schools, all enrolled students are eligible to receive SBHC services.

Curiously, the organization of SBHCs and school-driven health services for CSHCN have remained two distinct and parallel systems of health care delivery in schools. SBHCs and schools have not maximized their partnership in serving this population. With ever growing pressure to meet expanding need amidst shrinking resources and limited clinical capacity, while raising academic achievement standards, schools are overwhelmed. In this environment it seems natural that existing community-based health care partnerships would play a more pivotal role in supporting CSHCN with high quality, on-site health care.

To guide the discussion, we asked the group to consider: *How can SBHCs provide capacity for schools in meeting primary and specialty health care services to CSHCN?*

The objectives for the meeting were to:

1. Build a common understanding of how SBHCs and school systems serve CSHCN;

2. Identify areas of service delivery with the greatest collaborative potential and determine the benefits of a synergetic relationship between SBHCs and school systems serving this population;
3. Explore the key challenges to collaboration between SBHCs and schools to better support this population; and
4. Identify short-term priorities and the top three areas of service delivery with the greatest potential to benefit SBHCs and schools in serving this population.

This document summarizes the meeting's findings and outlines next steps to continue exploring the collaboration between SBHCs and school systems in serving CSHCN.

### **Meeting Proceedings and Findings**

After a review of school health service concepts and models, which included working definitions of the various legal or regulatory components impacting some CSHCN (i.e., special education laws, Section 504), we asked participants to identify areas and/or services with the greatest potential for synergy between SBHCs and school systems in serving CSHCN (see appendix D). The resulting list of services was ranked by the group (low, medium, high) using the following criteria: patient satisfaction; greater health care outcomes; greater academic outcomes; potential financial savings; and reduced legal liability.

We employed a consensus process to prioritize services areas that participants believed to have the greatest potential for collaboration, the greatest beneficial impact on CSHCN, and the greatest opportunity for efficiencies in combining the resources of schools and SBHCs. Strong agreement was reached on the following three areas that represent the greatest potential for synergy:

- Mental health services
- Primary care/health assessment services
- Identification and referral for special education

What follows is a description of these priorities and the key challenges to SBHC-school system collaboration, keeping in mind existing education and health care policy, finance mechanisms, and school system and SBHC infrastructure.

### **Mental Health**

Mental health services are a top concern of school districts and education leaders given the increasing number of students being identified as having special health care needs, referred for special education services based on mental health issues, and exposed to high profile violent events that have occurred in schools. Participants identified many reasons to support collaboration around the provision of mental health services.

#### *Reasons to collaborate with SBHCs:*

- Proximity of SBHCs to the students having a daily presence in the school and an understanding of current happenings in the school.
- SBHC is a multi-disciplinary environment providing a holistic approach to coordination of services for CSHCN.

- Ability to recognize and treat additional health needs while attending to mental health needs.
- Capacity for improved mental health screening and identification of children with mental health needs.
- Opportunity to identify and address mental health issues that may initially present as physical health issues both within the SBHC and the larger school environment.
- Expertise in training for classroom teachers to reduce classroom behavioral disruption.
- Stabilize support for students with mental health issues and to assist teachers in understanding the CSHCN experience from the student's perspective.
- The ability to support siblings of CSHCN.
- Opportunity to de-stigmatize mental health services since they are co-located with the school instead of provided remotely.

*Challenges:*

- Given the shortage of licensed and qualified child mental health providers nationally, it can be difficult to recruit and hire qualified mental health providers to adequately staff SBHCs.
- Around the country, even very generously staffed schools are not fully able to manage the high level of mental health needs of their students.
- Mental health services provided at SBHCs may not be covered by private insurance.
- Services in an SBHC are vulnerable if there is not a mechanism to reimburse for these services.
- Educating SBHC providers about special education and its requirements.
- School social worker or counselor might perceive the "collaboration" as duplication of services.
- Greater confusion regarding authority and ultimate responsibility for the child's services might develop between school and SBHC personnel.
- Time needed for school and SBHC to discuss collaboration and creation of systems of accountability and authority that would clearly delineate the roles and responsibilities of each party regarding the delivery of services to children with IEPs and 504 plans.

**Primary Health Care Assessment/Medical Care**

Coordination of primary health care assessments and services through a SBHC would benefit students with special health care needs, general students, as well as the academic and health care systems serving them.

*Reasons to collaborate with SBHCs:*

- Due to their location, relationship to the school, and expertise, SBHCs are well positioned to understand the special relationship between the health and mental health needs of students and the school environment.
- The SBHC model is characterized by the flexibility it offers practitioners. For example, this can be flexibility with time as students are accessible for follow-up.

- SBHC could provide guidance to teachers on how best to manage a students' needs and challenges within the classroom and other aspects of their educational experience.
- Student follow-up, monitoring of needed medications, routine lab tests and screenings, and additional medical management tasks are more centralized and accessible at the SBHC.
- SBHCs have an excellent track record improving quality of care.

#### *Challenges*

- Formally recognizing SBHC providers as primary care providers for CSHCN may cause more confusion and difficulty in fully coordinating the health care services a child may be receiving from other providers.
- Lack of awareness and understanding in community about services provided in an SBHC.
- Parents may perceive health services provided at an SBHC to be inferior to those in a more traditional doctor's office. For example, some parents have said when offered the services of an SBHC that they would prefer to take their child to see a "real doctor."
- Limitations of some SBHC staff in understanding special education laws, requirements, and how funding for services provided under IDEA may be used.
- SBHC might be reluctant to become involved in the development and implementation of a special education student's IEP due to the additional burdens of paperwork, reporting, meeting times, and oversight.
- Legal liability for SBHCs if services were not provided to students as required by their IEP and whether such liability might impact an SBHCs willingness to participate in the delivery of services to special populations.

#### **Identification of Accommodations for CSHCN and Referral of Students for Identification of Special Education Needs**

SBHC practitioners could greatly assist school systems in meeting their legal obligations regarding CSHCN and identification of students with special education needs.

#### *Reasons to collaborate with SBHCs*

- Given their expertise and relationship with students, SBHCs are in a good position to identify accommodations needed by CSHCN.
- SBHC practitioners serve as a resource for children and youth within a school and are often the place where students go to received support when needed.
- SBHCs can increase appropriate referral of students for testing of special education services.
- SBHC practitioners could help to ensure the appropriateness and effectiveness of specialized services.

#### *Challenges*

- Coordination between the school and SBHC

- Difficulty of strong communication between the SBHC and school around the identification, referral, delivery of services, and follow-up.
- Adds another entity into the process of accountability
- “Practitioner Lens” – assessing the child strictly from a medical standpoint may increase the tendency to see identified problems as strictly medical and to treat the child as such, without referring the child to special education. As a result, a child may miss an opportunity to access IDEA.

*For a full list of opportunities and challenges identified in the areas of Mental Health Services, Primary Health Care, and Identification and Referral, see Appendix E.*

## **Next Steps**

### Conduct a Readiness Assessment of the SBHC Field

Research was conducted prior to the summit to give participants a greater understanding of the current role that SBHCs have in addressing the medical and mental health needs of CSHCN. Summit participants felt that they needed additional data to comprehensively assess the SBHC field’s knowledge of CSHCN and the field’s willingness and receptivity to providing services in collaboration with schools and school systems. Results by non-attending experts in phone interviews as well as responses from attending meeting participants could help formulate recommendations in response to the follow questions:

1. Are SBHC practitioners interested in collaborating with their schools to deliver services to CSHCN? If so, do they have the staff necessary to do so (both in number and expertise)?
2. What services do SBHC practitioners and administrators feel they are best equipped to deliver?
3. What are SBHC practitioners and administrators concerns regarding the delivery of care to this population?
4. What kind of training is needed in order to adequately prepare SBHC practitioners and administrators to serve this population?

### Investigate Policy/Legislative Opportunities for Formalizing Collaborations between School Systems and SBHCs

Participants felt it was imperative that an investigation into relevant legislation, regulations, and policies be conducted in order to understand the current legal and regulatory parameters of a potential collaboration between school systems and SBHCs. Of particular importance were those policies that defined reimbursement mechanisms for the delivery of services to CSHCN and the legal liability for doing so. Concern was raised that if either SBHCs or schools were not supported through policy, they may be unwilling to collaborate. Additionally, participants articulated their desire to become more familiar with existing research on the intersections between SBHCs and school systems in serving CSHCN and to explore opportunities for creating new or revising existing policies.

### Develop and Disseminate Guidelines for SBHCs in Serving Special Populations

Participants suggested that NASBHC develop principles for the SBHC field that would help to define the role SBHCs could play (given the current financial and legislative structure) in serving CSHCN in schools. These principles would reflect the best practices in the fields of education and health and guide practitioners on the administrative, organizational, and policy considerations that would ensure high quality, reliable, and appropriate care to students with special health care needs.

#### Provide Training to SBHCs and the Education Field

Participants recognized that education and awareness building among SBHC providers and educators was necessary in order to move this dialogue forward. Meeting participants from the SBHC field suggested that trainings be offered to SBHC practitioners and administrators on: (1) the general academic needs of CSHCN; (2) the school's legal obligations in meeting the health and mental health needs of this population; and (3) how SBHCs might effectively participate in that process.

Meeting participants from within the education field, suggested that trainings be offered to relevant school personnel on: (1) what an SBHCs offers; (2) how SBHCs are integrated within schools and how they collaborate with school programs; and (3) how education personnel might consider utilizing these centers to support their work with CSHCN.

#### Foster Strategic Partnerships and Establish an Entity to Oversee the Development and Execution of a Work Plan

Participants articulated their hope that NASBHC, as a leader in the SBHC field, would utilize their position to bring together national, state, and local partners from both the SBHC and education fields to create a collaborative entity to address how both fields can partner to support CSHCN. Critical to the continuation of this dialogue and investigation would be the gathering of additional data (e.g., policies, legislation, readiness data) which would require the active participation of additional partners. The summit provided an initial forum for this dialogue, and all participants agreed that additional organizations and individuals with relevant expertise and/or interests would need to be invited into the conversation to continue productively. Similarly, participants agreed that an entity would need to be created to support and oversee this initiative as well as organize and supervise all strategic partners. It was thought that this entity could not only help facilitate the research phase, but could also help oversee and organize efforts needed to enact policy or program changes that emerge as a result of additional investigation.

#### **Conclusion**

Meeting participants outlined several ways in which NASBHC can lead SBHC-focused work to promote activities that support the needs and challenges of CSHCN. These include:

- Assessing the SBHC field to determine knowledge of, willingness, capacity, and receptivity to provide services collaboratively with schools to support CSHCN.
- Investigating policy/legislative opportunities for formalizing collaborations between school systems and SBHCs.

- Developing and disseminating principles for SBHCs that would provide guidance to the field.
- Leading training efforts on working with CSHCN.
- Fostering strategic partnerships to involve multiple stakeholders in the work to ensure a diverse range of needs are met.

Collaboration between SBHCs and schools is a natural and effective way to address the challenges faced by CSHCN. By supporting their medical and mental health needs, SBHCs and schools can partner to assist CSHCN in being healthy, present learners. This collaboration promotes a wider use of limited resources, improved compliance of federal and state mandates, and, most importantly, meeting the educational and health needs of children and adolescents with physical, emotional, or behavioral challenges that impact their educational experience.

## **Appendix A**

### **Federal Policies on Special Populations**

The two laws that specifically govern special education and related health and mental health services are the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Americans with Disabilities Act.

#### Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA) requires schools to identify and evaluate all children with disabilities to determine eligibility for special education and related services.

*Categories of qualifying conditions.* IDEA law defines 13 categories of qualifying conditions such as autism, specific learning disabilities, speech or language impairments, emotional disturbance, traumatic brain injury, orthopedic impairment, visual impairment, hearing impairment, and other health impairments.

*Individualized Education Program (IEP).* For each child deemed eligible, schools must convene a multi-disciplinary team of educators, specialty providers, family members, and when appropriate, the student, to develop an IEP that meets the student's learning needs in the least restrictive environment possible. The program should be designed to provide all additional health and related services necessary to allow that student to fully participate in their education.

*Related Services.* Under IDEA legislation "related services" includes transportation, counseling, developmental, corrective, or other supportive services. Over time this definition has been interpreted to include: language pathology and audiology services, psychological services, physical and occupational therapy, recreation (including therapeutic recreation), social work services, counseling services (including rehabilitative counseling) orientation and mobility services, and medical services (for diagnostic or evaluation purposes only) that are required to assist a child with a disability to benefit from special education (20 U.S.C. section 1401 (22)). Climate control, special diet/nutrition education counseling, school health services, medication administration, emergency care and "do not resuscitate" requests have been considered "related services."

*Evaluation.* The multi-disciplinary team must meet annually to review the individual progress for each student, assess academic goal attainment, and determine the adequacy of the resources and services being delivered. Every three years, the student's disability is reassessed and eligibility for special education services is reviewed.

### Section 504 of the Disability Rights Act

Section 504 of the Disability Rights Act (ADA) protects individuals from discrimination and ensures that children with disabilities have equal access to an education. To be eligible for protections under Section 504, the child must have a physical or mental impairment that *substantially limits* at least one major life activity (i.e. walking, seeing, hearing, speaking, breathing, learning, reading, writing, performing math equations, working, caring for oneself, and performing manual tasks). In meeting the responsibilities to students with disabilities under Section 504 and Title II of the ADA, school systems must accommodate the needs of students with disabilities. Modifications can include changing rules, policies or practices, removing architectural or communication barriers, and/or providing aids, services, or assistive technology.

### Differences between IDEA and Section 504

A child whose disability severely limits at least one major life activity may be entitled to protection and accommodations under Section 504 (ramps, temperature control, elevator use, etc.) If the disability *does not adversely affect educational performance* the child is *not* protected by IDEA. Children who are eligible for special education services under IDEA are also protected under Section 504.

[See the Council for Exceptional Children's "Understanding the Differences Between IDEA and Section 504" for a more comprehensive overview.]

## **Appendix B**

### **School-Based Health Centers**

School-based health centers (SBHCs) are located in or near a school facility and are organized through school, community, and health provider relationships. An SBHC is administered by a sponsoring facility and its health professionals provide, at a minimum, comprehensive primary health services during school hours to children and adolescents. The number of SBHCs has grown rapidly over the past two decades. In 1988, there were 120 SBHCs nationally. By the 2004-2005 school year NASBHC identified 1708 school-based and school connected programs in 43 states, the District of Columbia and Puerto Rico (Juszczak, Schlitt, Moore, 2007). These programs are often the primary (or sole) provider of health care to the 1.7 million children and adolescents they serve.

The scope of services provided by an SBHC typically falls into three categories: physical health, mental health, and optional services. Physical health care typically consists of comprehensive health assessment; diagnosis and treatment of minor, acute and chronic medical conditions; and referrals to and follow-up for specialty care. Mental health care often includes mental health assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, outpatient and inpatient care, and substance abuse programs. Optional Services may include oral health, social and health education services, and case management. Ultimately, the scope of services provided by a SBHC is determined at the local level and depends upon the needs, desires, and available resources of the community being served.

The most common component of a SBHC's scope of services is primary preventive care. Over 90% of SBHCs provide comprehensive health assessments, vision and hearing screenings, anticipatory guidance, immunizations, and prescription services, in addition to treating acute and chronic illness (Juszczak, Schlitt, Moore, 2007).

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## Appendix D

**What are the services with commonalities or potential for synergy between SBHCs and school systems in serving special populations? (Frequency of mention in parentheses.)**

- Mental Health Counseling (15)
- Medication Management (7)
- Health Assessments (6)
- Social Work Support (6)
- Behavioral health evaluation plan and treatment (4)
- Obesity counseling and recreation (4)
- Identification: eligibility determination (3)
- Primary care (3)
- SBHC participation in IEP/504 teams (3)
- Transition Assistance and planning (3)
- Chronic Care (2)
- Health education (2)
- Occupational and Physical Therapy (2)
- Well visits (2)
- Mental advocacy services for families
- Psychiatric Services
- Psychology Services (schools)
- Therapy
- Support Services – Annual Yearly Progress (AYP)
- EPSDT Services- Early Periodic Screening, Diagnostic, and Treatment Services
- Evaluation and Assessments
- Psycho-educational evaluations
- Speech Language
- Dental
- Student Services Teams: identification
- Training and support to school
- Community organizing
- Nutrition
- Health education staff training
- Emergency response planning for SBHCs
- Specialized technological support to students
- SBHC housing for specialists
- Outreach services
- Substance abuse services in high schools
- Advocacy for SBHCs
- Student advocacy for access services
- After school/extended learning opportunities
- Counseling for gender identity issues
- Referral processes
- SBHCs interface with families

**Appendix E**  
**Services with Greatest Potential for Synergy: Opportunities and Challenges**

**GROUP FEEDBACK**

<b>Services with Greatest Potential for Synergy</b>	<b>Description of Potential Opportunities</b>	<b>Description of Potential Challenges</b>
Mental Health Services	<ul style="list-style-type: none"> <li>• Children are in the schools and we have access to them, so it makes considerable sense relative to the proximity</li> <li>• School-based health center staff have a sensitivity relative to the needs of the students</li> <li>• In line with the top concerns of school districts, etc. recent violence in schools</li> <li>• Confidentiality relative to HIPAA</li> <li>• Ability to increase the quality of services that are so instrumental to success</li> <li>• Ability to access services</li> <li>• Evaluate the value of outsourcing</li> <li>• More comprehensive rather than a “siloeed” approach to coordination</li> <li>• Improved identification of kids in need of services</li> <li>• Better utilization, better outcomes</li> <li>• The clinical competence of trained MH providers</li> <li>• Multi-disciplinary and enhanced collaboration</li> <li>• Devote more educational time to the academic mission if specialist there to take on the health issues</li> </ul>	<ul style="list-style-type: none"> <li>• Represents the perspective of people who think about SBHCs               <ul style="list-style-type: none"> <li>◦ What do stakeholders such as nurses, school counselors, etc. think?</li> </ul> </li> <li>• Lack of qualified workforce (MH providers) – where will they come from? 30% of clinics don’t have MH staff - what are the expectations from PCPs?</li> <li>• Need coordination with school social worker– school accountability for making sure services are provided without possible authority for executing</li> <li>• Staffing is a problem – however, MH services are one of the reason (according to studies) why students access services in the clinic in the first place</li> <li>• If school has a mechanism for funding mental health resources, but the SBHC can not access this resource and the SBHC takes on these cases, may not have enough resources – different funding streams</li> <li>• Programs that do have not have mental services – in order to manage and support mental services there is a completely different expertise and skill required, schools may not have the expertise/resources, and medical providers may not understand the special education requirements</li> <li>• Staffing: Even very generously staffed programs don’t come close to being able to manage the mental health needs of many school’s populations</li> <li>• Expectations of the Board of Education making sure they think of SBHC as an opportunity to pool resources</li> <li>• When children have private insurance, if they are not in special education, their MH may not be covered in schools – so providing the service in an SBHC does not necessarily mean increased access for those children</li> <li>• Coordination of service delivery between the two different entities</li> <li>• Determining the roles and boundaries of each entity</li> </ul>

Services with Greatest Potential for Synergy	Description of Potential Opportunities	Description of Potential Challenges
	<ul style="list-style-type: none"> <li>• Reduced classroom behavioral disruption and stabilizing support for students in the classroom</li> <li>• Co-location would help de-stigmatize service delivery for mental health as opposed to a remote location</li> </ul>	<ul style="list-style-type: none"> <li>• Clarifying the funding streams that would support the services and who would receive those funds.</li> <li>• No centralized voice for MH or single point of contact (e.g., director of guidance counseling) – catch as catch can – no easy access point</li> <li>• Risk might be a lot of wasted energy in trying to bring MH access to schools</li> </ul>
Primary Care Health Assessment/Medical Care	<ul style="list-style-type: none"> <li>• Improved absenteeism and truancy</li> <li>• Primary care professional able to coordinate and improve access to specialists (impact on reimbursement)</li> <li>• Access to a network</li> <li>• Referral to school and larger community by virtue of having a better understanding of the child's needs</li> <li>• Credit from MCOs in seeing children might be possible</li> <li>• Follow up with monitoring of medications from a more centralized posture</li> <li>• Better position to understand the special needs in the global environment in a effect to get this person to stay in school and achieve academic success</li> <li>• Assessments of greater quality and more specific. Helping teachers to understand what can be done in an educational setting</li> <li>• Improved coordination with faculty in the school, parents, other health care providers –</li> </ul>	<ul style="list-style-type: none"> <li>• When health services are provided at school by primary care providers, services are not valued the same way as health services that you pay for on the outside (e.g., I will take them to see a “real doctor” – it’s a PR issue). Polling that the Kellogg foundation recently did reinforces that lack of understanding and connectedness</li> <li>• Lack of awareness and understanding among the greater population that the services being provided to students are truly quality medical services</li> <li>• On the other hand parents – don’t know that the schools provide these services</li> <li>• Limitations in some of the SBHC staff in understanding the special education laws, how funding can be used – where do we get our information and what do we need to give to our own providers so that they can be completely up to speed</li> <li>• SBHC might be reluctant to become involved in an IEP team because they might not want to become responsible for the paperwork that the IEP might require. Looking at a more limited service – the 504 - those are services that we traditionally provide even if there is not a 504. Then there is an added burden of reporting, paperwork, and oversight that has little or no effect on the quality of the service. Some cases might require two sets of records – separate and distinct from the notes in the IEP – some overlap other distinct – lots of confusion on guiding providers on language – standardization around documentation/definitions</li> <li>• Absenteeism and truancy is an opportunity for collaboration – often the clinic is not engaged in a partnership with the school staff that are trying to bring these kids into schools</li> <li>• Training that would be required for an SBHC in serving kids with special needs.</li> <li>• Compliance – understanding some of the</li> </ul>

Services with Greatest Potential for Synergy	Description of Potential Opportunities	Description of Potential Challenges
	<p>nurses in position to be recognized and respected when there is a concern about a child's education</p> <ul style="list-style-type: none"> <li>• Multi-disciplinary therefore better position to benefit from best practices</li> <li>• Caring adult</li> </ul>	<p>nuances in the new version of IDEA – a large # of children being referred to schools along the autism disorder – perhaps we would help our school nurses in how to interact with children and those who are demonstrating these behaviors around a full spectrum</p> <ul style="list-style-type: none"> <li>• If services on an IEP are not provided then there is the potential for a lawsuit</li> <li>• There are distinctions between the way schools and SBHCs approach children with special health care needs – not talking about taking away these distinctions but how you bridge them</li> </ul>
Identification and Referral	<ul style="list-style-type: none"> <li>• Streamline the coordination of students through the process by having a better understanding of their needs</li> <li>• Greater degree of effectiveness and better financial results and better chance for student success (reduce isolated environments and increase health inclusive environments)</li> <li>• Better chance for dismissal from special ed (with some support services)</li> <li>• SBHC practitioners in a better position to measure the effectiveness of specialized services than outsourced providers</li> </ul>	<ul style="list-style-type: none"> <li>• Coordination between the school and the SBHC</li> <li>• Practitioner lens – when practitioner assesses the child with his/her medical hat on, there might be the tendency to see any identified problems as strictly medical and to treat the child as such, without referring the child to special education.</li> </ul>

## Appendix F References

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