Hallways to Health: School Health Beyond School-Based Health Center Walls

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Objective: In this paper, we describe the implementation and outcomes of an initiative that engaged school-based health centers (SBHCs) in a learning community to create programmatic and policy school health changes beyond the health center walls. **Methods:** Sixty respondents completed impact surveys and 13 coalitions completed progress reports to document schoolwide wellness efforts and outcomes in stakeholder engagement, student healthy eating and active living, student social and emotional wellness, and school staff wellness. **Results:** Respondents reported pre- to post-intervention improvements in stakeholder engagement, including school administration promotion of school health policies (from 64% to 95%), and teacher participation in SBHC sponsored activities (from 63% to 98%). They reported schoolwide policy and programmatic achievements including increased opportunities for physical activity for students during school hours (from 55% to 85%), access to behavioral health counseling and support services to all students, either on-site or through referrals (from 62% to 89%), and offering healthy food or nutrition education to staff (from 10% to 73%). **Conclusions:** SBHC staff, school employees, and community members can work collaboratively to assess student physical and mental health needs, and develop and implement school policies and programs beyond the clinic walls.

Key words: school-based health center; school health; school collaboration; child health; school-community partnerships
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Seismic changes are occurring across the United States as the country responds to the COVID-19 pandemic. Schools must prioritize protecting students' mental, emotional, and social health, particularly now.[1] School wellness efforts are as critical to addressing students' and school staff members' social and emotional health as well as physical health needs. Given the inextricable relationship between health and education outcomes, schools and local healthcare systems are exploring strategic intersections that can support children's optimal physical, emotional, cognitive, and social development. The nation's more than 2500 school-based health centers (SBHCs)[2] represent one collaborative strategy. SBHCs provide essential care to low-income students and families. SBHCs are a shared commitment between education and healthcare organizations. They bring needed services within easy reach of students – on campus, during and after school hours, and often during the summer – to support their health, well-being, and academic success. Schools partner with SBHCs by offering space and in-kind support. Local healthcare organizations contribute an array of services delivered by a multidisciplinary team, including primary healthcare, and often mental healthcare, social services, oral healthcare, reproductive health, nutrition education, vision services, and health promotion.

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Services are delivered in-person and, increasingly, via telehealth.[3]

SBHCs are an effective delivery model for advancing health equity.[4] They help youth and their families overcome access barriers that may prevent them from receiving needed healthcare services, including transportation, time, costs, and lack of continuity of care. The presence and use of SBHCs is associated with improved health-related outcomes, including increased preventive screening for oral health, vision, substance use, and nutrition, increased vaccinations, increased use of contraceptives, increased access to and utilization of mental and behavioral health services, decreased asthma morbidity, and reduced emergency department use and hospital admissions. Research shows SBHCs improve student achievement outcomes, grade-point average, grade promotion, and suspension rates.[5]

Recognizing that well-being is determined, in part, by where children learn, live, and grow, SBHCs can deliver clinical services and create a wellness culture that extends beyond the health center – into school hallways, classrooms, cafeterias, teachers lounges, and other campus spaces. By reaching beyond the clinic walls to create schoolwide wellness programs and policies, SBHCs can help build a learning environment that is healthy, safe (both physically and psychologically), and welcoming to all students.[6]

The Hallways to Health initiative was a 4-year learning community that encouraged SBHCs to build coalitions and coordinate with their education and community partners to create systemic conditions – policies, practices, programs, and partnerships – that promote student and staff health. The School-Based Health Alliance (SBHA), with support from the initiative's funder, Kaiser Permanente (KP)'s Thriving Schools, placed a call for proposals for SBHCs in California, Georgia, Maryland, Oregon, and Washington to patriciate in the Hallways to Health initiative. These states were selected primarily because of the presence of SBHCs and state-level SBHC membership associations.

SBHA selected 13 SBHC sites, including 5 in California, 3 in Georgia, 3 in Oregon, 2 in Maryland, and 2 in Washington. These SBHCs provided access to care to diverse geographic and demographic communities. Five of the SBHCs were in elementary schools, 2 in middle schools, and 6 in high schools. Eight delivered services to communities characterized as urban, 4 suburban, and one rural. Twelve were in public schools; only one was private. School population sizes ranged from 131 to 2370 students, with an average of 795 students. Students in 12 of the schools were predominantly African-American or Hispanic. Each SBHC had primary care providers on staff; 12 of the 13 also had behavioral health providers.

SBHA developed a learning community framework to structure and guide the Hallways to Health initiative. The organization provided training and technical assistance to support SBHCs in these efforts through monthly collaborative calls, annual site visits, and regional and national meetings. The SBHA encouraged the SBHCs and their school and community partners to work collaboratively in 3 domains: (1) student access to healthy food, snacks, drinking water, and physical activity; (2) social and emotional health supports, school climate, and school discipline approaches; and (3) school staff wellness, all through coalition-building and collaboration with school and community partners. The SBHA provided each SBHC a stipend of $30,000 to hire or expand the roles of existing primary care providers, health educators, behavioral health providers, and/or program coordinators to participate in Hallways to Health. In addition, the SBHA funded state-level SBHC membership associations in the corresponding states as co-collaborators in project implementation. In partnership with their state associations, the SBHCs built coalitions of stakeholders, including teachers, school administrators, student support professionals, primary and behavioral health professionals, health educators, youth, and community organizations. Each of the coalitions undertook environmental scans and developed work plans in the 3 domains.

Coalitions participated in the learning community, a quality improvement method that combines multidisciplinary teams working in consultation with recognized experts to address a specific, complex challenge.[7] The SBHA staff facilitated routine in-person and monthly virtual training and technical assistance sessions for the coalitions, featuring experiential learning techniques on quality improvement tactics. These included monthly plan-do-study-act (PDSA) cycles and expert-led didactic content to develop core competencies around the 3

domains. In addition, annual regional meetings and national conferences provided in-person skill-building opportunities such as storytelling, engaging local partners, and planning for sustainability for their school wellness programs. Hallways to Health participants shared promising strategies through these venues, as well as through online sharing platforms. The learning community helped to encourage success by building and maintaining community stakeholder engagement and partnerships, sharing and selecting appropriate implementation strategies, and documenting the lessons learned and outcomes of the initiative for future replication.

The evaluation of the initiative aimed to address the following questions: How were stakeholders involved during the initiative, and was there increased engagement and integration by school stakeholders over time? Did schools successfully implement sustainable policies, protocols, and programs in each of the 3 domains, and what challenges did they encounter during the process? Finally, what are the lessons learned from this effort to improve school health strategies moving forward?

METHODS

Instrumentation

The SBHA used quantitative and qualitative methods to evaluate the Hallways to Health initiative. To understand how the initiative influenced engagement and integration among school stakeholders, members from each coalition completed an online impact survey at the end of the learning community. Respondents reported on how their stakeholder (teachers, students, parents/guardians, school administrators, community agencies) involvement in schoolwide health efforts changed since the learning community started. The survey also included questions about the status and sustainability of policies, protocols, and programs implemented in each of the 3 domains. To capture additional detail on the implementation of the policies, protocols, and programs, the SBHA also collected data through progress reports in the final year of the initiative from each of the 13 SBHC teams. These data described their successes and challenges, whether they targeted a schoolwide population or clinical-level populations in the SBHC, if their efforts resulted in a changed protocol, policy, or program, and creation of sustainability plans.

Participants

The SBHA invited all members of each coalition to complete the impact survey. There were 60 respondents. Of these, 25% were administrators who worked with the school and/or the health center, 23% were medical providers, 20% were health educators, 7% were behavioral health providers, and 7% were teachers. In addition, 15% provided technical assistance and/or were with the state SBHC affiliates. Most (68%) worked directly with the SBHC, 37% helped plan or develop school health policies, services and/or instruction, and 37% provided direct health or wellness services. Each of the respondents participated in the learning community's final year, and nearly half (43%) had participated since its start. The number of respondents per SBHC ranged from 2 to 8, with an average of 4.6. California's 5 sites had an average of 4 respondents per site; Georgia's 3 sites averaged 5 respondents per site, Maryland's 2 sites averaged 6 respondents per site, and Oregon/Washington's 3 sites averaged 4 respondents per site.

Data Analysis

We calculated percentages of responses to questions about perceived changes in the schoolwide wellness program and protocol, and policy implementation using the impact survey at "pre" (before or at beginning of the initiative) to "post" (end of initiative). We used the Wilcoxon signed-rank test to test for statistical significance in differences for the matched pre/post data and verified the results using paired t-tests. Reported responses exclude those who responded, "not sure." We used Stata Version 15 for all analyses.[8] We used thematic analysis to examine the qualitative data to identify activities undertaken by the coalitions and themes of promising strategies and lessons learned to implement and sustain the work.

RESULTS

Stakeholder Engagement in School Population Health Efforts

Findings from the impact survey describe stakeholders' involvement and demonstrate increased engagement and integration in SBHC clinical and population health efforts by school stakeholders over time. According to the progress reports, participation in Hallways to Health strengthened

Table 1
Stakeholder Involvement in Schoolwide Wellness (Data Source: *Impact Survey*)

Percentage of respondents agreeing or strongly agreeing that:	Pre (N = 38-57)	Post (N = 42-59)	Probability
School Administration			
Supports SBHC efforts	84%	97%	< .001
Promotes school health policies	64%	95%	< .001
Provides requested support to the SBHC	70%	95%	< .001
Meets regularly with the SBHC staff	56%	91%	< .001
Students			
Know about SBHC services	69%	100%	< .001
Participate in school wide SBHC sponsored activities and programs	70%	100%	< .001
Utilize SBHC services	80%	98%	< .001
Teachers			
Allow class time for SBHC staff to provide health education/ wellness programs	71%	98%	< .001
Participate in SBHC sponsored activities (clinical and schoolwide)	63%	98%	< .001
Refer students to the SBHC for services	87%	98%	< .001
Local community agencies			
Offer schoolwide health and wellness programs (such as YMCA, Boys & Girls Club, yoga teachers, etc.)	76%	92%	< .001
Provide clinical services at the SBHC (such as FQHC, behavioral health provider, etc.)	79%	88%	< .001
Receive referrals from the SBHC	95%	100%	< .001
Parent/Guardians			
Participate in SBHC sponsored family activities and programs	48%	80%	< .001
Provide consent (if needed) for their children to use the SBHC	88%	100%	< .001

relationships between SBHC and school personnel. Relationships formed among SBHC staff, teachers, administrators, cafeteria managers, and after-school program coordinators that were driven by a focus on a shared goal of student health and wellness. The SBHC staff led or joined school and district wellness committees and participated in student support teams and curriculum development teams. SBHC staff also joined school staff meetings, teacher orientations, parent-teacher association (PTA) meetings, back-to-school nights, attendance conferences, and discipline teams. As a result, Hallways to Health coalition members reported pre- to post-improvements on the impact survey in each category of school population health engagement and connectedness across each key stakeholder group (Table 1). Significantly more coalition members reported that school administrators promote school health policies (from 64% to 95%) and that more teachers participate in SBHC sponsored activities (from 63% to 98%).

SBHC staff also conducted schoolwide needs assessments and youth focus groups to identify health and wellness priorities and encouraged youth to design and lead schoolwide wellness efforts. The initiative strengthened connections between SBHC staff and youth. SBHC staff created forums where youth shared their opinions, values, and concerns by developing or enhancing youth advisory councils and other student leaders. Youth leaders served on task forces and as peer educators and developed plans to improve their school environments. As a result, significantly more coalition members reported on the impact survey at the end of the initiative that students were generally aware of SBHC services (from 69% to 100%) and par-

Table 2
Implementation of Schoolwide Student Healthy Eating and Active Living Programs, Protocols, and Policies (Data Source: *Impact Survey*)

	Percentage of respondents reporting that student health eating & active living programs and policies are fully in place at their school or SBHC.		
	Pre (N = 28-47)	Post (N = 35-57)	Probability
BMI Screenings			
Has a policy or protocol to conduct Body Mass Index (BMI) screenings for all students.	32%	54%	.01
Has a policy or protocol to conduct BMI screenings for SBHC clients.	58%	85%	< .001
Has a policy or protocol to provide follow-up services to students with high BMI results.	56%	81%	< .001
Food Insecurity Screenings			
Has a policy or protocol to conduct food insecurity screenings in the SBHC.	20%	70%	< .001
Has a policy or protocol to conduct food insecurity screenings to all students.	21%	43%	.03
Healthy Food			
Provides a school breakfast program that ensures all students have access to a healthy breakfast.	50%	78%	.001
Has a school garden that involves students, shares produce with students, and/or that educates students about nutrition.	13%	56%	< .001
Has implemented healthy food polices that limit/restrict unhealthy foods from being sold or given to students at school.	20%	56%	< .001
Physical Activity			
Offers students opportunities for physical activity during school hours.	55%	85%	< .001
Offers students opportunities for physical activity before/after school hours.	45%	75%	< .001

ticipate in schoolwide SBHC-sponsored activities and programs (from 70% to 100%).

Hallways to Health created partnerships between SBHCs and community partners, including pediatricians, youth service leaders, nutrition and wellness experts, and organizations such as hospitals, gyms, YMCAs, nonprofits, and universities. These partnerships enriched the resources and support of school wellness program goals, expanded the school wellness team's capacity, and brought in subject matter experts on various topics. One SBHC in Oregon engaged a local chef, a yoga instructor, a dance instructor, a massage therapist, and a martial arts provider as wellness program partners. An SBHC in Maryland invited staff from a local university to teach nutrition classes during and after school, a chef to teach students healthy modifications to recipes from their home countries, and a community partner to teach school staff meditation and mindfulness. As a result, significantly more coalition members reported on the impact survey that local community agencies offered schoolwide health and wellness programs for parents and guardians (from 76% to 92%) and provided clinical services at the SBHC (from 79% to 88%).

The sites connected with parents and guardians by offering family support services such as workshops on nutrition and social and emotional health, sharing schoolwide wellness updates with parents, and connecting families to resources. They also provided enrollment assistance for health insurance and social services during back-to-school

Table 3
Implementation of Student Social and Emotional Wellness Programs, Protocols, and Policies (Data Source: *Impact Survey*)

	Percentage of respondents reporting that student social & emotional wellness programs and policies are fully in place at their school or SBHC.		
	Pre (N = 37-46)	Post (N = 50-58)	Probability
Provides clinical behavioral health assessments and screenings.	61%	91%	< .001
Provides access to behavioral health counseling and support services to all students, either on-site or through referrals.	62%	89%	< .001
Emphasizes mindfulness, conflict resolution, or opportunities for behavioral health counseling in place of suspension and detention.	21%	72%	< .001
Provides schoolwide behavioral health assessments and screenings to identify youth with behavioral health needs.	20%	70%	< .001
Provides schoolwide programs to improve student social and emotional wellness.	20%	68%	< .001
Emphasizes teaching relaxation and stress-reduction techniques to students through programs such as meditation or yoga.	13%	57%	< .001
Provides school staff with professional development to help them support students with behavioral health needs.	14%	51%	< .001

nights, parent conferences, and parent education nights. As a result, significantly more coalition members reported on the impact survey that parents/guardians participated in SBHC sponsored family activities and programs (from 48% to 80%) and provided consent for their children to use the SBHC (from 88% to 100%). Overall, findings from the impact survey and progress reports demonstrate successful implementation of sustainable policies, protocols, and programs in each of the 3 domains, as described below.

Domain #1: Collaborating to Improve Healthy Eating and Active Living

Significantly more coalition members reported on the impact survey that healthy eating and active living policies, protocols, and programs were "fully in place" from pre- to post-initiative (Table 2). Some of the most successful changes introduced or expanded school breakfast programs (from 50% to 78%), as well as increased opportunities for physical activity for students, both during school hours (from 55% to 85%) and before/after school hours (from 45% to 75%). For example, according to the progress reports, the staff at one California SBHC engaged local parks departments and community centers to access outdoor spaces, share sports equipment, and lead fitness classes for youth and school employees.

More members reported that their SBHC had a policy or protocol to conduct body mass index (BMI) screenings for SBHC clients (from 58% to 85%), provided follow-up services to those with elevated BMI results (from 56% to 81%), and had a policy or protocol to conduct food insecurity screenings with SBHC clients (from 20% to 70%). Changing protocols to implement schoolwide BMI screenings (only 54% at post) and schoolwide food insecurity screenings (only 43% at post) proved to be more challenging than at the SBHC level.

Although by the end of the initiative only 56% reported that their school had a school garden or had implemented healthy food policies, this is still a large increase from before the initiative. According to the progress reports, some of the coalitions' achievements included implementing "smart snack" guidelines for campus events, replacing food vending options with healthier choices, leading "Be

Table 4
Implementation of Staff Wellness Programs, Protocols, and Policies (Data Source: *Impact Survey*)

	Percentage of respondents reporting that staff wellness programs and policies are fully in place at their school or SBHC.		
	Pre (N = 41-44)	Post (N = 52-56)	Probability
Promotes school staff nutrition by offering healthy food at meetings and through staff appreciation events and/or providing nutrition education through bulletin board or email postings.	10%	73%	< .001
Assesses the needs of school staff to design school staff wellness strategies with their needs/wants in mind	5%	68%	< .001
Promotes school staff physical activity and stress reduction through chair massages, yoga classes, mindfulness exercises, walking clubs, and/or other exercise opportunities.	7%	64%	< .001

Smarter, Drink Water" campaigns, and encouraging more generous fruit and nutritious snack offerings at local stores.

Domain #2: Supporting Student Social and Emotional Wellness

Results from the impact survey showed that significantly more coalition members reported that student social and emotional wellness policies, protocols, and programs were "fully in place" at the end of the learning community compared with the beginning (Table 3). More members reported that their SBHC conducted clinical behavioral health assessments and screenings (from 61% to 91%), provided access to behavioral health counseling and support services to all students, either on-site or through referrals (from 62% to 89%), emphasized mindfulness, conflict resolution, or opportunities for behavioral health counseling in place of suspension and detention (from 21% to 72%), provided schoolwide behavioral health assessments and screenings (from 20% to 70%), and provided schoolwide programs to improve student social and emotional wellness (from 20% to 68%). For example, according to the progress reports, one California SBHC used the Adverse Childhood Experiences (ACE) survey tool[9] during every SBHC intake assessment and with all freshman students. They then connected students to individual and group supports as needed based on their survey results. Less widely implemented programs and policies taught relaxation and stress-reduction techniques (from 13% to 57%) and provided school staff with professional development to support students with behavioral health needs (from 14% to 51%).

Domain #3: Promoting School Staff Wellness

Results from the impact survey showed that significantly more Hallways to Health coalition members reported school staff wellness programs and policies were "fully in place" at the end of the learning community compared with the beginning (Table 4). According to the progress reports, the SBHCs succeeded in bringing school staff wellness programs (several for the first time in school history) to focus on exercise, stress management, and nutrition. Many more respondents reported their schools promoted school staff nutrition by offering healthy food at meetings and through staff appreciation events and/or providing nutrition education through a bulletin board or email postings (from 10% to 73%), assessed the needs of school staff to design school staff wellness strategies with their needs/wants in mind (from 5% to 68%), and promoted school staff physical activity and stress reduction through chair massages, yoga classes, mindfulness exercises, walking clubs, and/or other exercise opportunities (from 7% to 64%). According to the progress reports, one SBHC in Georgia invited teachers to be part of an employee wellness

committee. Within months, the group was running an after-school walking club, a wellness night, a 30-day abdominal muscle/squat challenge, and twice-weekly on-campus Zumba classes (in which about half of the school staff participated). The SBHC also successfully advocated with district administrators to adopt employee wellness activities districtwide.

DISCUSSION

The Hallways to Health learning community aimed to expand the influence and impact of SBHCs beyond the health center walls. Over 4 years, the 13 coalitions reimagined how SBHCs, traditionally a more clinical intervention, can create a culture of health that permeates multiple dimensions of the learning environment. Their success resulted from deepening relationships with school partners and community collaborators, students, and families to advance a shared vision for health-promoting schools. They championed school policies that influenced school climate, and provided access to nutritious foods and physical activity, behavioral health and social service supports, and discipline policies. They led programs that supported both the student body and the school staff's social and emotional wellness. Ultimately, they strengthened their clinical services to reflect a growing understanding of social determinants' effects on health, well-being, and academic success. By taking active leadership in school wellness, the SBHCs increased awareness, visibility, support, and participation from staff, administrators, community members, and students.

SBHCs fit within other cross-disciplinary school wellness frameworks and initiatives that strive to improve student health and education outcomes[10] such as the Whole School, Whole Community, Whole Child model.[11] However, whereas other initiatives may create the structure and set the policy agenda for schools, the value of the Hallways to Health framework is the role of SBHCs in connecting youth to healthcare providers in the school, and in expanding their role outside of clinical services. SBHCs are ideally positioned to create sustainable school programs, protocols, and policies, including classrooms, cafeterias, teachers' lounges, and other campus spaces – ultimately seeking to create a culture of schoolwide health.

Limitations

There are some limitations to consider with these findings. The impact survey relied upon recall from the respondents to the beginning of the initiative. Most of the schools had some school health programs in place at the start of the initiative, and in some instances, the initiative exposed schools to additional wellness initiatives for collaboration. However, the evaluation did not specifically account for differences in baseline program implementation; thus, we cannot completely ensure that schools would not have implemented a new program without the Hallways to Health initiative. Additionally, findings from the 13 coalitions that participated in the learning community may not be generalizable to all schools with SBHCs. However, the results and themes that emerged may be valuable to schools and SBHCs interested in exploring ways to create or leverage school wellness infrastructures to improve healthy eating and active living, student social and emotional wellness, and school staff wellness.

IMPLICATIONS FOR HEALTH BEHAVIOR OR POLICY

At this critical time in our nation, following the devastating impact of the COVID-19 pandemic, SBHCs are recognized as an important partner to address the growing physical and social-emotional needs of students and school staff. As demonstrated through Hallways to Health, SBHC staff, school employees, and community members can work collaboratively to assess student physical and mental health needs and develop and implement school policies and programs that increase access to nutritious foods, physical activity, and behavioral health supports. Based on the Hallways to Health initiative's experiences and lessons learned, we recommend the following actions or education and health policymakers and practitioners.

Implement Hallways to Health to Achieve *Healthy People 2030* Goals

Healthy People 2030 establishes goals for communities and for schools.[12] Several of these goals align with Hallways to Health, and the results of this paper demonstrate how they can be achieved through collaboration between SBHCs, schools, and community agencies.

Strive for Healthy People 2030 goals related to student healthy eating and active living. As described in the results, Hallways to Health helped schools strive towards the *Healthy People 2030* goals to increase the proportion of students participating in school breakfast programs (AH-04),[13] the proportion of schools that do not sell less healthy foods and drinks (developmental ECBP-DO2),[14] and adolescents who participate in daily school physical education (ECBP-01).[15] Hallways to Health schools provided increased participation in school breakfast programs, increased access to nutritious food and safe drinking water, limited the availability of less healthy foods, and guaranteed activity, play, and recreation opportunities.

Strive for Healthy People 2030 goals related to student social and emotional wellness. As described in the results, Hallways to Health helped schools strive towards the *Healthy People 2030* goal to increase the proportion of children and adolescents who get preventive mental healthcare in school (developmental EMC-DO6).[16] The Hallways to Health SBHCs improved outreach and successfully created opportunities for students to practice skills for mental health. More were able to institute clinical behavioral health assessments and screenings, provide counseling and support services, and advocate for discipline policies that employ therapeutic approaches such as restorative justice instead of suspension and expulsion. By serving the school population, SBHCs built bridges in the schools that led to a healthier school environment for student mental health.

Strive for Healthy People 2030 goals related to school employee wellness. Investment in school employee wellness is an essential strategy for school wellness, as demonstrated in the *Healthy People 2030* developmental goal of increasing the proportion of worksites that offer an employee health promotion programs (ECBP-DO3).[17] The impact of professional development and wellness programs on employee recruitment, morale, retention, and productivity has been documented.[18] School administrators, teachers, and staff may face physical inactivity, poor eating, and stress-related health problems, particularly now, given the need to adapt to the stresses of the COVID-19 pandemic. Through Hallways to Health, SBHCs showed that staff, school employees, and community members can work collaboratively to adopt school employee wellness protocols, school-based policies, and programs to support employee wellness programs.

Expand the role of SBHCs in School and Community Collaboration

Hallways to Health explored the expanded role SBHCs can play in organizing and implementing schoolwide policy and programmatic change related to healthy eating, active living, and student and staff social and emotional wellness. Adopting a population-level lens enables SBHCs to collaborate with their education and community partners to address students' complex health and wellness needs, engage and motivate them in their academic pursuits, and provide the support of caring, nurturing adults.

SBHCs can facilitate schoolwide health and wellness changes. To collaborate successfully with schools, the SBHCs found it helpful to have the structure of the Hallways to Health learning community framework. The SBHCs first formed teams consisting not only of SBHC staff, but also members of the school administration, school staff, and community partners. With the guidance and motivation from the SBHA, these coalitions undertook environmental scans to assess and identify the health needs and priorities of students and school staff and develop goals and objectives. As dissemination and implementation science frameworks suggest,[19] the Hallways to Health learning community framework was useful because it helped guide the coalitions in their planning and implementation of selected strategies. With this common vision and approach, the SBHCs helped facilitate these important changes in the school environment.

Schools without an SBHC can apply the lessons learned from Hallways to Health. Examples of successful school district wellness policies and Hallways to Health wellness policies are in the Hallways to Health Toolkit[20] that provides instructions on implementing and replicating lessons learned. School staff can learn in the toolkit how to establish a coalition of school and community partners, establish shared priorities, discuss timelines and probable challenges, and identify additional resources. All these strategies can lead to successful integration between school and community

partners, and to development of sustainable programs, protocols, and policies to improve student and school staff health and well-being. School or district-level leaders can advocate for new SBHCs, or form coalitions of school and community stakeholders to replicate Hallways to Health in schools with no SBHCs.

Prioritize Funding and Supportive Policies for SBHCs

The need for federal and state investment in SBHCs has only increased due to the COVID-19 pandemic. Federal and state policymakers must prioritize SBHC funding and supportive policies. To support schools' growing need for student mental health and primary healthcare, the following strategies could help SBHCs work towards improved schoolwide health and wellness.

Ensure that telehealth reimbursement continues. During the COVID-19 pandemic, SBHCs have increased telehealth use, reducing unnecessary in-person visits while allowing access to continuous care for students who would typically utilize the SBHC. Changes made in 2020 to increase state authority and flexibility for telehealth reimbursement should be made permanent to ensure that this funding stream remains viable for SBHCs, even after the pandemic. States should remove as many barriers to the utilization of telehealth in Medicaid as possible, particularly those that impede access for children and adolescents, such as restrictions to audio/video communication and the ability of FQHCs to serve as distant site providers.

National and state-level support of schoolwide health frameworks. SBHCs sit at the intersection of health and education and should be supported so that they can work to address gaps in population health. At the national level, organizations such as the Centers for Disease Control and Prevention, and professional organizations representing education sectors, can promote Hallways to Health and other schoolwide frameworks to create systemic conditions that promote student and staff wellness. State departments of education as well as SBHC associations also can help SBHCs to build coalitions of stakeholders to lead school health and wellness efforts. They can take on the facilitation role that the SBHA played with Hallways to Health, to create and nurture teams of SBHCs to work towards schoolwide health and wellness changes. In fact, after Hallways to Health, several state SBHC associations invited the SBHA staff to present the model and lead workshops on replicating the model.

SBHCs need dedicated federal and state funding streams. Whereas there is no dedicated federal funding for SBHCs, some benefit from federally funded programs within the Health Resources and Services Administration (HRSA), including the Section 330 Health Center Program. More than half of SBHCs partner with a federally qualified health center (FQHC) to serve as their medical sponsoring institution – providing clinical staff, professional liability insurance, and billing services. Many of these SBHCs benefit from federal discretionary funding for the Health Center Program and the higher reimbursement rate for services that FQHCs receive under Medicaid. However, dedicated federal SBHC funding, regardless of medical sponsor type, would provide valuable support. In addition, more states need to dedicate funding to SBHCs and increase overall funding amounts each year. Fewer than 20 states allocate dedicated funds to support SBHCs. These investments range from $500,000 to $20 million and are subject to annual budget cuts.[21] State health and education leaders should continue to advocate for the expansion of and continual support of SBHCs. Each state with SBHCs should have a state SBHC association to advance the mission and vision of the SBHA, and to build a comprehensive movement to support and strengthen the school-based healthcare model.

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Human Subjects Approval Statement

This evaluation was exempt from human subjects review.

Conflict of Interest Disclosure Statement

All authors of this article declare they have no conflicts of interest.

References

1. School-Based Health Alliance. School-Based Health Alliance Statement on Re-opening School Buildings. https://sbh4all.org/2020/07/school-based-health-alliance-statement-on-re-opening-school-buildings. Published July 2020. Accessed December 12, 2020.
2. Love H, Schlitt J, Soleimanpour S, Panchal N, Behr C. Twenty years of school-based health care growth and expansion. *Health Aff (Millwood).* 2019;38(5):755-764. doi: org/10.1377/hlthaff.2018.05472
3. Love H, Panchal N, Schlitt J, Behr C, Soleimanpour S. The use of telehealth in school-based health centers. *Glob Pediatr Health*. 2019;6:1-10. doi: org/10.1177/2333794X19884194
4. Knopf JA, Finnie RK, Peng Y, Hahn RA, Truman BI, Vernon-Smiley M, et al. School-based health centers to advance health equity: a community guide systematic review. *Am J Prev Med.* 2016;51(1):114-126. doi: org/10.1016/j.amepre.2016.01.009
5. Keeton V, Soleimanpour S, Brindis CD. School-based health centers in an era of health care reform: building on history. *Curr Probl Pediatr Adolesc Health Care.* 2012;42(6):132-156; discussion 157-138. doi: org/10.1016/j.cppeds.2012.03.002
6. Strolin-Goltzman J, Sisselman A, Melekis K, Auerbach C. Understanding the relationship between school-based health center use, school connection, and academic performance. *Health Soc Work.* 2014;39(2):83-91. doi: org/10.1093/hsw/hlu018
7. *Institute for Healthcare Improvement (IHI). Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement.* Boston, MA: IHI; 2003.
8. Stata-Corp. *Stata Statistical Software: Release 15.* College Station, TX: StataCorp LP; 2017.
9. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. the Adverse Childhood Experiences (ACE) Study. *Am J Prev Med.* 1998;14(4):245-258. doi: org/10.1016/s0749-3797(98)00017-8
10. Kolbe LJ. School health as a strategy to improve both public health and education. *Annu Rev Public Health*. 2019;40(1):443-463. doi: org/10.1146/annurev-publhealth-040218-043727
11. US Centers for Disease Control and Prevention. Whole School, Whole Community, Whole Child (WSCC). https://cdc.gov/healthyschools/wscc/index.htm. Published March 21, 2021. Accessed March 23, 2021.
12. US Department of Health and Human Services. Healthy People 2030. Social Determinants of Health. https://health.gov/healthypeople/objectives-and-data/social-determinants-health. Published 2020. Accessed October 29, 2021.
13. US Department of Health and Human Services. Healthy People 2030. School Breakfast Program. https://health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating/increase-proportion-students-participating-school-breakfast-program-ah-04. Published 2020. Accessed April 1, 2021.
14. US Department of Health and Human Services. *Healthy People 2030.* Increase the proportion of schools that don't sell less healthy foods and drinks – ECBP-D02. https://health.gov/healthypeople/objectives-and-data/browse-objectives/schools/increase-proportion-schools-dont-sell-less-healthy-foods-and-drinks-ecbp-d02. Published 2020. Accessed April 1, 2021.
15. US Department of Health and Human Services. Healthy People 2030. Daily School Physical Education. https://health.gov/healthypeople/objectives-and-data/browse-objectives/schools/increase-proportion-adolescents-who-participate-daily-school-physical-education-ecbp-01. Published 2020. Accessed April 1, 2021.
16. US Department of Health and Human Services. Healthy People 2030. Preventive Mental Health Care in Schools. https://health.gov/healthypeople/objectives-and-data/browse-objectives/children/increase-proportion-children-and-adolescents-who-get-preventive-mental-health-care-school-emc-d06. Published 2020. Accessed April 1, 2021.
17. US Department of Health and Human Services. Healthy People 2030. Prevention and Health Promotion. Employee Health Promotion. https://health.gov/healthypeople/objectives-and-data/browse-objectives/workplace/increase-proportion-worksites-offer-employee-health-promotion-program-ecbp-d03. Published 2020. Accessed April 1, 2021.
18. National Association of Chronic Disease Directors (NACDD). 2018. *Healthy School, Healthy Staff, Healthy Students. A Guide to Improving School Employee Wellness*. Decatur, GA: NACDD; 2018. https://chronicdisease.org/healthy-school-staff-students-a-guide-to-improving-school-employee-wellness. Published 2018. Accessed October 29, 2021.
19. Moullin, J., Dickson, KS, Stadnick, NA, Albers B, Nilsen P, Broder-Fingert S, et al. Ten recommendations for using implementation frameworks in research and practice. *Implement Sci Commun.* 2020;1:42. doi: org/10.1186/s43058-020-00023-7
20. Snyder J, Duncan N, Shore A. Hallways to Health: Creating a School-wide Culture of Wellness. School-Based Health Alliance website: https://tools.sbh4all.org/hallways-to-health/hallways-to-health-home/. Published June 19, 2018. Accessed December 12, 2020.
21. School-Based Health Alliance. School-Based Health Care: State Policies and Funding, FY 2017. http://sbh4all.org/school-health-care/aboutsbhcs/school-based-health-care-state-policy-survey. Published 2017. Accessed December 12, 2020.