Update 1995: School-Linked Health Centers

Advocates for Youth

Margaret Pruitt Clark, PhD, President

Advocates for Youth is a nonprofit organization that works to increase the opportunities for and abilities of youth to make healthy decisions about sexuality. Since 1980, Advocates has provided information, education, and advocacy to youth-serving agencies and professionals, policy makers, and the media.

Support Center for School-Based and School-Linked Health Care

Kate Fothergill, M.P.H., Program Director

The Support Center, a project of Advocates for Youth, provides information, technical assistance, training, policy analysis, and advocacy to assist in establishing and enhancing school-based and school-linked health centers.

Principal Authors:

Kate Fothergill, M.P.H., Program Director, Support Center for School-Based and School-Linked Health Care
Elisa Ballard, M.A., Evaluation Analyst

Editor: Robin Hatziyannis
Design and Production: Katharine Jewler
Special Assistants: Beth Orlick, Jugna Shah

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Suite 200
1025 Vermont Avenue, NW
Washington, DC 20005
202/347-5700; fax 202/347-2263

Advocates for Youth's Media Project
Suite 204
3733 Motor Avenue
Los Angeles, CA 90034
310/559-5700; fax 310/559-5784
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Special thanks also goes to the Support Center’s advisory committee for taking the time to review this report. Finally, the Support Center staff thanks our colleagues at Advocates for Youth who assisted us throughout the study process.
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Introduction

Since 1986, the Support Center for School-Based and School-Linked Health Care (Support Center) at Advocates for Youth has conducted an annual survey to provide information on school-based and school-linked health centers (SBHCs/SLHCs). Each year’s Update presents survey findings for practitioners, administrators, policy makers, and other individuals interested in improving adolescents’ access to health care.

Historically, the Support Center has compiled data on school-based and school-linked health centers to present a picture of all programs reaching youth through schools. In 1995, however, with the school-based health center movement strong and growing, the Support Center decided to dedicate its research on the less understood school-linked health center model. Supported by the W.K. Kellogg Foundation and the Carnegie Corporation of New York, the Support Center studied 21 SLHCs in the United States, collecting data through written surveys, phone interviews, and site visits.

There are five main purposes of this study:

- To describe the characteristics common to a sample of existing SLHCs;
- To explain the nature of the linkages between these health centers and schools;
- To compile data on a sample of SLHCs, providing a general description of their services, staffing, financing, and other operational details;
- To discuss the advantages and disadvantages of this model of care;
- To feature case studies of six SLHCs, providing more detailed information on specific SLHC programs and operations.

Update 1995 reports on the findings of this study and their implications. The Appendices include the case studies and a directory of the SLHCs that participated in the survey.
The Need for Adolescent Health Care Services

During the last decade, a number of reports have documented the significant health problems of American youth. In *Code Blue: Uniting for a Healthier Youth*, the National Association of State Boards of Education and the American Medical Association reported that "never before has one generation of American adolescents been less healthy, less cared for, or less prepared for life than their parents were at the same age." The Carnegie Council on Adolescent Development also described the problem in urgent terms: "In the 1990s, the state of adolescent health in America reached crisis proportions: large numbers of ten- to fifteen-year-olds suffer from depression that may lead to suicide; they jeopardize their future by abusing illegal drugs and alcohol, and by smoking; they engage in premature, unprotected sexual activity; they are victims or perpetrators of violence; they lack proper nutrition and exercise. Their glaring need for health services is largely ignored."

Despite the extent of these problems among adolescents, data indicate that this population underutilizes the health care system, largely because of a number of access barriers, including a lack of insurance coverage, transportation problems, and a dearth of age-appropriate services. As noted by the National Research Council, "Adolescents — and especially adolescents who engage in high-risk behavior — have no apparent home in the U.S. medical system. They have relatively low visit rates in office-based practice, and their problems are poorly represented in standard medical data." In addition, the fragmentation of the current system makes it especially difficult for adolescents to access services for their multiple and diverse needs. As a result, teenagers do not seek health care, and their problems often go undetected and untreated.

As it is increasingly understood that health services for young children and for adults are neither appropriate nor adequate for adolescents, more efforts are being made to develop health services designed for the particular needs of this population. Communities are recognizing the importance of providing adolescents with an entry point into the health care system, hiring providers experienced in adolescent health care, and offering comprehensive medical and mental health services. In particular, developing adolescents' trust in their providers is absolutely critical. "Students report that the quality of 'trust' is the most important attribute of those they rely on for help. They require constant assurance that their need for confidentiality is respected." This issue of trust is particularly relevant for teenagers seeking services for sensitive issues, such as family planning, STD prevention and treatment, and mental health services.
The Emergence of School-Based and School-Linked Health Centers

In response to this need for adolescent-oriented health services, a number of communities have established SBHCs. SBHCs have become popular for their provision of affordable, convenient, confidential, and comprehensive services at the school, and there are now over 700 SBHCs nationwide.

Although SBHCs are praised for their delivery of comprehensive services, they often are pressured to omit reproductive health care, and, in some cases, mental health and substance abuse services because of community or state opposition to the provision of these services on school grounds. “Many states prohibit the provision of contraception on school sites. Even in states with no restrictions, most school health centers do not provide comprehensive family planning services to students.”” In the past year, many states considered or enacted more restrictive legislation, and many school boards tightened policies regarding contraceptives.

For those communities wanting to provide reproductive health care and mental health services as part of their comprehensive service package, the school-linked model is a viable option. “Centers located off of school property have a much easier time providing quality birth control services that include not only counseling, physical examinations, and screening and treatment for sexually transmitted diseases, but also provision of contraceptive methods and referral for abortion counseling and services, if requested.”” In the current political climate, SLHCs may well be the structure to increase young people’s access to reproductive health care.

To date, very little is known about the characteristics of SLHCs, let alone their effectiveness. In 1986, in one of the few studies on the SLHC model, researchers demonstrated a 30% reduction in teenage pregnancy within three years of implementing a multi-modal teen pregnancy prevention program through a school-linked health center. Comparison schools without SLHCs showed a 58% increase in teenage pregnancy during the same three years. The study further found that the program helped delay sexual initiation for younger clients by seven months and increased the use of contraceptives among sexually active teens.

Although these findings indicate a promising health care delivery model, there are still very few SLHCs. Many communities are unaware of the SLHC option or do not fully understand the SLHC design nor how to link community health centers with schools. Before this model can be replicated across the country, communities need more information about SLHC programs, how they work with the schools, and their ability to serve adolescents. To provide an initial glimpse at the SLHC model, the following pages offer a summary and discussion of the data collected from a sample of SLHCs.
Survey Methodology

The Support Center for School-Based and School-Linked Health Centers has collected data and published reports on school-based and school-linked health centers since 1986, but Update 1995 is the first report that focuses entirely on the school-linked model. To obtain the type of descriptive and statistical information essential to the production of this report, the Support Center staff employed two data collection methods. A written survey served as the instrument to collect primary data, and a follow-up telephone interview or a site visit by the Support Center Director provided additional data.

Data Collection Methods
The written survey instrument was a modified version of the 1994 school-based health center questionnaire. The questionnaire requested data on a range of operational issues, including types of services provided, enrollment and utilization rates, budgets, and descriptions of populations served. The questionnaire was pre-tested by a subsample of the eligible respondents.

The telephone questionnaire and personal interviews yielded more detailed data on operational issues, as well as staffing patterns, outreach mechanisms, and linkages between the health centers and the schools they serve. In addition, Support Center staff had the opportunity to clarify issues from the written survey. The telephone questionnaire was also pilot-tested prior to its use in this research. The data are from the health centers' most recently completed fiscal year. This period extends from October 1993 to September 1995.

Sampling Frame
The sample consisted of all SLHCs in the United States known to the Support Center at the time of the survey. Support Center staff constructed the sampling frame from its database of school-based and school-linked health centers. Although the database had been updated in December 1994, there were concerns that some health centers had been misclassified due to the lack of a clear, universally recognized definition of a school-linked health center. Therefore, in July 1995, Advocates for Youth developed the following definition:

A school-linked health center is located beyond school property, serves one or more schools, and has linkages with each. The center should have a visible presence in the school(s). Services should include but not be limited to health education and promotion, primary and preventive health care, screenings, diagnosis, on-site treatment, mental health counseling, referral, and follow-up.

The Support Center sent letters with this definition to approximately 35 of the database entries whose classifications were unknown or unclear. We asked each center to consider the definition before self-identifying as school-linked. A final review of the database and follow-up correspondence revealed 54 eligible centers for the study.

Response Rate
In August 1995, Support Center staff mailed the written survey to all of the 54 identified health centers. Included among the returned surveys were several completed questionnaires from school-based centers, an indication that the sampling frame contained ineligible entries. In an effort to correct this situation, staff made numerous attempts to contact the non-respondents to ascertain their eligibility for the sampling frame. In all, staff members were able to positively identify 13 ineligible health centers from the original sampling frame of 54. Thus, the response rate for the written survey was 51% (21 completed surveys/41 eligible respondents). Because not all non-respondents could be contacted, it is possible that there are additional ineligible entries (i.e., school-based centers) among these 41. For this reason, the response rate may be an underestimation.

In addition to the fact that the sampling frame contained an unquantified number of ineligible
respondents, a few other factors may have affected
the response rate. First, the questionnaires arrived
in August 1995, a time when many staff members
were on vacation or busy preparing for the
upcoming school year. This situation may have
occurred among school-linked health center
personnel, even though the centers are generally
open during the summer vacation months.
Second, many SLHCs do not have adequate data
collection procedures or systems in place and were
unable to respond to some of the questions.
Finally, not all SLHCs collect the same type of
data as that requested on the survey; thus, some
were not able to respond to all questions. The
total number of responses (N) is reported for each
figure and table in this report.

After reviewing the data from the returned
written surveys, Support Center staff decided to
conduct on-site interviews with six centers and
follow-up telephone interviews with the remaining
14 survey respondents. (Because the written survey
was returned late, 1 survey respondent was not
interviewed.) Follow-up interviews were carried
out between October and December 1995.

Site visits were made to North Carolina and
Michigan because these two states have a long
history of supporting adolescent health services,
and both had more SLHCs than any other state.
The sites in Virginia and Maryland offered ad-
tional examples. The intent of including these
case studies was to provide in-depth information
on program operations and enhance the reader’s
understanding of SLHCs.
Summary of Survey Results

What Are School-Linked Health Centers (SLHCs)?
Summarizing the SLHC model is difficult, as these programs are not homogenous. According to the surveys, a SLHC is an adolescent health care facility that is located beyond school property but has a formal or informal relationship with one or more schools in the community. Although the extent and type of services provided vary from center to center, the range of services offered include health education and promotion, primary and preventive care, reproductive health care, mental health counseling, and social services.

The distribution of the 21 responding SLHCs across the United States is shown in Figure 1. Notably, one-half of the surveyed SLHCs are located in two states, Michigan and North Carolina. As a result of strong adolescent coalitions, both states have enacted legislation that supports the establishment of school-based and school-linked health centers.

What Are Their Goals and Objectives?
Most SLHCs are established to improve adolescents’ access to medical and mental health services. School-linked health centers are usually developed in response to a particular need identified in the community, such as poor adolescent access to primary care, reproductive health care, or mental health services.

On another level, SLHCs have several other important objectives that distinguish them from their school-based counterparts. Among the most important of these objectives is the intent of school-linked health centers to target out-of-school youth, many of whom lack access to basic health care services. Consequently, these underserved youth are at high risk for poor physical and mental health. Many SLHCs have developed strategies to reach this often neglected segment of the adolescent population.

In addition, several communities have opted to establish SLHCs to avoid politically sensitive issues and restrictions faced by SBHCs. These issues and restrictions are predominantly related to the provision of family planning services.

SLHCs also give teens access to year-round quality health care by remaining open during the summer. Extended hours are critical, as SLHCs are the only source of health care for some youth.

Finally, several proponents in the school-linked health care community explicitly desire to see services provided in a non-educational setting, where students might feel more comfortable discussing important needs. Staff members also observe increased levels of parental involvement because parents are more likely to accompany their teenagers to an off-campus SLHC than to a SBHC. While it is true that a lot of services that adolescents seek do not require parental permission, and many teens desire privacy when seeking various types of health care, it is nonetheless important to foster an environment that is conducive to parent-child interaction and communication. This is especially true in cases related to mental health and other types of counseling.

What Services Do SLHCs Offer?
The type and extent of services provided vary from SLHC to SLHC. SLHC services usually depend on the perceived needs of the community, existing community resources (e.g., private providers, hospitals, community agencies), the availability of funding, and the level of community support for or opposition to a particular service. The type of services provided by the 21 SLHCs in this survey were categorized for summary purposes into four groups: general medical care, reproductive health care, counseling, and social services. Survey respondents were also asked to describe follow-up, referral, and after-hours-care procedures and to identify unmet needs.
Figure 1. Distribution of 21 SLHCs Responding to Survey

N=21 clinics

Figure 2. Percentage of Clinics Offering General Medical Care

- 100% of surveyed clinics provide 1 or more general medical care services.
- Only 1 clinic offers all types of general medical care.
- 100% of clinics have follow-up procedures.
- 100% of clinics make referrals.
- 76% of clinics have arranged sources of after-hours care.
General Medical Care
All of the health centers surveyed provide one or more of the general medical care services shown in Figure 2, but only one SLHC offers all types of general medical care. Almost all of the SLHCs offer routine and sports physicals, give vaccinations, prescribe and dispense medications, and conduct their own lab tests. Eighty-one percent currently provide primary care, one SLHC intends to begin offering primary care in its next fiscal year, and another plans to expand the primary care it currently offers. Only three SLHCs offer dental services, although several respondents commented that they frequently make referrals for clients with dental care needs. Nearly one-quarter of school-linked health centers provide pediatric care for the children of eligible adolescents.

Reproductive Health Care
Every health center in the survey provides one or more reproductive health care service, and two SLHCs make available the full array of services in Figure 3. All the SLHCs both diagnose and treat sexually transmitted diseases (STDs), and roughly 90% of the others offer gynecological exams, pregnancy testing, HIV testing, HIV/AIDS counseling, family planning counseling, and family planning follow-up. Ninety-one percent of the health centers dispense one or more family planning method, and about 80% of the SLHCs supply birth control pills, condoms, and Depo-Provera. Approximately one-third of the sample provides prenatal care. The estimated percentage of client visits related to reproductive health care varies from four percent in one SLHC to 100% in another.

Counseling Services
Of the 21 SLHCs surveyed, 86% provide one or more counseling service (Figure 4). From 6% to 80% offer counseling for substance abuse, depression, suicide, violence prevention, rage and anger, sexual abuse/incest, and dysfunctional families. Individual counseling sessions are most common, although some SLHCs reported making group sessions available as well. Nearly one-fifth of the sample offers all types of counseling services.

Social Services
In Figure 5, 71% of surveyed SLHCs provide one or more social service. Counseling or information for negotiating systems such as Aid to Families with Dependent Children (AFDC) and Medicaid is offered by 62% of the SLHCs. Approximately one-half provide guidance to adolescents who participate in the Women, Infants, and Children (WIC) program. No SLHC offers all of the social services listed on the questionnaire.

Follow-up, Referrals, and After-Hours Care
Every one of the SLHCs has follow-up procedures in place, but the extent of follow-up varies depending on the availability of time and staff and the philosophy of health center personnel regarding patient responsibility. For the most part, health center staff indicated that adolescents are often noncompliant. As a result, in many SLHCs workers spend a lot of time on the telephone, most frequently reminding clients of appointments, making appointments for outside referrals, and reporting lab results. A few SLHCs employ case managers, and one indicated that it had an extensive computerized case management system. Several others described their follow-up procedures as efficient and thorough. On the other hand, the director of one SLHC reported that staff sends a registered letter to advise a client of an abnormal lab result only after sufficient time has lapsed and that client has not called to request results.

All SLHCs refer for specialty care from time to time. The most common referral is for mental health services. Substance abuse counseling and treatment, prenatal care, dental care, vision care, and technical procedures such as ultrasounds and colposcopies are other needs that require outside referrals. Three-quarters of the surveyed SLHCs
Figure 3. Percentage of Clinics Offering Reproductive Health Care Services

- 100% of surveyed clinics provide 1 or more reproductive health care service
- Only 2 clinics offer all types of reproductive health care
- 91% offer family planning counseling
- 91% dispense 1 or more family planning method
- The estimated % of client visits related to reproductive health care varies from 4% in 1 clinic to 100% in another

Figure 4. Percentage of Clinics Offering Counseling Services
(86% of surveyed clinics provide 1 or more counseling service; 19% offer all types of counseling services)

- Substance abuse
- Depression
- Suicide
- Violence prevention
- Rage and anger
- Sexual abuse/incest
- Dysfunctional families
- Sexual orientation
- Affective disorders
- Personality disorders
- Neuroses/psychoses

N=21 clinics

Legend:
- Group sessions
- Individual sessions
- % Provide service
have procedures for after-hours care. In general, school-linked health centers that are administered by a county or community health department follow that system’s after-hours referral protocol. Other centers usually have a physician on call to respond to immediate needs, but almost all of the SLHCs advise their clients to go to an emergency room in the event of a true emergency.

What Are the Unmet “Services” Needs?
Given the difficulties in reaching youth, many health care providers agree that the one-stop shopping model is desirable. Most SLHCs prefer to provide as many services as possible while the teen is in the center. Unfortunately, few SLHCs can boast this capability today. When asked if service capacity was meeting demand, survey respondents cited mental health, substance abuse, and social services counseling as unmet needs. Another common unmet services need is health and nutrition education. Unmet needs are largely the result of limited financial resources or staff time.

What Populations Are Served By SLHCs?
For the most part, SLHCs are designed to serve adolescents, and all of the centers indicated adolescents as their primary target audience. In addition, one-third of the SLHCs reported providing services to other age groups, including young adults up to 23 years of age and children of adolescents. In fact, one SLHC reported that 37% of its visits are for children of teens.

Because they are designed to reach adolescents, all SLHCs serve one or more high-schools in their catchment area. The average SLHC serves 5.9 high schools. Almost three-quarters of the sample (71%) serves students in middle/junior high schools, but only two SLHCs (9.5%) reported serving students from elementary schools.

Demographic characteristics of clients in the 21 SLHCs are presented in Table 1. On average, 68% of SLHC users are female, although there is some variation among SLHCs. Most SLHCs report serving a population that is representative of the community at large. A review of mean percentages of the six ethnic categories reveals that 45% of SLHC clients are white, 29% are black, 11% are of Hispanic origin, 4% are of Asian origin, 3% are Native Americans, and 8% are all others. Analysis of the data also reveals that individual SLHCs often serve adolescents from predominantly one ethnic background. For example, the percentage of black clients varies from 0% in one SLHC to 98% in another. A similar range exists among the percentage of white clients, with values varying from 5% to 99%. For this reason, medians are also presented in Table 1. (Note: the SLHC in Table 1 with 90% other serves 90% Arabs/Arab-Americans in a suburban community.)

SLHCs are often thought to provide care to low-income populations. When asked about the socioeconomic status of their SLHC users, respondents universally replied that they were unable to provide accurate data on issues related to family income, and few could provide information on the percentage of SLHC users who are eligible for Medicaid or do not have any medical insurance. Nevertheless, most SLHC representatives believe their clients are predominantly from low-income households. A few noted that their clients also include youth from middle and upper-income families. It was also noted that community providers refer teens of all economic backgrounds to these centers for their expertise in adolescent health.

SLHCs have also been associated with care provision to populations at high risk. Figure 6 shows the percentage of SLHCs providing care to different population groups. All but one of the SLHCs see youth who have dropped out of school. The estimated mean percentage of SLHC users who are not in school is 15%, although this figure varies from only 3% in two SLHCs to 60% in another. A large number of SLHCs (81%) also reported providing services to homeless youth and students.
Figure 5. Percentage of Clinics Offering Social Services
(71% of surveyed clinics provide 1 or more social service; None of the clinics offers all types of social services)

AFDC or Medicaid
WIC
Academic tutoring
Job placement
Job training
Food bank
Clothing bank
Child care

0% 10% 20% 30% 40% 50% 60% 70%
N=21 clinics

Figure 6. Percentage of Clinics Serving Selected Populations
(Categories are not mutually exclusive)

N=21 clinics

Adolescent populations

Dry youth
Unicef funded
Homeless
Pregnant
Teen care facilities
Detention centers
Parenting
Young adults (26 & over)
Children of adult
School staff
in universities. More than half of the health centers give care to pregnant teenagers, although some of these young women do not receive care directly related to their pregnancy. Twenty to approximately 30% of the SLHCs see adolescents who are part of the social services system (foster care, shelters, treatment facilities) or who are in detention centers. About 20% provide care to parenting youth. The percentages of SLHCs that provide care to other age groups are also displayed in Figure 6.

These data demonstrate that SLHCs reach segments of the adolescent population that are historically critically underserved and at high risk for certain health problems: low-income, homeless, out-of-school, or troubled youth.

How Are SLHCs Staffed?
Figure 7 presents the staffing patterns of the 21 SLHCs in the survey. The staffing of a SLHC corresponds to the center’s scope of services and budget. As most SLHCs offer comprehensive services, the staff usually includes at a minimum a SLHC director or administrator, a primary care provider, a registered, licensed practical or public health nurse, and a medical and/or administrative assistant. The primary care provider may be a physician, nurse practitioner, or physician’s assistant. It is not uncommon for a primary care provider on staff to serve as SLHC director or administrator. Over 80% of the SLHCs employ one or more persons in these positions.

About 70% of the SLHCs employ one or more health educators, and 50% employ mental health counselors. Twenty-five percent or fewer of the SLHCs have social service counselors, substance abuse counselors, nutritionists, or dentists on staff. Other staff positions not listed on the questionnaire but reported by respondents include education specialists, recreation specialists, public relations staff, fund raisers, outreach workers, drivers, volunteers, and peer counselors. Peer counselors are used in 25% of the SLHCs.

Both smaller and larger SLHCs often employ one or more staff members to work part-time hours. The percentages of SLHCs that employ one or more full-time equivalent (FTE - 35 hours or more per week) staff are displayed in Figure 7. About 40% of SLHCs have a full-time director and/or full-time medical and administrative support staff. Sixty percent have one or more FTE primary care providers, but only 20% employ a FTE physician. Only 24% of directors think that their SLHC is adequately staffed. Among the most commonly cited staff needs are more administrative assistants, social workers, mental health counselors, health educators, nurses, and nutritionists.

What Are Their Hours of Operation?
The hours of operation vary considerably among SLHCs. For summary purposes, types of schedules were categorized into three groups: full-time (open 40 hours or more per week), half-time (open 20-39 hours per week), and part-time (open fewer than 20 hours per week). As shown in Table 2, 45% of the SLHCs are open Monday through Friday for 40 hours or more each week. Another 25% of SLHCs are open Monday through Saturday, usually for one-half day on Saturday. All of the SLHCs that reported half-time hours (20%) have different schedules, though a typical schedule is several afternoons and one evening session each week. The remaining SLHCs (15%) are open fewer than 20 hours per week. These health centers usually operate one or two days each month.

All of the SLHCs have summer hours. SLHC staff reported that their busiest hours are typically after school, on Saturdays, and during the summer. Of course, these times vary according to hours of operation and the day and time particular services are offered. Most SLHCs (80%) require scheduled appointments, although all but one take walk-ins.

Where Are SLHCs Located?
SLHCs are usually established in communities with a clear need for additional youth services.
Figure 7. Percentage of SLHCs Employing Selected Staff Positions by Position and Number of Hours Worked

- Only 24% of directors think their SLHC is adequately staffed.
- Other staff positions not illustrated here include educ. specialist, rec. specialist, P.R./fund raiser, outreach workers, drivers, and volunteers.
- The most commonly cited staff needs are more admin. staff, social workers, mental health counselors, health educators, nurses, and nutritionists.

Figure 8. Percentage of SLHCs Participating in Selected School-Based Activities

- N=20 clinics.

[Bar charts and percentages for various activities like classroom work, workshops, lunch programs, etc.]

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They are typically established near a community school in order to facilitate access for students. For several SLHCs, the nearest school is across the street. For others, it is five miles away. About one-half of the SLHCs deliver their services to youth within a 10 mile radius of the SLHC. The other half serve larger areas, which sometimes extend 60 miles beyond the SLHC. The majority (57%) of the health centers in the survey are located in urban areas, but many of these reach youth in outlying areas. Just two centers are located in and serve rural areas only. One-third of the SLHCs in the survey have changed location since opening. Location changes usually result from a need for more space as services grow or a need to be in closer proximity to the most at-risk youth.

Despite attempts to facilitate access by locating centers near the schools they serve, transportation was cited as a problem by 75% of survey respondents. Transportation problems are most often associated with long distances and traveling times between homes or schools and the SLHCs, prohibitive costs for public transit, or lack of access to any means of transportation. SLHCs are responding to these problems by distributing vouchers for bus tickets and recruiting volunteers to drive adolescents to SLHCs for their appointments. One SLHC contracts a shuttle service to accommodate transportation needs.

Although 75% of SLHCs are accessible by public transportation, 80% reported that most of their clients get to the SLHC by personal car. Approximately 40% listed public buses as a common means of transportation, and 25% said that most of their clients walk to the SLHC (categories are not exclusive).

What Are Client Utilization Figures?
Within a one-year time frame, the 21 SLHCs in the survey provided services to approximately 27,300 clients who visited the SLHCs at least 66,100 times (Table 3). In the smallest SLHC of the sample, SLHC staff cared for 97 teens during 97 visits in one year. In the largest SLHC, staff cared for about 4,000 clients during 11,133 visits. Hence, the median number of users in this sample is 1,089 and the median number of visits is 2,458.

There are several reasons why these figures are inexact. First, the majority of center directors or administrators who participated in this research indicated that they do not have adequate data collection systems in place to accurately track these data. Second, among those who do have management information systems, there was some confusion about what information to report — the actual number of visits or the number of different services provided during each visit. In most cases, respondents reported number of visits. Third, some SLHCs do not keep track of non-medical visits. Thus, the number of counseling or education sessions provided were not reported in all cases. Despite these issues, SLHCs are clearly reaching a significant number of youth in need.

How Do SLHCs Link With Schools?
A primary goal of the Support Center study was to better understand the relationships between SLHCs and the schools they serve. According to the data collected from written surveys and interviews, the nature of the relationship or linkage with the schools varies from center to center. Formal linkages are agreements that dictate the way the health center and schools relate to each other. These agreements usually acknowledge reciprocal arrangements in which the two parties provide mutually beneficial assistance to each other. Only one-quarter of the SLHCs reported having a formal agreement with the schools.

Other SLHCs and schools do not necessarily have written agreements but have informal arrangements to work together on a regular basis to serve student populations. Informal linkages are implied or verbal understandings between the health facility and the school. There are usually no formal ties or reciprocal arrangements. At
### Table 1. Demographic Characteristics of Clients in 21 SLHCs

<table>
<thead>
<tr>
<th>Gender</th>
<th>Mean %</th>
<th>Smallest value</th>
<th>Largest value</th>
<th>Median %</th>
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<td>Black</td>
<td>29%</td>
<td>2%</td>
<td>98%</td>
<td>15%</td>
</tr>
<tr>
<td>White</td>
<td>45%</td>
<td>5%</td>
<td>99%</td>
<td>44%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>11%</td>
<td>0%</td>
<td>55%</td>
<td>4%</td>
</tr>
<tr>
<td>Asian</td>
<td>4%</td>
<td>0%</td>
<td>45%</td>
<td>1%</td>
</tr>
<tr>
<td>Native</td>
<td>3%</td>
<td>0%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>8%</td>
<td>0%</td>
<td>90%</td>
<td>1%</td>
</tr>
</tbody>
</table>

*The value that lies halfway between the two extremes
*all figures are based on estimates

### Table 2. Hours of Operation

<table>
<thead>
<tr>
<th>Schedule type</th>
<th>% of SLHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full-time (40 or more hrs.)</td>
<td>45%</td>
</tr>
<tr>
<td>Mon.-Fri.</td>
<td>45%</td>
</tr>
<tr>
<td>Mon.-Sat. (Sat. 1/2 day)</td>
<td>20%</td>
</tr>
<tr>
<td>Half-time (20-30 hrs.)</td>
<td>20%</td>
</tr>
<tr>
<td>Part-time (&lt; 20 hrs.)</td>
<td>15%</td>
</tr>
</tbody>
</table>

| Summer hours                  | 100%       |

<table>
<thead>
<tr>
<th>Appointments</th>
<th>% of SLHCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require scheduled appts.</td>
<td>80%</td>
</tr>
<tr>
<td>Accept walk-ins</td>
<td>95%</td>
</tr>
</tbody>
</table>

N=20 clinics
best, the health facility may benefit from referrals from school personnel. For example, an informal linkage occurs between the school nurse and the health center staff who develop a collaborative system for consultation, referrals, and follow-up. Under this arrangement, school staff make regular referrals to the health center and confer with the health center providers about students' conditions. Also, some SLHCs send staff to schools on a regular basis to screen students or make regular presentations to students, faculty, and parents.

The types of activities that define both formal and informal linkages and the percentage of SLHCs that participate in each activity are presented in Figure 8. The most common type of school-based activity in which health center staff participate is classroom presentations for students. All but two centers visit classrooms to give presentations on various topics. Sixty percent of the centers give workshops for teachers and parents, and between 35% and 40% host or present at PTA meetings, parent/teacher conferences, or special school events.

Health center providers also coordinate with school staff on health-related school curricula. Between 40% and 60% of SLHCs coordinate with school staff on mental health, substance abuse, health education/sex education, or primary care school-based activities. Roughly 40% of SLHCs have an office or access to an office on school grounds. A couple of centers maintain full-time staff in school-based offices. Others use the offices on an as needed basis.

All of the SLHCs in the survey receive referrals from school personnel. It is not uncommon for school staff to participate in other SLHC-based activities. About 70% of the SLHCs said that school staff attend SLHC board meetings, and 45% said that school staff participate in the planning or implementation of SLHC-based activities. School staff offer in-kind support, such as helping with follow-up or special clinic-sponsored events, in 55% of the surveyed SLHCs.

How Much Do SLHCs Cost and How Are They Financed?

The budget of each SLHC depends on a number of factors, including the type and scope of services offered, staffing patterns, overhead costs, and availability of funds. Due to the variability in SLHC size, the budget range in this survey is from $30,000 to $1,500,000. The mean and median figures are $436,511 and $410,000, respectively. Total in-kind contributions also vary considerably, ranging from $0 to $300,000, with a mean of $98,604 and a median of $55,000. About 90% of SLHCs reported that they receive in-kind contributions.

The SLHCs in the survey receive funding from an assortment of sources that include federal, state, and local monies. The funding sources and the percentages of SLHCs that receive money from each source are listed in Table 4. All the SLHCs receive public money. The most commonly cited sources of public money are Medicaid, Title V - MCH block grants, Early Prevention, Screening, Diagnosis, and Treatment (EPSDT), and other state or local funds. Included most frequently among the other sources are city tax dollars and county funds.

Approximately 71% of the SLHCs receive private funds. The majority (57%) of SLHCs are partly financed through patient fees, which may be nominal in low-income areas. Nearly one-half receive funds from private insurance payments. Private, corporate, individual, and charitable contributions are also common sources of funding.

Most of the health centers are funded from a mixture of the sources listed in Table 4. When asked to identify the greatest source of funding and its percentage of the budget, center directors or administrators gave estimates that ranged from...
Table 3. Estimates of the Number of Users and User Visits

<table>
<thead>
<tr>
<th>Total # of users</th>
<th>27,291</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>median</strong></td>
<td>1,089</td>
</tr>
<tr>
<td>smallest value</td>
<td>97</td>
</tr>
<tr>
<td>largest value</td>
<td>4,000</td>
</tr>
<tr>
<td>Total # of visits</td>
<td>66,156</td>
</tr>
<tr>
<td><strong>median</strong></td>
<td>2,438</td>
</tr>
<tr>
<td>smallest value</td>
<td>97</td>
</tr>
<tr>
<td>largest value</td>
<td>11,133</td>
</tr>
</tbody>
</table>

*the value that lies halfway between the two extremes

*N = 21 clinics

*N = 20 clinics

---

Table 4. Percentage of SLHCs Receiving Funds from Selected Sources

<table>
<thead>
<tr>
<th>Source</th>
<th>Public</th>
<th>Private</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title V. (Medicaid)</td>
<td>48</td>
<td>37</td>
<td>19</td>
</tr>
<tr>
<td>Title X.</td>
<td>14</td>
<td>43</td>
<td>24</td>
</tr>
<tr>
<td>Title XX.</td>
<td>5</td>
<td>38</td>
<td>29</td>
</tr>
<tr>
<td>EPSDT (non EPSDT)</td>
<td>38</td>
<td>29</td>
<td>23</td>
</tr>
<tr>
<td>Medicaid (not EPSDT)</td>
<td>62</td>
<td>23</td>
<td>24</td>
</tr>
<tr>
<td>Prev. Health &amp; Health Serv. (PDHS)</td>
<td>5</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>Substance Abuse Prev. &amp; Treatment</td>
<td>5</td>
<td>24</td>
<td>29</td>
</tr>
<tr>
<td>Recent &amp; Sec. Ed. Act (Chapter 1)</td>
<td>5</td>
<td>99%</td>
<td>0%</td>
</tr>
<tr>
<td>Indian Health Service</td>
<td>5</td>
<td>99%</td>
<td>0%</td>
</tr>
<tr>
<td>State social services</td>
<td>14</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Local social services</td>
<td>19</td>
<td>0%</td>
<td>100%</td>
</tr>
<tr>
<td>Other state/local funds</td>
<td>19</td>
<td>0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*N = 21 clinics
27% to 100%. On average, the single greatest source of funding provides 68% of a health center’s budget.

About one-third of survey respondents believe their budgets are adequate to meet the needs of their clients.

**How Do SLHCs Deal With Parental Consent?**

Most states have statutes that protect an adolescent’s right to privacy in the case of reproductive health; thus, the SLHCs surveyed do not require parental consent for this type of care. On the other hand, 20 of the 21 SLHCs responding to the survey require parental consent for the provision of general medical care services. The one site that does not require parental consent for primary care observes “mature informed consent.” When parental permission is required, it is usually obtained from the parents via a consent form available at the SLHCs. A few SLHCs will accept verbal permission by telephone.
Advantages and Disadvantages

A review of the surveys and transcripts of the phone interviews and site visits revealed a number of benefits and some drawbacks of the SLHC model. This section summarizes the programs strengths and weaknesses as reported by the SLHCs during the study. The case studies in Appendix A provide further details on many of these issues along with names to contact for further information.

**Advantages**

Although the history and design of each SLHC in this study are unique, there are a number of shared characteristics that make this delivery vehicle an attractive option for communities attempting to meet the health care needs of their adolescents.

**Age-Appropriate, Comprehensive Care**

SLHCs appeal to young people because they respond to adolescent health and development issues, and the providers are experienced with this population. By offering comprehensive services, SLHCs can respond to multiple problems at one time, and adolescents have one central place to go for all needs. In addition to offering a breadth of services, in most SLHCs staff employ specific procedures to facilitate and encourage adolescent use of services, such as calling youth to remind them of appointments and to conduct follow-up.

**Linkage With Schools**

SLHCs’ special relationships with schools gives them a distinct advantage over other community-based models of care. SLHCs reported various types of linkages with schools, ranging from occasional presentations to regular involvement in school activities; regardless of the degree of interaction, each site commented on the benefits of the ties with schools. The school provides the health center with a natural audience for outreach and education, increasing utilization of health services by these teenagers. The relationships with school staff facilitates two-way referrals and consultations, improving overall quality of care.

**Ability to Reach Out-of-School Youth and Other Hard-to-Reach Populations**

All SLHCs noted they reach beyond school populations and serve dropouts, homeless youth, runaways, and youth in detention centers, shelters, and other social service programs. The ability to provide services to these populations is a significant strength of the SLHC model as it allows communities to reach those at high risk of unwanted pregnancies, HIV infection, drug abuse, violence, and the other morbidities common among youth today. Often SBHCs are limited to serving in-school populations.

**Versatility in Service Design**

One of the primary reasons cited for developing school-linked rather than school-based health centers is to be able to determine the scope of services offered without school control or opposition. For example, many schools do not approve of the delivery of reproductive health care on school grounds; others object to the delivery of mental health services; and some believe that schools are inappropriate sites for any health service delivery. Maintaining control of the service design is a significant benefit of the SLHC model.

**Provision of Reproductive Health Care**

For communities attempting to prevent and reduce adolescent pregnancies and STD infections, including HIV, the provision of reproductive health care to teens is critical. The SLHC model’s ability to provide confidential, age-appropriate, reproductive health services is one of its major strengths. It is important to note that most SLHCs provide reproductive health care with the approval and support of their community while SBHCs are usually restricted by schools and/or communities from providing such services.

**Ability to Serve More Than One School**

One clear benefit of the SLHC model is the ability to serve students from more than one school. The
programs reported strategically locating their sites to be convenient for youth from a number of schools and neighborhoods. This convenience to multiple schools not only improves adolescents' access to services but is less expensive than establishing a health center at each school. When a SLHC serves junior and senior high schools in a community, it is able to provide continuity of care to youth over time.

**Extensive Hours**

Unlike most SBHCs, SLHCs are able to provide services in the evenings, during school vacations, and in the summer. A few SLHCs even offer services on Saturday. Such hours are a distinct advantage for adolescents who require scheduling flexibility. SBHCs are not able to be as flexible, as they must open and close according to the schedule determined by the school.

**Cost-Effectiveness**

By providing comprehensive, preventive care, SLHCs are able to detect a wide range of problems in their early stages, thereby reducing the incidence of serious, more costly conditions. SLHCs are also cost-effective when volunteers and community providers donate time and resources. One site has documented the cost-effectiveness of its program.

**Use of Billing to Cover Costs**

Unlike many SBHCs, most SLHCs reported charging a fee, even if minimal, for each service provided. Use of sliding scale fees and innovative billing systems allows SLHCs to recover some of their costs.

**Acceptance By Community**

SLHCs are developed when a community identifies a clear need for adolescent health care. By responding directly to community needs, SLHCs usually receive steady community support. This support is demonstrated by extensive referrals to the SLHCs by community agencies and private providers. SLHCs reported that community opposition flared up when SLHCs consider establishing new or satellite health centers in the schools, and one SLHC reported a small faction of political religious extremists opposing any adolescent health care, school-based or school-linked, in their community.

**Preparation for Managed Care**

Since they are community-based health care providers with a history of communicating with other providers and billing clients for services, SLHCs will have an easier time negotiating with managed care plans than SBHCs which are not free-standing independent health centers, have limited experience billing clients, and are less likely to meet the stringent criteria imposed by the managed care plans (e.g., hours of service, composition of staff, record/information exchange, and billing procedures).

**Disadvantages**

Despite the many strengths of the SLHC health care delivery model, a number of drawbacks to SLHCs were noted.

**Costs of Providing Comprehensive Care for Adolescents**

In general, providing comprehensive services to adolescents is expensive. One key component of effective adolescent health care is to take as much time as necessary in each visit to make sure the young person is comfortable and understands the issues at hand. Rent and overhead add to the costs of running SLHCs. At SBHCs, on the other hand, rent and overhead are usually provided by the schools as an in-kind contribution.

**Access Barriers**

Although the SLHC serves multiple schools and out-of-school youth, its location off school grounds can be a barrier for some adolescents. Some teenagers do not have the time or will not make the effort to get to a community-based health center, some cannot afford the cost of transportation, and others are intimidated by the
notion of going to a community health center. For some, even the minimal cost of a visit to a SLHC is a barrier. Furthermore, it is more difficult to do follow-up with clients at SLHCs than SBHCs where providers can access students in the classrooms.

**Managed Care**

As with other models of care for adolescents, managed care is of increasing concern to SLHCs. Many SLHCs mentioned an imminent need to reconfigure their operation to fit within a managed care environment. SLHCs worry that managed care organizations (MCOs) will have no interest in SLHCs, perceive them to be duplicative, or disapprove of their service mix. Each SLHC is considering its desire and/or need to work with MCOs. To contract with these MCOs requires meeting certain criteria determined by the plans. For example, managed care plans often have requirements about treatment authorization, level of patient utilization, scope of services, staffing, communication and record exchange, and 24-hour coverage.

SLHCs are attempting to demonstrate to MCOs the value of SLHCs’ expertise in adolescent health care. They hope that as MCOs realize SLHCs ability to reach adolescents, MCOs will be more inclined to include SLHCs in their provider networks.

**Stigma**

Because SLHCs are often identified as health centers for low-income populations, some middle-income adolescents falsely perceive the care to be substandard. Many SLHCs have to constantly work to improve their public image.

**Lower Utilization Than at SBHCs**

Because SBHCs are more conveniently located than SLHCs, utilization per student is usually higher at SBHCs. In addition, SLHCs have to make much more extensive efforts to follow-up with clinic users than do SBHCs, which have access to students on a daily basis.
Conclusions

The goal of this study was to provide an orientation to the school-linked health center model. With synthesized data collected from 21 SLHCs, this report provides a general description of SLHC services, staffing, populations served, utilization patterns, financing of services, and the relationships with schools.

Although each SLHC has a unique program design, the study identified characteristics common to all sites. In general, SLHCs provide comprehensive medical, mental health, and health education services designed for adolescents. In particular, SLHCs help adolescents in a number of ways:

- By providing an effective way to deliver reproductive health care services to adolescents;
- By serving out-of-school youth;
- By reaching high-risk youth who do not use traditional health care systems;
- By serving students from more than one school;
- By providing extended hours, often staying open in the evenings and during the summer.

The extent of the SLHCs’ relationships with schools varies, ranging from informal linkages that facilitate information exchange and follow-up to formalized arrangements that guide participation in school activities. All SLHCs in the study agreed that any linkages are advantageous to conducting outreach and follow-up to ensure the provision of timely and continual care.

The SLHC’s ability to provide reproductive health care to adolescents gives this model of care a distinct advantage over SBHCs in preventing pregnancy and STDs. According to the Support Center’s survey of SBHCs in 1993, 74.4% of the responding centers reported that provision of contraceptives was restricted. These restrictions were by state policy (11.7%), school district policy (81.4%), policies of sponsoring agencies (20.7%), and by health center choice (17.9%). For the most part, SLHCs do not face such restrictions.

On the other hand, SLHCs are not entirely free from opposition to their family planning programs. Despite the SLHC’s distinct and invaluable role in community health care delivery, one-quarter of the center directors reported active opposition from extremists in their communities over the dispensation of family planning methods or HIV/AIDS prevention activities. As a result of this type of opposition, some SLHCs reported having to limit the scope of their reproductive health services. Consequently, advocates still have serious work to do to inform communities of the strengths of SLHCs and to promote this delivery model as a way to improve adolescents’ access to comprehensive health care services.

For those who are planning programs or policies pertaining to community health care for adolescents, the SLHC is worthy of consideration. The Support Center concludes that SLHCs are a promising model for providing affordable, age-appropriate, confidential, convenient care to a population that traditionally has been very hard to reach.

This study is a first step in the examination of school-linked health centers. Further research is needed to determine the impact of SLHC programs, the viability of negotiating with managed care organizations, and methods to reduce barriers to accessing SLHC services.
President Clinton visits the Teen Health Connection, one of the six case study sites.
Appendix A
Case Studies of Six School-Linked Health Centers

As part of this study, the Support Center developed case studies to obtain a better understanding of school-linked health centers. Staff visited six sites to conduct in-depth interviews with health center staff, collecting detailed information on services, staffing, and financing of these centers. In particular, staff examined the relationship between the schools and the health centers and the advantages of establishing these health centers in the community. The case studies that follow summarize the main issues covered in the interviews; more specific information on operations is available from the site directly.
Case Study #1
The Corner Health Center

Address: 47 North Huron Street
Ypsilanti, MI 48197
313/484-3700

Contact: Joan Chesler
Executive Director

Fiscal Year Reported: October 1993-September 1994

Overview
The Corner Health Center (TCHC) is a private, non-profit, community-sponsored health center in downtown Ypsilanti, a small city in Michigan. It offers medical care, health education, and support services for adolescents and their children.

In 1976, a special task force examined the problem of teen pregnancy in Washtenaw County, Michigan. This group found the teen pregnancy problem to be greatest in the city of Ypsilanti where the birth rate to teenagers was eight times greater than in Ann Arbor and the rest of the county. A large portion of the county's poor lives in Ypsilanti, eight miles east of Ann Arbor.

The original 1980 plan for TCHC was the result of a "request for proposals" issued by the Office of Adolescent Pregnancy and Parenting (OAPP) in the Department of Health, Education, and Welfare. Concerned about the inadequacy of services to low-income teenagers in Ypsilanti, a group of agency directors and community leaders wrote a proposal for a comprehensive health center for teenagers and their infants. Although this proposal did not get funded by OAPP, the collaboration involved in developing the grant led to strong community support for the project. As a result, support for the center was finally secured through local and state funds, and the grand opening was held on March 7, 1981.

Originally TCHC was located in the Community Education Building, space donated by the Ypsilanti school superintendent. The program moved out of the education building a few years later when it needed more space. Also, community conservatives had objected to the placement of a health center in an education building which made adolescents' access to family planning services too easy. In 1987, TCHC purchased and moved to an historic building in downtown Ypsilanti, and the opposition to the program diminished.

In 1991, the health center purchased the adjacent building to accommodate the ever-increasing need for space. This expansion allowed for four new exam rooms, offices for social work, nutrition, Women, Infants, and Children (WIC) program, the Maternal Support Services program, and the hearing and vision screening program.

Services
The concept of one-stop shopping for teenagers with multi-disciplinary, integrated services in one location lies at the heart of TCHC's design and structure. TCHC provides comprehensive medical care, including general medical care, obstetrics, gynecology, pediatrics, short-term counseling, supportive services, nutritional assistance, and health education. Services include on-site HIV testing and counseling. It also runs a health education theatre troupe and an outreach education program.

TCHC's WIC program reaches 700 low-income teen mothers and their babies each month. The Maternal and Infant Support Services Programs provides enriched nursing, nutrition, and social work services to pregnant and postpartum women and their children. Lamaze childbirth preparation classes are available to all pregnant patients on site.

From 1993 to 1996, the Kellogg Foundation-funded Adolescent and Professional Training Project has trained adolescents to work effectively and sensitively with low-income adolescent clients at TCHC. For three years, five adolescents were trained to work at TCHC as peer birth control educators and medical assistants.
The Theatre Troupe, a group of local high school students trained by TCHC’s health educator and an actor/playwright, performs skits on teens’ health risks at schools, community centers, and treatment centers. AIDS and substance abuse prevention are an important focus of the Troupe’s work.

Staffing
TCHC has an extensive staff to run its very large program. It has a Medical Director 8 hours a week, a pediatrician 12 hours a week and two to three pediatric residents every month (in-kind), nurse practitioners for a total of 35 hours per week, a nurse midwife 4 hours a week, faculty and students for 8 months per year (in kind), a nurse for 25 hours a week, an infant support services nurse for 40 hours a week, an obstetrics nurse coordinator for 20 hours a week, a triage nurse for 35 hours a week, medical assistants for 65 hours, a full-time health educator (not certified), receptionists for 50 hours per week, peer educators for 50 hours per week, and a nutritionist for 21 hours. The program also has a medical education liaison from the Department of Family Practice at the University of Michigan for 16 grant-paid hours per week and two to three Family Practice residents for 8 to 12 hours per week. Beginning in May 1996, the medical education liaison position will be in-kind, and the hours will likely be reduced.

Hours
TCHC is open from 10 a.m. to 6 p.m. every Monday through Friday, and every other Monday has evening hours. The center is open during school vacations and throughout the summer. The busiest hours during the school year are after school adjourns, from 2:30 p.m. until closing.

Relationship With Schools
The center reports informal ties with at least six schools, although TCHC’s theatre troupe is the only visible presence in any of the schools. Relative to other SLCHs, TCHC’s ties with schools are much less defined, as this center is largely community oriented and serves well beyond the school population. TCHC works with the schools to provide health education, and TCHC’s theatre troupe recruits students from two schools. Among the informal linkages, the health center’s Board of Directors includes three school staff members and four to six students from two community schools, the schools provide space for rehearsals, and TCHC extends an open invitation to school faculty and students to visit the health center.

Populations Served
TCHC is designed to serve adolescents ages 12 to 21 and their children. The teens who use TCHC come from all across the southeastern part of Michigan, with 68% from Ypsilanti, 12% from Ann Arbor, 8% from Belleville, and 4% from Milan.

In addition to serving students from community schools, it provides services to homeless, pregnant and parenting youth, youth from shelters, group homes and detention centers, and youth referred by the juvenile court. The SLHC targets low-income populations, although it serves adolescents of all economic backgrounds. Students from the local community college also use TCHC.

According to TCHC’s 1993-94 annual report, the racial distribution of the clients corresponds to that of Ypsilanti: 38% African American, 59% white, and the remaining 3% Hispanic, Asian, or Native American. Roughly 20% of the clients are male.

Utilization
The SLHC reported 11,090 visits by 2,511 enrolled clients, just under four visits per client. These clients received 19,159 separate clinical services. Public outreach and education encounters were not included in total visits.

Funding
TCHC operates with a $1,000,000 budget. TCHC’s three primary sources of funding are state and
federal government (39%), foundation funds (22%), and in-kind support (12%).

According to the Michigan Department of Public Health, "TCHC’s funding base is the most diverse of all Michigan teen health centers. It includes United Way funds, grants from both Ypsilanti and Ann Arbor city councils, a variety of local and regional private foundations, and individual donations."

Billing/Insurance Information
TCHC bills for services, and the billing revenue accounts for 9% of the total funding. Roughly 50% of TCHC’s clients have insurance, of which 98% is Medicaid coverage; the other 50% is uninsured.

What Makes This Program Work?

The Corner provides affordable primary care, reproductive health services, infant care, and social support services in a confidential, convenient location.

Convenience: The health center is located on a main street in the downtown Ypsilanti area, making it easily accessible by public transportation.

Comprehensive, Integrated Services: The program is designed to be comprehensive because teens are more likely to utilize all available services when they are located under one roof, integrated, accessible, and affordable.

Cost-Effectiveness: According to TCHC’s 1993-94 annual report, "TCHC is cost-effective in part because of its reliance on donated services by physicians and certified nurse midwives from the University of Michigan Medical Center and St. Joseph Mercy Hospital. Additional volunteers help the nurses, receptionists, social workers, and administrative staff. The preventive services offered by TCHC are cost-effective and result in public dollars saved. An analysis of cost savings in the 1994-95 fiscal year indicated that over $1.3 million public dollars were saved by providing immunizations, family planning services, prenatal care, WIC services, and Medicaid screening exams. The cost savings, in fact, were nearly triple the SLHC budget." A separate evaluation of TCHC found the average cost of resources consumed during prenatal care was 41% less than that of controls. These findings have contributed to TCHC’s solid image as a model teen health center.

Community Support: TCHC has always had bipartisan support for its goals to reduce teen pregnancy and to provide health care to low-income adolescents. In the beginning, the center purposely kept a low profile, and the publicity was always favorable. United Way member agency status and study results showing a 56% reduction in live births to teenagers living in Ypsilanti from 1981 to 1985 further enhanced the center’s positive image.

To maintain its credibility in the community, TCHC has consistently included representatives of diverse community interests on its board. According to the Center’s Executive Director Joan Chesler, “Early on, Board members were chosen to lend credibility to the fledgling organization as well as to set policy and program directions. Highly respected community leaders either sat on the Board or served as Friend of The Corner. As the agency became better known and respected, Board members were chosen in part for their interest in TCHC and in part for their business perspective or links with other important service providers.”

Managed Care Relationships: TCHC is the only Teen Health Center in Michigan that has successfully contracted with managed care organizations. Currently TCHC has 70 patients from one health maintenance organization (HMO) and has provided reimbursed services for patients from a second HMO. TCHC is also a physician sponsored plan (PSP) managed care provider with a current case load of 200 patients.
Training Opportunities: TCHC is an attractive training site for the University of Michigan's Departments of Family Practice and Pediatrics. The University of Michigan is trying to strengthen its community-based training component, and TCHC offers preceptorships in return for in-kind support.

What Are the Challenges?
Managed Care: Although TCHC has made progress in contracting with HMOs, managed care is complicating access to health care for teenagers. There is now a lot of competition for Medicaid patients, and managed care plans are actively recruiting clients at welfare offices, preventing many potential clients from seeking care at TCHC. Although the managed care plans have contracts with TCHC, they are not referring their adolescent clients very often. In order to survive in the managed care environment, TCHC must have its marketing efforts and expand them to a broader audience.

Stigma: TCHC is stigmatized for its identification as a low-income SLHC and as a pregnancy clinic. Because of its image as a low-income SLHC, some adolescents from middle-income families falsely perceive TCHC's care to be substandard. Other adolescents do not want to be seen going to a clinic known for its pregnancy services.

Underutilization by Males: The center is not reaching enough males, as it is perceived to be primarily a SLHC for females seeking family planning, prenatal, or infant care.

Long Waits: As with most adolescent health centers, TCHC's clients often have waits of one to two weeks for appointments. The center is currently working to reduce the waiting time as much as possible.

Community Opposition: As a community-based health center for low-income teens, TCHC has received significant community support. When it was located on school-owned property, however, conservatives in the community raised opposition. They objected to making it too easy for students to access the health center and obtain family planning services, and they did not want the school district to become closely allied with the health center. This community opposition may limit TCHC's future work in schools.

State Laws: TCHC is one of the many SLHCs supported by state funds. According to Michigan law, centers receiving state funds may not provide abortion counseling, information, or referrals. The program is allowed, however, to prescribe and dispense contraceptives, services that school-based health centers are not allowed to provide in Michigan.
Case Study #2
North Carolina’s Teen Health Connection

Address: 1509 Elizabeth Avenue
Charlotte, NC 28204-2509
704/344-teen (8336)

Contact: Barbara Ziegler
Executive Director

Fiscal Year Reported: 1994-1995

Overview
The Teen Health Connection (THC), a private, non-profit health center, provides affordable, accessible physical and mental health care to young men and young women ages 11 to 22. It opened in February 1992, in response to the community’s adolescent health care crisis.

In the 1980s, Mecklenburg County looked at information on school-based clinics, and there was some interest in their development. Conservative forces in the community, however, voiced strong opposition, and the idea was tabled. There continued to be advocacy for a comprehensive approach to adolescent health care, and the County appointed a Task Force to study the need. The Task Force asked the Mecklenburg Medical Alliance to convene a Planning Team to begin the creation of a free-standing health center for adolescents.

In February 1992, with the support of the Mecklenburg County Commission, the Mecklenburg Medical Society Alliance, and the Junior League of Charlotte, Inc., THC opened in mid-town Charlotte. The first adolescent health center in the county, THC provides affordable, accessible health care to teens emphasizing a family-centered approach. It is close to hospitals, low-income neighborhoods, and five bus lines. Carolina’s Medical Center and Presbyterian Hospital generously provide valuable professional guidance, expertise, and support on an on-going basis.

A 24-member volunteer Board of Directors, with recommendations from the Medical Advisory Board, sets THC’s policies. THC also has a teen board to advise the health center and conduct public outreach. The teen board maintains visibility in the community by attending community events, such as school board meetings and county hearings. The teen board also runs focus groups in schools to learn more about current issues of interest to teens.

Services
THC provides comprehensive primary care, including acute and chronic medical care, preventive health care, reproductive health care, and counseling services. Adolescents use the SLHC for illnesses, minor injuries, skin problems, sports, school, and employment physicals, family planning, STDs, weight concerns, sexuality issues, and counseling for stress, family, school, relationships, drug use and abuse. THC has diagnosed malaria, malignant melanoma, diabetes, HIV infections, eating disorders, and different types of emotional illnesses.

The health center reported the following breakdown of services in the 1994-95 fiscal year: 33% acute/chronic medical care, 32% reproductive health care, 25% preventive health care, and 10% behavior/psychosocial care.

Staffing
THC employs health care professionals trained in adolescent health. The staff includes a full-time medical director, a part-time pediatrician, two family nurse practitioners, a mental health counselor, two nurses, a part-time nutritionist, a medical office assistant, and volunteer physicians. Special staff include a full-time financial manager and half-time public relations/fund raiser. THC would like to have a full-time health educator to conduct outreach.

Hours
THC sees adolescents by appointment Monday through Friday, 9 a.m. to 6 p.m. There are occasional walk-in patients from the nearby community college. The busiest hours are from
1 to 6 p.m. each day. The center is open during school holidays and throughout the summer.

**Relationship With Schools**
THC serves all adolescents in the county, which has over 50 schools. The closest school is 2.5 blocks away, the farthest 20 miles away. The health center's strongest connection to the schools is through its relationships with school nurses and counselors who make regular and frequent referrals to the health center. In addition, the health center performs a number of informal activities at the schools, such as speaking on certain health topics, offering weekly group counseling sessions at the schools, providing annual orientations for school staff and principals, and hosting an orientation for all school nurses. Finally, an assistant superintendent serves on the clinic's medical advisory board.

**Populations Served**
THC is open to the surrounding counties for adolescents ages 11 to 22, although it primarily serves youth from Charlotte. In addition to serving the students from the county schools, the clinic serves homeless youth and those living in detention centers.

The racial/ethnic breakdown in the reported year was 60% to 70% African American and 30% to 40% white. The remaining two percent were a mix of Hispanic, Asian, and other races, and this population is growing. Roughly 35% to 40% of the patients were male.

The majority of clients come from low-income families, and most of the adolescents are on Medicaid. For many, the health clinic is their medical home.

THC conducts outreach in a number of ways, including the use of media announcements. Approximately 10% of clients in the last fiscal year heard of the health center through the media.

In addition, schools, the courts, runaway shelters for youth, and private physicians who do not specialize in adolescent health care, make referrals to THC. THC provides all care for 11- to 18-year-olds in custody of the Department of Social Services and in group homes. The clinic occasionally sees students from the University of North Carolina at Charlotte, Central Piedmont Community College, and Kings and Queens Colleges.

**Utilization**
THC reported 3,729 visits in the 1994-95 fiscal year, approximately one to two visits per client. Roughly 7% of teens who visit THC once will come in for a second visit within a year.

**Funding**
In the fiscal year that ended June 1995, the THC received 46% of its funds from private sources and 54% from local and state funding. The primary sources of funding were the Carolinas Medical Center, Presbyterian Hospital, Mecklenberg county, and Medicaid. Other funders included the Mecklenburg Medical Endowment, United Way of Central Carolinas, North Carolina Department of Health, Environment and Natural Resources, local foundations, corporate and individual donors, service clubs, and churches.

**Billing/Insurance Information**
THC asks everyone to pay something according to a sliding scale fee. The clinic bills Medicaid and other agencies responsible for patient care. Approximately 65% to 70% of billed patients are on Medicaid, and 30% pay according to the sliding scale fee. Very little comes from third-party payments. Roughly 30% of clients have no form of health insurance.

**What Makes This Program Work?**
**Community Support:** THC support varies from the Junior League to conservative community groups. From the very beginning, staff was very careful not to intrude upon private practitioners,
and now THC receives a number of referrals from community physicians who either do not want or are not prepared to serve this population.

Volunteers: The program is helped a great deal by its volunteers. A gynecologist volunteers twice a month, and a dermatologist volunteers once a month. There are resident rotations in family practice, pediatrics, and internal medicine. Volunteers have painted the clinic and provide administrative support.

Staff Trained in Adolescent Health: Key to THC’s success is a staff trained in adolescent health and comfortable working with this population.

Relationship with School Nurses: The school nurses help the students obtain consent by calling home to parents before the student goes to the health center. Consent for primary care can be given over the phone, followed up with a form. This system not only expedites the students’ visit at the health center, but it is likely to increase the chance the students will visit the clinic if they know consent will not be an issue.

High Need for Adolescent Services in this Community: Since the health department does not provide primary care, THC is the first choice for many teens. The only other place to obtain specific adolescent health services is one morning per week at Carolinas Medical Center and one afternoon at a community center.

Special Follow-up and Outreach Efforts: On average nationwide, 50% of adolescents do not show for health care appointments. THC has achieved a 30% no-show rate as THC staff spend a significant amount of time on the phone reminding teens of their appointments and conducting appointment follow-up. THC also sends birthday cards, graduation congratulations, and other personal messages when necessary to keep the bond between client and provider.

Electronic Access to Medicaid Information: THC has succeeded in hooking up electronically with the state office of Medicaid. This allows clinic staff to look up Medicaid numbers. This saves a tremendous amount of hassle and paper work.

Cost-Effectiveness: THC estimates a savings to Mecklenburg County of over $3,500,000 during just the first two years of operation by providing services for acute physical and mental health care as well as preventive services.

What Are its Challenges?

High Costs: The time and money required to provide quality care to adolescents is expensive, a challenge inherent in effective adolescent health care programs.

Transportation: The SLHC is not accessible by public transportation for people in some parts of town and in distant parts of the county. THC would like to establish satellite offices in other areas.

Insufficient Outreach: Some teens are not aware THC exists, and more outreach is needed to get the word out.

Managed Care: The SLHC is not big enough to be an independent managed care provider. At this time, both local hospitals have expressed interest in having the health center as a satellite. The health center will soon have to make adjustments to operate in a managed care environment.
Case Study #3
Wake Teen Medical Center

Address: 3344 Hillsborough Street
          Suite 300
          Raleigh, NC 27602
          919/828-0035

Contact: Drew Pledger
        Executive Director

Fiscal Year Reported: June 30, 1994-July 1, 1995

Overview
Wake Teen Medical Center (WTMC) is a private, non-profit corporation serving under its own board of directors.

WTMC is located on a main road four miles west of city center. The closest school is three blocks; the farthest is 15 miles. Bus transportation is available.

Services
WTMC provides comprehensive primary care, reproductive health, and mental health services. In the last fiscal year, 40% of client visits were for counseling services, 25% for reproductive health care, 25% for preventive care, and 10% for acute care.

Staffing
WTMC staff include one full-time physician, one full-time resident, two nurses, one psychologist for 20% time, one social worker for 30% time, three full-time and one 30% time licensed counselors with masters degrees in education, a full-time receptionist, a full-time manager, a nutritionist four hours per week, and a director for 70% time. All have experience working with adolescents.

WTMC hopes to hire another physician, resident, and nurse to accommodate the demand for primary care, which is increasing as teens learn that primary care is available in addition to reproductive health care. The center also wants to hire two additional mental health providers to cover the demand for counseling services.

Hours
WTMC is open from 9 a.m. to 6 p.m. on Monday, 9 a.m. to 5 p.m. on Tuesday and Wednesday, 9 a.m. to 7 p.m. on Thursday, and 8:30 a.m. to 1 p.m. on Friday. Thursday is usually the busiest day. The SLHC is open during the summer.

Relationship With Schools
WTMC serves roughly 25 middle and high schools through informal arrangements. The school social workers refer students to the center on a regular basis and obtain consent from parents. If a school social worker has three students needing counseling at one time, the SLHC has agreed to send a provider to the school. The primary care linkage is not as strong as the counseling linkage between the SLHC and the schools. School nurses, employed by the health department, generally refer first to the health department.

WTMC is active at the schools, conducting schoolwide presentations for parents and children and conducting workshops for parents and the community. The center also offers reduced rates to groups of students needing sports physicals and inoculations.

Populations Served
WTMC serves adolescents ages 13 to 24 in Wake County. Most of the clients are from the Raleigh area where the health center is located. The center works hard to reach out-of-school youth such as those who are homeless or pregnant or who live in detention centers or shelters.

The racial composition of the clients during the reported fiscal year was as follows: 40% African American, 50% White, and 10% Hispanic, Asian, and other races.

Utilization
In the 1994-95 fiscal year, the center reported 2,746 visits, roughly two to three visits per client.
Funding
Client fees (60%), United Way (30%), and grants (10%) represented the three largest sources of funding.

Billing/Insurance Information
The majority of the clients has Medicaid coverage or no insurance, very few have private insurance. Of the clients billed in 1994-95, 64% used Medicaid, 20% paid directly according to a sliding fee scale, and 10% used third-party insurance.

What Makes This Program Work?
Popularity with Teens: The word is out "on the street" that teens like the services and feel comfortable with the providers. There is a wait list for counseling services.

Referrals by Private Providers: Private providers who do not want to serve adolescents or who do not provide both mental health and medical services refer teens to WTMC.

Referrals by Community Agencies: The juvenile court uses the SLHC for counseling, as do group homes and long term shelters. As an example of the health center's popularity in the juvenile justice system, the Chief District Court Judge designated the SLHC on a United Way donation.

Lack of Other Free Community Mental Health Services: The community mental health center has changed its policy and accepts only those who pay a full fee or qualify for Medicaid.

Extensive Outreach: The health center believes outreach is critical for its success. For example, at the beginning of each school year, the staff goes to the most distant schools in the county to assess students' needs for services and share information on the health center's programs. If a school expresses a need for health services, the health center will arrange to visit that school on a weekly basis. If not, they move on to other schools requesting care.

Contracting with Mental Health Providers:
Most of the mental health providers are on contract with the SLHC, and thus their schedules can fluctuate during the summer. Also, since their contracts are based on the demand for services, the staff is motivated to encourage student utilization. This also increases billing income since the SLHC bills for mental health services through Medicaid or a sliding fee scale.

What Are Its Challenges?
Accessibility, politics, and financing continue to be the three major problems faced by the health center.

Transportation: Not all adolescents can find transportation to the health center. Most of Wake County is rural and without public transportation.

Time and Convenience: Not all adolescents will take the time or make the effort to go to the health center for care. Compared to school-based health centers, school-linked health centers require more effort by the adolescents.

Cost: There is always a bill for every visit, even if it is small. This can be a barrier for some low-income adolescents.

School Restrictions: Because of community concerns that teens would flock to the health center for family planning services, the schools have asked that any health center staff visiting the school mention only the center's mental health services, not the medical services. This condition significantly hinders the health center's outreach efforts at schools.

Need for Earlier Interventions: The problems facing adolescents often start at an early age; the SLHC may need to begin serving younger children. If the center does begin to serve younger age groups, it will have to add staff trained in early childhood; right now it has only one such individual on staff. All of the other staff have skills in working with adolescents.
Case Study #4
Young People's Health Connection

Address: 109 Mondawmin Mall
          Baltimore, MD 21215
          410/396-0353

Contact: Dena Green
         Administrator

Fiscal Year Reported: 1994-1995

Overview
The Baltimore City Health Department runs the Young People’s Health Connection (YPHC) as part of the Healthy Teens and Young Adults Program. This health center, which serves the whole city, is located across the street from a high school, down the street from a middle school, and in a shopping mall in the inner city of Baltimore on major subway and bus routes.

Services
YPHC offers comprehensive primary medical and mental health services, although adolescents use it most for reproductive health care. During the 1994-1995 fiscal year, 90% of the services were reproductive health care.

Staffing
YPHC has a full-time Medical Director (pediatrician), a part-time family planning nurse practitioner, a full-time adult nurse practitioner (14 years and older), one full-time and one part-time physician’s assistant, a full-time nurse clinic manager, a part-time mental health social worker, three full-time medical office assistants, and two full-time office/billing assistants. The following staff provide services on-site but have offices off-site: a full-time Project Director/Administrator, a full-time Director of Health Education and Outreach, four full-time health educators, two full-time male outreach workers, and one full-time office assistant.

If YPHC had more funds, it would add more support staff. The number of SLHC clinicians is adequate for now.

Hours
The SLHC is open from 10 a.m. to 6 p.m. on Monday and Wednesday; from 9 a.m. to 5 p.m. on Tuesday, Thursday, and Friday, and 12:30 to 4 p.m. on Saturday. The busiest hours are during the walk-in hours, which are Wednesday afternoon, Monday morning, and all day Saturday. YPHC uses a 24-hour telephone system to refer callers to health department physicians. The SLHC is open during school vacations and the summer.

Relationship With Schools
YPHC serves six middle schools and four high schools in Baltimore. The school superintendent and the health center director signed a formal letter of agreement when the SLHC opened in 1990. The letter stated that a major activity of the program is to link the health center’s activities with those of area schools. Sports physicals, health assessments, counseling, and referral services are provided as health center services at the schools. Students in need of family planning services are referred to the health center for reproductive health services. YPHC now tailors its school activities according to the needs of each school. More recent arrangements are less formal but more likely to address the particular concerns at a school.

YPHC’s constant presence in the schools strengthens its relationship with the schools. The health center promotes its services at the schools and conducts health education and reproductive health sessions upon request. It also conducts weekly classroom presentations, two workshops a year for parents, special sessions on substance abuse, health fairs, on-site screenings, and PTA presentations upon request. The schools let the health center staff use the health suites for individual health education counseling sessions.

Populations Served
YPHC serves all adolescents ages 10 to 25 in Baltimore. Originally the SLHC targeted areas
having the highest rates of teen pregnancy, STDs, and infant mortality, but over time it came to serve all youth in the city, including teen runaways and out-of-school youth. It does not serve infants, but occasionally it has support groups for 7- to 10-year-olds.

Out-of-school youth make up 20% of the population served, and 35% of clients are males. In the last fiscal year, 98% of the clients were African American, and the remaining 2% were a mixture of white, Hispanic, and Asian adolescents. Last year, 90% of the SLHC population came from low-income families, but the health center welcomes teens of all incomes.

**Utilization**
During the 1994-95 fiscal year, YPHC recorded 6,800 visits.

**Funding**
State funds (95%), Medicaid (3%), and self-payment (2%) constitute the primary sources of funding.

**Billing/Insurance Information**
Less than 5% of the total budget comes from billing. Roughly 3% of the bills go to Medicaid, and 2% is self-payment. Approximately 25% of the clients have either Medicaid or third-party insurance, and 75% are either uninsured or underinsured.

**What Makes This Program Work?**
**Strong Need for Health Education:** The Baltimore schools do not offer much health education, creating a clear need for the health center’s services.

**School Referrals:** Working with the schools has helped the health center from the very beginning. Not only does it provide a “captive audience” for the health center promotions and education efforts, the school plays an instrumental role in referring teens to the center for care. As the health department employs both the school nurses and health center staff, it is very natural and easy for the school nurses to refer students to YPHC. Also, the health center contracts its mental health services from the same agency as one school, which also allows for easy referrals and follow-up between sites.

**Community Collaboration and Outreach:** General community acceptance and use of the center is maintained through the YPHC’s collaboration with recreation centers, churches, the Urban League, Job Corps, and other adolescent service providers. These relationships help with outreach and general community acceptance. In general, many community agencies refer teens to the health center because adolescent reproductive health services are very limited in Baltimore. Currently, the health center enjoys strong community support.

Reaching out to the community was particularly important when the health center was new. Fortunately, at the beginning of the program the health center hired a very charismatic outreach coordinator who conducted a number of activities that helped attract teenagers and spread the word about YPHC’s services, including community presentations, tours of the SLHC, orientations at the area meeting of principals, a grand opening of the health center with radio personalities, and incentives to teens, such as free t-shirts to those who brought friends to the SLHC. Special fun classes, such as nail care classes, provided an orientation to the center for teens who just needed to “check out” the center before joining. Also, special ongoing efforts are made to reach males.

**Broad Range of Services:** The challenge for many adolescent health providers is getting the teen to make the first visit to the facility for an orientation. By offering health education, peer counseling, and other non-medical services, the health center appeals to a large number of teens who
might not normally seek health care. Once teens become familiar with the health center, they are more likely to return again.

YPHC's provision of comprehensive services also allows the health center staff to introduce the program to middle school students without focusing on family planning. If it were otherwise, the school, and possibly parents, would not welcome the orientation as readily.

HIV Prevention Specialist: One of the health educators is a HIV risk reduction specialist and offers HIV education/prevention.

Extra Follow-up Efforts: The extent of follow-up is critical to the center's success. Health center staff make many phone calls to clients, and staff will also page those teens who cannot be called at home but have pagers.

Parent Support: The health center made efforts to explain to parents how teens need access to primary and specialized services, as they tend not to visit traditional health centers. Parents recognized the value in their teens being able to access health care in a comfortable age-appropriate setting.

Male Staff and Outreach to Males: YPHC has worked to increase use of the SLHC by males. Targeting males in outreach and hiring male counselors has helped to increase the number of male clients.

Open Door Policy: By being a drop-in center, the SLHC offers teens a safe community place to go at all times. This also allows the schools to make emergency referrals when necessary.

Saturday Hours: Many teenagers need access to health care on the weekends, and the Saturday afternoon hours at YPHC are very much needed and appreciated by this population.

Transportation: YPHC's location on major subway and bus routes facilitates teens' access to the center's services.

What Are Its Challenges?

Lack of Insurance Coverage: Very little revenue is obtained through third-party billing.

Long Wait for Appointments: As the center has become popular, the wait for appointments has grown.

Bureaucratic Burdens: Health department bureaucratic requirements are often time consuming. Ideally, the SLHC would be an independent non-profit agency.
Case Study #5
Alexandria Adolescent Center

Address: 3701 West Braddock Road
Alexandria, VA 22302
703/820-8006 or 838-4400

Contact: Darhyl Jasper, Public
Health Nurse Supervisor

Fiscal Year Reported: June 1994-June 1995

Overview
The creation and subsequent operation of the Alexandria Adolescent Center (AAC) was a response by Alexandria’s City Council to recommendations made by the city’s Adolescent Clinic Task Force in 1987. The creation of the task force was itself a response to one of a dozen recommendations of the Joint Task Force on Adolescent Pregnancy, sponsored by the Alexandria United Way and Alexandria Youth Services Commission and released in its December 1985 “Report on Adolescent Pregnancy Needs and Resources in Alexandria.” Although motivated by the need to address the city’s adolescent pregnancy rates, the task force became aware of a number of other adolescent health problems that could be addressed by a school-linked model of care. The Task Force also acknowledged that the health center alone would not solve the adolescent pregnancy problem.

In December 1987 the City Manager recommended to the Mayor and the City Council that an adolescent health center be established within walking distance of T.C. Williams High School. The off-campus location was proposed for the purpose of allowing the health center to be open when school was not and to serve adolescents not presently enrolled in T.C. Williams. This health center would work closely with the Alexandria schools to serve all teens ages 12 to 19 who are residents of the city. From the very beginning, school representatives, including a school nurse, principal, and school board member were involved with the health center’s development.

AAC is currently located in a pre-manufactured portable office on the City’s Minnie Howard Park land. It is two blocks from T.C. Williams High School and just down the street from the Minnie Howard ninth grade school. The farthest school served by the center is 3.5 miles away. The center is fully supported by the city.

Services
AAC’s primary services are counseling and reproductive health care. Between June 1994 and June 1995, the health center’s services were 40% counseling, 36% reproductive health care, 20% preventive care, and 2% acute care. The center refers most chronic problems such as diabetes to the Alexandria Health Department’s primary health care site or to private physicians or managed care organizations.

Most of the follow-up services relate to STD and pregnancy tests. An LPN who serves as a case manager helps the center with family planning follow-up.

Staffing
AAC has a physician on staff for 28 hours per week, a nurse practitioner for 30 hours a week, a medical assistant for 30 hours a week, two psychological counselors (psychology majors with master’s degrees in education), each for 30 hours a week, a receptionist/clerk for 30 hours per week, and a part-time nutritionist.

Hours
AAC is open from 10 a.m. to 5 p.m., Monday through Friday. The busiest hours are from 10 a.m. to 12 p.m., which is the lunch hour of the nearby high school, and then again from 2:15 to 4 p.m. when school is out. Usually during the early parts of the summer months the number of clients using the center drops somewhat and then starts picking up again as students get ready for fall sports.
AAC does not have coverage at night or on the weekends. The phone machine instructs callers to go to the emergency room if they need immediate care.

**Relationship With Schools**

AAC sends two counselors to the two middle schools for 10 hours a week, and the school provides the counselors with office space. The relationships with the other schools are based on regular informal communication and referrals. During school hours, students who are registered at the center and have a parental consent form on file may be referred by the school nurse, principal, or a counselor to the health center. If they do not want to go through the established referral sources, students must visit the center during the lunch hour or go after school.

AAC participates informally at the school in a number of ways: making one or two classroom presentations a year, conducting in-service workshops for nurses upon request, offering sports physicals to students (an informal invitation, not a formal arrangement), speaking regularly with school health staff about students, and providing orientations and health fairs at schools. The health center also conducts a condom availability program in T.C. Williams High School and at the ninth grade center. AAC provides all of the condoms, nurse training, literature, and final reports.

In addition to relying on AAC for these activities, the school system sends students to the health center for immunizations. Also, a school nurse, PTA representatives, and private citizens sit on AAC’s community advisory board.

**Populations Served**

AAC is open to all adolescents ages 12 to 19 who are residents of Alexandria. The majority of the clients comes from T.C. Williams High School and the Minnie Howard School, the two closest schools. Also, the center works with social services, detention centers, and youth shelters to ensure these youth receive health care services.

The racial/ethnic background of the clients during the June 1994 to June 1995 fiscal year was as follows: 46% African American, 23% white, 18% Hispanic, 7% Asian/Pacific Islander, and 6% other.

This composition is slightly more diverse than that of the city which, according to the 1990 Census for Alexandria, breaks down as follows: 21.9% African American, 69.1% white, 9.7% Hispanic 4.1% Asian/Pacific Islander and 4.6% other.

Approximately 43% of the users were male in the 1994-95 fiscal year.

**Billing/Insurance Information**

Because AAC does not bill, neither client income nor insurance information was available.

**Funding**

AAC is fully funded by the city and does not bill for any services. The city funding is supplemented by approximately $7,000 from in-kind contributions. Because the center does not bill for services, client insurance information was not available.

**What Makes This Program Work?**

**Reaching Out-of-School Youth:** AAC is able to work with hard-to-reach populations such as those from runaway shelters, detention centers, and social service programs like foster care.

**Community Support:** Although a small group opposed the health center during its development, the SLHC has been able to maintain a significant level of community support and has not been hindered by opposition. Having diverse community representation on the board helps the SLHC to maintain this support. The current board includes school nurses, a principal, representatives from youth-serving organizations, PTA representatives, and an adolescent health care expert.

**Service Design Versatility:** By being school-linked, it has versatility in its service design and offers more privacy to students than it could on
school grounds. If it had been school-based, it could not have provided family planning services.

**Serving More Than One School:** AAC is able to serve multiple schools, including private schools.

**Summer Hours:** Summer hours improve general access to services and continuity of care.

**What Are Its Challenges?**

**Transportation:** Not all teens in Alexandria have access to transportation to get to the SLHC. The center would like the schools to offer transportation, but the school cannot take on that liability.

**Outreach:** Some adolescents are not yet aware the SLHC exists.

**Utilization:** Utilization from any one school is probably not as high as it would be if the health center were based on school grounds. This is largely due to transportation, cost, and convenience issues.

**Stigma:** At first the SLHC faced the stigma of being a "free clinic," which was correlated with poor care. Over time, however, it became popular with teens of all economic backgrounds, and now the stigma is gone.
Case Study #6
Taylor Teen Health Center

Address: 21123 Eureka Road
Taylor, MI 48180
313/374-2273

Contact: Janice Fialka
Program Director

Fiscal Year Reported: October 1, 1994-
September 30, 1995

History
The Taylor Teen Health Center (TTHC) is a
program of Oakwood Hospital-Heritage Center, a
non-profit tax-exempt agency. TTHC receives a
portion of its funds from the Michigan Depart-
ment of Public Health. An Advisory Council
which includes parents, clergy, teens, doctors,
nurses, social workers, lawyers, educators, and
representatives of other civic groups, provides
input, support, and guidance to the center and its
program.

TTHC is located on a main thoroughfare in
Taylor, Michigan, 20 miles southwest of Detroit.
TTHC was originally planned to be a school-based
clinic, but opposition by conservatives in the
community led to its establishment as a school-
linked health center. The health center was
opened in May 1987 at a small shopping mall,
which also houses the county health department.
At this location, the health center can serve youth
from several schools in the county as well as out-
of-school youth.

Services
TTHC provides comprehensive health services,
counseling, and health education for adolescents
between the ages of 11 and 21 in Wayne County,
Michigan. Special education students are eligible
through the age of 26. The health center requires
parental consent for all medical services. Basic
health education and crisis intervention are
offered without parental consent.

Unlike most school-linked health centers, TTHC
does not offer family planning services. It offers

birth control counseling, pregnancy testing, and
general gynecological exams, but it does not
provide contraceptive prescriptions or devices because
of community restrictions. Teens are referred to the
teen family planning clinic sponsored by the county
health department located in the same shopping
mall. The center also refers youth to other providers
for substance abuse treatment, specialty procedures,
and psychiatric services.

At TTHC during the 1994-95 fiscal year, 56% of
services were preventive, 21% were general medical
services, 11% were mental health counseling, and
the rest were other services such as substance abuse
prevention, STD diagnosis and treatment
(roughly 4%), and immunizations. Soon the
SLHC will offer HIV testing and counseling. If
more funds become available, the center would
like to add obstetrics and prenatal care programs.

Two teen peer education programs are operated
by the Center; one focuses on HIV/AIDS preven-
tion, and the other on substance abuse preven-
tion. These teens, hired by TTHC, provide most
of the education programs and outreach activities.
They also adeptly promote the services and recruit
teens.

TTHC offers several intensive after-school and
Saturday programs for high-risk youth who reside
in subsidized apartment complexes in Taylor.
These groups, co-facilitated by the TTHC staff and
teen peer educators, provide meaningful experi-
ences for youth during their “leisure time.”
Efforts are focused on building self-esteem, en-
hancing drug resistance skills, increasing friend-
ship skills, and developing a sense of a positive
community spirit. These groups are respected by
the schools and community-at-large, both of
which provide referrals and financial support for
this project.

The TTHC sponsors an annual statewide profes-
sional conference on specific topic related to
adolescent issues. The conference primarily draws
professionals and some parents and provides some
additional funding for the center. The conference strengthens the idea that the TTHC is a local leader in the field of adolescent services.

**Staffing**

TTHC has one physician 10 hours a week, a full-time nurse practitioner, a part-time counselor with a bachelor’s degree in counseling (provided in-kind by a local youth serving agency), a full-time office manager, a full-time substance abuse counselor, a full-time health educator/HIV prevention specialist, and a health center director for 29 hours a week.

Ideally the SLHC would have a receptionist, a full-time program director, a full-time social worker, a fund raiser, a nutrition consultant, and a recreation specialist.

**Hours**

TTHC is open from 9 a.m. to 5 p.m., Monday through Friday, and it is open late one night a week. The busiest hours are in the late afternoon. The back-up system is minimal; clients are instructed to use the emergency room.

**Relationship With Schools**

TTHC serves three middle schools and three high schools located in Taylor, Michigan. Students from numerous other schools also use the health center.

The nearest Taylor school served by the SLHC is 1.5 miles away, and the farthest is 7 miles away, although some youth come from as far as 30 miles away.

TTHC maintains its relationship with the schools by providing regular classroom presentations on health issues, primarily HIV/AIDS and substance abuse prevention. The health center staff provide almost all state required HIV/AIDS education for the Taylor School District, which means providing AIDS education for the seventh, ninth, and eleventh grades at each of the six schools.

Other involvement with the schools includes offering peer education sessions in the schools several times a week, attending school “parenting days” four or five times a year, and serving on the school reproductive health committee.

The health center staff are connected to the school through their professional relationships with school nurses, counselors, and administrators. Because there are only two and one-half school nurses in the district, a nurse is at each school only one-half day per week. Therefore, the school nurse relies on the SLHC for referrals and follow-up. The school counselors also refer students to the health center and confer regularly with health center staff about students’ needs and treatment.

Schools are linked to the health center in a number of ways. For example, a school board member and a school staff person sit on the Advisory Council, the school pays for training stipends for teen peer educators, and the school employs TTHC peer educators over the summer. Also, the health center and the schools have collaborated on grants. Such a grant received by one school was used to support the health center’s summer program for children and youth ages six and older.

**Populations Served**

TTHC serves adolescents ages 11 to 21 in Taylor, Michigan. The SLHC also serves other Wayne County youth from approximately 10 communities referred to as “Downriver.” The center primarily serves low-income youth because it offers a sliding fee scale.

Referrals to TTHC are made by the health department, homeless shelters, churches, businesses, agency staff, teen clients, and the community at large. Approximately 9% of the clients are homeless youth. The SLHC also serves pregnant and parenting youth as well as some university students. Roughly 34% of the clients are male.
Outreach is done with other community agencies at health fairs, a “teen day” at the mall, parenting days, etc. Health center staff also sit on a countywide school committee and several coalitions to keep others informed about the health center and to encourage referrals to the center.

Utilization
In the 1994-95 fiscal year, the SLHC reported 1,504 visits. This figure does not include the intensive health education activities conducted in the schools and community.

Funding
The three primary sources of funding are the Michigan Department of Health (70%), federal and state substance abuse prevention funding (23%), and billing, including Medicaid, third-party insurance, and self payments (3%). The fiduciary provides fringe benefits, in-kind services, and administrative support. The city of Taylor, through its Community Development Block Grant (CDBG) funds, contributes approximately $5,000 to the center annually. Immunizations are provided in-kind by the county health department.

Billing/Insurance Information
A nominal fee is charged for services, but no one is denied services if unable to pay. Billing revenue is only 3% of the incoming funding largely because 50% of the clients have no form of health insurance. Although roughly 41% of the clients have some form of private insurance, most health insurance will not reimburse for primary health care services provided at the TTHC. Billing their insurance also could jeopardize confidentiality. The remaining 9% of the clients have Medicaid.

What Makes This Program Work?
Follow-up Efforts: Staff spends a tremendous amount of time on the phone to remind clients of their appointments, to follow-up on lab tests and referrals, and to offer counseling.

Popularity with Adolescents and Parents: The adolescents like the providers and return for follow-up visits. Patient satisfaction surveys indicate that the youth feel comfortable going to the health center and tell their friends about it. Parents too report high satisfaction with services and often refer other families to the center for counseling and health services. There is a low turnover rate for staff which has allowed them to maintain long-term relationships with the teen clients and their families.

What Are Its Challenges?
Stigma: Even though the SLHC does not offer reproductive health services, some perceive it to be a birth control and abortion clinic, a stigma to a few.

Parental Consent: Because the health center was originally designed to be school-based, it planned from the beginning to obtain parental consent forms from all enrollees. When it became community-based and school-linked, it kept this policy to appease community conservatives who distrusted the intentions of health center staff. For some teenagers, however, the consent requirement is a barrier.

Transportation: Transportation is not accessible to everyone. The clinic offers some taxi vouchers, but there is still an access problem.

Community Opposition: There is general suspicion among a small group of conservatives in the community about the intent of the SLHC’s program. There is also specific opposition to the HIV/AIDS prevention work in the schools. Because of this opposition, the health center does not provide family planning services.

In 1993, the TTHC opened a satellite health center at Brake Junior High School. It was closed due to opposition by community conservative extremists. According to 1993 reports in the Heritage Sunday/News Herald, the Brake SBHC “was closed indefinitely Tuesday because of some residents’
concerns that services such as reproductive counseling would be provided without the knowledge of parents.” In fact, the SBC did not offer these services and had made a strong public campaign to inform the community that birth control was not a provided service.

_Michigan Law:_ Because the health center receives state funds, it must abide by state law. According to Michigan law, all adolescent health programs funded by the state department of public health, regardless of location (school-based, school-linked, or community based), “shall not, as part of the services offered, provide abortion counseling or services or make referrals for abortion counseling.” In other words, TTHC staff are not allowed to provide abortion counseling or referrals.
# Appendix B
## Directory of Participating School-Linked Health Centers

### Daly City Youth Health Center
- Carol Forest, Center Coordinator
- 2780 Junipero Serra Boulevard
- Daly City, CA 94015
- 415/991-2240; fax 415/991-7498

### Redwood City Youth Health Center
- Michael Sally, Program Coordinator
- 560 Arguello
- Redwood City, CA 94063
- 415/366-2927; fax 415/366-0183

### Young People’s Health Connection
- Dena Green, Administrator
- 109 Mondawmin Mall
- Baltimore, MD 21215
- 410/396-0335; fax 410/396-0190

### Access Teen Health Center
- Joanna El-Hajj, Teen Health Coordinator
- 9708 Dix Avenue
- Dearborn, MI 48120
- 313/842-0700; fax 313/841-6340

### Community Health Field Services
- Detroit City Health Department
- Gwendolyn Franklin, SPHN, Health Center Administrator
- 1151 Taylor, Building #6
- Detroit, MI 48202
- 313/876-4660; fax 313/873-0523

### Willow Plaza Services
- Ingham County Health Department
- Debbie Brinson, Adolescent Health Coordinator
- 306 West Willow Street
- Lansing, MI 48906
- 517/484-9292; fax 517/484-5169

### New Haven Adolescent Services
- Marilyn Keesler, Coordinator
- 57737 Gratiot
- New Haven, MI 48048
- 810/749-5173; fax 810/749-5560

### Taylor Teen Health Center
- Janice Fialka, Program Director
- 21123 Eureka Road
- Taylor, MI 48180
- 313/374-2273

### The Corner Health Center
- Joan Chesler, Executive Director
- 47 North Huron
- Ypsilanti, MI 48197
- 313/484-3700; fax 313/484-3100

### Nucleus Clinic
- Jerri Loughry, Clinic Manager
- 1323 Coons Rapid Boulevard
- Coons Rapid, MN 55433
- 612/755-5300; fax 612/754-9403

### Face to Face Health and Counseling
- Ann Ricketts, Executive Director
- 1165 Arcade Street
- St. Paul, MN 55106
- 612/772-2539; fax 612/772-3216

### Common Health Clinic
- Cherylee Sherry, Executive Director
- 13961 North 60th Street
- Stillwater, MN 55082
- 612/430-1880; fax 612/430-1323

### Floating Hospital
- Abbe Kirsch, Director of Education
- Pier 11 Wall Street & East River
- New York, NY 10005
- 212/514-7400; fax 212/514-5645

### Teen Health Connection
- Barbara Ziegler, Executive Director
- 1509 Elizabeth Avenue
- Charlotte, NC 28204-2509
- 704/344-8336; fax 704/373-0639
Lincoln Community Health Center
Kathleen Fitzsimmons, Teen-Link Coordinator
1301 Fayetteville Street
Durham, NC 27707
919/956-4070; fax 919/687-4257

Adolescent Health Program
Orange County Health Department
Diane Rocker, Child Health Coordinator
PO Box 8181
Hillsborough, NC 27278
919/732-8181; fax 919/644-3007

"Can-Stop" Program
Davie County Health Department
Dennis Harrington, Health Director
210 Hospital Street, PO Box 665
Mocksville, NC 27208
704/634-8700; fax 704/634-0335

Wake Teen Medical Services
Drew Pledger, Executive Director
3344 Hillsborough St., Suite 300
Raleigh, NC 27602
919/828-0035; fax 828-0355

Payne County Health Department
Karen Waldron, Advanced Practice Nurse Practitioner
701 S. Walnut Street
Stillwater, OK 74074
405/372-8200; fax 405/743-2619

Alexandria Adolescent Clinic
Darhyll Jasper, PH Nurse Supervisor
3701 W. Braddock Road
Alexandria, VA 22032
703/838-4400; fax 703/838-4038
Appendix C: References


