A Guide to Opening a School-Based or School-Linked Health Center in Michigan

School–Community Health Alliance of Michigan

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WELCOME!

The School-Community Health Alliance of Michigan is excited for your interest in exploring the feasibility of a new school-based health center in your community. It is our hope that this guide helps provide some insight regarding the services available, and the process to determine the best model of care in your school.

School-based health centers (SBHCs) and school-linked health centers (SLHCs) have flourished in the United States for several decades. In Michigan, the first historically recognized SBHC was established in 1981, and our first SLHC, known as Corner Health, was created in 1979. Michigan is a national leader in terms of providing state funding for education and public health, including funds for the proliferation of school-based health centers.

This guide will help you formulate a plan and begin conversations with key community stakeholders who will play a large role in your plan's effectiveness. Partnerships are crucial to making your school-based health center a successful reality. State funding is not intended to provide all the funds necessary to create an SBHC. It will provide the bulk of your funds but will not wholly sustain a full-time center. The state program is built on the pillars of school, community, and health. Indeed, it will take all three pillars to build a thriving health center for the children and youth in your school or school district.

The School-Community Health Alliance of Michigan (SCHA-MI) is available to provide advice and guidance whenever possible. Please don't hesitate to e-mail us with your questions. Contact Robin Turner, Director of Field Outreach and Training, at: rturner@scha-mi.org.

Best wishes in your endeavors!

Deb Brinson
Interim Executive Director
School-Community Health Alliance of Michigan

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LIST OF APPENDICES

The items below are for informational purposes only, including samples of policies that centers have used in the past. They are not meant to be duplicated in any way.

A Guide to Opening a School-Based or School-Linked Health Center in Michigan

CHAPTER 1: OVERVIEW

The first teen health centers in Michigan opened in 1979, building on models developed in both Minnesota and Texas. In 1985, then-Governor James Blanchard and then-State Health Director Gloria Smith commissioned a group to develop a five-year plan for adolescent health. State funding in 1987 was appropriated to fund planning grants, with the first 26 state-funded centers opening in 1988. A unique Medicaid matching program was created in 2003, allowing for a significant expansion of sites. In 2015, new centers were funded. Funding for additional mental health sites was allocated in 2018, with further expansion in 2020. Currently there are 280 state-funded school-based/linked health centers and programs throughout the state of Michigan, and over 80 that are not state funded. A map of these state-funded centers is available in Appendix A.

The School-Community Health Alliance of Michigan (SCHA-MI) was initially founded in 1999 as a networking and advocacy group. When then-Governor John Engler issued an executive order in November 2001 to cut all state funding to these programs, a rally took place in Lansing, where center staff, parents, students, school staff, and others were able to overturn the executive order and keep the centers of SCHA-MI open. The Kellogg Foundation stepped in to fund the embattled program, which resulted in a stronger advocacy voice as well as further networking and educational opportunities.

SCHA-MI was funded with only $1.25 million from MDHHS beginning in 1987. Funding today is $47.3 million total for school-based health centers and mental health only sites in Michigan. In terms of advocacy and legislation, it is a program that enjoys bipartisan support.

Why We Have Programs and Centers in Schools: How They Help Kids

The philosophy behind placing health services in or near schools is simple: that is where children and youth spend the bulk of their time. Placing services inside the schools eliminates many barriers children and teens face. For example, transportation, and working parents who are unable to take time off for a child's doctor visits. It is well accepted that healthy children make better learners and research supports a connection between health status and academic performance. Students and teachers alike say that school-based/school-linked health centers (SBHCs/SLHCs) make a difference because they take health issues out of the classroom and into the hands of qualified medical professionals.

For additional information, see the following resources in the appendix:

- *American Journal of Public Health* on the Cost Benefit Analysis of School-Based Health Centers and their Impact on Health Disparities (see Appendix B).
- FAQ on School-Based Health Centers (see Appendix C).

How Michigan's Programs are Funded

Michigan's programs are funded in a variety of ways. Because of Michigan's Medicaid Matching Initiative passed in 2003, the state has increased funding appropriations through matching federal Medicaid funds. State funding makes up the bulk of the funding for most sites, but not all centers have funding from the state. Local and national foundations are significant funders across Michigan, as are individual donors and local fundraising efforts. Finally, the centers bill insurers and/or Medicaid aggressively for those services that are billable. Reimbursement is not a large portion of the program's support, but it remains critical.

CHAPTER 2: PLANNING

Planning For Your Community: Creating a Work Group

There are a few initial steps to consider as you plan for a center.

1. Identify stakeholders that would be supporters of a school-based health center (SBHC) or school-linked health center (SLHC). This should include identifying a hospital, clinic, federally qualified health center (FQHC), or health department that could act as the fiduciary for your site. The fiduciary may be the agency for whom clinical staff will work because a center will require medical oversight as well as malpractice insurance. See the *Service Delivery Models of Care* on the next page for state-funded sites. Please note, not ALL models are available for funding every time—it will depend on the request for proposal (RFP) from the State of Michigan.
2. Develop a community advisory committee. Contact youth-serving agencies in the community who would help in the planning. In addition, identify parents/guardians, students, school staff, and others with a vested interest in this program to sit on your program's advisory committee. It is a Michigan Department of Health and Human Services (MDHHS) requirement to do so in order to obtain funding; however, it is also a key channel through which you can immediately gain buy-in within the community.
3. Educate your advisory committee about SBHCs and SLHCs. The members of your newly formed committee may not be familiar with their function and purpose. Visit operational centers in your area. Share contacts and information with your committee. SCHA-MI can assist you in making connections with existing centers.

Identify possible schools and ascertain their desire for a center or program.

1. Identify schools/communities for the programs. Be sure to engage the school principal(s) to secure their support.
2. Identify the location within the school/community where the SBHC/SLHC or program will reside. Make sure the location is easily accessible to students and staff. If at all possible, determine if community members can access the site easily (i.e., without having to search and wander the school). The health center will be open all summer long, so easy access is critical both from within and outside the school. This may not be possible, but it is worth exploring. Make sure the location is near plumbing for handwashing, patient space, laboratory, and all necessary resources. It may be challenging, but locating a site near city water access will significantly decrease renovation costs.
3. Determine if the site will need remodeling. If possible, your identified sponsoring agency/fiduciary may be able to assist with architectural drawings and a contractor.
4. Determine the costs of renovating the location. Please note that MDHHS funding can be used for renovations, but such funding will be limited and will certainly fall short of what you'll need for remodeling and setup. With help from the advisory committee and the sponsoring agency, identify other possible sources of renovation funds. This could include local businesses, individual donors, or location foundations. Depending on the extent of the renovations, the cost could range from $50,000 to $200,000.
5. Conduct a needs assessment. **This is a critical component of your planning.** Visit the SCHA-MI website (https://scha-mi.org) for suggested resources that can assist you. If possible, seek assistance with a needs assessment from a local university or other agency with experience in this. The needs assessment should include input from parents, youth, teachers, school staff, and the community at large, as well as the youth-serving agencies. With a well-developed needs assessment, you will be able to design the center's services to specifically address the needs of your community. (See Appendix D for sample needs assessment resources and sample sizes.)

6. Develop a memorandum of understanding (MOU) between the school district and the medical sponsor which delineates the responsibilities of each party, and how the school-based health center will be governed. Plan for the MOU approval to be protracted because the process can take some time. (A sample MOU is in Appendix E.)

Service Delivery Models of Care

Target Population

The target population for school-based child and adolescent health centers (CAHCs), school wellness programs (SWPs) and expanding, enhancing emotional health (E3) programs consist of children and youth 3 to 21 years old. School-linked health centers (e.g., community-based) serve only adolescents ages 10 to 21 years old (including special education students up to age 26). School-based and school-linked health centers may also serve the infants and young children of adolescents.

Service Delivery Models

CAHCs (also known as school based/linked health centers). Child and adolescent health centers provide comprehensive primary care (including well care and diagnosis/treatment for acute and chronic illness), behavioral health, health promotion/disease prevention, Medicaid outreach and enrollment, and access to Medicaid preventive services in a developmentally appropriate manner to eligible children and youth. They are staffed by a mid-level provider (Nurse Practitioner or Physician Assistant) and a licensed master's level mental health provider. Clinical services are provided a minimum of five days, or 30 hours per week. Mental health services are provided a minimum of 40 hours per week, or whatever your center's full-time equivalent is. With some variation depending on school size, a general average of 500 unduplicated youth must be served each year, per Michigan's minimum program requirements (MPRs). A new model for mid-size schools with less than 700 students is available, and requires a minimum of 350 unduplicated users.

Alternative Clinical Health Centers. These centers provide comprehensive primary care (including well care and diagnosis/treatment for acute and chronic illness), behavioral health, health promotion/disease prevention, Medicaid outreach and enrollment, and access to Medicaid preventive services in a developmentally appropriate manner to eligible children and youth. They are staffed by a mid-level provider (Nurse Practitioner or Physician Assistant) and a licensed master's level mental health provider. Alternative Centers differ only in the number of hours required to be open, and the number of youth served. Clinical services are provided a minimum of three days, or 24 hours per week. Mental health services specifically are also provided a minimum of 24 hours per week. A minimum of 200 unduplicated youth must be served each year. *This model was developed for smaller, high need schools such as alternative high schools.*

Expanding, Enhancing Emotional Health (E3) sites. E3 sites provide mental and behavioral health in individual and group settings. E3 models are staffed by a full-time and licensed master's level mental health provider in one school building, year-round. Services fall within the current, recognized scope of mental health practice in Michigan and meet the current, recognized standards of care for children and/or adolescents.

School Wellness Programs (SWPs). SWPs provide school nursing services, behavioral health, health promotion/disease prevention, Medicaid outreach and enrollment, and access to Medicaid preventive services in a developmentally appropriate manner to eligible children and youth. SWP staff also provide professional development to school staff on a variety of topics. SWPs are staffed by a full-time RN/school nurse and licensed master's level mental health provider. SWPs are open a minimum of five days per week and a minimum of 250 unduplicated youth must be served per year.

See Appendix N for a table depicting service models of care, funding, and other specifications.

CHAPTER 3: PROGRAM STRUCTURE

Based on your needs assessment, identify the service delivery model for the community. Do you need full-service SBHC/SLHC; a wellness program only (i.e., health education and promotion); or limited services, such as mental health only?

Once the scope of services is determined, the next step is to decide what facility and/or space is needed and where. Services for your program will generally need to include:

- Wellness exams
- Sports physicals
- Immunizations
- Sick visits
- Hearing/vision screening
- Telehealth, if possible
- Health education
- Chronic health conditions: obesity, diabetes, asthma
- STI testing and treatment
- Pregnancy testing and referral
- HIV/AIDS testing and treatment

Behavioral health services offered through school-based health centers, school-linked health centers, school-wellness programs, or mental health only health centers:

- Group counseling
- Individual counseling
- Family counseling
- Rotating psychiatrist, if possible

Identify Your Site: Planning the Facility and/or Designing the Program

- The first task is to identify the school/community where the SBHC/SLHC will be located. Identify specific space within the school or community. Make sure there is plumbing for hand-washing sink, patient bathroom(s), laboratory space. Plumbing work can be very expensive, so it is best to identify a space in proximity to water.
- The space will likely need remodeling and it is here where the health fiduciary and/or the school district or community can assist in key tasks by helping to obtain:
  - Architectural drawings
  - Formal approval from the school district (SBHC). (See sample MOU with a school district in Appendix F.)
  - A building contractor. Again, the fiduciary and/or school district can help with this.
  - Funding for the renovations. Note that MDHHS allows very limited funding to cover renovation. (See Chapter 4 regarding funding.)

While health centers may range from a cot and first-aid station to a comprehensive clinic offering physical, behavioral, and mental health services to students and their families, all health facilities should guarantee privacy, confidentiality, and comfort.

- **Privacy:** The facility's physical layout should address students' psychological and social need for privacy. The waiting area should not be visible from an external corridor; the examination room should be secluded from the rest of the health center by walls or movable partitions; and the phone should be in a private or semiprivate enclosure.
- **Confidentiality:** The mental and physical health of an individual should be confidential. Therefore, equip the health center with locking filing cabinets and storage spaces for medical records and personalized pharmaceuticals; keep administrative files, information, and equipment out of patients' reach; and provide separate restrooms, waiting and rest areas, and sound machines to damper overhearing conversations among clients and providers.

To allow for the various functions that transpire in a school-based health clinic, the following minimum facilities should be available:

- **Private office space:** Private office space should be provided for each full-time provider. Each office should be wired for telephone, computer, and modem access to the internet. Further, structural walls should be insulated in offices and exam rooms to mitigate the possibility of overhearing confidential conversations.
- **Secure storage area(s):** Secure storage areas should be provided for pharmaceuticals, sterile supplies, and medical records.
- **Private examination and treatment room(s):** There should be a minimum of one examination room per full-time provider. Each room should have a sink with hot and cold water and storage space for first aid and examination supplies. If the room is to be used for more specialized treatment, consideration should be given to ensuring an appropriate number of electrical outlets are available.
- **Utility area(s):** The utility area should have a designated clean and soiled space for clinical functions and disposal of waste.
- **Hearing and vision screening area:** A designated area should include eyecharts and instrument-based vision screening using automated devices such as photoscreeners and autorefractors. For hearing tests, you will need audiometric headphones and a dedicated quiet space free of ambient noise.
- **Laboratory:** The laboratory area should have multiple electrical outlets, bright and directed light, and easy access to a refrigerator and ice maker. The laboratory area and the rest of the health clinic should be designed to follow infection control practices and universal precautions as defined by the Occupational Safety and Health Administration (OSHA) regulations. For example, you will need a special immunization refrigerator with an alarm to notify personnel in case of a power outage. Ideally, your lab will include a pass-through door in the wall adjoining the restroom for collecting urine samples. (See Chapter 6 regarding other lab requirements.)

Additional Considerations

- Square footage requirements for school-based health clinics, while not standardized, have been found to be approximately 1,500 to 2,000 square feet per 700 students. Certain functions may require more than one space and some spaces may be shared by two or more health care providers.
- School-based/school-linked health centers frequently operate year-round with extended hours, often when the rest of the school is closed. This has important implications on a range of facility issues. Heating and ventilation systems should serve the health center independently from the rest of the school. Telephone and electrical wiring should be dedicated exclusively for health center use and should be independent from school telephones and wiring. The health center should be adjacent to public parking, and should have a prominent entrance with outdoor lighting for night use. Finally, the health center should be easily closed off from the rest of the school without affecting external access to the health center or internal access to restrooms or administrative supplies.
- Work with your fiduciary/sponsoring agency to meet their requirements. Depending on the sponsoring agency's requirements, the space may need to adhere to the Joint Commission's specifications for square footage, utilities, access, and Americans with Disabilities Act (ADA) requirements. (The Joint Commission is a United States-based nonprofit tax-exempt 501(c) organization that accredits more than 22,000 U.S. health care organizations and programs.) Before proceeding, be sure that those requirements are known and followed.

Be aware that your chosen school/community may not have the space outlined above. You may need to cut down on the size and perhaps the scope of your services or find another school or external site in which to establish your services. Be creative. Work with the school principal—with an architect if possible—to identify alternative space or for assistance in reconfiguring an existing space.

CHAPTER 4: FUNDING

The funding you will need will depend in large part on the scope of the program. If opting for a full-service SBHC/SLHC, the primary expense will be staff salaries and benefits. This will likely consist of around 75% of overall expenses (e.g., provider type [nurse practitioner (NP) or physician assistant (PA)]; general medical assistance; physician oversight). In addition, a full-service SBHC/SLHC will also include a social worker. Of course, those costs will vary based on your local market and on whether staff are full- or part-time. However, a full-time mid-level provider alone might garner a salary of $90,000 to $100,000 plus benefits. Additional staff salaries/benefits can run as much as $75,000 or more. Medical supplies and administrative resources will easily bring the total cost to $200,000 annually. (Note that these dollar amounts may vary based on your local market.)

To operate a full-time, full-service SBHC/SLHC it will cost approximately $200,000 per year; an alternative model (with fewer hours of operation, for example), or health education-only, or mental health-only services will greatly reduce the costs. Which model you choose should depend on the needs identified in your needs assessment but may also depend on available funding.

So, how can you find the funds to support all this?

- Target state and national foundations, businesses, donors, and potential investors.
  - There are national foundations that have supported these programs in the past (e.g., Kellogg Foundation; Kresge Foundation; Robert Wood Johnson Foundation) although securing a grant from them might be challenging.
  - A critical IRS requirement, known as "community benefit," obligates a nonprofit hospital to demonstrate that a certain dollar amount will be spent in return to their community; maintaining their nonprofit status depends on this. Your program is a perfect example of a community benefactor that the fiduciary can highlight to meet this IRS requirement.
- If you are *not* seeking state funding, identify local, community, or other networking sources. If possible, seek the advice of your fiduciary, the school district, and local youth-serving agencies.
  - Your best option for funding might be a local or family foundation. Many communities have such entities as well as local businesses that may be interested in providing support.
  - Businesses, such as a bank, are often open to a request as a way for them to demonstrate local and community support and involvement.
  - Determine if a local individual or family would like to give back to the community. Again, seek advice from others as to who might be willing to consider this investment.
- If seeking MDHHS funding, be aware of what those grants do cover and don't cover.
  - In Michigan, the MDHHS is a primary funder for these programs. MDHHS provides very limited funding to cover renovation costs and any equipment or items that will be permanent in the site (e.g., construction of a wall or the cost of air conditioning). Again, MDHHS has very specific minimum program requirements (MPRs) to qualify for their funding. (See Appendix G for MDHHS/CAHC MPRs.)

CHAPTER 5: PROGRAM POLICIES AND PROCEDURES

Even if you do not seek funding for your program from MDHHS, their MPRs provide an excellent template for establishing a center, behavioral, or alternative program that will provide the best quality of care for your patients as well as meet many other regulatory requirements. (See Appendix H for a guide to best practices.) In accordance with these MPRs, following are suggestions for establishing your programs policies and procedures.

- Seek the guidance of your designated fiduciary/sponsoring agency for any requirements, policies, and procedures they may require.
    - Your sponsoring agency may have policy or other requirements for a health service. For example, if a private, nonprofit hospital will be your fiduciary, it is likely they will want the physical site itself to meet Joint Commission requirements. (As a regulatory agency, the Joint Commission certifies all health entities in the country meet the highest standards. Hospitals and health systems are visited every three years by the Joint Commission and can impose significant fines or sanctions if an organization is deemed non-compliant. While it is likely the Joint Commission will not actually visit your site, you must be prepared. Your hospital sponsor will assist in this endeavor.)
- Develop administrative, clinical, and other policies and procedures. The MDHHS CAHC webpage contains a wealth of resources to guide your planning.
    - For further information, see the required Policies and Procedure Checklist in Appendix I.
- Create a sliding-fee-scale policy and procedure.
    - Most SBHCs/SLHCs and programs are located in high need/high poverty communities. It is likely that your program will serve a population with a low family income. You will want to assure community members that you are able to see any child/adolescent regardless of health insurance status or ability to pay. The federal government provides income guidelines to help create a sliding-fee-scale for your use. In most cases, the scale will use the child/adolescent's "income" to determine if they qualify for no fees, or discounted charges. The U.S. Heath Resources and Services Administration (HRSA)'s 2021 Sliding Fee Discount Program guidelines can be found in Appendix J or at www.hrsa.gov.
    - MPRs require that no one be turned away regardless of any balance or ability to pay. Most centers will bill only those on private insurance for 30 days, after which they are permitted to write off the loss for tax purposes.
- Determine how to bill for services—that is, *who* can bill for services rendered, and *what* services are billable.
    - You will want to secure all available funding sources; this should include billing for services offered. If your SBHC or program is staffed by a physician/NP/PA, their services are reimbursable. (Services directly provided by a physician will be reimbursed at a higher level than those provided by a NP or PA). MDHHS has established a certification process in order to bill, and will require that your providers are credentialed with any and all Medicaid health plans.
    - Mental health services provided by a social worker with a master's degree (MSW) may be reimbursable, depending on the type of services provided (e.g., treatment or preventive). You should seek to credential your MSW with available health plans if possible. Please be aware that your mental health provider should be a MSW rather than a psychologist or counselor because many health plans do not reimburse services provided by those individuals.
    - In keeping with MDHHS requirements, you will need to establish an outreach plan to enroll families in Medicaid if they are not already. Even if you do not seek MDHHS funding, this is an integral component of any level of programming and will add to your program's reach.

CHAPTER 6: LICENSING AND REGULATORY REQUIREMENTS

Health care abounds in regulatory requirements (for good reason) and your school health services are not exempt, especially if you are opting for a full-service SBHC/SLHC. The following is a list of considerations for licensing and other requirements.

- **Minimum Program Requirements:** MDHHS has developed an extensive list of MPRs for school-community-based health services. While it is compulsory for state funding that you meet these requirements, they are—regardless of funding sources—a valuable resource for developing your program. (See Appendix G, or visit www.MDHHS/cahc.gov for more information on MPRs.)
- **Lab Services:** You will need the capacity for basic lab testing in the clinic, usually called point-of-care testing. Common lab tests include pregnancy or STD testing and minor blood draws, for example. In order to set up lab services, you must obtain a Clinical Laboratory Improvement Amendments (CLIA) waiver from MDHHS. Again, check www.MDHHS/cahc.gov for CAHC resources. (See also the Centers for Medicare & Medicaid Services at www.cms/clia.gov for the CLIA application form.)
- **OSHA Requirements:** The Occupational Safety and Health Administration (OSHA) has specific requirements you will need to address. Your health care fiduciary should be able to help with this process. See www.osha.gov for details.
- **Credentialing of Providers with Insurers to Allow for Billing:** An additional step is to have your providers credentialed by the health insurance plans covering your patients. This will allow your providers to bill for services for those patients in the plans. This can be an extremely time-consuming endeavor, so you will want to start this process as soon as you have hired a provider, even before the person begins working. Your health care fiduciary will be critical in assisting with this process as it is required for all providers in any setting in the health care system.
- **Memorandum of Understanding with your School District:** You will need to obtain an MOU with the school district to establish the program. (See Appendix F for a sample MOU between a health center and a mental health organization.)
- **Consent Policies and Procedures:** You will need to have a consent form and related policies for your program. The form for the parent or guardian to sign that authorizes treatment of the child must be accompanied by specific, detailed policies for enforcement. See Appendix K and L for a sample consent form and policy sheet. The necessary verbiage may vary for your community, and your health care fiduciary can assist in this process as well. SCHA-MI has developed a guide that further explains Parent/Guardian Consent and Minor Consent Laws in Michigan. (Please visit www.scha-mi.org for further info on consent policies.)
- **Minor Consent Laws:** You will want to familiarize yourself with Michigan's minor consent laws and guidance. A minor may receive some services from a provider, without parent/guardian knowledge or consent. Those include substance abuse services, certain reproductive health services, or mental health services. These MAY be provided without consent from a parent if the patient is at least 14 years old. See Appendix M for a list of services available without parental consent with **any provider**, or check www.MDHHS.gov for details. It is best to seek legal advice from your fiduciary if you have questions. A key concept to keep in mind is that the provider is never obligated to waive parental consent, but is permitted to do so if it is in the best interest of the child. (As above, see www.scha-mi.org for a guide on Parent/Guardian Consent and Minor Consent Laws in Michigan.)

Overall, the best resource for ensuring your program aligns with all these regulations is the MDHHS CAHC website, particularly if you are considering state funding.

CHAPTER 7: NON-STATE-FUNDED PROGRAMS

Most school-based health centers in Michigan are state-funded. If funds are not available from the State of Michigan, you can compose a request for proposal (RFP) to develop your own center based on the needs of your community. The best way to go about this is to partner with a fiduciary to garner some interest, and then start collaborating on means for gaining community interest as well. Local banks, businesses, and other organizations are potential sources of support. With this initiative, you might offer limited services at first, and expand them as resources become more available.

Requirements for state funding are very robust and may be difficult to achieve, especially as a new program. Alternatively, you might decide that a school nurse and a mental health provider will suit your needs, or a full-time mental health provider and a half-time nurse practitioner, or other model of care.

Securing funding will be more challenging if not provided by the state, but there are foundations that can possibly help, along with sponsoring agencies. Hospitals that are nonprofit are required to do some community benefit work and a school-based health center would easily fulfill that requirement.

Because yours is not a state-funded program, you might decide to start small, providing staff on only a few days of the week, or possibly moving from building to building with your team to better address needs. You might begin with only a nurse, and then phase in a mental health provider to round out your team. We do encourage placing both providers in the same proximity to allow for warm hand-offs between the two if possible, and to facilitate easier collaboration.

The flexibility afforded because your establishment is not state funded can be very liberating, and of course that can easily change based on needs. You should keep your eyes open for potential state funding in the longer term. But do not let a lack of state funding deter you from creating services that could, at a minimum, address some of the needs of your community.

GLOSSARY OF TERMS

E3 – expanding, enhancing emotional health, a Michigan state-funded program that provides only mental health services in a school.

fiduciary (or sponsoring) agency – an organization, usually a hospital, FQHC, or county health department that provides health services in a school or proximal location.

FQHC – federally qualified health center, a federally-funded health center for all people.

MOU – memorandum of understanding, an agreement between parties.

MPRs – minimum program requirements for the program as stipulated by state funding.

MSW – a licensed social worker who holds a master's degree.

RFP – request for proposal, a document submitted for funding; state funding is only issued if new funding is available, which is seldom.

SBHC – school-based health center, a primary care service for children and youth in a school.

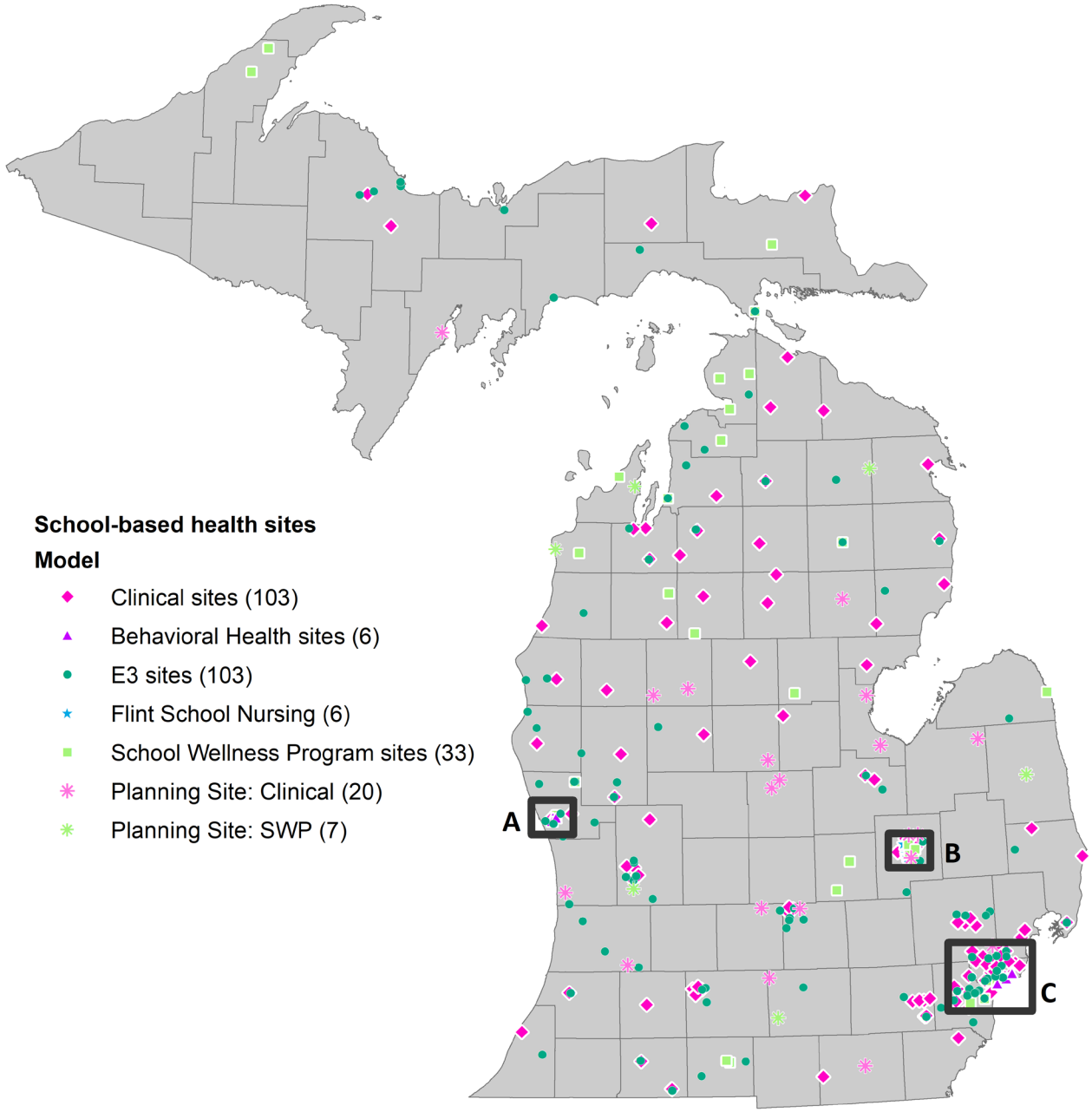
SCHA-MI – School-Community Health Alliance of MI, the state association for school-based health centers and programs.

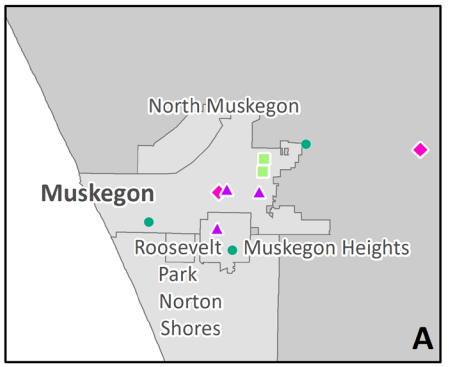
SLHC – school-linked health center, a primary care service for children and youth, not on school property.

SWP – school wellness program, a state-funded program that features a nurse and mental health worker.

unduplicated youth – young patients who are counted only one time, not twice, although they may have two or more visits to a health center.

APPENDIX A:
MAP OF CLINICAL SITES


School-based health sites
Model
Clinical sites (103)
Behavioral Health sites (6)
E3 sites (103)
Flint School Nursing (6)
School Wellness Program sites (33)
Planning Site: Clinical (20)
Planning Site: SWP (7)
A
B
C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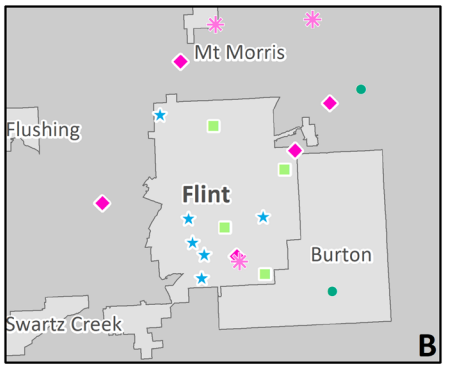
Roosevelt Park
Muskegon Heights
Norton Shores
A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Flushing
Flint
Burton
Swartz Creek
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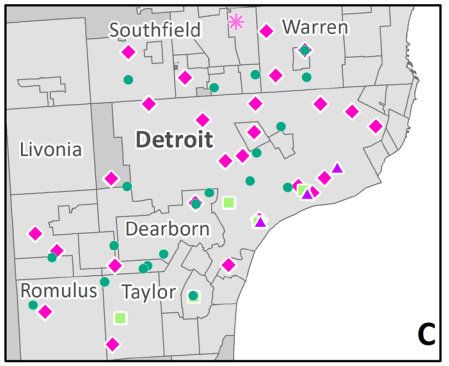
Southfield
Warren
Livonia
Detroit
Dearborn
Romulus
Taylor
C

APPENDIX B:
VALUE OF SCHOOL-BASED HEALTH CENTERS: A COST-BENEFIT ANALYSIS

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School-Based Health Centers: Cost–Benefit Analysis and Impact on Health Care Disparities

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Objectives. We evaluated the impact of school-based health centers—which provide essential health care for students by aiming to eliminate many access barriers—on health care access disparities and conducted a cost–benefit analysis.

Methods. We employed a longitudinal quasi-experimental repeated-measures design. Primary data sources included the Ohio Medicaid claims, enrollment file with race/ethnicity, and survey reports from parents. We used hierarchical linear modeling to control unbalanced data because of student attrition. We assessed quarterly total Medicaid reimbursement costs for 5056 students in the SBHC and non-SBHC groups from 1997 to 2003. We calculated net social benefit to compare the cost of the SBHC programs with the value that SBHCs might save or create.

Results. With SBHCs, the gap of lower health care cost for African Americans was closed. The net social benefits of the SBHC program in 4 school districts were estimated as $1 352 087 over 3 years. We estimated that the SBHCs could have saved Medicaid about $35 per student per year.

Conclusions. SBHCs are cost beneficial to both the Medicaid system and society, and may close health care disparity gaps. (*Am J Public Health*. Published online ahead of print July 15, 2010: e1–e7. doi:10.2105/AJPH.2009.185181)

Racial or ethnic health care disparities are a social phenomenon that reveals differences in utilization and quality of health care because of accessibility, operation of health care systems, cultural or socioeconomic status, and discrimination at the individual and patient–provider level.[1–5] Recent literature has documented ethnic and racial disparities in the health care system across a wide range of diseases. According to the Centers for Disease Control and Prevention,[6] African Americans had higher prevalence rates across many chronic diseases, including perinatal diseases, diabetes mellitus, hypertension, and obesity. Health care disparities can lead to decreased quality of life, loss of economic opportunities, and perceptions of injustice.[7] Twenty-two percent of African American children and adolescents were classified as overweight or obese and 68% were fully vaccinated, compared with White children and adolescents, who were less likely to be overweight or obese (12%) and more likely to be fully vaccinated (78%).[6,8]

For some illnesses, health care disparities are manifested through the underuse of treatments and procedures.[9–11] School-aged children and adolescents have high prevalence rates of some chronic diseases, including asthma (estimated at 7%) and attention deficit/hyperactivity disorder (estimated at between 3% and 6%).[7,12,13] However, African American children and adolescents with asthma had more hospitalizations, disability, and a higher mortality rate compared with that of White children and adolescents with asthma.[14,15] Moreover, African American children and adolescents were also less likely to access mental health services.[16–19]

School-based health centers (SBHCs) are thought to be 1 solution to reduce these health status and health care disparities across groups. SBHCs provide essential primary care (e.g., mental health treatment, dental care, well-child checkups) for students. SBHCs, by their location in schools, are designed to overcome many health care access barriers, including transportation, lack of providers, lack of insurance coverage, and inconvenient appointment times because of parents working. By 2008, more than 1980 SBHCs nationwide had been established with partial support from the federal government, foundations, Medicaid, health insurance companies, and other programs such as "Healthy Schools Healthy Communities."[20–22] In many SBHCs, the majority of enrolled students are uninsured or low income, ranging from 50% to 90% of the patient load.

Numerous studies have documented that SBHCs can effectively reduce health care access barriers and emergency room visits in children and adolescents.[23–31] These in-school services can also alleviate barriers such as nonadherence and inadequate access to mental health services for youths.[23,32–34] With the SBHC, students received more mental health care services,[23] less hospitalization,[24,26] fewer urgent or emergency visits,[25–28] and fewer transportation and pharmacy costs.[26]

Although SBHCs have demonstrated their value to school-aged children and adolescents, their impact on addressing health care disparities has not been evaluated. Moreover, it is unclear whether the SBHC is cost-beneficial. With these considerations in mind, we sought to measure the impact of SBHCs on addressing health care disparities among students in schools with SBHCs compared with students in comparable schools without SBHCs. The central hypotheses were that increased accessibility to primary care services with SBHCs would reduce the gaps of health care disparities over time by increasing needed primary care. Second, by providing timely and essential primary care, the SBHC program would have a positive net social benefit to the population.

METHODS

We used a longitudinal quasi-experimental repeated-measures design. Four school districts (7 schools in total) with newly implemented SBHCs were matched with 2 other school districts (6 schools in total), based on urban or rural status, percentage of non-White students, and percentage of students in the free or reduced-price school lunch program. The target population was school-aged students (kindergarten through 12th grade) enrolled in schools in the Greater Cincinnati, Ohio, area who were also enrolled in Ohio Medicaid or the State Children's Health Insurance Program (SCHIP) from

academic years 1997 through 2003. All students in the SBHC had parental approval to participate. The written consents for evaluation were documented in each SBHC. Because of the nature of retrospective data analysis, researchers did not modify or alter any medical treatment or services for student participants. There was little risk to study participants.

The SBHCs were established in September 2000 and provided for students in kindergarten through eighth grade. All enrolled students were eligible to use the SBHC. The SBHCs were open on weekdays during the school academic quarters and closed in the summer quarter. Each SBHC was equipped with basic medical instruments (examination bed, blood pressure meter, weight and height scale, urgent medications) and the Welligent version 5.0 Web-based computerized medical record system (Welligent Inc, Norfolk, VA) to track SBHC encounters. The SBHC was managed by a medical partner (e.g., nurse practitioner and health worker) related to primary care and specialist physicians (e.g., pediatrician). Each SBHC was typically staffed by 1 nurse practitioner and 1 nurse technician. A part-time pediatrician was present in some schools for 3 hours per week. A licensed mental health therapist was in service in some schools 1 or more days per week. Among these school districts, a large number of students (ranging from 50% to 88%) was enrolled in the free or reduced-price school lunch program because of their low family incomes.[35]

Data Sources

Four primary data sources were used for this study: school enrollment files, Ohio Medicaid claims, SBHC encounter records, and parents' and SBHC coordinators' survey data. First, schools provided student enrollment databases identifying student names and demographics for each school year from the 2000–2001 school year to the 2002–2003 school year. There were 9240 unique students.

Second, school enrollment data were linked with the Ohio Medicaid claim database, which is an automated database that includes Medicaid enrollment records, as well as patients' pharmacy, medical, hospital inpatient, and outpatient institutional claims from September 1997 to February 2003. This totaled 5069 unique students based on matched name, sex, race, date of birth, and county code. Thirteen students who switched between an SBHC and non-SBHC comparison school were excluded. Because of the implementation of the Health Insurance Portability and Accountability Act and other regulation changes, we were unable to collect and use the completed Medicaid claims data from March 2003 to August 2003.

Third, SBHC encounter data from the 4 intervention schools that documented students' visits in SBHCs were retrieved from the Welligent database. During the study period, 4136 students were enrolled in the SBHC program, of which 2314 students used the service, generating a total of 7572 SBHC encounters.

Fourth, surveys of both parents and SBHC coordinators were conducted to collect data regarding cost and benefit information (such as travel distance from home to the hospital or clinic), hours spent for students' physician visits, facility utility and space cost, and health care grants received as a result of local SBHC programs.

Outcome Measures and Covariates

The primary outcome measure for our study was quarterly total health care cost per student, as a proxy for health care utilization, which was defined as the total dollar amount that Medicaid paid for inpatient and outpatient care, physician encounters, mental health services, pharmacy, procedures, and diagnoses. For each claim reimbursement, total health care reimbursement was adjusted by using the medical component of the Consumer Price Index (MCPI) as the dollar value in 2002. The annual MCPI rates of change were 4.6% in 2002, 4.7% in 2001, 4.2% in 2000, 3.7% in 1999, 3.4% in 1998, and 2.8% in 1997.[36–38]

The covariates included the student's age as of September 30, 2000. Sex and race were dichotomous variables. The number of enrollment months was defined for each child enrolled in the Medicaid program during the study period. Enrollment categories included aid for disabled or blind, Temporary Assistance for Needy Families (TANF), SCHIP, and managed care organizations (MCOs).

Cost–Benefit Analysis

Cost–benefit analysis (CBA) is a method to compare the value of resources consumed (costs) in providing a program or intervention to the value of the consequence (benefit) from that program or intervention.[36] Two major components for CBA are costs and consequences. This view of CBA assumes that the SBHC is being compared with a non-SBHC alternative. A CBA requires health outcomes of the SBHC to be valued in monetary units, thus enabling us to compare the program's incremental cost with its incremental outcomes.

We looked at the costs of (or resources consumed by) the SBHCs from 3 sectors: (1) the health care sector (e.g., SBHC operation costs, such as prescription drugs, medical equipment, and physician and nurse hours), (2) the patient and family sector (e.g, out-of-pocket expenses in traveling to get medical care, copayments, and lost work time), and (3) other sectors (e.g., essential start-up funds [not including SBHC operational costs] and costs for school facility use).

We considered certain activities that would not have occurred without a SBHC to be incremental benefits from the program, including (1) the students' health status change, which can be measured in terms of equivalent value of clinical effects; (2) other sector savings, including other value or grants created by the SBHCs; (3) resources saved by the SBHCs or costs not spent on an alternative, which mirror the costs and were measured according to the 3 cost sectors: health care savings, patient and family savings, and other sector savings such as the community multiplier effect (R. Greenbaum, PhD and A. Desai, PhD, Ohio State University, written communication, April 30, 2003); and (4) unquantifiable benefits, such as healthy students having better attendance and better learning performance, and increased access to care for racial/ethnic minorities.

The net social benefit[36] from implementing the SBHC was calculated as total benefits minus the total costs based on the previously defined components. To measure and estimate the cost–benefit variables, we constructed 2 sets of questionnaires. The first was administered to a random sample of parents through phone interviews,[23] including the frequency of child sick visits and hospitalizations, distance from home to physician offices and hospitals, and number of days off for child sick leave. Study samples were randomly selected from SBHC and non-SBHC schools and, as such, we assume the results from questionnaires to be representative of all parents in the specific schools. The second survey was

administered through self-report to the SBHC administrative staff or coordinators in each SBHC about their working hours, facility and equipment costs, and other operational costs.

Data Analysis

To test equivalency between SBHC and non-SBHC comparison schools on demographic characteristics, we used the *t* test for continuous data including age, months enrolled, and percentages of enrollment categories; we used the χ^2 test for dichotomous variables.

We employed hierarchical linear modeling using HLM version 5.05 (Scientific Software International Inc, Lincolnwood, IL)[39] on a repeated-measures basis, allowing for the control of unbalanced observations with time-series quarterly data because of student attrition in different schools or different enrollment periods in Medicaid programs. The multiple observations are properly originated as nested within students. The quarterly total Medicaid costs (adjusted 2002 dollar value) per student were measured as time-related variables for all eligible students to analyze growth trends, including linear, quadratic, and cubic growth trends.[39] The nested-structure growth analysis allows for examination of students' health care utilization changes over time. Unlike other repeated measures analyses, HLM can examine the fit of data with an unequal number of repeated observations for each individual student. Two levels of HLM models were involved in the analysis: a level-1 polynomial model of the repeated observations for the effect of time including 22 quarters from fall 1997 to winter 2003 on the outcome variable of the quarterly health care cost, and level-2 linear models of the individual student-level measures for the effects of the individual differences (such as sex, race, age, SBHC intervention, SCHIP, aid for disabled or blind, and MCO) on the linear, quadratic, and cubic growth trends.

TABLE 1—Demographics and Characteristics for Students Enrolled in Both Medicaid and Schools With School-Based Health Centers (SBHCs) and for Students Enrolled in Schools Without SBHCs: Greater Cincinatti, OH, 1997–2003

	Students Enrolled in Schools With SBHCs (n = 3673)	Students Enrolled in Schools Without SBHCs (n = 1383)	*P*[a]
Male, no. (%)	1906 (51.9)	697 (50.4)	.315
Age[b], y, mean (range)	8.41 (3–15)	8.04 (3–15)	<.001
Race, no. (%)			
White	1947 (53)	732 (52.9)	.917
Black	1664 (45.3)	613 (44.3)	.508
Hispanic	18 (0.5)	4 (0.3)	
Asian	4 (0.1)	0	
American Indians	4 (0.1)	0	
Other	37 (1.0)	35 (2.5)	
No. of months enrolled in Medicaid program,[c] mean (SD)	40.3 (18.1)	38.4 (18.0)	<.001
Enrollment[c], % (SD)			
SCHIP	32.5 (0.35)	37.3 (0.37)	<.001
Aid to disabled or blind	4.2 (0.18)	4.5 (0.18)	.613
MCO	24.8 (0.27)	14.6 (0.27)	<.001
TANF	94.5 (0.20)	93.5 (0.21)	.144
Quarterly total cost 1997–1998 academic year, mean $			
Black	173.9	208.9	
Non-Black	158.8	230.3	
Quarterly total cost 1998–1999 academic year, mean $			
Black	198.6	250.7	
Non-Black	152.1	245.0	
Quarterly total cost 1999–2000 academic year, mean $			
Black	210.5	289.9	
Non-Black	214.5	321.2	
Quarterly total cost 2000–2001 academic year, mean $			
Black	293.7	364.2	
Non-Black	276.7	340.3	
Quarterly total cost 2001–2002 academic year, mean $			
Black	401.8	343.6	
Non-Black	348.3	423.0	
Quarterly total cost 2002–2003 academic year, mean $			
Black	394.5	341.6	
Non-Black	374.2	334.2	

Note. MCO = managed care organization; SCHIP = State Children Health Insurance Plan; TANF = Temporary Assistance for Needy Families. The total sample size was n = 5056.
[a]Students in schools with SBHCs compared with students in schools without SBHCs, by the *t* test for age and months enrolled, and by the χ^2 test for other variables.
[b]Age was calculated as (September 30, 2000 minus the student's date of birth) divided by 365.25.
[c]Enrollment category is not mutually exclusive. As recipients could have been in multiple enrollment categories during the study period, the recipient's aid category was defined by the percentage of enrollment months for which the recipient was enrolled in each program.

RESULTS

Of 5056 students (45% African American and 49% female), there were 3673 students enrolled in SBHC schools and 1383 students enrolled in schools without SBHCs (Table 1). The students in the non-SBHC comparison group were younger, had fewer enrollment months, were enrolled in the SCHIP program at greater proportions, and were enrolled in an MCO in smaller proportions compared with that of students in the SBHC group. Medicaid spent a total of $30 million dollars on all 5056 students during the 5.5 years. The major cost components included mental health services ($8.9 million, 29.7%), outpatient care ($7.3 million, 24.3%), hospitalization and emergency room visits ($5.7 million, 19%),

physician encounters ($3.3 million, 11%), and prescription drugs ($2.8 million, 9.3%).

Health Care Disparities

Table 2 summarizes the final least-squares estimates of fixed effects with robust standard errors for quarterly total Medicaid costs under the HLM analysis. African American students had lower health care costs than did other students (P=.061) in Fall 2000, indicating some health care disparities at the beginning of the SBHC program. The gap was closed after the implementation of the SBHC according to the growth curves displayed in Figure 1.

Cost–Benefit Analysis

Figure 2 summarizes both costs and benefits that were estimated based on 3 years of SBHC operation. The CBA was based on all students enrolled in each SBHC school, regardless of different medical insurance or noninsurance. There were a total of 7608 students enrolled in 4 schools or districts with SBHCs.

Costs. For health care sector costs, we used total funding of $1 382 260 for the first 3 years of operation as a proxy for the costs of SBHC operation because the funding enabled SBHCs to initiate and maintain personnel, equipment, and space for SBHC activities. We estimated the 7572 SBHC encounters as $479 929 by using Medicaid reimbursement value. For patient and family sector costs, we estimated a copayment total of $75 720 with $10 per SBHC encounter. Also, although each school donated space to the SBHCs, we estimated $60 750 for the market value of the space over the 3 years in the schools with SBHCs.

Benefits. We estimated total value of health state changes to be $954 387 on the basis of Medicaid claims, including (1) the total value of the additional mental health care for students was $771 840 over 3 years, (2) the increased dental care benefit was $38 568 over the first 3 years, and (3) that nurse practitioners spent 30% to 50% of their time on nonbillable activities such as services for teachers and staff, student smoking cessation programs, student health status consultations, and staff meetings. The value of nonbillable health care activities was estimated as 30% of SBHC office visits with a total cost of $143 979. Other created value was estimated to be $457 598 from the additional funding attracted by SBHCs from

TABLE 2—Final Estimation of Effects of the School-Based Health Center (SBHC) Program on the Growth Trends of the Quarterly Total Medical Costs: Greater Cincinatti, OH, 1997–2003

Fixed Effect[a]	Growth Trend Variable[b]	b (SE)	t	P
Initial status[c]	B_0			
Intercept[2]	G_{00}	193.270 (50.31)	3.842	<.001
Sex	G_{01}	48.979 (32.81)	1.493	.135
Race	G_{02}	−86.095 (46.01)	−1.871	.061
Age	G_{03}	13.190 (5.97)	2.210	.027
SBHC	G_{04}	−48.477 (37.82)	−1.282	.200
MCO	G_{05}	−12.987 (47.55)	−0.273	.785
SCHIP	G_{06}	10.520 (38.26)	0.275	.783
Disabled	G_{07}	1825.471 (290.68)	6.280	<.001
Linear growth[d]	B_1			
Intercept[2]	G_{10}	−9.859 (9.69)	−1.018	.309
Sex	G_{11}	5.373 (5.24)	1.025	.306
Race	G_{12}	−0.148 (6.71)	−0.022	.983
Age	G_{13}	2.482 (1.05)	2.363	.018
SBHC	G_{14}	8.338 (5.96)	1.398	.162
MCO	G_{15}	−8.412 (8.16)	−1.030	.303
SCHIP	G_{16}	−3.020 (6.04)	−0.500	.616
Disabled	G_{17}	−9.771 (34.61)	−0.282	.778
Quadratic growth[d]	B_2			
Intercept[2]	G_{20}	−0.615 (0.66)	−0.931	.352
Sex	G_{21}	−0.084 (0.40)	−0.208	.835
Race	G_{22}	0.732 (0.55)	1.325	.185
Age	G_{23}	0.044 (0.08)	0.521	.602
SBHC	G_{24}	0.711 (0.50)	1.411	.158
MCO	G_{25}	−0.553 (0.77)	−0.720	.471
SCHIP	G_{26}	−0.127 (0.57)	−0.222	.824
Disabled	G_{27}	−7.969 (2.28)	−3.500	.001
Cubic growth[d]	B_3			
Intercept[2]	G_{30}	−0.004 (0.10)	−0.042	.967
Sex	G_{31}	−0.010 (0.06)	−0.174	.863
Race	G_{32}	0.057 (0.08)	0.755	.450
Age	G_{33}	−0.008 (0.01)	−0.620	.535
SBHC	G_{34}	−0.010 (0.07)	−0.140	.889
MCO	G_{35}	−0.004 (0.10)	−0.035	.972
SCHIP	G_{36}	−0.089 (0.08)	−1.159	.247
Disabled	G_{37}	−0.067 (0.30)	−0.224	.823

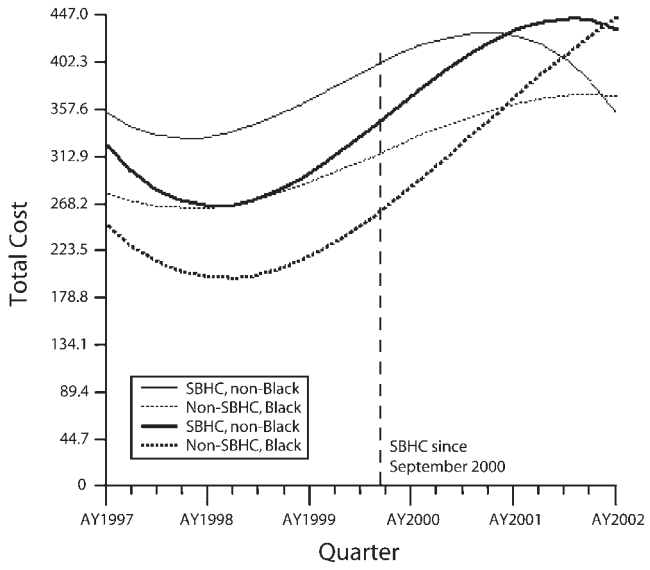
Note. MCO = managed care organization; SCHIP = State Children Health Insurance Plan. Final estimation of variance component: level 1 = 1 537 702.88; degrees of freedom = 5048; χ^2 = 33 762; P < .001. The total sample size of eligible students was n = 5056.

[a]Linear model of quarterly Medicaid cost was regressed on race, sex, age, SBHC, SCHIP, aid for disabled or blind, and MCO for their growth trends.

[b]G_{00}, G_{10}, G_{20}, and G_{30} are for the intercepts; G_{01}, G_{11}, G_{21}, and G_{31} are for the effects of gender (male = 1 and female = 0) on the growth trends; G_{02}, G_{12}, G_{22}, and G_{32} are for the effects of race (Black = 1 and others = 0) on the growth trends; G_{03}, G_{13}, G_{23}, and G_{33} are for the effects of age (years in September 2000) on the growth trends; G_{04}, G_{14}, G_{24}, and G_{34} are for the effects of SBHC (SBHC = 1 and non-SBHC = 0) on the growth trends; G_{05}, G_{15}, G_{25}, and G_{35} are for the effects of MCO enrollment on the growth trends; G_{06}, G_{16}, G_{26}, and G_{36} are for the effects of SCHIP enrollment on the growth trends; and G_{07}, G_{17}, G_{27}, and G_{37} are for the effects of disabled enrollment on the growth trends.

[c]Degrees of freedom for initial status are 5048.

[d]Degrees of freedom for linear growth, quadratic growth, and cubic growth are 74 565.



Note. AY = academic year. The sample size for eligible students enrolled in a participating school and enrolled in Medicaid was n = 5056. Total cost equals the quarterly total Medicaid reimbursement amount per student.

FIGURE 1—Growth trends of quarterly total Medicaid costs by school-based health center (SBHC) and race: Greater Cincinatti, OH, 1997–2003.

local children's hospitals and Healthy School Healthy Community grants.

Resources saved from the health care sector included potential cost-savings for hospitalization, estimated as $228 144 or $970 per student with asthma,[24] and, according to Medicaid claims, potential savings for prescription drugs were estimated to be $443 532. From the patient and family sector, SBHCs prevented productivity losses of $542 761 by parents who would otherwise have had to take their children to other sources of care. We estimated the value of the parent's time in the Cincinnati metropolitan region as equal to the blue- and white-collar combined average hourly rate of $17.92. Over the 7572 SBHC encounters, the SBHCs saved parents between $542 761 (4 hours work time per parent) and $1 085 522 (8 hours work time per parent). Also, because students received care in the SBHCs their parents saved a substantial amount of travel expenses. From parent survey data, the average time to a physician's office was 28 minutes round trip in an urban area and 46 minutes round trip in a rural area. With the rate of $0.35 per mile, we estimated total travel expenses to be $42 956.

Regarding resources saved from other sectors, SBHC staff identified and referred students to additional primary care. With a Medicaid reimbursement rate of $69 per visit, we estimated Medicaid spent $42 642 for the 618 documented referrals. We also estimated the community multiplier effect as $638 726 from a societal perspective, which was related to $1.00 Medicaid spent for a $3.15 multiplier effect in Ohio (written communication with Professors R. Greenbaum, PhD and A. Desai, PhD, Ohio State University, written communication, April 30, 2003). For the 42.25% of students with Medicaid, the community multiplier effect was estimated as:

$$(1)\quad \$479\,929 \times 42.25\% \times 3.15 = \$638\,726.$$

Finally, the unquantifiable benefits included at least 5 aspects. First, SBHCs helped African American children and adolescents from low-income families get health care they may not have otherwise received, closing the gap in potential health care disparities (Figure 1). Second, about 80% of students in schools with SBHCs returned to class after SBHC encounters. We believe that students with better attendance are more successful at school. However, because this was beyond our study scope, we were unable to quantify this benefit. Third, increased early mental health services received by students in SBHC schools may reduce costly future treatment of those students. Because of the limited time frame of this study, we were unable to quantify this impact. Fourth, increased dental care received by students in SBHC schools might prevent or reduce costly future dental treatment. Fifth, we found that students with asthma in schools with SBHCs had a lower risk of hospitalization and emergency room visits compared with that of students with asthma in schools without SBHCs. It is possible that students with asthma in schools with SBHCs had better asthma management. However, we were unable to quantify the benefit related to quality of life and future health care savings.

Net Social Benefit Estimation

On the basis of the assumptions made and the calculations performed, as described previously, we estimated the net social benefit of the SBHCs over the 3 years to be $1.35 million. This is a low-end estimation that is based on total costs of $1 998 659 and total benefits of $3 350 746.

DISCUSSION

In the urban areas within Cincinnati, increased attention has been paid to racial and ethnic health disparities in an effort to increase the accessibility to health care services for African Americans and low-income families. When one considers that nearly 50% of the population in urban areas within Cincinnati is African American, it is very meaningful that SBHCs provide essential health care for these students and aim at eliminating barriers to health care.

SBHCs appear to have a significant ability to reduce health care access disparities among African Americans and disabled students because these groups received more primary care since SBHCs opened in September 2000. This suggests that having access to an SBHC can help reduce or eliminate access barriers to care and reduce health care disparities for these vulnerable populations—a matter of equity in utilization and not excess utilization. This finding should be robust because the time-series HLM analysis was employed to control for some variations in students' ages and Medicaid enrollments.

The cost–benefit analysis showed that a net social benefit of the SBHC program in the 4 Ohio school districts was about $1.35 million

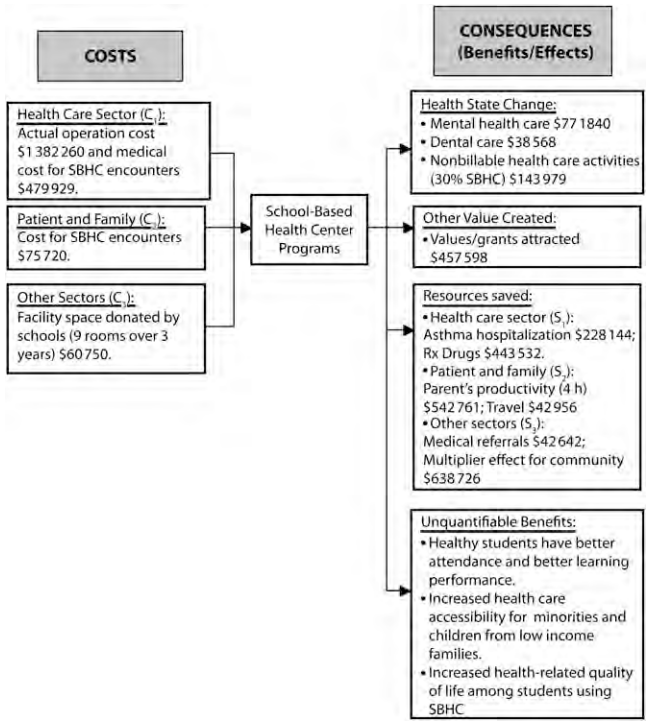


FIGURE 2—Estimated net social benefits of school-based health centers (SBHCs), with components of costs and benefits over the 3-year period: Greater Cincinatti, OH, 2001–2003.

over 3 years. Because Medicaid was the primary payer of services to children and adolescents, we also looked at the cost benefits to Ohio Medicaid. In our previously published studies and final report,[24,25,40] students in SBHC schools benefited from more dental services, less prescription drug use, more mental health services, and fewer hospitalizations. Increased Medicaid costs of $1179 264 (increased dental care of $121 344 plus increased mental health services of $1 057 920) were offset by the total savings of $1 713 228 (savings of $1 395 456 from prescription drugs and savings of $317 772 from hospitalization for students with asthma). Net 3-year Medicaid savings was $533 964, which equals roughly $35.20 savings per child per year.

Our study does not account for the reported increase in health-related quality of life among students participating in SBHCs as compared with students in schools without SBHCs.[41] These unquantifiable benefits of SBHCs may also exceed any extra costs to the Medicaid program. Although we can only speculate as to how much benefit there is to Medicaid, we still believe it is important for Medicaid to foster improved access to health care for minorities and children from low-income families and to increase access to children's mental health services, dental care, and other health care.

Our study also has relevance to broader health policy issues. SBHCs provide important primary care for children and adolescents, indicating benefits to federal and state governments for improving coordination between the SBHCs and state Medicaid and managed care organizations.[42–44] The SBHC schools in Greater Cincinnati have a large proportion of children and adolescents who are African American students from lower-income families. If one considers concerns about racial disparities and acknowledged barriers to care for the poor and uninsured, the SBHC program is particularly well suited to address these disparities, especially among students with chronic disease such as mental health conditions and asthma.

The SBHC is a model for providing quality health care services for children and adolescents that eliminates most barriers students face when they are trying to access health care. SBHCs address problems regarding transportation, lack of nearby providers, lack of providers accepting public insurance, and parental difficulties getting time away from work to take a child to the doctor, which in turn helps parents retain employment and helps employers increase worker productivity. Moreover, they are in a unique position to reduce financial, language, familial, and cultural barriers in providing care for children and adolescents in the community in which they live. By providing services on-site, SBHCs help return students to the classroom more quickly, meaning they miss less instruction time.

Our study was limited to school-aged children and adolescents in the Greater Cincinnati area. We were unable to assess students with other insurance plans or no insurance because the primary data source used was retrospective Medicaid claims database. We also did not differentiate between students who were treated by the SBHCs and students in the SBHC schools who were not treated. Finally, during the 5.5-year study period, the natural history of disease epidemics among school-age children and adolescents varies along with maturation of students, which may influence the time trends.

In conclusion, SBHCs were cost beneficial to the society. The health care utilization for African American and disabled students increased after the SBHC program and closed the gaps of health care disparities. SBHCs should be seen as a health service delivery model to help address a lack of accessing timely care for disadvantaged students. ■

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Contributors

J.J. Guo and T.J. Wade originated the study and were responsible for research design, data collection, and article writing. W. Pan performed statistical analyses and contributed to writing pertinent sections. K.N. Keller was involved in research coordination and

contributed to writing pertinent sections. All authors conceptualized some ideas, interpreted findings, and reviewed drafts of the article.

Human Participant Protection

The research protocol was approved by the University of Cincinnati institutional review board.

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APPENDIX C:
FAQ ON SCHOOL-BASED/LINKED HEALTH CENTERS

School-Community Health Alliance of Michigan

Michigan School-Based Health Centers

FAQ

What is a school-based health center?	School-Based health centers, termed "Child and Adolescent Health Centers" in Michigan provide primary care services to children ages 4-21 where kids are: in school! Mental health services are also provided, which round out a team highly qualified to provide excellent care to children and youth. Services are full-time, provided in one building 5 days per week including summers. Two other models of care are available: Alternative School-Based Health center, which is just reduced hours, open only 3 days per week in lieu of 5. School-Wellness program is another model of care staffed by a registered nurse, and a licensed master's level mental health provider 5 days per week.
How many school-based programs are there in Michigan?	Currently, there are about 140 centers throughout Michigan providing physical and mental healthcare services inside or close to schools. Michigan is poised to have one of the largest programs in the United States.
Does the State of Michigan fully fund the school-based program?	No, the grants provided generally equal to around half to three quarters of what is needed to run a health center. In addition to the grant, revenue is generated by the healthcare visits that centers bill. All sponsoring agencies put additional funds and resources into the center as well. The grants are not intended to fully fund the center – it is intended to provide core funds.
How do I apply for funds, when are they available?	Funds become available when the legislature allocates additional funds. MDHHS and MDE cooperatively will issue a Request for Proposal (RFP).
Is the health center available to all students in the school they are located?	Care is for children and youth, ages 4-21. Children in the school in which the center is located are encouraged to use the center, and have to have a Parent/Guardian Consent Form on file. Family members as well, within the ages of 4-21 are welcome. Some centers are open to the public, but it is up to the school and center if they provide care to students from other schools.
What kind of services are available?	Mental health, and mental health therapy for issues such as depression, anxiety, family and school stress, relationship issues, Immunizations, well-child visits, minor acute visits, such as ears, nose, throat issues, asthma, diabetes, and obesity, to name some. For services outside the scope of care, referrals are made.
What is the cost to receive services?	There is no out-of-pocket expenses cost to families, their insurance or Medicaid is billed. If they do not have insurance, the health center will enroll them. No one is denied care for inability to pay.
What is the job of sponsoring agencies?	Sponsoring agencies provide the services of the health center. In Michigan the majority are about equally divided among health departments, federally qualified health centers and hospitals. It is their job to provide the healthcare staff and oversight, billing, and malpractice. They work together with the school and other community partners to be sure the needs of children and young people in the school are being met in a timely, efficient and appropriate manner. ***(Continued on back)***

What is the role of the school that the health center is located in?	The school works together with the health center to identify the needs of the student population, and to promote the health center to families. The school is a partner with the health center and helps address community healthcare needs and social determinates of health.
What is the cost to the school?	Schools will provide space and generally a computer to access kids schedules, but really, there isn't any out-of-pocket for the school too. The school and health center work in partnership to provide the best space possible for the delivery of care.
Are Parents/ Guardians Involved?	Yes! They help determine the services, approve policies, provide consent for their child to be seen, and attend Advisory Council meetings that are required annually.
What is the BEST thing about school-based health centers in Michigan?	Parent/guardians, providers, school staff and students would say easy access to services – they're right in the school building! School-based health care addresses the "whole" child, keeping them healthy and ready to learn in the classroom. School-based health centers provide the needed healthcare expertise a school needs day-to-day. Early detection of illness helps reduce time out of the classroom, keeping kids healthy.
What is the WORST thing about school-based health centers in Michigan?	That there isn't one in every school district.

FROM A TEACHER OF A SCHOOL

"The health center is fantastic – We can rely on them for anything from mental awareness to supporting our students while they are at school. As a teacher, there are many outside influences that we don't have control over that can prevent students from learning. We have had students that need anything from mental support to specific medical testing. The center has a huge impact."

Tylise Ivey, Teacher
Waterford Durant High School

FROM A PRINCIPAL OF A SCHOOL

"This new partnership is already producing positive results. As part of the Multi-Tiered System of Support, the E-3 project has positively impacted school attendance. Specifically, middle and high school students with a history of truancy have stated "It's important to come to school so I can talk to Mrs. McEvers." Manistique Area Schools is committed to supporting partnership with LMAS Health Department. Today's student stressors can have serious negative impacts on every aspect of their lives. From trauma and substance abuse to eating disorders and suicidal ideations. Some students have significant barriers to education. We are proud, and fortunate, to be able to offer this valuable service to our students."

Principal John Shiner
Manistique Middle and High School
(Speaking of the mental health E-3 grant received only 3 months before)

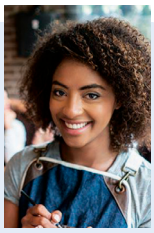
From Students:

"The clinic has helped me get over some of my fears. I have received help for my personal problems. I go there when I feel upset. I go there when I have a headache or fever and they help me. They call home so my parent knows what's going on. They can get me if I cannot stay in school.

The clinic has helped me get rid of my headaches and make me feel like I am a better person. This helps me to stay in school.

I have come to school instead of staying home many times because I know that the clinic is there if I need it."

Agnes, 13 years old



"Speaking personally, I am with friends and family here that I never had before. I used to fight everything in sight. I bullied kids. I often thought of harming people and myself. But thanks to the THC I now break up fights, and defend the bullied, and help kids like me find a better way than to harm themselves or others.

This program provides us help with issues such as depression, anxiety, health as well as providing us with supplies that we may need (toiletries, etc). We are also given advice with issues that we deal with outside of school and at home. They give us the care we need that others cannot or will not provide."

Amisael, 16 years old

For more information contact
School-Community Health Alliance of Michigan:

517.908.0847, www.scha-mi.org

School–Community Health Alliance of Michigan
www.scha-mi.org

APPENDIX D:
NEEDS ASSESSMENT RESOURCES AND SAMPLE SIZES

Child & Adolescent
HEALTH CENTER PROGRAM

Potential Data Sources for a Comprehensive Needs Assessment
Content Relevant to: All Models

This is a sampling of some of the more common data points for consideration in a comprehensive needs assessment (required of every CAHC/SWP at least every three years). Not every data point needs to be included but, the more robust the overall needs assessment is, the more information you will have to design services and supports that draw youth to your CAHC/SWP, and that meets client needs.

Risk Behavior Survey (required when serving adolescents):

The **Michigan Profile for Healthy Youth** (MiPHY) is the most common adolescent risk behavior survey that CAHC/SWP programs use as part of their overall needs assessment. The MiPHY is an online health survey offered by the Michigan Departments of Education and Health and Human Services, which provides results on health risk behaviors including substance use, violence, physical activity, nutrition, sexual behavior, and emotional health in grades 7, 9, and 11; and measures risk and protective factors most predictive of alcohol, tobacco, and other drug use and violence.

Survey data is available at the county level, if enough schools participate. Data is available at the local school/district level, but you must request the data directly (it will not be on the website). Make sure your browser isn't blocking pop-ups or the reports won't generate:

https://mdoe.state.mi.us/schoolhealthsurveys/externalreports/countyreportgeneration.aspx

The Youth Risk Behavior Survey (YRBS), although generalizable if enough students participate, is typically not favored as a risk behavior survey for the purposes of the needs assessment of your target population. However, the Detroit YRBS may be used for schools in the Detroit area if enough students participate to make the results generalizable. Data is not available by school level.

As a last resort, work with the school to implement a risk behavior survey if none exists for your target population. Contact your assigned Agency Consultant for technical assistance.

CAHC/SWP Data:

Risk Assessments: Review top risks and consider including data from the Risk Disparity Tool to identify disparities in risk among sub-populations

Diagnosis Codes: Review the most frequent diagnosis codes (as applicable to the model).

Client Satisfaction Surveys/Comment Cards: If open-ended questions on unmet needs or services that clients would like to see are included on the survey/cards, review these results for ideas.

Community Advisory Council/Youth Advisory Council: What do these advisory boards have to say about need/unmet need, services and health education that could be addressed by the CAHC/SWP?

Parent/Teacher/Staff Surveys: These simple surveys can be a great source of information on need that either the data doesn't show, or can add meaning to other data. Meetings, focus groups, or other forms of input from these partners can provide perspective on need that may not be found elsewhere.

School Organizations: What type of input can you get from active student and/or parent organizations about need? Input can be informal, but can still generate ideas on services and educational programming that would interest students and that parents would support.

Local School Data:

School Absences: Absences are tracked differently in every school/school district. Some schools may be able to provide much more detailed information than others. Schools may be willing to share school suspension data, but some are reluctant to do so.

Chronic Conditions: Some schools may be able to provide detailed (aggregate) information on number and type of various chronic conditions present among students in the school.

Other School Data: Having strong relationships with administrators and other key staff members is critical to acquiring data that may be beneficial. As schools more completely understand the services a CAHC/SWP provides, what data is needed, how the data will be used – and as CAHC/SWP staff better understand data limitations and concerns – the greater the likelihood will be of acquiring data useful in telling the story of the needs of youth in your target population.

Other School Data (available online):

A wealth of information available by ISD, local school district, and school building at www.mischooldata.org including enrollment, M-STEP scores, and rates of dropout, economically disadvantaged students, free and reduced-priced lunch rates, special education students, chronic absenteeism, and more. Much data is available by sub-population e.g., race, gender, homelessness, students with disabilities, etc.

Community Health Data/Vital Statistics:

County Immunization Report Cards (updated quarterly):
http://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4914_68361-321114--,00.html

Lead Testing Surveillance Data, by County:
https://www.cdc.gov/nceh/lead/data/state/midata.htm

Preventable Hospitalizations (Ambulatory Care Sensitive Hospitalizations), STI Rates, Teen Pregnancy and Birth Rates and Other Data:

MDHHS Vital Statistics, Community Health Information:
https://www.michigan.gov/mdhhs/inside-mdhhs/statisticsreports/vitalstats

Select "County and State Health Statistics Profiles" and navigate to the profile or health statistic you which to view. Some data may also be available for local communities with 10,000+ population.

Census Data:
Both the US Census Bureau's Quick Facts https://www.census.gov/quickfacts/fact/table/US/PST045216 and American Fact Finder https://data.census.gov are valuable data resources. Find the latest available statistics on a range of social, economic, educational and select health indicators.

Health Resources & Services Administration Shortage Area Designations:
Go to https://bhw.hrsa.gov/shortage-designation/what-is-shortage-designation and, on the right hand side of the page, click on HPSA Find and/or MUA/P Find to locate current Health Professional Shortage Areas and Medically Underserved Areas.

Healthy Michigan Plan Enrollment Statistics (includes County Enrollment Breakdown & Plan Enrollment):
http://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797---,00.html

Additionally, local government, non-profit and service organizations may have other local data to share:
For example, hospitals likely have data on most frequent diagnoses, top reasons for emergency department visits and more for youth in the target population. Police departments and courts may be able to provide information on juvenile "crime" indicators including minors in possession, tobacco violations and more. Some data can be found online, but local agencies may have more "real-time" data. Local non-profits and coalitions may have data relative to their respective missions that can round out a comprehensive needs assessment. Hospitals, local health departments, and many local United Way chapters conduct needs assessments or behavioral risk factor surveillance surveys (of adults) that may be worth reviewing for a more complete picture of family and community health, and how this may impact the health of your target population.

CHILD AND ADOLESCENT HEALTH CENTERS

Acceptable Sample Sizes

for Surveys Used in Needs Assessment

How Many Surveys...?

When CAHCs don't have access to risk behavior or similar survey data as part of a needs assessment for their target population, they may need to conduct their own surveys to get this information. One question often asked is, "How many surveys do we need to collect to get data we can really use?"

The table below shows the number of surveys that need to be collected based on total enrollment (student population) to get data that is within acceptable confidence intervals, simply meaning there is a small margin of error in your survey results.

For example, if your student population is 500 and you want to make sure your survey results are correct within +/- 5%, then you would need to collect 218 surveys from among the total student population of 500.

Enrollment/ Student Population	Confidence Intervals		
	1%	3%	5%
200	196	169	132
500	476	341	218
1000	906	517	278
1500	1298	624	306
2000	1656	696	323

Adapted from Guide to Conducting Youth Surveys, Pacific Institute for Research and Evaluation

For more information, contact your assigned CAHC Program Consultant.

Visit our website at www.michigan.gov/cahc for more great resources!

Sample Size

The value of a survey depends partly on the proportion of the total population surveyed, known as the sample size.

Confidence Level

In smaller populations, you must collect survey data from a larger proportion of the population to get results you can rely on. The greater the confidence level, the more sure you can be that your results are true.

As the population size *increases*, the sample size needed to obtain similar confidence levels *decreases*.

Use the table on the left as a quick reference, or search the Internet for free and easy-to-use sample size calculators.

APPENDIX E:
SAMPLE MEMORANDUM OF UNDERSTANDING (MOU)

INSERT

and

NAME

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding ("MOU") is entered into effective **Date**, by and between the **INSERT** (""), a Michigan municipal corporation and NAME ("Name"), a Michigan non-profit corporation.

RECITALS

WHEREAS, NAME is affiliated with a full-service hospital complex serving the State of Michigan area; and

WHEREAS, NAME has established a School Based Health Center Program ("Program") providing routine, primary care and acute medical services, mental health and health promotion services to students and eligible individuals at certain **INSERT**; and

WHEREAS, **INSERT** desires to participate in the Program consistent with the School Based Health Alliance ("SBHA") Principles & Goals.

NOW, THEREFORE, for the good and valuable consideration in the adequacy of which is acknowledged, the parties hereby agree as follows:

AGREEMENT

A. The foregoing recitals are true and are hereby incorporated herein by reference.

B. Program and Terms.

1. The Parties agree that NAME shall operate the Program to provide primary care medical services and health promotion services at **INSERT** for eligible students and individuals. Such services shall be provided in accordance with SBHA Principals & Goals, applicable federal and state law, **INSERT** policies and this MOU.

2. The term of this MOU is for one academic year and shall be automatically renewed annually, subject to the right of either party to terminate the MOU or to request amendment of the MOU.

3. This MOU may be terminated prior to the expiration of its terms as follows:
    i. by mutual agreement of the parties;
    ii. by either party, upon 30 days prior written notice to the other party, for "good cause" in the event one party has failed to fulfill its responsibilities and has not remedied the situation in a reasonable period (not longer than 30 days); or

iii. by either party, without cause, upon 60 days prior written notice to the other party to allow for orderly transition.

C. Roles and Responsibilities

1. **INSERT** shall:
   a) Facilitate operation of the Program with physical site support, including appropriate access to the Program Site subject to building protocols restricting access to the areas of the Program Site not dedicated to the purposes of this MOU, and with distribution of information about the Program.
   b) Provide the physical site for the Program centers and necessary custodial and maintenance services at no charge to NAME.
   c) Provide heating, water and electricity to the Program centers at no charge to NAME.
   d) Oversee efforts to establish a secured network connection for the Program via VPN to NAME, if needed, including obtaining agreement on cable installer due to strict requirements regarding installation.
   e) Allow distribution of Program information via **INSERT**' inter-office mail delivery or electronic distribution system. **INSERT** reserves the right to approve the content.
   f) Provide opportunities, upon mutual agreement of the parties, for NAME staff to participate in programs and/or meetings sponsored by **INSERT** (i.e. Parent Conversations with the Superintendent, Principals' Meetings, Board Meetings).
   g) Allow NAME and individuals enrolled in the School Based Health Center Program reasonable access to the Program centers for visits.
   h) Provide the NAME logo on the **INSERT** web-site strategic partnership page.
   i) Participate on the School Based Health Center Advisory Board.
   j) Allow the administration of a needs assessment process to determine priority health services for the population served; which includes, at a minimum, a risk behavior survey for adolescents served by the health center.
   k) Abide by the SBHA Principles & Goals for School Based Health Centers as described in Attachment A.

2. NAME shall:
   a) Establish Program center at **INSERT** and bear all costs associated with operating the health center, including, but not limited to, costs of personnel, supplies and materials.
   b) Operate the Program during hours agreed upon with the Office of Health, Physical Education, Safety Education and JROTC and in accordance with **INSERT** observed holidays and other school closures.
   c) Participate on the School-Based Health Center Advisory Board.
   d) Provide services to every student who enrolls in the Program regardless of ability to pay.
   e) Provide service to any other persons recommended as eligible by the School Based Health Center's local school advisory committee, subject to final approval of NAME.
   f) Provide signage, where appropriate and visible to all, indicating effectively that the clinic is independently operated by NAME.

g) Provide a monthly report to the Office of Health, Physical Education, Safety Education and JROTC detailing the number of individuals serviced at each Program site and types of services provided.
h) Based on the individual patient's need, provide one or more of the following services: health assessment/physicals; laboratory screening; immunizations; treatments for identified illness; mental health/social services; and health education.
i) Maintain patient records separate from student educational records and in accordance with federal and state law concerning confidentiality of protected health information and privacy (PHI) as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. This provision will survive termination or expiration of this agreement.
j) Own all patient records with access limited to relevant and appropriate medical and mental health personnel. Billing records are solely the property of NAME.
k) Provide competent, qualified mental health and medical practitioners, including, but not limited to, physicians, nurses, psychologists, etc., licensed to practice in the State of Michigan to administer, coordinate, and provide health and health related services pursuant to the Program in accordance with applicable state and federal law.
l) Hire and retain all staff of the Program as employees of NAME, subject to all policies, rules, and regulations of NAME as appropriate.
m) Have signed confidentiality agreements for all medical and mental health providers, including, but not limited to, physicians, nurses, etc. and other employees, contractors, agents or volunteers performing services under this MOU. All medical providers performing services under this MOU shall be required to adhere to all applicable provisions of state and federal laws regarding the privacy, security and confidentiality of protected health information as defined by HIPAA and related regulations. This provision shall survive termination or expiration of this MOU.
n) Certify that any and all employees working at Program sites are free and clear of any "listed offenses" (as defined in the Michigan School Safety Initiatives), any sexual or drug related convictions, and from felony convictions.
o) Abide by the SBHA Principles & Goals for School-Based Health Centers.
p) Operate in a manner consistent with all **INSERT** policies and applicable federal and state law, including, but not limited to, the Michigan Revised School Code.
q) Immediately notify **INSERT** Office of Health, Physical Education, Safety Education and JROTC of any variation to the Program provided by NAME prior to the beginning of the school year or as needed during the school year.
r) Dispose of all medical waste in accordance with applicable federal and state law.
s) Furnish all equipment and resources, including labor, if needed, to establish a secured network connection from the Program site via VPN connection back to NAME services, at no cost to INSERT.
t) Obtain **INSERT** agreement on the cable installer to be used for any work done in the school building.
u) Obtain the appropriate approval from parents before providing care to students based on our parental consent policy.

D. General Provisions

1. Fees. No fees or payments are due by or to either party for the services rendered pursuant to this MOU. Both parties acknowledge adequate and sufficient consideration due to the benefits derived from the nature of the arrangement under this MOU.

2. Revenue/Billing. All revenues generated for services provided at the School-Based Health Center with respect to revenue-generating patients and patients referred to NAME will be billed by NAME.

3. Insurance. The parties acknowledge and agree that each is self-insured. NAME is self-insured through Ascension Health. Each will provide a letter of self-insurance satisfactory in its coverage of all work or activities performed by employees, contractors, agents and volunteers pursuant to this MOU to its respective Office of Risk Management. Each party shall cooperate with and provide the other with written notice of claims received in connection with this MOU.

4. Own Acts. Each Party shall be responsible for the acts and omissions of itself and its employees, directors, officers, agents and students. Except as expressly provided herein, this Agreement shall not be construed to create a contractual obligation for either Party to indemnify the other for loss or damage resulting from any act or omission of the other Party or its employees, directors, officers and agents. This Section shall not constitute a waiver by either Party or any rights to indemnification, contribution or subrogation which the Party may have by operation of law.

5. Holidays. The Program sites shall observe the same holidays as **INSERT**, which are subject to change pursuant to State or Federal Law and/or any applicable board policies or collective bargaining agreements, and shall include, but are not limited to the following:

   Good Friday
   Memorial Day
   Independence Day
   Labor Day
   Veterans Day
   Thanksgiving Day
   Day after Thanksgiving
   Christmas Day
   New Year's Day
   Martin Luther King's Birthday

6. Non-Discrimination. The parties agree that there shall be no discrimination in the implementation of this MOU or in the provision of services hereunder by either **INSERT** or NAME on the basis of religion, race, age, creed, color, national origin, age, marital status, height, weight, veteran status, sexual orientation, covered disability, or any other characteristic protected from discrimination by applicable federal or state law.

   The parties further agree that there shall be no discrimination in the implementation of this MOU with respect to students or individuals enrolled in the Program and that

the standards applicable to the delivery of health care services shall not differ on the basis of whether an individual is uninsured or is subsequently determined to be insured.

7. Compliance. Each party shall be separately responsible for compliance with all laws, including anti-discrimination laws, which may be applicable to their respective activities under this MOU.

8. Stark Law Compliance. The parties to this MOU specifically intend to comply with all applicable laws, rules and regulations, including (i) the federal anti-kickback statute (42 U.S.C. § 1320a-7b) and (ii) the Limitation on Certain Physician Referrals, also referred to as the "Stark Law" (42 U.S.C. § 1395(n)). Subsequent to the execution of this MOU, should any provision of this MOU be deemed by either party to be contrary to the provisions of said Statute, Act, regulations, or the "safe harbor" regulations, then the Parties agree to attempt in good faith to renegotiate the problematic provision to the mutual satisfaction of the Parties. In the event the Parties are not able to mutually agree on modification of the problematic provision, either party may terminate this MOU upon thirty (30) days written notice to the other party if the terminating party has a good faith belief that the problematic provision creates an unfavorable exposure under said Statute, Act, regulations or safe harbor provisions. This MOU in no way financially obligates **INSERT** for any services and/or benefits provided or received by NAME.

9. Corporate Compliance. NAME has in place a Corporate Compliance Program ("CCP") which has as its goal to ensure that NAME complies with federal, state and local laws and regulations. The CCP focuses on risk management, the promotion of good corporate citizenship, including the commitment to uphold a high standard of ethical and legal business practices and the prevention of misconduct. The Parties acknowledge NAME's commitment to the CPP and NAME's intent to conduct the services required by this MOU in accordance with the underlying philosophy of its CCP.

10. Third Party Directive. The Parties acknowledge that NAME is a member of Ascension Health, a national faith-based health ministry and operates in accordance with the Ethical and Religious Directives and the principles and beliefs of the Roman Catholic Church ("Directives"). It is the intent and agreement of the parties that neither this MOU nor any part thereof shall be construed to require NAME to violate said Directives. All parts of this MOU will be interpreted with the intent that NAME remains consistent with the Directives.

    Notwithstanding the prior statements, it is the intent and agreement of the Parties that neither this MOU nor any part thereof shall be construed to require or cause **INSERT**, a public municipal corporation, through this MOU or the Program activities, to respect the establishment of religion or permit promotion of the principles or beliefs expressed in the Directives over any other religion or no religion in violation of the Establishment Clause of the First Amendment of the U.S. Constitution.

    Subsequent to the execution of this MOU, should any provision of this MOU be deemed by either party to be contrary to the provisions of the law, SBHA Guidelines or the Directives, then the Parties agree to attempt in good faith to

renegotiate the problematic provision to the mutual satisfaction of the Parties. In the event the Parties are not able to mutually agree on modification of the problematic provision, either party may terminate this MOU upon thirty (30) days written notice to the other party if the terminating party has a good faith belief that the problematic provision creates an unfavorable exposure.

11. Independent Entities. The autonomy of **INSERT** and NAME as independent entities shall be observed and maintained at all times. Nothing contained in this MOU shall be deemed or construed or any purpose to establish, between the parties, a partnership, joint venture or principal/agent relationship.

12. Amendment. This MOU may be modified or amended only in writing by mutual agreement and signed by both parties.

13. Severability. This MOU shall be administered in accordance with all applicable federal, state and local statutes, regulations and ordinances that in any way pertain to both or either party. In case any one or more of the terms or provisions contained herein shall be held to be invalid, illegal, unlawful, unenforceable or void, the nature of that term or provision shall not affect any other term or provision and this MOU shall be considered as if such term or provision had never been included herein.

14. Notices. All notices, requests, demands and other communications of any kind which either party may be required or desires to give or serve upon the other party, shall be made in writing and must be delivered in person, by recognized overnight courier services, or sent by United States mail, first-class, registered or certified, postage prepaid, return receipt requested, to the address listed below unless notice is given otherwise.

    NAME School Based Health Centers
    INSERT ADDRESS

    INSERT
    Attn: Superintendent
    INSERT ADDRESS

15. Assignment. NAME shall not assign, transfer or further sublet the responsibilities of NAME under this MOU without the written approval of **INSERT**.

16. Force Majeure. Neither party shall be obligated to perform any duty, requirement or obligation under this MOU if such performance is prevented by force majeure.

17. Jurisdiction. This MOU shall be governed by the laws of the State of Michigan.

18. Headings. Captions and headings used in this MOU are provided for convenience and ease of reference only and shall not have any effect on interpretation or construction.

19. Authority. The undersigned representatives of **INSERT** and NAME warrant and represent that they are duly authorized to enter into this MOU on behalf of the parties.

20. Merger. This MOU contains the entire agreement between the parties pertaining to the operation of the Program and fully supersedes all prior written or oral agreements and understandings between the parties pertaining to this subject.

[Signature Page Follows]

INSERT

_____

By:
Its: Superintendent

NAME

_____

By:
Its: Administrator

ATTACHMENT A

SBHA Principles & Goals for School Based Health Centers

SBHA established **seven fundamental principles** for school-based health centers (SBHC) that set a national standard for the field. The principles provide **guidelines** by which to **benchmark** programs, define the **essential elements** of a SBHC, and provide a framework for **accountability and continuous improvement.**

The principles are useful for planning, needs assessment, implementation, evaluation, and continuous quality improvement. They should be used as a building block at every level - local, state, and national.

1. The SBHC Supports the School

The SBHC is built upon mutual respect and collaboration between the school and the health provider to promote the health and educational success of school-aged children.

- Understands and respects accountability within the educational system.
- Works with the school administration to develop and achieve a shared vision.
- Communicates the vision to all school constituencies including teachers, support staff, students, and parents.
- Build collaborative and mutually respectful relationships with school personnel.
- Identifies community resources that provide support to students and promote successful learning.
- Serves as a resource in times of school crisis and community disasters.

2. The SBHC Responds to the Community

The SBHC is developed and operates based on continual assessment of local assets and needs.

- Assesses child and adolescent health care needs and available resources in the community through formal evaluation methods.
- Informs the community of student health needs and trends.
- Solicits community input to address unmet health needs and to support the operations of the program.

6. The SBHC Implements Effective Systems

Administrative and clinical systems are designed to support effective delivery of services incorporating accountability mechanisms and performance improvement practices.

- Ensures compliance with all relevant laws and regulations.
- Develops and measures annual program goals and objectives.
- Maintains a physical plant which is adequate to deliver high quality services and assure patient comfort and privacy.
- Develops all necessary policies and procedures, training manuals, and memoranda of agreement or understanding.
- Develops a human resources system for hiring, credentialing, training, and retaining high quality competent staff.
- Collects, evaluates, and reports health outcomes and utilization data.
- Establishes quality improvement practices including but not limited to assessment of patient and community satisfaction.
- Develops strategies and systems to support long-term financial stability.

7. The SBHC Provides Leadership in Adolescent and Child Health

The SBHC model provides unique opportunities to increase expertise in adolescent and child health, and to inform and influence policy and practice.

- Participates in national and local organizations that focus on adolescent and child health.
- Contributes to the body of knowledge on the health care needs of adolescents and children.
- Promotes the SBHC as a training site for healthcare professionals.
- Advocates for the resources necessary to increase access to physical, mental and dental health services for adolescents and children.
- Informs elected officials, policy-makers, health professionals, educators and the community-at-large regarding the unique value, acceptability, efficiency and convenience of the SBHC model of health care delivery.
- Forms partnerships to develop stable and sustainable funding mechanisms for expanded services.

Memorandum of Understanding

between

A Health Center and a Mental Health Organization

This Memorandum of Understanding (MOU} establishes a **programmatic relationship** between_____. This MOU provides the basic structure for the collaborative effort hereinafter referred to as **The Project.**

1. MISSION

_____focus on mental health services and public health issues within Metro Detroit. **Centro** provides culturally competent mental health services. _____ is a Federally Qualified Health Center (FQHC} that provides primary medical, dental, and behavioral healthcare to vulnerable populations throughout Oakland County.

Together, the above parties enter into this MOU to mutually provide and manage healthcare services within Oakland County. Accordingly, _____, operating under this MOU, agree as follows:

11. PURPOSE AND SCOPE

To promote coordination, collaboration, and referrals between and to assure the health and mental health needs of those experiencing a language barrier in Oakland County are met.

_____acknowledge that the programs and services outlined in this Memorandum are mutually beneficial to both and will promote the fulfillment of basic human needs, increase the continuity of care, improve access to and engagement in medical care and housing services, and thus improve health outcomes and quality of life for those who are experiencing a language barrier.

_____are committed to view this partnership as leveraging their respective partnerships, talents, and expertise to create a greater regional impact of the issues of access to healthcare. The purpose of this collaboration is to:

1. Serve the healthcare needs of those experiencing a language barrier in _____County
2. Connect individuals to primary care, behavioral health and dental services, emergency shelter, and housing opportunities
3. Improve health outcomes and quality of life for those experiencing a language barrier

111. RESPONSIBILITIES

Each party will appoint a person to serve as the official programmatic contact who will coordinate the activities of each organization in carrying out this MOU.

The parties agree to the following tasks of the MOU:

_____agrees to:

- Maintain a reciprocal, communicative relationship with_____ staff in the best interest of clients, including those experiencing a language barrier
- Provide services including but not limited to mental health services and case management
- Provide appropriate referrals to_____ for services
- Obtain all necessary releases to be able to work together collaboratively on behalf of clients

APPENDIX G:
STATE OF MICHIGAN MINIMUM PROGRAM REQUIREMENTS (MPRS)

5. The health center shall provide Medicaid outreach services to eligible youth and families and shall adhere to Child and Adolescent Health Centers and Programs outreach activities as outlined in MSA 04-13.

6. If the health center is located on school property, or in a building where K-12 education is provided, there shall be a current interagency agreement defining roles and responsibilities between the sponsoring agency and the local school district.

   Written approval by the school administration and local school board exists for the following:

   a) Location of the health center
   b) Administration of a needs assessment process to determine priority health services for the population served; which includes, at a minimum, a risk behavior survey for adolescents served by the health center
   c) Parental consent policy
   d) Services rendered in the health center

7. The health center shall be located in a school building or an easily accessible alternate location.

8. The health center shall be open during hours accessible to its target population, and provisions must be in place for the same services to be delivered during times when school is not in session. Not in session refers to times of the year when schools are closed for extended periods such as holidays, spring breaks, and summer vacation. The school-based health center shall designate specific hours for services to be provided to adolescents only (when the center serves both children aged 5 to 10 and adolescents), and a policy shall exist to this effect. These provisions shall be posted and explained to clients.

   Clinical Centers: The health center shall provide clinical services a minimum of five days per week. Total primary care provider clinical time shall be at least 30 hours per week. Mental health provider time must be a minimum of 20 hours per week. Hours of operation must be posted in areas frequented by the target population.

   Alternative Clinical Centers: The health center shall provide clinical services a minimum of three consistent days per week. Total primary care provider clinical time shall be at least 24 hours per week. Mental health provider time must be a minimum of 12 hours per week. Hours of operation must be posted in areas frequented by the target population.

   The health center shall have a written plan for after-hours and weekend care, which shall be posted in the health center including external doors, and explained to clients. An after-hours answering service and/or voicemail with instructions on accessing after-hours care is required.

9. The health center shall have a licensed physician as a medical director who supervises the medical services provided and who approves clinical policies, procedures and protocols.

10. The health center staff shall operate within their scope of practice as determined by certification and applicable agency policies:

    a) The center shall be staffed by a certified nurse practitioner (FNP, PNP), licensed physician, or a licensed physician assistant working under the supervision of a physician. Nurse practitioners must be certified or eligible for certification in Michigan; accredited by an appropriate national certification association or board; and have a current, signed collaborative practice agreement with the medical director or designee. Physicians and physician assistants must be licensed to practice in Michigan.

    b) The health center must be staffed with a minimum of a licensed Masters level mental health provider (i.e. counselor or Social Worker). Appropriate supervision must be available.

11. The health center must establish a procedure that doesn't violate confidentiality for communicating with the identified Primary Care Provider (PCP), based on criteria established by the provider and the Medical Director.

12. The health center shall implement a continuous quality improvement plan for medical and mental health services. Components of the plan shall include, at a minimum:

    a) Practice and record review shall be conducted at least twice annually by an appropriate peer and/or other staff of the sponsoring agency, to determine that conformity exists with current standards of care. A system shall also be in place to implement corrective actions when deficiencies are noted. A CQI Coordinator shall be identified. CQI meetings, that include staff of all disciplines working in the health center, shall be held at least quarterly. These meetings shall include discussion of reviews, client satisfaction survey and any identified clinical issues.

    b) Completing, updating, or having access to a needs assessment process conducted within the last three years to determine the health needs of the population served including, at a minimum, a risk behavior survey for adolescents.

    c) Conducting a client satisfaction survey at a minimum annually.

13. A local community advisory council shall be established and operated as follows:

    a) A minimum of two meetings per year
    b) The council must be representative of the community and include a broad range of stakeholders such as school staff
    c) One-third of council members must be parents of school-aged children/youth
    d) Health care providers shall not represent more than 50% of the council
    e) The council must approve the following policies and the health center must develop applicable procedures:

        1. Parental consent policy
        2. Requests for medical records and release of information that include the role of the non-custodial parent and parents with joint custody
        3. Confidential services as allowed by state and/or federal law
        4. Disclosure by clients or evidence of child physical or sexual abuse, and/or neglect

    f) Youth input to the council shall be maintained through either membership on the established advisory council; a youth advisory council; or through other formalized mechanisms of involvement and input.

14. The health center shall have space and equipment adequate for private physical examinations, private counseling, reception, laboratory services, secured storage for supplies and equipment, and secure paper and/or electronic client records. The physical facility must be barrier-free, clean, and safe.

15. The health center staff shall follow all Occupational Safety and Health Act guidelines to ensure protection of health center personnel and the public.

16. The health center shall conform to the regulations determined by the Department of Health and Human Services for laboratory standards.

17. The health center shall establish and implement a sliding fee scale, which is not a barrier to care for the population served. Clients must not be denied services because of inability to pay. CAHC state funding may be used to offset any outstanding balances to avoid collection notices and/or referrals to collection agencies for payment.

18. The health center shall establish and implement a process for billing Medicaid, Medicaid Health Plans and other third party payers.

19. The billing and fee collection processes do not breach the confidentiality of the client.

20. Revenue generated from the health center must be used to support health center operations and programming.

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MINIMUM PROGRAM REQUIREMENTS
SCHOOL WELLNESS PROGRAM

1. The School Wellness Program (SWP) shall provide a range of health and support services based on a needs assessment of the target population/community and approved by the community advisory council. The services shall be of high quality, accessible, and acceptable to youth in the target population. Age-appropriate prevention guidelines and screening tools must be utilized.

2. The SWP shall provide clinical nursing services fulltime during the school year. Clinical services shall include individual health services that fall within the current, recognized scope of registered nurse (RN) practice in Michigan.

   Individual health services provided by the RN may include: screening/nursing assessments, case finding, immunization assessment and administration, first aid for minor injuries, chronic care interventions, hearing and vision screening, blood pressure monitoring, blood glucose monitoring, case management and/or referral to other needed primary care and specialty medical services

3. Each SWP shall implement two evidence-based programs with fidelity and/or clinical interventions in at least one of the approved focus areas as determined through needs assessment data (For approved focus areas, see Attachment 2: Focus Areas).

4. The SWP shall develop a plan, in conjunction with appropriate school administration and personnel, to provide training and/or professional development to teachers and school staff in areas relevant to the SWP and school-specific needs.

5. The SWP shall provide direct mental health services fulltime during the school year. Mental health services provided shall fall within the scope of practice of the licensed mental health provider and shall meet the current recognized standards of mental health practice for care and treatment of the population served.

   Mental health services should minimally include screening/assessments, short term individual and/or family therapy, crisis intervention, therapeutic groups, prevention education in a classroom or group setting, case management and/or referral to other needed mental health services.

6. The SWP shall not, as part of the services offered, provide abortion counseling, services, or make referrals for abortion services.

7. The SWP shall not prescribe, dispense or otherwise distribute family planning drugs and/or devices on school property.

8. The SWP shall provide Medicaid outreach services to eligible youth and families and shall adhere to Child and Adolescent Health Centers and Programs outreach activities 1 and 2 as outlined in MSA 04-13.

9. The SWP shall have a licensed physician as a medical director who supervises the medical services provided and who approves clinical policies, procedures, protocols, and standing orders.

10. The SWP nursing staff shall adhere to medical orders/treatment plans written by the prescribing physician and/or standing orders/medical protocols written by other health care providers for individuals requiring health supervision while in school.

11. The SWP shall have a licensed registered nurse (preferably with experience working with child/adolescent populations) on staff, working under the general supervision of a physician during all hours of operation.

12. The SWP shall have a mental health provider on staff. The mental health provider shall hold a minimum of a master's level degree in an appropriate discipline and shall be licensed to practice in Michigan. Clinical supervision must be available for all fully licensed providers and provided for any master's level provider with limited licensure while completing hours towards full licensure.

13. The SWP staff shall provide services in no more than two school buildings. The SWP services shall be available during hours accessible to its target population.

14. Written approval by the school administration and local school board exists for the following:

    a) Location of the SWP within the school building
    b) Administration of a needs assessment process for students in the school
    c) Administration of or access to a needs assessment for teachers/staff
    d) Parental consent policy
    e) Services rendered through the SWP

15. A current interagency agreement shall define the roles and responsibilities between the local school district and sponsoring agency; and the school-based health center, if one exists in the same school district.

16. Services provided shall not breach confidentiality of the client. Policies and procedures shall be implemented regarding proper notification of parents, school officials (when allowable and appropriate), and/or other health care providers when additional care is needed or when further evaluation is recommended. The SWP must establish a procedure that doesn't violate confidentiality for communicating with the identified Primary Care Provider (PCP), based on criteria established by the provider and the Medical Director.

    Policies and procedures regarding notification and exchange of information shall comply with all applicable laws e.g., HIPAA, FERPA and Michigan statutes governing minors' rights to access consent for care.

17. The SWP shall implement a continuous quality improvement plan for nursing and mental health services. Components of the plan shall include at a minimum:

    a) Practice and client record review shall be conducted at least twice annually by an appropriate peer and/or other peer-level staff of the sponsoring agency, to determine that conformity exists with current standards of care. A system shall also be in place to implement corrective actions when deficiencies are noted.
    b) Completing, updating, or having access to a needs assessment process conducted within the last three years to determine the health needs of the population served including, at a minimum, a risk behavior survey for adolescents served by the SWP.
    c) Conducting a client satisfaction survey at a minimum annually.

18. A local community advisory council shall be established and operated as follows:

    a) A minimum of two meetings per year
    b) The council must be representative of the community and include a broad range of stakeholders such as school staff
    c) One-third of council members must be parents of school-aged children/youth
    d) Health care providers shall not represent more than 50% of the council
    e) The council must approve the following policies and the SWP must develop applicable procedures:

        1. Parental consent policy
        2. Requests for medical records and release of information that include the role of the non-custodial parent and parents with joint custody
        3. Confidential services as allowed by state and/or federal law
        4. Disclosure by clients or evidence of child physical or sexual abuse, and/or neglect

19. The SWP shall have space and equipment adequate for private visits, reception, private counseling, secured storage for supplies and equipment, and secure paper and/or electronic client records. The physical facility must be barrier-free, clean and safe.

20. The SWP shall follow all Occupational Safety and Health Act guidelines to ensure protection of SWP personnel and the public.

21. For SWPs participating in billing: the SWP shall establish and implement a sliding fee scale, which is not a barrier to care for the population served. Users must not be denied services because of inability to pay. CAHC state funding may be used to offset any outstanding balances to avoid collection notices and/or referrals to collection agencies for payment.

22. For SWPs participating in billing: the billing and fee collection processes do not breach the confidentiality of the client.

CHILD AND ADOLESCENT HEALTH CENTERS
CLINICAL AND ALTERNATIVE CLINICAL MODELS
Attachment 1: Services Detail

The following health services are required (*or recommended) as part of the Child and Adolescent Health Center service delivery plan:

PRIMARY CARE SERVICES

- Well child care
- EPSDT screenings and exams
- Comprehensive physical exams
- Risk assessment/other screening
- Laboratory services
    1. CLIA Waived testing
    2. Specimen collection for outside lab testing
- *Other diagnostic, screening and/or preventive services
    1. Hearing and vision screening
    2. Tympanometry
    3. Preventive oral applications
    4. Spirometry
    5. Pulse oximetery
    6. Telehealth capabilities
    7. Office microscopy

MENTAL HEALTH SERVICES

- Mental Health services provided by a Master's level mental health provider.

ILLNESS/INJURY CARE

- Minor injury assessment/treatment and follow up
- Acute illness assessment/ treatment and follow up &/or referral

CHRONIC CONDITIONS CARE

- Includes assessment, diagnosis and treatment of a new condition
- Maintenance of existing conditions based on need, collaborations with PCP/specialist or client/parental request
- Chronic conditions may include: asthma, diabetes, sickle cell, hypertension, obesity, metabolic syndrome, depression, allergy, skin conditions or other specific to a population

IMMUNIZATIONS

- Screening and assessment utilizing the MCIR and other data
- Complete range of immunizations for the target population utilizing Vaccine for Children and private stock
- Administration of immunizations
- Appropriate protocols, equipment, medication to handle vaccine reactions

HEALTH EDUCATION

STI & HIV EDUCATION, COUNSELING, & VOLUNTARY TESTING

- Education appropriate for age, other demographics of the target population, and needs assessment data
- Risk assessment, historical and physical assessment data informs individualized care
- CAHC-trained HIV counselor/tester is on site
- Testing for and treatment of STI and testing and referral for HIV treatment is on site

"CONFIDENTIAL SERVICES" AS DEFINED BY MICHIGAN AND/OR FEDERAL LAW

- Confidential services are those services that may be obtained by minors without parental consent
- Confidential services include: mental health counseling, pregnancy testing & services, STI/HIV testing and treatment, substance use disorder counseling and treatment, family planning (excluding contraceptive prescription/distribution on school property).

REFERRAL

- PCP, specialists, dental services, community agencies, etc.

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CHILD AND ADOLESCENT HEALTH CENTERS
CLINICAL AND ALTERNATIVE CLINICAL MODELS
and SCHOOL WELLNESS PROGRAMS
Attachment 2: Focus Areas

Each year, health centers and SWPs should review their needs assessment data to determine priority health issues that are of such significance to their target population to warrant an enhanced "focus" for the upcoming year. Each center is required to implement at least two evidence based programs or clinical interventions to begin to address the needs within the selected focus area(s).

FOCUS AREAS

- ALCOHOL/TOBACCO/OTHER DRUG PREVENTION
- CHRONIC DISEASE MANAGEMENT
- HIV/AIDS/STI PREVENTION
- NUTRITION AND PHYSICAL ACTIVITY
- PREGNANCY PREVENTION

Focus areas are meant to provide services above and beyond what would typically be provided in comprehensive primary care. It is expected that each of these focus areas will be a part of comprehensive primary care already, but interventions selected for the focus area requirement should be significantly beyond typical care. Strategies should be intensive, evidence-based, and include appropriate evaluation methods to assess impact and progress on meeting focus areas.

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APPENDIX H:
STATE OF MICHIGAN BEST PRACTICES POLICIES AND PROCEDURES CHECKLIST (CAHCS)

Child and Adolescent Health Center Program (CAHC)
Best Practices Policies and Procedures Checklist

Policies and procedures (P&Ps) included in this checklist are BEST PRACTICES for standards of care for child and adolescent health services. This list is not exhaustive and therefore your fiduciary may have, and is encouraged to have, more than listed below. Duplication may occur in sections.
It is encouraged for fiduciaries to review P&Ps regularly.

Administrative Policies and Procedures (Best Practice)	
☐ Non-Discrimination Policy: The program has a non-discrimination policy; services are offered without regard to sex, race, religion or sexual orientation.	☐ Walk-In Services: Walk-in services are available.
☐ Emergency Plan: Site-specific emergency plan includes staff, actions and/or responsibilities for emergency situations (fire, power outage, natural disaster, weapons on-site, violence, theft). The plan is accessible, reviewed and updated regularly.	☐ Evaluation of Staff: Recommended at least annually with clear performance measures.
Clinical Policies and Procedures (Best Practice)	
☐ Child Abuse and Neglect Reporting and Staff Education: P&P exists and describes how staff will respond to suspicion of abuse and neglect, as well as how often staff receive education on responsibilities as a mandated reporter. (Standard of Care)	☐ Telehealth: If telehealth services are provided, the health center has P&P for both medical and mental health on how consent is obtained, what services are allowed, how services are provided, how confidentiality is maintained, documentation and billing. (Standard of Care)
☐ Risk Screening: Risk screenings may include blood pressure with percentiles, BMI, alcohol tobacco and other drugs (ATOD), relational violence screening, harm reduction, trauma screening, social determinants of health, and suicidality. (Standard of Care)	☐ Fiduciary Annual Competency Trainings: The health center may include a policy of recommended trainings (implicit bias, cultural sensitivity, Abuse and Neglect Reporting, etc.). (Standard of Care)
Mental Health Policies and Procedures (Best Practice)	
☐ Intake/Assessment: Intake/assessment is completed by the third visit.	☐ Missed Appointments: A follow-up mechanism in place for missed appointments.
☐ Crisis Response Plan: A crisis response plan and communication plan exists where appropriate between the CAHC/sponsoring agency and the client's school.	☐ Treatment Groups: Each treatment group has an established number of structured sessions with at least one documented topic, with defined goals/outcomes for the treatment group.
☐ Group Participant Mental Health Record: Each group participant has a mental health record that contains a signed consent as necessary, a signed agreement/contract to participate and an understanding of confidentiality guidelines, diagnostic assessment, and individual treatment plan reflecting the group topic, current documentation completed after each session.	

APPENDIX I:
STATE OF MICHIGAN REQUIRED POLICIES AND PROCEDURES CHECKLIST (CAHCS)

Child and Adolescent Health Center Program (CAHC)
Required Policies and Procedures Checklist

Policies and procedures (P&Ps) included in this checklist are REQUIRED for the CAHC Program. This list is not exhaustive and therefore your fiduciary may have, and is encouraged to have, more than what is listed below. Duplication in sections may occur. Fiduciaries are encouraged to review P&Ps regularly.

Administrative Policies and Procedures (Required)	
☐ Eligibility: Outlines who can receive services at the CAHC; services offered to not breech the confidentiality of youth served. (Element definition of MPR, MDE RFP, CAHC Contract)	☐ Hours of Operation: P&P includes how hours are posted and shared with population served; voicemail includes telling students/parents where their clients can go to receive services during summer/holiday breaks; specific hours designated for adolescent only (when a health center serves both children aged 5 to 10 and adolescents). (MPR#8)
☐ Language Assistance: Language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. (CLAS Standards – Title VI of Civil Rights Act)	☐ Rights and Responsibilities Policy: A youth friendly Bill of Rights is posted throughout the site, distributed, and explained to clients and contains language about refusal and deferral of care (this can be a separate policy). (Patient Self-Determination Act of 1990)
☐ CQI: Continuous quality improvement (CQI) P&Ps for services that defines the site's CQI processes, inclusive of all required elements of MPR#12 (may include processes for client satisfaction survey, needs assessment completed within the last three years to determine the health needs of the population served including, at a minimum, a risk behavior survey for adolescents when adolescents are served or these may be separate policies). (MPR#12)	☐ Abortion Services: Does not provide abortion counseling services or make referrals to abortion services. (MPR#3 and State School Aid, Act 94 of 1979, as amended)
☐ Family Planning Prescribing: Not prescribe, dispense or otherwise distribute family planning drugs or devices on school property. (MPR#4, School Code, Act 451 of 1976 and State School Aid Act, Act 94 of 1979, as amended)	☐ Informed Consent: Informed consent including parent, minor consent and clients aged 18 and older. Mature minor consent includes the right to refuse or defer treatment unless intent exists to harm self or others. (MPR#1, MPR#2, Patient Self-Determination Act of 1990)
☐ Releases: Request for release of medical records and release of information. (MPR#13)	☐ Confidential Services: Confidential services as allowed by state and/or federal law and/or practice. Outline steps taken to maintain client confidentiality that includes physical and verbal confidentiality. (MPR#1, MPR#2, MPR#13)
☐ Abuse or Neglect: Disclosure by clients or evidence of child physical or sexual abuse or neglect. (MPR#13)	☐ Medicaid Eligibility: Method for determining and obtaining information on Medicaid eligibility. (MPR#5 and MSA Bulletin 04-13)
☐ Sliding Fee Scale: The health center shall establish and implement a sliding fee scale which is not a barrier to health care for the population served. Clients must not be denied services based on their inability to pay; policy stating services will not be denied for lack of payment (MPR#17)	☐ Parent/Guardian Consent: Parent(s)/guardian(s) of minors that consent to treatment for mental health services or STI/HIV as allowable under Michigan law shall not be liable for cost of services received by minor. (Mental Health Code: Act 258 of 1974 and Public Health Code: Act 368 of 1978, as amended)
☐ Medicaid Billing: Process for billing Medicaid, Medicaid health plans and other third parties. (MPR#18)	☐ Confidential Services Billing: Billing processes do not breech confidentiality of client. (MPR#19 and HIPAA)
☐ Revenue: Revenue generated from CAHC must be used to support CAHC operations and programming; policy and procedures describe how revenue generated by health center is returned to the health center account. (MPR#20)	☐ Secure Storage: The health center has secure storage for supplies and equipment, secure paper and/or electronic records that maintain client confidentiality. (MPR#14 and HIPAA)

Child and Adolescent Health Center Program (CAHC)
Required Policies and Procedures Checklist

Clinical Policies and Procedures (Required)	
☐ Medical Director: The health center shall have a licensed physician as a medical director who supervises the medical services provided and who approves clinical policies, procedures, and protocols. Standing orders include medications for treatment and/or clinical procedures if proved by staff other than the main clinical provider. (MPR#9)	☐ Informed Consent: There is a policy of informed consent including parent, minor (when adolescents are served), and clients age 18+. Policy and consent forms are inclusive of all applicable services provided by the health center. Includes right to refuse or defer services, as well as limits of confidentiality. (MPR#1, MPR#2, and Patient Self-Determination Act of 1990)
☐ Immunizations: Education, screening, and provision of immunizations is consistent with CDC-ACIP guidelines. The Michigan Care Improvement Registry (MCIR) is used consistently for assessment and administration documentation. Includes documentation of appropriate administration, refusals, deferrals, emergency treatment of adverse reactions, storage, handling, transport, and emergency plan. (MPR#1)	☐ HIV Services: P&P inclusive of education, counseling, testing and referral for HIV is consistent with CDC/other relevant guidelines. Includes documentation of refusals, deferrals, counseling, and referrals for positive and negative test results. (MPR#1 and MPR#2)
☐ STI Services: Education, testing, treatment and/or referral for STIs is consistent with CDC/other relevant guidelines. Includes how health center performs STI screenings, counseling for positive and negative test results, documentation of refusals, and deferrals. (MPR#1 and MPR#2)	☐ Pregnancy Services: Education and pregnancy testing is consistent with current guidelines. Includes counseling, referrals, and follow-up procedures for both negative and positive test results. (MPR#1 and MPR#2)
☐ Health Promotion: Health promotion and risk reduction services are consistent with recognized preventative services guidelines appropriate for age. P&Ps include risk assessment administration, anticipatory guidance, frequency of assessment, documentation of counseling and referral as needed. (MPR#1 and MPR#2)	☐ Client Confidentially: Client confidentiality is maintained. P&Ps outline steps taken to maintain client confidentiality. Includes environmental and procedural methods of maintaining confidentiality in the process of care provision. (MPR#2 and HIPPA)
☐ Consultation and Referrals: Physician consultant, treatment, referrals and follow-up for diagnostic testing or specialty consultation are appropriate for recognized guidelines and agreements. P&Ps complete and consistent with recognized guidelines and agreements. Includes frequency of assessment, documentation of counseling and referral as needed. (MPR#2 and MPR#9)	☐ Treatment Refusal or Deferment: The client has the right to refuse or defer treatment, unless intent exists to harm self or others. Their refusal or deferral of treatment is documented in the client record. Includes the process of educating the clients on rights and responsibilities, limits of confidentiality, and right to refuse or defer care. (MPR#2 and Patient Self-Determination Act of 1990)
☐ PCP Communication: The health center has established and implemented a process for communicating with the assigned primary care provider, based on criteria established by the provider and medical director, that does not violate confidentiality. P&Ps clearly define data/information that is to be communicated. Includes under which circumstances the PCP is notified of care provided in the CAHC. (MPR#11)	☐ Parent/Guardian Communication: Findings and treatment plan are reviewed/communicated with parents, unless prohibited by client and are consistent with Michigan minor consent laws. Includes under which circumstances the guardian is notified of care provided in the CAHC and notification of minor prior to communication of confidential services when required to break confidentiality. (MPR#2)
☐ Medications: All medications (OTC and prescription) are stored, dispensed, and disposed of in compliance with fiduciary guidelines and Public Health Code regulations. If dispensing, P&Ps includes how medications are labeled and how drug control license is maintained. Documentation of medication administration includes source of medication supply (stock, prescribed, dispensed). (MPR#2 and Public Health Code: Act 368 of 1978, as amended)	☐ Medical Emergencies: Handling of medical emergencies defines what, if any, emergencies will be responded to outside of the health center and what care will be provided. (If no emergency response outside of the health center is provided, P&P exist to this effect.) For emergencies managed by health center on or off-site, care and supplies are appropriate and match policy. Emergency supply kit matches care outlined in P&Ps, including but not limited to emergency medication (minimum – supplies for response to anaphylactic reaction in health center). (MPR#2)
☐ Medical Waste: The handling of medical waste is consistent with Michigan OSHA guidelines. A written plan for control of hazardous environmental exposure is consistent with the guidelines (site specific). Includes labeling and removal of sharps containers, bloodborne pathogens exposure plan, spill kit location and response for medical exposures, location of required posters, medical waste storage transport (if required), and pick-up procedures. (MPR#15)	☐ Laboratory Standards: The health center shall conform to the regulations determined by the Department of Health and Human Services for laboratory standards. CLIA certification is documented. Inclusive of procedural steps descriptive of how regulations are followed, competency and proficiency testing, lab direction, and reference to lab manual for all point-of-care and send out testing. (MPR#16)

Mental Health Policies and Procedures (Required)	
☐ CQI: The health center shall implement a continuous quality improvement (CQI) plan. Components of the plan shall include at a minimum: Practice and record review shall be conducted at least twice annually by an appropriate peer and/or other staff of the sponsoring agency, to determine that conformity exists with current standards of care. A system shall also be in place to implement corrective actions when deficiencies are noted. P&P includes mental health services. (MPR#12)	☐ Client Confidentiality: Client confidentiality is maintained, including physical and verbal privacy in the counseling area. (MPR#2, MPR#14, Mental Health Code: Act 258 of 1974, as amended, and HIPPA)
☐ Treatment Plans: Treatment plans are kept current, modified when indicated and are reviewed at reasonable intervals with client and with parents, unless prohibited by client (consistent with Michigan minor consent laws). (MPR#2 and Mental Health Code: Act 258 of 1974, as amended)	☐ Treatment Refusal or Deferment: The client has the right to refuse or defer treatment, unless intent exists to harm self or others. Their refusal or deferral of treatment is documented in the client record. (MPR#2 and Patient Self-Determination Act of 1990)
☐ Pharmacological Intervention: If the mental health clinician indicates a pharmacological intervention may be needed the provider refers to a clinical provider who can prescribe appropriate medications, when needed. P&Ps outline process for referral to clinical provider for pharmacological intervention. (Public Health Code: Act 368 of 1978, as amended)	☐ Referral Follow-Up: There are adequate procedures for the follow-up of internal and off-site referrals. (MPR#1)

APPENDIX J:
SAMPLE POLICY: FEES FOR SERVICES (SBHCS)

FEES FOR SERVICES

PURPOSE:
To establish a fee schedule for the School-Based Health Center (SBHC) program for collection of payment from patients and supporting processes for recording the payment.

DEFINITION:

N/A

POLICY STATEMENT:
SCHOOL-BASED HEALTH CENTERS:

A. School-Based Health Centers will establish a cost for all services, and each student's charge will be based on the approved fee schedule.
B. Sliding fee scale discounts are available to students whose parents have incomes at or below 200% of the federal poverty guidelines. Our sliding fee scale discounts apply to all who receive services through our SBHC program.
C. Any patient that presents in the SBHC and does not have the ability to pay for services is eligible for our Sliding Fee Discount Program. If the provider determines that a student is eligible for our sliding fee program, we will send an application home for their parent to complete and for them to provide proof of income. The established fee schedule shall not preclude the student from receiving services in the health center; students that do not possess insurance will not be billed. Students who present for confidential services will not be billed.
D. Each year, in September, the provider will reassess the student's eligibility for the Sliding Fee Discount Program. The student's eligibility is good for one school year.
E. Signage and our consent package will also communicate the availability of a sliding fee scale discount. To qualify for the sliding fee scale discount, parents must provide family and gross income information. A family consists of those members of the household supported by the reported income, typically the individuals reported on the federal tax return. The following documentation of gross income for all household members: Federal income tax return or -- Two current pay stubs or -- Unemployment benefit award letter or -- Letter from employer on letterhead or -- Award or benefit letter or -- Affiliated agency income verification documentation that meets above requirements or -- selfattestment of income statement.

A. Upon enrolling in the center, insurance information will be documented. Upon completion of services rendered, staff will make a good faith effort to collect payments per the sliding fee schedule for the uninsured. However, no one will be denied services for the inability to pay. The patient encounter will be forwarded to the department Biller. Efforts will be made to obtain reimbursements from a third party insurance or Medicaid. Those uninsured will be offered assistance with MI Child or other health insurance enrollment.
B. If students qualify for the sliding fee scale discount, it will be predated 30 days from the day they were approved.

C. Students are not responsible for their copay, based on our agreement with various managed care plans and our funding from the Michigan Department of Health and Human Services (MDHHS).

Collection of Fees

D. When receiving cash from a patient, for services rendered, the cash is placed in a lock box within the health center. When the lockbox exceeds 20.00 dollars, the cash is sent to the School-Based Health Center primary office to record and then forward to the cashier's office for deposit into the health center's account.
E. After rendering the services, the patient should be given a receipt for the amount paid.

APPENDIX K:
SAMPLE CONSENT FORM

Department of Pediatrics
School-Based and Community Health Program (SBCHP)

PATIENT (18 and OVER) OR GUARDIAN CONSENT FORM

Name: Last	First	M.I.	**Pronouns:**	**Grade:**
Name on Insurance: Last	First	M.I.	**Date of Birth:** Month / Day / Year	
What is the patient's (your) gender identity? ❒ Girl/Woman ❒ Transgender Girl/Woman ❒ Boy/Man ❒ Transgender Boy/Man ❒ Genderqueer or non-binary ❒ Additional identity (fill in)_____			**What was patient's (your) sex assigned at birth?** ❒ Male ❒ Intersex ❒ Female ❒ Don't know **Were you adopted?** ❒	
Race (Optional):	❒ Black/African American	❒ White	❒ Native Hawaiian/ Other Pacific Islander	
	❒ American Indian/Alaskan Native	❒ Asian	❒ More than one race	
Ethnicity (Optional):	❒ Hispanic/Latino	❒ Arab/Chaldean	❒ Non-Hispanic/Latino/Arabic	

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ( ) **Ok to leave voicemail?** ❒ Yes ❒ No	**Parent Cell Phone** ( ) **Parent Email address:**	**Work/Alternate Phone** ( ) **Ok to leave voicemail?** ❒ Yes ❒ No	**Patient Cell Phone** ( ) **Ok to text?** ❒ Yes ❒ No
Address		**City**	**Zip Code**
Name of Emergency Contact	**Relationship to Patient**	**Telephone Number**	
Medical Insurance Type:	**Member ID Number**	**Group Number**	
Insurance Member Name (parent/guardian/self)	**Member Birth Date** / /	**Relationship to Patient**	
IF PATIENT IS UNDER 18 Please provide the following information of the PARENT OR GUARDIAN: Last Name: First Name: M.I. Date of Birth: / / Relationship To Patient:			

PATIENT MEDICAL HISTORY: Please Check 'Yes' or 'No' for each item listed below

When was last physical?	
Any allergies to medications? If yes, please list medication and reaction:	❒Yes ❒No
Any history of severe allergic reaction or anaphylaxis?	❒Yes ❒No
Any food allergies? If yes, please list:	❒Yes ❒No
Any medications on a daily basis? If yes, please: list medication and dose:	❒Yes ❒No
Any surgeries (i.e., tonsils, hernia, appendix). If yes, please list type of surgery:	❒Yes ❒No
Any mental health history (i.e. anxiety, depression):	❒Yes ❒No

Does the patient have any of the following:	
Asthma	❒Yes ❒No
Bladder problems (bedwetting)	❒Yes ❒No
Seizure (epilepsy)	❒Yes ❒No
Anemia (low iron/blood count)	❒Yes ❒No
Diabetes	❒Yes ❒No
Hypertension (high blood pressure)	❒Yes ❒No
Concerns with weight	❒Yes ❒No
Sickle Cell Disease/Trait	❒Yes ❒No
Eczema/rashes/skin problems	❒Yes ❒No
Heart problems	❒Yes ❒No
Stomach problems	❒Yes ❒No
Headaches	❒Yes ❒No
ADD/ADHD (attention deficit disorder)	❒Yes ❒No
Fainting or concussion	❒Yes ❒No
Hay fever/Sinus problems	❒Yes ❒No
Other health problems. Please list:	❒Yes ❒No

FAMILY HISTORY: Please place a check below each family member who may have one of the diseases below. Unknown? ❒Yes

	Mental Health	**Asthma**	**Cancer**	**Diabetes**	**Heart Disease**	**High Cholesterol**	**High Blood Pressure**	**Seizures**	**Sickle Cell**	**Thyroid Disease**
Mother										
Father										
Sister										
Brother										
Grand-mother										
Grand-father										
Other:										

PLEASE TURN OVER ➔

Patient Name: _____ Date of Birth: _____

I consent to all of the following:

- The above named patient may receive all available medical and behavioral health services provided at your HFHS SBCHP location.
- Tele-health services, available at specific sites provide your child an opportunity to receive services by a licensed health care provider when a provider is not on site.
- The SBCHP, my child's school and my child's health care provider may exchange health care information and school records for the purpose of continuity and coordination of care.
- The SBCHP may release information regarding treatment to insurance companies or others for the purpose of receiving payment for services.
- If my child is found to need prescription medication at the time of the clinic visit, I give permission for him/her to transport the medication unsupervised from school to home.

By completing and signing this form, I am saying that I am the guardian of the student named above who is under the age of 18; or I am the patient named above and 18 or older. I also understand that if my child is currently in elementary, middle or high school, that this consent will remain valid until my child changes schools or graduates. If your child's new school is affiliated with our program, you will be asked to complete a new consent at that time. I understand that I may cancel my consent for services by giving written notice to SBCHP at any time.

I acknowledge receiving a copy of the Henry Ford Health System Notice of Privacy Practices.

_____

SIGNATURE OF PARENT/GUARDIAN/PATIENT (18 and Older) DATE

I consent for the staff of the SBCHP to obtain a copy of the above named patient's immunization record from the patient's school office, primary care provider's office, local health department and/or MCIR (Michigan Care Improvement Registry). If the records show that my child needs any immunizations, as recommended by the Center for Disease Control and the American Academy of Pediatrics, I agree that all can be given at the SBCHP location. I understand that a form explaining any shots my child needs along with specific vaccine information sheets (VIS) will be sent home prior to the vaccine being given. If I decide that I do not want a shot(s) to be given to my child then I must sign and return the form to the school within the following week.

_____

SIGNATURE OF PARENT/GUARDIAN/PATIENT (18 and Older) DATE

If the HFHS SBCHP has taken photos/videos that include my child, they may be used to promote the health center and healthy activities through various print and internet media, including the Children's Health Fund.

_____

SIGNATURE OF PARENT/GUARDIAN/PATIENT (18 and Older) DATE

If an urgent but non-emergency health care related issue comes up on a day that the medical provider is at a different location and you are unable to come to the school (due to work or transportation reasons), your signature below authorizes us to provide tele-health provider services (if available) or transport your child to receive the necessary care. Your child will be chaperoned (by school personnel, school nurse or a Henry Ford Health System employee) to the provider location (mobile medical unit or fixed health center). We will contact you prior to transportation. Once the evaluation is complete, we will notify you of our findings and whether your child is ok to return to school or needs to go home. Please note that transportation for emergency care does not require your consent. If any emergency situation arises while your child is in our care, we will first call EMS and then immediately notify you.

_____

SIGNATURE OF PARENT/GUARDIAN/PATIENT (18 and Older) DATE

Please complete both sides of this form and return to:
Henry Ford School-Based and Community Health Program. Thank you.

APPENDIX L:
SAMPLE CONSENT POLICY

Dear Parent or Guardian,

School-Based Health Centers and the School District are pleased to provide health services for students at School. The Health Center's hours of operation are 8:00 a.m. to 4:30 p.m., Monday – Friday, closed weekends and holidays.

School-Based Health Center is overseen by a Medical Director that is a board-certified Family Practice Physician. A certified Nurse Practitioner, a Therapist who is a Licensed Mental Health Professional and a Medical Assistant will provide care to students. We provide a wide range of services, including physical exams, sick visits, individual/group counseling, and a variety of school and community educational programs.

Our goal is to improve the health and well-being of students at the School. All interactions between the health center staff and the student will be kept confidential to the extent provided by law.

We are approved by the Michigan Department of Health and Human Services to bill medical insurance companies for services provided in the health center. School-Based Health Centers transmits claims directly from our office to your insurance company for payment. Parents or Guardians of students will never be responsible for unpaid bills or portions of unpaid bills. Therefore, please do not discourage your child from participating because of lack of insurance or problems with bill payment. Health Center management will address all billing issues.

If you do not have medical insurance, please call, PHONE, for assistance; we can help you enroll your child/children in Healthy Kids or MIChild. It is important that you help us by providing Health Center Staff the most accurate and up-to-date information possible.

Attached are the consent form, medical insurance registration form, and a parent questionnaire. Please return these completed forms to us as soon as possible. By providing us with up-to-date information about your child's health, it will further help us to better serve the needs of your child.

We look forward to serving you and your child. If you have any questions or would like further information, please call. In case of a medical emergency during business hours, please call 911 or go to the nearest emergency room. For mental health crisis, please contact the 24 hour Crisis Line for information and referrals.

Available Services:

Medical	General health assessment, school/sports physicals, sick care, immunizations, vision, and hearing testing, laboratory screening, health education, and nutrition counseling.
Counseling	Counseling and referrals for various concerns related to school age children and adolescents including depression, behavioral issues, personal relationships, violence prevention, family problems and substance abuse.
Health Education	Student and parent educational programs related to the school age child's health issues; i.e. asthma, hypertension, diabetes, nutrition, abstinence, substance abuse prevention, and conflict resolution.

Sincerely,
School-Based Health Center Staff

Name: _____

Birth date: _____

Although crisis intervention and emergency care do not require consent, medical services require a signed consent before services are provided. The following services are available from your **School-Based Health Center**:

- Physical exams
- Diagnosis and management of acute and chronic illnesses/disease
- Immunizations
- Dental, Vision, and Hearing screenings
- Basic Laboratory tests including urinalysis, glucose, rapid strep test, cholesterol, hemoglobin

- Health education, activity groups, risk prevention counseling
- Counseling and referrals for mental health, physical/sexual abuse, substance abuse*
- Crisis intervention
- Group and Family Counseling
- Referral for resources such as food, shelter, financial issues, transportation

* Current Michigan Law mandates for confidential services to minors in these areas, as well as Pregnancy/STI/HIV testing and counseling.

I consent to all the following:

- I have reviewed and understand the services offered by the **School-Based Health Center**. I give consent for my child to receive the services indicated on this document. By signing this consent form I certify that I am the legal guardian and legal custodian of:_____.

- I understand this consent will remain valid until my child graduates, and that I may withdraw my consent for services upon writ- ten notice to the **NAME School-Based Health Center** at any time.

- I further authorize the **NAME School-Based Health Center** to release/exchange information regarding treat-ment to 1) my child's primary care physician or mental health providers when needed for coordination of care, 2) school staff when needed to coordinate services at school, 3) third party payers or others for the purpose of receiving payment for services. ***However services will be provided regardless of insurance and/or ability to pay.***

- The School-Based Program may obtain a copy of the above name student's/patient's immunization re- cord from the student's/patient's school office, primary care provider's office, and/or local health department.

- I understand all NAME School-Based Health Center's medical records are part of the NAME electronic medical records system.

- I understand that testing for bloodborne diseases, including HIV / AIDS, may be performed upon a patient without a separate written consent in the event that a healthcare professional from the Center sustains exposure to blood or bodily fluids from the patient's open wound, percutaneous mucous membrane or occupational hazard.

_____ _____

Signature of Parent/Guardian/Patient: **Date:**

Guidelines for Adolescent Preventive Services

Confidential (Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____
Parent/Guardian name _____ Relationship to adolescent _____
Your phone number: Home _____ Work _____

Adolescent Health

1. Is your adolescent allergic to any medicines?
   ☐ Yes ☐ No If yes, what medicines? _____
2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken

3. Has your adolescent ever been hospitalized overnight?
   ☐ ☐
4. Has your adolescent ever had any serious injuries?
   ☐ Yes ☐ No If yes, please explain. _____
5. Have there been any changes in your adolescent's health during the past 12 months?
   ☐ Yes ☐ No If yes, please explain. _____

Yes	No	If yes, give the age at time of hospitalization and describe the problem.
Age		Problem

6. Please check (✓) whether your adolescent ever had any of the following health problems. If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	☐	☐		Headaches/migraines	☐	☐	
Allergies/hayfever	☐	☐		Low iron in blood (anemia)	☐	☐	
Asthma	☐	☐		Pneumonia	☐	☐	
Bladder or kidney infections	☐	☐		Rheumatic fever or heart disease	☐	☐	
Blood disorders/sickle cell anemia	☐	☐		Scoliosis (curved spine)	☐	☐	
Cancer	☐	☐		Seizures/epilepsy	☐	☐	
Chicken pox	☐	☐		Severe acne	☐	☐	
Depression	☐	☐		Stomach problems	☐	☐	
Diabetes	☐	☐		Tuberculosis (TB)/lung disease	☐	☐	
Eating disorder	☐	☐		Mononucleosis (mono)	☐	☐	
Emotional disorder	☐	☐		Other: _____	☐	☐	
Hepatitis (liver disease)	☐	☐			☐	☐	

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")? ☐ Yes ☐ No ☐ Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	☐				
Arthritis	☐				
Birth defects	☐				
Blood disorders/sickle cell anemia	☐				

	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type_____)	☐	☐	☐	_____	_____
Depression	☐	☐	☐	_____	_____
Diabetes				_____	_____
Drinking problem/alcoholism	☐	☐	☐	_____	_____
Drug addiction	☐	☐	☐	_____	_____
Endocrine/gland disease	☐	☐	☐	_____	_____
Heart attack or stroke *before* age 55				_____	_____
Heart attack or stroke *after* age 55	☐	☐	☐	_____	_____
High blood pressure	☐	☐		_____	_____
High cholesterol	☐	☐		_____	_____
Kidney disease	☐	☐	☐	_____	_____
Learning disability	☐	☐	☐	_____	_____
Liver disease	☐	☐	☐	_____	_____
Mental health	☐	☐	☐	_____	_____
Mental retardation	☐	☐	☐	_____	_____
Migraine headaches	☐	☐	☐	_____	_____
Obesity	☐	☐	☐	_____	_____
Seizures/epilepsy	☐	☐	☐	_____	_____
Smoking	☐	☐	☐	_____	_____
Tuberculosis/lung disease	☐	☐	☐	_____	_____

9. With whom does the adolescent live most of the time? *(Check all that apply.)*

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

1

☐ ☐ ☐ ☐ ☐ ☐

Parental/Guardian

11. Please review the topics listed below. Check(if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	☐	Guns/weapons	☐
Physical development	☐	School grades/absences/dropout	☐
Weight	☐	Smoking cigarettes/chewing tobacco	☐
Change of appetite	☐	Drug use	☐
Sleep patterns	☐	Alcohol use	☐
Diet/nutrition	☐	Dating/parties	☐
Amount of physical activity	☐	Sexual behavior	☐
Emotional development	☐	Unprotected sex	☐
Relationships with parents and family	☐	HIV/AIDS	☐
Choice of friends	☐	Sexual transmitted diseases (STDs)	☐
Self image or self worth	☐	Pregnancy	☐
Excessive moodiness or rebellion	☐	Sexual identity	
Depression	☐	(heterosexual/homosexual/bisexual)	☐
Lying, stealing, or vandalism	☐	Work or job	☐
Violence/gangs	☐	Other: _____	☐
	☐		

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?

What is it? _____

15. Can we share your answers to Question 13 with your teen? Yes ☐ N ☐

Both parents in same household
Mother
Father
Other adult relative
Stepmother
Stepfather
Guardian
Brother(s)/ages _____
Sister(s)/ages _____
Other _____
Alone

0. In the past year, have there been any changes in your family? *(Check all that apply.)*

Marriage Separation Divorce	Loss of job Move to a new neighborhood A new school or college	Births Serious illness Deaths	Other _

VACCINE PREVENTABLE DISEASE INFORMATION/CONSENT FORM

CHILD'S NAME: _____ CHILD'S BIRTHDATE _____

I _____ have read or had the risks associated with vaccination explained to
(Parent/guardian name - Print)

me. I have had the opportunity to ask questions and feel satisfied with the answers given. I give permission to vaccinate my child

_____.
Child's Name

Signature of Parent/Guardian: _____ Date: _____

Chickenpox (Varicella) Chickenpox is a common childhood disease which can be serious. Chickenpox can lead to pneumonia, brain damage, or death. Children who receive the chickenpox vaccination may experience fever, soreness, a mild rash, or swelling where the shot was giv-en. In rare cases a child may experience a seizure (less than 1 out of 1,000 cases). It may be possible for someone who gets a rash from the chicken pox shot to give chickenpox to another person. If the person getting the vaccine has an immune system that is not working properly, or is in close contact with anyone whose immune system is not working properly, please inform the nurse/doctor. **If the person who is get-ting the vaccine has ever had a serious allergic reaction to the chickenpox vaccine, neomycin, or gelatin, please inform the nurse/doctor**.

Diphtheria, Tetanus, Pertussis (DTaP, Tdap, DT, Td) Diphtheria is a serious illness in which a thick membrane is formed in the back of the throat. This covering can cause breathing problems and even death. Tetanus (Lockjaw) causes muscles in the body to painfully tighten. Pertussis can cause severe coughing spells that can last for weeks. **DTaP is for children younger than 7 years; DT is for a child younger than 7 years who should not have the pertussis vaccine. Adolescents 11 through 18 years of age should receive 1 dose of Tdap; Td should be given for later booster doses**. Children who receive the DTaP, Tdap, or Td vaccine commonly experience soreness at the injection site, fever, fussiness, and poor appetite. Children who receive this vaccine rarely experience seizures, become less alert, or develop difficulty breathing.

Hepatitis A (HAV) is a serious liver disease caused by the Hepatitis A virus. Hepatitis A is spread by close personal contact and sometimes by eating food or drinking water containing Hepatitis A virus. Persons at risk should have this vaccine. Two doses, 6 months apart, are needed for lasting immunity. Soreness at the injection site, headache, loss of appetite and tiredness may occur 3 - 5 days after the shot has been given. Rarely does serious allergic reaction occur. **People who have had an allergic reaction to one dose should not receive the second dose**.

Hepatitis B (HBV) Hepatitis is a serious liver infection caused by the Hepatitis B virus. People with this infection are at risk for developing diseases such as liver cancer, cirrhosis, or even death. Three doses are required for total immunity. Potential side effects of this vaccine include soreness at the injection site and fever. People who are allergic to baker's yeast should not receive this vaccine.

Haemophilus Influenzae Type b (HIB) is a bacterium that can cause children to develop serious illness such as infection of his/her brain or heart. These infections can cause permanent problems such as brain damage or even death. **HIB vaccination is recommended for anyone under the age of 60 months (5 years)**. Potential side effects of this vaccine include fever, swelling, or redness at the site of the injection. These reactions generally start within 24 hours of the vaccination and subside within 48 hours. **People who have had an allergic reaction to one dose should not receive another dose**

Human Papillomavirus (HPV) is spread through sexual contact. HPV is important mainly because it can cause cervical cancer in women. HPV vaccine is an inactivated (not live) vaccine which protects against 4 major types of HPV. HPV vaccine can prevent some genital warts and some cases of cervical cancer. **HPV vaccine is routinely recommended for girls and boys 11-12 years of age. The vaccine is also recom-mended for females 13-26 years of age and males 12 through 21 who did not receive it when they were younger**. Protection from

VACCINE PREVENTABLE DISEASE INFORMATION/CONSENT FORM

Influenza is a serious disease caused by a virus that spreads from infected persons via the nose or throat of others. The "Influenza Season" in the U.S. is from November through April of each year. Influenza viruses change often. Therefore, influenza vaccine is updated each year to make sure it is as effective as possible. **Annual flu shots should be given to people at risk for getting a serious case of influenza or influenza complications and people in close contact with them. This includes people with long-term health problems (example: Asthma) or a compromised immune system**. The risk of the vaccine causing serious harm is extremely small. The virus in the vaccine is killed, so you cannot get influenza from the vaccine. Mild problems such as soreness at the injection site, fever, or aches may occur soon after shot and last 1-2 days. **Talk with a Doctor/Nurse before getting vaccine if you have had a seri-ous allergic reaction to eggs or to a previous dose of influenza vaccine, or have a history of Guillain-Barre' Syndrome (GBS). If your child has a fever or is severely ill, postpone the Influenza vaccine until the child has recovered.**

Measles, Mumps and Rubella (MMR) Measles and Rubella (German Measles) are diseases that can cause rashes, fever, seizures, brain damage, and death. Children with Mumps often experience fever, headache, and swollen glands. Less often these children may develop hearing loss and infections of their brain or spine. Risks associated with taking the MMR vaccine include soreness at the injection site, fever, and swollen glands in the cheeks or under the jaw, and joint pain/stiffness. Although rare, other problems that your child may develop include severe allergic reactions, bleeding, and seizures. **Persons should not be given this vaccine if they have experienced a severe allergic reaction to gelatin or to the drug neomycin, seizures, transfused with blood or blood products, or those who may be pregnant**.

Meningococcal Conjugate (MCV4) Meningitis is a serious illness caused by a bacterial infection which is the leading cause of bacterial meningitis in children 2 -18 years of age. The vaccine can prevent 4 types of Meningococcal disease. **The vaccine is recommended for all children at the pre-adolescent visit (11-12 years) or college freshmen. MCV4 is also recommended for individuals 11-55 years of age.**

Meningococcal Polysaccharide (MPSV4) prevents 4 types of Meningococcal disease, the same as the conjugate vaccine, and should be **used for children Z -10 years of age and adults over 55 who are at risk**.

Pneumococcal Conjugate {PVC) Pneumococcal infection causes serious illness and death. Pneumococcal infection causes serious disease in children less than 5 years of age and is the leading cause of bacterial meningitis in the United States. Risks associated with the PVC vaccine are redness, tenderness, or swelling at the site and/or mild fever. Severe reactions are rare. **Children should not get this vaccine if they had a severe allergic reaction to a previous dose**.

Pneumococcal Polysaccharide (PPV) is recommended in addition to PCV for certain high-risk groups.

Inactivated Polio Vaccine (IPV) Polio is a disease that can cause severe muscle weakness, paralysis, and death. The risk of IPV caus-ing serious harm is extremely small. A risk associated with the vaccine is soreness at the injection site. **Anyone who has ever had a serious allergic reaction to Neomycin, Streptomycin, or Polymyxin B should not receive IPV**.

Tuberculosis {PPD) Tuberculosis (TB) is a disease that is caused by mycobacterium tuberculosis that is spread through the air from one person to another. The bacteria is put in the air when a person with active TB disease coughs or sneezes. Tuberculosis can cause disability and/or death if not detected and treated appropriately. TB skin testing is recommended for children with risk factors. Peri-odic skin testing is also recommended if exposure is suspected.

WITH ANY VACCINE THERE IS A POSSIBILITY THAT A REACTION MAY OCCUR. Children, adolescents, or adults who are moderately or severely ill at the time the shot is scheduled should wait until they recover before getting the vaccine(s). IF ANY UNUSUAL PROBLEMS OCCUR SUCH AS TROUBLE BREATHING OR MAJOR CHANGES IN BEHAVIOR SEEK IMMEDIATE MEDICAL ATTENTION.

Notice of Privacy Practices

1. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

2. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

We are legally required to protect the privacy of your health information. We call this information "protected health information" or "PHI" for short, and it includes information that can be used to identify you that we have created or received about your past, present, or future health or condition, the provision of healthcare to you, or the payment for this health care. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice. However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice near the main entrance to each St. John Providence Health System facility. You can also request a copy of this notice from the contact person listed in Section 7 below at any time and can view a copy of the notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your prior specific authorization. Below, we describe the different categories of our uses and disclosures and give you some examples of each.

2.1. Uses and Disclosures Relating to Treatment, Payment or Health Care Operations.

We may use and disclose your PHI for the following reasons:

2.1.1. **For treatment.** We may disclose your PHI to physicians, nurses, medical students and other health care personnel who provide you with health care services or are involved in your care. For example, if you're being treated for a knee injury, we may disclose your PHI to the physical therapy department in order to coordinate your care.

2.1.2. **To obtain payment for treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you. We may also provide your PHI to our business associates, such as billing companies, claims processing companies and others that process our health care claims.

2.1.3. **For health care operations.** We may disclose your PHI in order to operate our hospitals, clinics, urgent care centers and other health care service locations. For example, we may use your PHI in order to evaluate the quality of health care services that you received or evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, and consultants who perform services on our behalf.

2.2. Other Uses and Disclosures That Do Not Require Your Authorization

2.2.1. **When disclosure is required by federal, state or local law, judicial or administrative proceedings, or law enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect or domestic violence; when dealing with gunshot and other wounds, or when ordered in a judicial or administrative proceeding.

2.2.2. **For public health activities.** For example, we report information about births, deaths and various diseases to government officials in charge of collecting that information, and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.

2.2.3. **For health oversight activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a health care provider or organization.

2.2.4. **For purposes of organ donation.** We may notify organ procurement organizations to assist them in organ, eye or tissue donation and transplants.

2.2.5. **For research purposes.** In certain circumstances, we may provide PHI in order to conduct research.

2.2.6. **To avoid harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

2.2.7. **For specific government functions.** We may disclose the PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the president of the United States or conducting intelligence operations.

2.2.8. **For workers' compensation purposes.** We may provide PHI in order to comply with workers' compensation laws.

2.2.9. **Appointment reminders and health-related benefits or services.** We may use PHI to provide appointment reminders through the mail or by telephone or give you information about treatment alternatives, or other health care services or benefits we offer.

2.2.10. **Fundraising activities.** We may use PHI to raise funds for our organization. The money raised through these activities is used to expand and support the health care services and educational programs we provide to the community. If you do not wish to be contacted as part of our fundraising efforts, please contact the person listed at the end of this notice.

2.3. Uses and Disclosures to Which You Have an Opportunity to Object

2.3.1. **Patient directories.** We may include your name, location in this facility, general condition in our patient directory and disclose it to visitors who ask for you by name, unless you object in whole or in part. We also may include your religious affiliation (if any) in the facility directory and disclose facility directory information to clergy members, unless you object in whole or part.

2.3.2. **Disclosure to family, friends, or others.** We may provide your PHI to a family member, friend or other person to the extent that person is involved in your care or the payment for your health care, unless you object in whole or in part.

2.3.3. **Special Legal Restrictions** Frequently, Michigan Law And/or Federal Regulations require explicit authorization of the disclosure of PHI of patients treated for mental health, substance abuse and HIV/AIDSconditions.

2.4. All Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in this section, we will ask for your written authorization before using or disclosing any of your PHI.

3. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

3.1. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. However, if you pay in full out-of-pocket and you request that we not disclose any information to your health plan about that service, we must grant that request. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make related to your treatment.

3.2. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you at an alternate address (for example, to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

3.3. **The Right to See and Get Copies of Your PHI.** In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.
If you request copies of your PHI, we will charge you a reasonable copying fee.

3.4. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include any of the uses or disclosures for treatment, payment and health care operation and some other purposes per the law. The list also will not include any uses or disclosures made before April 14, 2003.
We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, but if you make more than one request in the same year, we will charge you $25 for each additional request.

3.5. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. We will respond within 60 days of receiving your request. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not required to be disclosed to you, or (iv) not part of your medical record. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change to your PHI.

3.6. **Notice by E-Mail.** If you agree to receive this notice via email, you still have the right to request a paper copy of this notice.

3.7. **Psychotherapy Notes.** We must obtain your written authorization before we may use or disclose your psychotherapy notes, except for: use by the originator of the psychotherapy notes for treatment; use or disclosure by Covered Entity for its own mental health training programs; or use or disclosure by Covered Entity to defend itself in a legal action or other proceeding brought by the individual.

3.8. **Marketing.** We must obtain your written authorization before we may use or disclose your PHI for marketing purposes, except for face-to face communications made by us to you or a promotional gift of nominal value provided by us to you.

3.9. **Sale of PHI.** We must obtain your written authorization before we sell your PHI.

3.10. **Breach of PHI.** We are required to notify you in the event of a breach of your unsecured PHI.

4. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with: **NAME HIPAA Privacy Office -** (See section 7 of this Notice.)
You also may send a written complaint to: Secretary of the Department of Health and Human Services We will take no retaliatory action against you if you file a complaint.

5. WHO WILL FOLLOW THIS NOTICE OF PRIVACY PRACTICES

This notice describes the practices of the employees, medical staff, volunteers, departments, units and joint ventures of the Organization.

Also, these entities, sites and locations may share medical information with physicians and other healthcare professionals within NAME and as a Member of a Regional Health Information Organization ("RHIO") or other Health Information Exchange ("HIE"). If you want to "opt out" of the RHIO or HIE, please notify the Privacy Officer listed under Section 7.

6. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES.

If you have questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact the HIPAA Privacy Officer. All complaints must be submitted in writing to:

Organization

7. EFFECTIVE DATE OF THIS NOTICE: April 14, 2003. REVISED: August 6, 2013

Notice of Privacy Practices

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction but if they agree they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the NAME Notice of Privacy Practices.

_____

Signature of Parent/Guardian/Patient

APPENDIX M:

LAWS REGARDING MINOR'S RIGHTS TO CONFIDENTIAL SERVICES IN MICHIGAN

School–Community Health Alliance of Michigan

CONSENT FOR HEALTH CARE AND CONFIDENTIALITY OF HEALTH INFORMATION FOR ADOLESCENT MINORS: OVERVIEW OF MICHIGAN AND FEDERAL LAWS

Michigan Laws Based on Adolescent Minor's Status or Living Situation

Minor Status or Living Situation	Citations	Consent	Confidentiality & Disclosure	Notes
Unemancipated Minor	MCL §§ 722.1, 722.52	Age of majority is 18 years; parental consent generally required for health care provided to unemancipated minor (under age 18 years) unless exceptions apply	Parent generally has access to health information of unemancipated minor unless exceptions apply	Exceptions to parental consent may be based on minor's status, living situation, or specific services they are seeking as outlined in this "Overview"
Emancipated Minor	MCL §§ 722.4, 722.4e	Emancipated minor has the right to authorize their own preventive health care, medical care, dental care, and mental health care	Emancipated minor may authorize their own health care without parental knowledge	MCL §§ 722.4-722.4e contain requirements and procedures for obtaining a court order of emancipation
Married Minor	MCL §§ 722.4, 722.4e	Married minor has the right to authorize their own preventive health care, medical care, dental care, and mental health care	Married minor may authorize their own health care without parental knowledge	Married minor is considered emancipated; MCL § 551.103 contains legal requirements for a minor to marry
Pregnant Minor	MCL § 333.9132	Pregnant minor may consent for prenatal and pregnancy related treatment or services intended to maintain the life and improve the health of the minor and her child	Provider has discretion to notify (or not) the putative father or minor's spouse, parent, guardian, or person *in loco parentis* of health care given or needed; notification must be for medical reasons and may be given without minor's permission, but minor's permission must be requested	Pregnant minor is not considered fully emancipated on the basis of pregnancy but may be emancipated if other criteria are met
Minor Parent	MCL § 333.9132	Minor parent may consent for health care for their child	Same confidentiality provision as for pregnant minor	Minor parent not considered fully emancipated based on status as parent
Minor in Custody of Law Enforcement	MCL §§ 722.4(2)(d), 722.4e	Minor in custody of law enforcement may consent for routine, nonsurgical medical care or emergency medical treatment if minor's parent cannot be promptly located	No confidentiality provision specified	"Emancipation" of minor in custody of law enforcement is only for purpose of consenting to health care
Minor in Custody of Department of Corrections	MCL §§ 722.4(2)(e), 722.4e	Minor prisoner in state or youth correctional facility or probationer in special alternative incarceration unit may consent for preventive health care or medical care including surgery, dental care, or mental health care, except vasectomies or any procedure related to reproduction, If parent cannot be promptly located	No confidentiality provision specified	"Emancipation" of minor prisoner or probationer is only for purpose of consenting to health care
Minor on Active Military Service	MCL §§ 722.4(2)(c), 722.4e	Minor on active military service has the right to the right to authorize their own preventive health care, medical care, dental care, and mental health care	Minor on active military service may authorize their own health care without parental knowledge	

This Overview was prepared for SCHA-MI by Abigail English, JD, consultant. The information in this "Overview "does not constitute legal advice. For legal advice, an attorney familiar with relevant state and federal laws should be consulted. Each of the laws included in this "Overview" is explained in further detail in "Consent for Health Care and Confidentiality of Health Information for Adolescent Minors and Young Adults: A Guide to Michigan and Federal Laws" (forthcoming Fall 2022). An updated version of this "Overview" will be issued to accompany the "Guide" when it is released. Information in this "Overview" is current as of October 1, 2022.

School–Community Health Alliance of Michigan

CONSENT FOR HEALTH CARE AND CONFIDENTIALITY OF HEALTH INFORMATION FOR ADOLESCENT MINORS: OVERVIEW OF MICHIGAN AND FEDERAL LAWS

Michigan Laws Based on Specific Health Care Services				
Health Care Service	**Citations**	**Consent**	**Confidentiality**	**Notes**
Emergency Care	No specific MI statutes	No specific MI statutes	No specific MI statutes	MI court decisions allow consent to be implied for emergency care
Family Planning & Contraception	No specific MI statute	No specific MI statute; minor's federal constitutional right of privacy related to contraception recognized by U.S. Supreme Court in Carey v. Population Services Int'l (1977)	No specific MI statute; federal appeals court determined parent does not have constitutional right to be notified that minor is seeking or has obtained contraceptives in Doe v. Irwin (1980)	Federal Title X Family Planning Program must offer confidential services to adolescents—see details in section on "Other Important Laws"; MI Atty General agreed parental notification or consent not required in Title X funded agencies (1993)
Pregnancy Related Care	MCL § 333.9132	Minor may consent for prenatal and pregnancy related treatment or services intended to maintain the life and improve the health of the minor and her child	Provider has discretion to notify (or not) putative father or minor's spouse, parent, guardian, or person *in loco parentis* of health care given or needed; notification must be for medical reasons and may be given without minor's permission, but minor's permission must be requested	
Abortion	MCL §§ 722.901 - 722.908	Written parental consent required; exception for emergencies; special provisions related to sexual abuse	Minor may seek court order in "judicial bypass" proceeding to obtain abortion without parental consent or notification	Abortion laws are changing rapidly; updated information about the situation in MI is essential
Sexually Transmitted Infection (STI) /HIV	MCL § 333.5127	Minor who is or professes to be infected with a STI or HIV may consent for medical or surgical care, treatment, or services by a physician, hospital, or clinic	Provider has discretion to notify (or not) the putative father or minor's spouse, parent, guardian, or person *in loco parentis* of health care given or needed; notification must be for medical reasons and may be given without minor's permission, but minor's permission must be requested	
Mental Health - Inpatient	MCL §§ 330.1498a - 330.1498t	Minor found suitable for hospitalization may be admitted for inpatient mental health care based on request by a parent or by or a minor age 14 or older	Detailed requirements specified related to parent involvement, contact, knowledge	Minor age 14 or older may object to hospitalization and obtain court review; human services or juvenile agency may also request hospitalization
Mental Health - Outpatient	MCL § 330.1707	Minor age 14 or older may consent for outpatient mental health services	Minor's parent or guardian not informed of services without minor's consent, unless mental health professional determines that compelling need for disclosure exists based on substantial probability of harm to minor or other persons; mental health provider must notify minor of intent to inform minor's parent or guardian	Limit of 12 sessions or 4 months per request; psychotropic medication and referral for abortion not included
Substance Use Disorder (SUD)	MCL § 330.1264	Minor who has or professes to have a substance use disorder may consent for medical or surgical care, treatment, or services related to the substance use disorder	Provider has discretion to notify (or not) the putative father or minor's spouse, parent, guardian, or person *in loco parentis* of health care given or needed; notification must be for medical reasons and may be given without minor's permission	See MCL §§ 1265-1268 re procedures when parent requests services for minor; see section on "Other Important Laws" for information about federal "Part 2" SUD confidentiality regulations

Other Important Laws Related to Privacy, Confidentiality, Disclosure, and Reporting

Law	Citations	Selected Provisions Related to Privacy, Confidentiality, Disclosure, or Reporting	Notes
Medical Records Access Act (Michigan)	MCL §§ 333.26261 – 333.26271	Emancipated minor or minor who lawfully obtained health care without the consent or notification of a parent, guardian, or other person acting in loco parentis has the exclusive right to exercise the rights of a patient with respect to medical records relating to that care	The Act focuses on access to medical records rather than confidentiality generally
HIPAA Privacy Rule (Federal)	45 C.F.R. §§ 164.502(g)(3) and (5); 164.524(a)(3)(iii)	Minor who consents to their own care is an "individual" with some control over their own protected health information (PHI); parent's access to PHI when minor is the "individual" depends on other state and federal laws; provider may choose not to treat parent as minor's "personal representative" if minor subject to domestic violence, abuse, neglect, or endangerment and other criteria met; parent's access may be denied if health care professional determines It would cause substantial harm to minor or another individual	HIPAA Privacy Rule, 45 C.F.R. Parts 160 and 164, contains numerous provisions that are not specific to minors but have important implications for the privacy of their health information
21st Century Cures Act Information Blocking Rule (Federal)	85 Fed. Reg. 25642, May 1, 2020; 45 C.F.R. Parts 170, 171	Rule requires that patients have "immediate access" to their electronic health information (EHI) in response to patient requests subject to several exceptions, including a "Privacy" exception and a "Preventing Harm" exception	Parents often have access to minor's EHI via patient portal; Rule contains many other specific requirements
Family Education Rights and Privacy Act (FERPA) (Federal)	20 U.S.C §1232g, 34 C.F.R. Part 99; 45 C.F.R. § 160.103	Information about health services provided by a school may be included in a students' "education records" and is subject to FERPA, not HIPAA; parents have access to minors' education records; HIPAA Privacy Rule excludes from definition of "Protected Health Information" any records that are protected by FERPA	Detailed guidance available from the Federal Department of Education and Office of Civil Rights about relationship of HIPAA and FERPA
Title X Family Planning Program (Federal)	42 C.F.R. § 59.10	Information about family planning services received at Title X funded sites is confidential and may only be disclosed with the minor's permission or if required by law; family involvement must be encouraged to the extent practical; parental consent may not be required and notice to parents is not permitted without minor's permission unless required by law	Title X programs are required to comply with state child abuse reporting laws and other reporting required by law
"Part 2" Confidentiality of Substance Use Disorder (SUD) Patient Records (Federal)	42 C.F.R. Part 2; 42 C.F.R. § 2.14	In federally assisted programs, consent for disclosure must be obtained from minor who is authorized under state law to consent for alcohol or drug abuse treatment; disclosure to parents may occur only if minor lacks capacity for rational choice due to extreme youth, physical incapacity, or substantial threat to minor or another	"Part 2" contains numerous other sections with detailed requirements for handling patients' substance use disorder information
Medicaid (Federal)	42 U.S.C. §§ 1396a(a)(7), 1396d(a)(4)(C)	Family planning services are a covered benefit for adolescent minors who are eligible for Medicaid; Medicaid confidentiality requirements apply to the services	Medicaid requirements evolve; current information about implementation in MI is essential
Federally Qualified Health Centers (FQHC) (Federal)	42 U.S.C. § 254b(k)(3)(C); 42 C.F.R. § 51c.110	FQHCs are required to maintain the confidentiality of patient records and, if they receive Title X Family Planning funds, to comply with Title X confidentiality regulations; confidentiality regulation for FQHCs provides that information about services may only be disclosed with patient's permission or if required by law	FQHC confidentiality rule contains language similar to Title X confidentiality rule
Child Protection Law (Michigan)	MCL §§ 722.621 et seq.	Long list of health care providers and school personnel are required to report wide range of child abuse and neglect	Detailed guidance from Michigan Health & Human Services Agency available here
Reporting of Communicable Diseases (Michigan)	MCL §§ 333.5111, 333.5131; MAC R. §§ 325.171 et seq.	Specific communicable diseases, disabilities, and conditions are required to be reported; confidentiality protections and disclosure requirements apply	MI regulations specify a list of reportable diseases, disabilities, and conditions

APPENDIX N:
SERVICE DELIVERY MODELS OF CARE

SUMMARY TABLE 2024

Model of Care	Funding	Provider Weekly Hours Minimum	Providers Needed	Provider Minimum # of Days	Minimum Unduplicated Users	Location	Open in Summer
Clinical School-Based	$275,000	30	Primary Care and Mental Health	5	500	1	Yes
Clinical Middle-Sized *	$275,000	30	Primary Care and Mental Health	5	350	1	Yes
Alternative Clinical School-Based	$180,000	24	Primary Care and Mental Health	3	200	1	Yes
Clinical CAHC School-Linked (not on school property)	$330,000 ($275,000 FQHCs)	30	Primary Care and Mental Health	5	500	1	Yes
Alternative School-Linked (not on school property)	$235,000 ($210,000 FQHCs)	24	Primary Care and Mental Health	3	200	1	Yes
School-Wellness	$200,000	30	Nurse and Mental Health	5	250	1 or 2	No

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School–Community
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