School-Based Health Centers to Promote Health Equity

Recommendation of the Community Preventive Services Task Force

Community Preventive Services Task Force

Task Force Finding

The Community Preventive Services Task Force recommends the implementation and maintenance of school-based health centers (SBHCs) in low-income communities, based on sufficient evidence of effectiveness in improving educational and health outcomes. Improved educational outcomes include school performance, grade promotion, and high school completion. Improved health outcomes include the delivery of vaccinations and other recommended preventive services, asthma morbidity, emergency department and hospital admissions, contraceptive use among females, prenatal care and birth weight, and other health risk behaviors.

Most evidence derives from studies of SBHCs in low-income populations. As SBHCs are commonly implemented in low-income communities and communities with high proportions of racial and ethnic minority populations, many of whom are low-income, this source of student health care and health education may be an effective means of advancing health equity.

A summary of the Task Force finding and rationale is available at: www.thecommunityguide.org/healthequity/education/RRschoolbasedhealthcenters.html.

Definition

An SBHC provides health services to students in pre-Kindergarten through Grade 12 offered onsite (i.e., school-based center) or offsite (i.e., school-linked center). SBHCs are often established in schools that serve predominantly low-income communities and have the following characteristics:

- SBHCs must provide primary health care and may also provide mental health care, social services, dentistry, and health education.
- Primary care services are sometimes provided by a single clinician, or comprehensive services may be provided by multidisciplinary teams.
- Services may be available only during some school days or hours, and may also be available in non-school hours.
- Student participation requires parental consent, and services provided for individual students are sometimes limited for specific types of care, such as reproductive or mental health.
- Services may be provided to school staff, student family members, and others within the surrounding community.
- Services are often provided by a medical center or provider independent of the school system, such as a federally qualified health center or academic institution.

Basis of Finding

The Task Force finding is based on evidence from a systematic review of 46 program studies (search period through July 2014) that used diverse designs to assess multiple academic and health-related outcomes.[1] Twenty-three studies assessed the effects of SBHCs in overall school populations by comparing all students who had SBHCs in or linked to their schools with all students who did not (14 studies) or by assessing students before and after implementation of an SBHC (eight studies); one study made both comparisons. In these "whole-school" studies, the evaluation examined SBHC effects in the student population, including both users and non-users of the SBHC. A total of 17 "SBHC user" studies compared students who received services with students who did not receive services (eight studies) or received care from other sources (nine studies). Four studies included both whole-school and SBHC user study arms. Another two studies compared SBHCs; one compared an SBHC that offered onsite contraceptive

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services with an SBHC that did not, and the other study reported outcomes from an SBHC before and after implementation of onsite contraceptive services.

Applicability

Applicability to younger grade levels is unclear, as most studies evaluated high school SBHCs, whereas one study assessed middle school SBHCs, seven studies evaluated pre-Kindergarten or elementary school SBHCs, and the remaining 12 studies assessed some combination of grade levels.

Most studies of SBHCs were conducted in urban communities. Adapting SBHC models to rural areas may be challenging because regions of low population density might not be able to sustain the SBHC models that are effective in higher-density regions.

The impact of SBHCs has not been evaluated in higher-income communities. Because healthcare needs in these communities may be fewer and otherwise provided, it is unclear whether SBHCs would be useful or effective. On the other hand, schools may be an effective way of delivering and supplementing health care to all students.

Most of the included studies assessed onsite SBHCs and several evaluated a combination of onsite and offsite SBHCs. No included studies evaluated offsite centers alone, so the effectiveness of this option is not known.

Considerations for Implementation

In the implementation of SBHCs, the following issues should be considered:

- Billing and financing are major challenges to SBHC implementation and sustainability.
- Lack of full uptake of SHBC services by students for whom those services are made available is another challenge of SBHC implementation.
- There may be a threshold of population size or density to achieve SBHC benefits. It may be necessary to develop modified models for settings with low population density, such as rural areas.
- Included studies indicated that the greater the range of offered services, the greater the benefits. Offering services outside of as well as within school hours also increases effectiveness.

Information From Other Advisory Groups

The American Academy of Pediatrics recommends SBHCs as "one model of a system of health care delivery that provides a health care 'safety net' for children and adolescents who are uninsured or underinsured or represent special populations who do not regularly access health care."[2] The Patient Protection and Affordable Care Act initially provided funding of $200 million for the construction and equipment for SBHCs in "populations of children and adolescents who are residents of an area designated a medically underserved or health professional shortage area by the Secretary."[3]

In summary, the Task Force recommends the implementation and maintenance of SBHCs in low-income communities, based on sufficient evidence of effectiveness in improving educational and health outcomes.

References

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3. Patient Protection and Affordable Care Act, §4101. www.ncsl.org/documents/health/ppaca-consolidated.pdf. 2010.