Date of Hearing: April 24, 2024

ASSEMBLY COMMITTEE ON EDUCATION
Al Muratsuchi, Chair
AB 2052 (Jones-Sawyer) – As Amended April 8, 2024

[This bill is double referred to the Assembly Health Committee and was heard by that Committee as it relates to issues under its jurisdiction.]

SUBJECT: School-Based Health and Education Partnership Program

SUMMARY: Updates and expands current law related to the School-Based Health Center Support Program (Program) to provide technical assistance; funding for the expansion, renovation, and retrofitting of existing school-based health centers (SBHCs); and the development of new SBHCs; and increases the level of funding for the grants to plan and implement SBHCs, contingent upon funding being appropriated for this purpose. Specifically, **this bill**:

1) Updates existing statutory language which requires the California Department of Public Health (CDPH) to establish the Program to provide technical assistance, and funding for the expansion, renovation, and retrofitting of existing SBHCs and the development of new SBHCs, contingent upon funding being appropriated for this purpose.

2) Requires the California Department of Education's (CDE) Office of School-Based Health to work with the CDPH to support the Program.

3) Requires the Office of School-Based Health Programs in the CDE to coordinate programs within the CDE supporting SBHCs, including technical assistance to local education agencies (LEAs) in establishing, retaining, and expanding SBHCs.

4) Updates the requirements for CDPH, in consultation with the CDE, in performing the following functions:

    a) Providing technical assistance to SBHCs on effective outreach and enrollment strategies to identify children eligible for, but not enrolled in, health insurance affordability programs for children;

    b) Serving as a liaison to organizations within the CDPH, including those relating to health equity, oral health, and behavioral health; and

    c) Providing technical assistance to SBHCs in identifying funding sources including state demonstration projects or incentive programs;

5) Authorizes the CDPH to enter into a contract with an entity that coordinates the efforts of SBHCs to provide assistance to SBHCs that receive grant funding and requires the entity to perform the following:

    a) Provide technical assistance and community-specific ongoing training to SBHCs, school districts, and LEAs;

b) Assist SBHCs in improving business practices, including, but not limited to, practices related to billing and efficiencies;

c) Assist SBHCs in expanding their relationships with coordinated care organizations, sponsors of medical care for schoolage children, and other community-based providers of school-based health and mental health services; and

d) Facilitate the integration of health and education policies and programs at the local level.

6) Requires the CDPH to consult with interested parties and appropriate health and education stakeholders, including the California School-Based Health Alliance as well as youth and parents.

7) Clarifies that SBHCs are required to report data, as specified, to the CDPH only when state funding is provided to SBHCs under this Program.

8) Updates the requirements that SBHCs receiving grant funds under the Program meet, including the following:

a) Provide primary medical care and may also include other health care services, including behavioral health, dental care, health education, and related services;

b) Strive to provide a comprehensive and integrated set of health care services, provided or supervised by licensed or credentialed professionals;

c) Add substance use disorder services to the list of services that may be provided by SBHCs, including education, prevention, screening, early interventions, counseling, and referral to treatment;

d) Strive to address the population health of the entire school campus by focusing on prevention services, including but not limited to, group and classroom education, schoolwide prevention programs, and community outreach strategies within the school's Multi-Tiered System of Support (MTSS) or other similar framework employed by the LEA;

e) Strive to provide integrated and individualized support for students and families and act as a partner with the student or family to ensure that health, social, or behavioral challenges are addressed; and

f) Strive to integrate the SBHC into the school or LEA's community school model, if applicable.

9) Beginning on January 1, 2026, increases the dollar value of planning grants to between $50,000 and $100,000, and extends the timeframe for expenditure to 24 months.

10) Beginning on January 1, 2026, increases the dollar value of facilities and start-up grants to between $300,000 and $850,000 per year for a three-year period and authorizes grant funds to be used for a mobile health unit in addition to the existing authorization to use the funds

for the design, retrofit, renovation, construction, or purchase of a facility, as well as for the purchase of medical equipment and supplies.

11) Requires that preference for facility and start-up grants be given to proposals that include a plan for cost sharing among LEAs, health providers, and community organizations, or that identify matching funding; and also requires that preference be given to proposals that include plans to provide integrated primary medical care and behavioral health services.

12) Beginning January 1, 2026, increases the dollar value for expansion grants to between $150,000 and $300,000 for up to a three-year period for the purpose of renovating and improving an existing SBHC or enhancing and expanding programming, including adding physical health, oral health, or behavioral health services; and requires that preference be given to proposals that increase access to comprehensive health services by adding staff or services, or expanding the facility.

13) Beginning January 1, 2026, provides ongoing sustainability grants in amounts between $150,000 and $300,000 per year for the purpose of operating a SBHC. Requires applicants for sustainability grants to meet all of the following criteria:

    a) Be eligible to become, or already be, an approved Medi-Cal provider;

    b) Have the ability and procedures in place to bill managed health care plans or county mental health plans, in addition to the current requirement to bill public insurance programs; and

    c) Seek reimbursement and have procedures in place to bill public and private insurance that covers students receiving services at the SBHC.

14) Requires the CDPH to award technical assistance grants, through a competitive bidding process, to qualified contractors to support grantees receiving grants under the Program.

15) Requires the CDPH, in collaboration with the CDE, to give preference for grant funding under the Program to SBHCs serving any of the following:

    a) Areas with a shortage of health professionals;

    b) Areas experiencing health disparities in child and adolescent access to primary care, behavioral health, preventative health, or oral health services;

    c) Schools in which more than 55% of the pupils enrolled are unduplicated pupils.

16) Defines the following terms:

    a) “Program” as the School-Based Health Center Support Program;

    b) “SBHC” as a student-focused health center or clinic that is located at or near a school or schools; is organized through school, community, and health provider relationships; provides age-appropriate, clinical health care services onsite by qualified health professionals; and may provide primary medical care, behavioral health services, or dental care services onsite or through mobile health or telehealth; and

c) "LEA" as a school, school district, charter school, or county office of education (COE), if the COE serves students in any of grades kindergarten through grade 12.

EXISTING LAW:

1) Requires the CDPH to establish the Program, in collaboration with the CDE, to perform specified functions relating to the establishment, retention, or expansion of SBHCs in California. (Health and Safety Code (HSC) 124174.2)

2) Requires the CDPH to provide technical assistance and funding to SBHCs, to the extent funds are appropriated for implementation of the Program. Provides for planning grants of $25,000 to $50,000; facilities and startup grants of $20,000 to $250,000; and sustainability and technical assistance grants of $25,000 to $125,000 per year. (HSC 124174.6)

3) Requires a SBHC receiving grant funds to meet, or have a plan to meet the following:

   a) Provide a comprehensive set of services, including medical, oral health, mental health, health education, and related services, in response to community needs;

   b) Provide primary and other health care services, provided or supervised by a licensed professional, which may include all of the following:

      i) Physical examinations, immunizations, and other preventive medical services;

      ii) Diagnosis and treatment of minor injuries and acute medical conditions;

      iii) Management of chronic medical conditions;

      iv) Basic laboratory tests;

      v) Referrals to and follow-up for specialty care;

      vi) Reproductive health services;

      vii) Nutrition services;

      viii) Mental health services, as specified; and

      ix) Oral health services that may include preventive services, basic restorative services, and referral to specialty services. (HSC 124174.6)

4) Requires grant funding preference to be given to the following schools:

   a) Those located in areas designated as federally medically underserved areas or in areas with medically underserved populations;

   b) Those with a high percentage of low-income and uninsured children and youth;

   c) Those with large numbers of limited English-proficient students;

d) Those in areas with a shortage of health professionals; and,

e) Those that are low-performing with Academic Performance Index rankings in the deciles of three and below. (HSC 124174.6)

5) Defines an SBHC, for purposes of the Program, as a center or program located at or near an LEA that provides age-appropriate health care services at the program site or through referrals, and may conduct routine physical, mental, and oral health assessments and provide referrals for any services not offered onsite. An SBHC may serve two or more nonadjacent schools or LEAs. (HSC 124174)

6) Defines an LEA as a school, school district, charter school, or COE. (HSC 124174)

7) Establishes the Office of School-Based Health at the CDE for the purpose of assisting LEAs regarding the current health-related programs under the purview of the CDE and requires the scope of the Office to include collaborating with the DHCS and other departments in the provision of school-based health services and assisting LEAs with information on and participation in specified school-based health programs. (Education Code (EC) 49419)

8) Requires the governing board of any school district to give diligent care to the health and physical development of pupils and authorizes it to employ properly certified persons to conduct this work. (EC 49400)

9) Requires the DHCS, in collaboration with the Department of Managed Health Care, to develop and maintain a multi-payer, school-linked statewide fee schedule for outpatient mental health or substance use disorder services provided to students 25 years of age or younger at or near a schoolsite and requires commercial health plans and Medi-Cal to reimburse school-linked providers at or above the published rates. (Welfare and Institutions Code (WIC) 5961.4)

FISCAL EFFECT: Unknown

COMMENTS:

This bill updates current law and increases the proposed funding levels for an existing program to support and expand SBHCs that has not been funded and thus has not been implemented. The implementation of this bill is contingent upon funding being appropriated for this purpose.

Need for the bill. According to the author, "The Public School-Based Health Center Support Program was established in 2009 and since then the number of school-based health centers in California has grown to 377 centers spread across 37 counties. School-based health centers provide accessible and integrated physical and behavioral health care services to students and their families, regardless of their ability to pay for health services, and have been proven to improve attendance, academic achievement, and aid in school climate.

In order to make sure these health centers are able to expand and continue serving students and communities, existing law needs to be cleaned-up and improved. AB 2052 will do so by requiring the Department of Public Health to coordinate with the Office of School-Based Health in the grant awarding and administration process. Additionally, this bill will update the

preference for grant funding to align with existing language in the Education Code and ensure that schools serving students with the greatest need are prioritized."

Wide range of health needs of children and adolescents. There are a multitude of health conditions impacting children and youth that may impact their school attendance and academic performance. Data from the Population Research Bureau (PRB) identifies the impacts and incidences of childhood conditions:

- More than 1.25 million California children and youth, have, or are at increased risk for, a chronic health condition and require care and related services of a type or amount beyond that required by children generally. Their ongoing health problems, physical, behavioral, or developmental, can affect their ability to function and participate in important educational and social activities and, in some cases, can shorten their lives. The vast majority of children with special health care needs nationally (86%) do not receive care that meets federal standards for a well-functioning system. Further, racial/ethnic and socioeconomic inequities in access to care and other supports can lead to poorer outcomes for vulnerable children and their families;

- Asthma is one of the most common chronic diseases among children in the U.S. and is the top reason for missed school days, accounting for more than 5.2 million absences annually. Asthma affects around 6 million children nationwide. Approximately 14.3% of children in California aged 1-17 years have been diagnosed with asthma, which can be life-threatening when it is not managed properly. The Centers for Disease Control and Prevention (CDC) estimates that approximately 40% of children with asthma do not have their disease under control. Children who face difficulty accessing quality health care are less likely to have well-controlled asthma; and

- Oral health affects overall health and is essential for healthy development. Tooth decay is the most common chronic disease and the greatest unmet health need among children in California and the U.S. Untreated dental problems such as cavities and gum disease can affect a child's health and quality of life by causing pain, loss of teeth, impaired growth, sleep and speech issues, self-confidence problems, poor school performance, and increased school absences, among other issues. Nationwide, children miss more than 51 million hours of school each year due to dental problems. In California, the disparity in oral health between low- and higher-income children is among the worst in the nation.

Youth mental health identified as a crisis. The American Academy of Pediatrics noted in recent guidance that "emotional and behavioral health challenges were of growing concern before the COVID-19 pandemic, and the public health emergency has only exacerbated these challenges." Prior to the pandemic, the incidence of youth mental health crises was increasing at an alarming rate. Suicide rates among youth ages 10-24 increased by over 57% between 2007 and 2018, and as of 2018 suicide was the second leading cause of death for youth ages 15-19, according to the CDC. Youth visits to pediatric emergency departments for suicide and suicidal ideation also doubled during this time period (Burstein, 2019).

Mental health issues are the number one reason that children in California are hospitalized. In 2002, 9% of all California child hospitalizations were for mental diseases and disorders; by 2022, this had risen to 19%. In 2022, California ranked 51st out of 50 states and D.C. for access to mental health care for children. (Children Now, 2024)

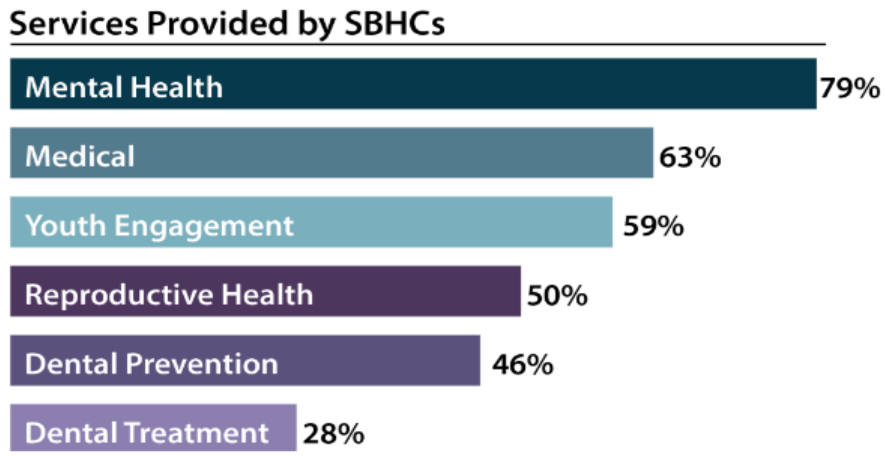
Linkages between health and educational outcomes. A factor contributing to the demand for increased capacity and collaboration between health and education agencies is the renewed and increasing recognition of the intrinsic connection between student health and academic outcomes. While the associations between physical health problems and school attendance, behavior, and academic achievement have been noted for decades, increasing attention is now being paid to the relationship between adverse childhood experiences (ACEs), student mental health, and academic outcomes. Research has demonstrated a strong association between ACEs and poor performance in school, including a higher risk of learning and behavior problems. Other research into the effects of chronic stress on children (often caused by ACEs), has identified a profound effect on the developing brain, which in turn affects school performance and behavior. This research has led to an increased focus on the provision of health services at schools and is promoting closer connections between health and education agencies.

What is a SBHC? According to the California School-Based Health Alliance:

SBHCs offer a range of health services, with the most common being primary medical services. Many SBHCs play an important role in managing students' chronic illnesses, such as asthma and diabetes, and in responding to acute injuries or illness on campus. Some SBHCs in secondary schools offer reproductive health services, such as abstinence counseling, pregnancy prevention, and sexually transmitted disease (STD) testing and treatment. Other services provided by SBHCs include dental care, mental health counseling, and youth development programs.

SBHCs are uniquely situated to bring healthcare professionals and educators together to address the multifaceted needs of children, youth, and families. Some SBHCs serve only students, while others also serve family members or the broader community surrounding the school. SBHCs provide a safe place for students and family members to talk about challenging issues (depression, behavior problems, academic performance, substance abuse, sexuality or relationships, etc.). The unique value of SBHCs is that they can connect medical services and mental health services to classroom health education, group interventions, and other campus

SBHCs respond to the needs of the schools and communities they serve. Local school boards give final approval to the services provided by the SBHC. According to the California School-Based Health Alliance, SBHCs in California offer a variety of services as shown in the chart below:



Source: California School-Based Health Alliance

SBHCs may be operated by different entities, including the following:

- 52% by federally qualified health centers;
- 27% by school districts; and
- 22% by other agencies, including hospitals or local health departments.

How many SBHCs are there in California? According to the California School-Based Health Alliance, while there are over 10,000 schools in California, there are 377 SBHCs, up from 108 in 2000. These SBHCs are spread throughout the state, with high concentrations in Los Angeles and the San Francisco Bay Area. They tend to be located in schools with higher concentrations of low-income Latino and African American students. Most of California's SBHCs are physically located on campus within a main building or in a portable. In some areas, health services are provided by mobile medical or dental vans, and in other areas, "school-linked" health centers are off campus and have formal operating agreements with schools.

Disproportionate access to SBHCs. Currently, 70% of students attending schools with an SBHC are socioeconomically disadvantaged. The SBHCs reduce health disparities for these students by increasing access to comprehensive health care, and may also improve educational equity by reducing missed school days due to illness, often disproportionately experienced by low-income students and students of color.

As noted above, the current SBHCs in California are largely concentrated in large urban areas. The California School-Based Health Alliance recently released the *Student Health Index,* focusing on the need to support more SBHCs across the state to reach students facing the greatest health and education disparities.

The Student Health Index is made up of 12 indicators that characterize population characteristics and healthcare access and combines the component scores into a need score, based upon data from a variety of sources, including the American Community Survey, the U.S. Census Bureau, the CDE, the CDC, and institutions of higher education.

Over 8,000 schools serving pupils in kindergarten through 12th grade and having over 100 pupils were included in the initial analysis. Further analysis focused on schools with large enough populations to warrant the construction of an SBHC, so additional schools were excluded including small rural schools and urban high schools with enrollments under 1,000 students. The final list includes 4,752 urban schools and 69 rural schools.

The indicators used in the student health index include the following:

- Health: diabetes rates, asthma admissions, teen birth rates, health professional shortage areas;
- Socio-economic: poverty among children and youth, lack of insurance coverage, healthy places index; and
- School: % free and reduced lunch, % English learners, % homeless, chronic absenteeism, suspension rate.

Currently, the counties with the greatest number of SBHCs are Los Angeles (38), Alameda (15), and Santa Clara (10). 23 counties have no SBHCs. Based upon the analysis conducted, the study concludes that San Bernardino, Fresno, San Joaquin, Kern, Riverside, and Los Angeles Counties all have over 100 schools, and more than 25% of those schools have the highest relative need level. The majority of the top ten districts with the highest need are located inland, in the Central Valley and southern counties east of Los Angeles and San Diego.

These factors will be important considerations in determining the feasibility of constructing or expanding SBHCs in high need locations. In some cases, telehealth options or mobile health clinics may be better suited to meet a school's and community's needs.

SBHCs are funded through a variety of funding streams. The existing SBHCs in California are financed through:

- Reimbursement for services through Medi-Cal and contracts for mental health services;
- School district contributions and in-kind support of space, nurses, utilities, and custodial services;
- Sponsoring agency contributions or subsidies; and
- Federal government and private grants.

Despite having had statutory authorization to establish SBHCs in California since 2006, California has not provided any state funds to establish or expand SBHCs.

Arguments in support. The California School-Based Health Alliance, a co-sponsor, writes, "The Public School Health Center Support Program was established in 2009 to oversee grant awards for the establishment, expansion, and operational sustainability of SBHCs. Despite its 15-year existence, the Program has never seen an appropriation to fund the awarding of grants. With recent historic investments by the state of California in child and youth well-being, CSHA has identified areas of alignment and improvement for the Program to build upon the momentum generated by these investments.

SBHCs and wellness centers (WCs) provide accessible and integrated physical and behavioral health services to students and their families regardless of ability to pay. For many students, SBHCs/WCs may be the only way they can receive quality health care. Beyond the obvious health benefits, SBHCs/WCs have led to improved academic outcomes for students including better attendance rates and school climate. A study conducted by The Los Angeles Trust for Children's Health in 2021 showed that a student's attendance improved by an average of five days per school year following services at an SBHC/WC. Increased attendance by students due to less days missed for illness translates to better school funding to be invested back into students. California's children and youth deserve access to quality care where they are – in school."

Arguments in opposition. Moms for Liberty Placer County writes, "It is not the school's role and responsibility to provide and oversee healthcare in schools. Spending millions of taxpayer dollars to insert more government control and increasing mental health services in schools needs to stop. This is another attempt to strip away parental rights and involvement with our children.

Stop trying to manipulate students, pad special interest pockets and sway California taxpayers to advance the WSCC Community Schools agenda.

It is not the governments job to provide increased access to any mental health services in schools. For students that may want or need any mental health support services, leave it up to the parents, guardians and community to come together and meet that need. The state of California's budget is in a serious deficit. Adding more money to a program that should have never been allowed in education needs to be severed."

Related legislation. AB 912 (Jones-Sawyer) of the 2023-24 Session would have provided for the establishment, expansion, and funding for early-violence-intervention programs, school-based physical and mental health services, and youth-recreational activities, contingent upon an appropriation. This bill was vetoed by the Governor with the following message, which read:

> While I appreciate the author's commitment to early interdiction and violence reduction efforts, this bill creates new additional cost pressures and must be considered in the annual budget in the context of all state funding priorities.
>
> In partnership with the Legislature, we enacted a budget that closed a shortfall of more than $30 billion through balanced solutions that avoided deep program cuts and protected education, health care, climate, public safety, and social service programs that are relied on by millions of Californians. With our state facing continuing economic risk and revenue uncertainty, it is important to remain disciplined when considering bills with significant fiscal implications, such as this measure. For this reason, I cannot sign this bill.

AB 1940 (Salas) of the 2021-22 Session would have updated current law requiring the CDPH to establish the SBHC Support Program, contingent upon funding being appropriated for this purpose, to provide technical assistance, and funding for the expansion, renovation, and retrofitting of existing SBHCs and the development of new SBHCs, and increases the level of funding for the grants to plan and implement SBHCs. This bill was vetoed by the Governor with the following message:

> I appreciate the author's effort to modernize the existing Public School Health Center Support Program and their intent to increase access to physical and behavioral health services for students. SBHCs are vital tools to address the significant disparities in both health and educational outcomes for our state's children and youth. However, I have concerns this bill could create significant one-time Proposition 98 General Fund cost pressures in the tens of millions of dollars to fund the SBHC Support Program, and ongoing General Fund costs in the millions of dollars for CDPH to administer the program that were not included in the budget.
>
> With our state facing lower-than-expected revenues over the first few months of this fiscal year, it is important to remain disciplined when it comes to spending. We must prioritize existing obligations and priorities, including education, health care, public safety and safety-net programs. The Legislature sent measures with potential costs of well over $20 billion in one-time spending commitments and more than $10 billion in ongoing commitments not accounted for in the state budget. Bills with significant fiscal impact, such as this measure, should be considered and accounted for as part of the annual budget process. For these reasons, I cannot sign this bill.

SB 118 (Liu) of the 2015-16 Session would have modified an existing unfunded grant program administered by the CDPH to add substance use as an allowable service, changed the purpose of sustainability grants to the development of sustainable funding models, and created a new population health grant category to fund specified public health topics. This bill was held in the Assembly Appropriations Committee.

AB 766 (Ridley-Thomas) of the 2015-16 Session would have required the CDPH to give grant funding preference to schools with a high percentage of students enrolled in Medi-Cal, under the Public School Health Center Support Program. This bill was held in the Senate Appropriations Committee.

SB 1055 (Liu) of the 2013-14 Session would have renamed the Public School Health Center Support Program the School-Based Health and Education Partnership Program; made changes to the requirements and funding levels; and created a new type of grant to fund interventions related to obesity, asthma, alcohol and substance abuse, and mental health. This bill was held on the Senate Floor.

SB 564 (Ridley-Thomas) Chapter 381, Statutes of 2008, specified that an SBHC may conduct routine physical health, mental health, and oral health assessments and provide for any services not offered onsite or through a referral process. The bill also required CDPH, to the extent funds are appropriated for implementation of the Public School Health Center Support Program, to establish a grant program to provide technical assistance and funding for the expansion, renovation, and retrofitting of existing SBHCs and the development of new SBHCs in accordance with specified procedures.

AB 2560 (Ridley-Thomas) Chapter 334, Statutes of 2006, required the DHCS, in cooperation with CDE, to establish the PSHCSP to perform specified functions relating to the establishment, retention, or expansion of SBHCs; required DHS to establish standardized data collection procedures and collect specified data from SBHCs on an ongoing basis; required CDE, in collaboration with DHS, to coordinate programs within CDE and programs within other specified departments to support SBHCs and to provide technical assistance to facilitate and encourage the establishment, retention, and expansion of SBHCs; and required the program to provide a biennial update to the appropriate policy and fiscal committees of the Legislature containing specified information regarding SBHCs, beginning on or before January 1, 2009.

SB 566 (Escutia) of the 1999-2000 Session would have established the SBHC Grant Program, to be administered by DHCS, to provide grants to qualifying SBHCs in order to assist the centers in providing health services to students, provided that funds were appropriated in the annual Budget Act. This bill would also have required DHCS to convene a study group to explore long-term strategies to support SBHCs and incorporate these centers into a comprehensive and coordinated health care system. This bill was held on the Senate Floor.

REGISTERED SUPPORT / OPPOSITION:

Support

Alameda County Office of Education
California School-Based Health Alliance
Kern County Superintendent of Schools Office
Teens for Vaccines

The Los Angeles Trust for Children's Health
Voters of Tomorrow
1 individual

Opposition

Moms for Liberty Placer County

Analysis Prepared by: Debbie Look / ED. / (916) 319-2087