



Rep. Young

State Funding for Colorado's School-Based Health Centers

School-based health centers are a crucial part of Colorado's safety net for vulnerable children and youth. They provide accessible, high-quality, affordable health care to those who otherwise would not have access to the care they need. School-based health centers also equip students to make healthy choices throughout their lives.

The outcomes achieved by school-based health centers have been measured. Published studies affirm the benefits: improvement in health status, school attendance and graduation rates; decreases in health care costs and health disparities. Public officials, educators, health care professionals, community leaders, parents and students have embraced school-based health centers as an efficient way to meet the health care needs of the state's low-income, uninsured, and geographically isolated children.

HB06-1396 established the state's school-based health center grant program **"for the purpose of assisting the establishment, expansion, and ongoing operations of school-based health centers in Colorado"**. Unfortunately, Colorado's general fund appropriation for the program is insufficient to support both the growth of new sites and the existing needs of operational sites. Since the program's last general fund increase in fiscal year 2008-09, the number of health centers in public schools has grown to 52. Yet, in fiscal year 2012-13, the Colorado Department of Public Health and Environment (CDPHE) was able to support only 35 of these. This is because, in 2010, CDPHE made the difficult decision to continue to fund existing grantees at close to their previous level, rather than significantly shrink the size of all grants in order to also support new sites. If CDPHE were to fund all 55 sites that are expected to be operational by July 1, 2013 within the current appropriation¹, the average grant size would be only about \$17,000 per site, or about 6.6% of the required average annual income.²

Other public and private sources of funding have become available in recent years because of the growing recognition that this model is an efficient and effective way to improve both the health status and academic achievement of our most vulnerable children and youth. In 2007, The Colorado Trust provided a two-year grant of \$1 million to CDPHE to boost the growth of school-based health care, and in 2009 the Colorado Health Foundation made a four-year, \$10.8 million investment to support the planning and implementation of new sites and to expand existing sites. The federal Patient Protection and Affordable Care Act, passed in 2010, authorized an emergency appropriation of \$200 million over four years for construction and equipment related to school-based health centers across the nation. So far, Colorado school-based health centers have received \$2.9 million of this appropriation. However, no federal funding is currently available for operations.

¹ The FY 2012-13 Long Bill Appropriation for the School-Based Health Center Grant Program was \$994,316 of which about 6.5% pays for a .7 FTE employed by CDPHE to manage the process. This leaves \$929,685 to be distributed in grants. This amount, divided by 55 sites, equals \$16,903 - the average grant size if all operational school-based health centers were supported.

² School-Based Health Centers average annual income is \$255,238, according to the Colorado Association for School-Based health Care and Colorado Health Institute's *Survey on School-Based Health Care*. Denver, 2010-2011.

Fourteen other states contribute general fund dollars to school-based health centers with an average investment of \$71,000 per center.³ In 2013, Connecticut will distribute \$11.5 million to approximately 75 centers. Connecticut Governor Dan Malloy, a champion for school-based health care, asked that \$1.1 million of those funds go toward building new school-based health centers placed in the state's lowest performing schools. New Mexico has approximately the same number of school-based health centers as Colorado, but contributes over \$5 million in general fund dollars.⁴

The Right Solution for Colorado

The general fund appropriation that supports the school-based health center grant program should be increased in fiscal year 2013-14. This will enhance the viability of centers that are open but are not currently receiving state grants, and allow for the planning and start-up of new sites. Initially, CDPHE was able to offer planning grants of up to \$20,000 as well as start-up funding for new school-based health centers in school districts with a large percentage of students qualifying for the National School Lunch Program. The last year that CDPHE was able to award planning and start-up grants was 2008-09.

Colorado's investment in school-based health centers is cost-effective. Nearly half of all school-based health center users are enrolled in Medicaid or CHP+. Several studies have shown that school-based health centers lower Medicaid costs by increasing preventive and primary care and decreasing emergency room utilization. School-based health centers also improve access to physical, behavioral and oral health care, reduce student absenteeism, and lessen health disparities.⁵

The Colorado Association for School-Based Health Care has identified an additional 32 urban schools and 14 rural school districts whose students have a very high need for a school-based health center. Increasing the appropriation for the school-based health center grant program would allow CDPHE to fully implement HB06-1396 "for the purpose of assisting the establishment, expansion, and ongoing operations of school-based health centers in Colorado". The appropriation should provide a fair share of public funding for all existing eligible centers and to once again support the planning and implementation of new centers that would open in communities with a high need for these essential services. This public commitment would encourage additional private investment because foundations are seeking more robust public-private partnerships and strongly believe that achieving diversified funding improves long-term sustainability. In times of austerity, public investments that are certain to provide positive returns just make sense.

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³ National Assembly on School-Based Health Care. *2011 State Policy Survey*. Washington, DC, 2011.

⁴ *Ibid*

⁵ See "A Bibliography: Measuring the Impact of School-Based Health Centers on Student Health and Academic Achievement" available at <http://www.casbhc.org/publications/Bibliography.pdf> for an annotated list of peer-reviewed journal articles and other publications discussing the benefits of school-based health centers.



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Rep. Young

TO: Megan Davisson, Joint Budget Committee Staff
FROM: Deborah Costin, Executive Director
DATE: November 19, 2012
SUBJECT: School-Based Health Center Capacity and Revenue

Megan, per our conversation on November 6, I am forwarding to you an analysis of the amount of state investment that would be required if the school-based health centers that were operational last school year were to increase their capacity to provide primary and preventive physical, behavioral and oral health care to their target population of Colorado school-aged children and youth.

Colorado Association for School-Based Health Care (CASBHC) and Colorado Health Institute (CHI) recently completed their sixth annual survey of Colorado's school-based health centers (SBHCs). The information presented below is for school year 2011-12, during which 49 SBHCs were operational. Two of these (one located in a small private school and one located in an alternative school) did not complete the survey. Therefore, these results represent 47 respondents. By the end of 2012, there will be 55 operational SBHCs in Colorado.

Populations Served:

Each SBHC establishes a target population of children who can access the SBHC's services. This decision is made based on the size of the host school, the capacity of the SBHC, and community need. Based on information collected in the 2011-12 survey, 16 of the 47 respondents served only the students enrolled in the host school, 10 also served students in select feeder schools, 16 (mostly located in rural areas) served all students enrolled in the school district, and 5 served all children aged birth to 21 regardless of school enrollment. There are other variations. For example, a SBHC might elect to serve the students enrolled in the host school AND their siblings.

Host school = school where a SBHC is located

Feeder school = a designated school in the vicinity of the host school whose students are eligible to become patients of the SBHC

<i>Eligibility Requirements for Children Served</i>	<i># of SBHCs</i>
Only those students enrolled in the host school	16
Students enrolled in the host school and designated feeder schools	10
Students enrolled in any school in the school district(s)	16
All children, birth to age 21	05

We know that the total number of students enrolled in host schools on October 1, 2012 was 44,453 and the number of students enroll in designated feeder schools on October 1, 2012 was 26,188.

Therefore, we can say that the primary target population of the 47 reporting school-based health centers was 70, 641 students. We do not have sufficient data to estimate the secondary target population (i.e. siblings of students, other students enrolled in districts served, and other children living in the community who may have access to a SBHC)

The number of unduplicated users of the 47 SBHCs was 28,930. While the numerator (users) includes some children that are not included in the denominator (students enrolled in host and feeder schools), we can estimate from this data that the SBHCs served approximately **41 percent** of the primary target population.

During the same time period (school year 2011-12) the 47 reporting school-based health centers operated on cash revenue of \$8,981,136 of which the state contributed \$1,841,238 or 20.5%. The state contribution included monies from: Tobacco Tax Primary Care Fund (HCPF), MCH Block Grant (CDPHE), State General Fund (CDPHE), and CICP.

The following table illustrates the amount of state investment that would be required if the 47 operational and reporting SBHCs were to increase their capacity to serve 50%, 75% and 100% of their primary target population, maintaining a constant 20.5% state contribution rate.

Percent of Primary Target Population Served	41% (2011-12) 47 SBHCs reporting	50%	75%	100%
Number of Children Served (Users)	28,930	35,320	52,981	70,641
Total cash revenue required (not adjusted for inflation)	\$8,981,136	\$10,964,740	\$16,447,421	\$21,929,792
Cash revenue required from state sources (at 20.5% of total)	\$1,841,238	\$2,247,772	\$3,371,721	\$4,495,607

If we included in the analysis the additional eight SBHCs that will be operational by December 31, 2012, the results would be as follows:

Percent of Primary Target Population Served	41% 55 SBHCs existing	50%	75%	100%
Number of Children Served (Users)	33,893	41,332	61,999	82,665
Total cash revenue required (not adjusted for inflation)	\$10,521,742	\$12,831,106	\$19,246,969	\$25,662,522
Cash revenue required from state sources (at 20.5% of total)	\$2,156,951	\$2,630,377	\$3,945,628	\$5,260,817

