Date of Hearing: April 27, 2022

ASSEMBLY COMMITTEE ON EDUCATION
Patrick O'Donnell, Chair
AB 1940 (Salas) – As Amended March 17, 2022

[This bill was 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 Center Support Program

SUMMARY: Updates current law requiring the State Department of Public Health (CDPH) to establish the School-Based Health Center Support Program (Program), contingent upon funding being appropriated for this purpose, to provide technical assistance, and 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. Specifically, **this bill**:

1) Updates existing statutory language requiring the 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 that SBHCs receiving grant funds under the Program meet specified requirements, including:

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

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

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

    d) Striving 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) Striving 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) Striving to integrate the SBHC in the school or LEA's community school model, if applicable.

4) States that it is not the intent of the Legislature that a SBHC serve as a substitute for a school nurse employed by a local educational agency (LEA).

5) Increases the dollar value of planning grants from a range of $25,000 to $50,000 to $50,000 to $100,000, and extends the timeframe for expenditure to 24 months; and adds a requirement to collect data on the percentage of students eligible for private health care coverage benefits during the planning process.

6) Requires the applicant for planning grants to have a letter of interest from an LEA if the applicant is not an LEA.

7) Increases the dollar value of facilities and start-up grants to between $300,000 and $850,000 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.

8) 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.

9) Requires applicants for facility and start-up grants to have a contract or memorandum of understanding (MOU) between the LEA and the health care provider, if other than the LEA, and any other provider agencies, among other requirements.

10) Changes the term "sustainability grants" to "expansion grants", and increases the dollar value to between $150,000 and $300,000 for up to a three-year period for these grants, 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.

11) Adds the following to the existing requirements that an LEA must meet, to be eligible for an expansion grant:

    a) Have the ability and procedures in place to bill managed health care plans or county mental health plans; and

    b) Develop a plan to sustain expanded services after the grant period.

12) Requires the CDPH, in collaboration with the CDE's Office of School-Based Health, to determine which proposals receive grant funding; and requires the CDPH to give preference to SBHCs serving any of the following:

    a) Areas designated as federally medically underserved areas with medically underserved populations or 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; and

c) Schools in which more than 50% of pupils are unduplicated pupils, as defined.

13) Adds findings and declarations regarding the purpose and value of SBHCs, and expresses the intent of the Legislature to support existing, and expand the number of, SBHCs in California by placing funds within the Program.

14) Defines the following terms:

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

b) "School-based health center (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) "Local educational agency (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 Public School Health Center Support Program (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) Establishes a grant program administered by 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, as specified. (HSC 124174.6)

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

a) Strive to 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 a LEA that provides age-appropriate health care services at the program site or through referrals, and may conduct routine physical, mental health, and oral health assessments, and provide referrals for any services not offered onsite. A school health center may serve two or more nonadjacent schools or LEAs. (HSC 124174)

6) Defines a "LEA" as a school, school district, charter school, or county office of education. (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)

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 was never funded, and thus has not been implemented. The implementation of the proposal is contingent upon funding being appropriated for this purpose. The author indicates that he is requesting $100 million in one-time funding for planning, facilities and start-up, and expansion grants as required under this bill.

Need for the bill. According to the author, "SBHCs help our underserved families and children access preventative, primary, and behavioral health care. These centers have become an important part of the health care safety net, especially at a time when many of our families in rural areas are experiencing barriers to care. AB 1940 lays the framework for state funding that will grow and strengthen our SBHCs, and will go a long way to addressing the significant disparities in child and youth health and education outcomes."

Youth mental health crisis intensifying as a result of the COVID-19 pandemic. 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 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 Centers for Disease Control and Prevention (CDC). Youth visits to pediatric emergency departments for suicide and suicidal ideation also doubled during this time period (Burstein, 2019).

Since the pandemic began, rates of psychological distress among young people, including symptoms of anxiety, depression, and other mental health disorders, have increased. During 2020, the proportion of mental health-related emergency visits among adolescents aged 12-17 years increased 31% compared with during 2019. In early 2021, emergency department visits in the U.S. for suspected suicide attempts were 51% higher for adolescent girls and 4% higher for adolescent boys compared to the same period in 2019 (Yard, 2021).

Wide range of health needs of children and adolescents. In addition to behavioral health issues, 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 (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.

Many children are not receiving adequate medical services. A 2018 report by the California State Auditor on the oversight of the delivery of preventative services to children enrolled in the Medi-Cal program found that millions of children do not receive the preventative services to which they are entitled. The report notes that California ranks 40th for all states in providing preventative health services to children, and further states

According to the U.S. Centers for Disease Control and Prevention, preventive services significantly reduce the risk of illness, disability, early death, and expensive medical care while providing cost savings. In 2014 the American Academy of Pediatrics published a national report stating that the vaccination of 4.3 million children, a key preventive health service, would prevent approximately 42,000 deaths and 20 million cases of disease, with a net savings of nearly $14 billion in direct costs and $69 billion in total societal costs. A 2015 report published by the National Bureau of Economic Research on the long-term impact of Medicaid expansion analyzed increases in Medicaid spending caused by the expansions and the government's return on investment. The report found that the government recoups its investment in a child's preventive care by age 36 through additional tax payments, and preventive services result in the government earning a 550 percent return on investment by age 60.

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 school-based health center (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 STD/HIV testing and treatment. Other services provided by SBHCs include dental care, mental health counseling, and youth development programs.
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> SBHCs are uniquely situated to bring health care 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 projects, clubs or activities.

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, common services provided by SBHCs in California, and the percentage of SBHCs offering them, include:

- Medical services 85%;
- Mental health services 70%;
- Reproductive health 60%;
- Dental prevention 65%;
- Dental treatment 35%; and
- Youth engagement programs 51%.

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 only 293 SBHCs, distributed as follows:

- 39% in high schools;
- 21% in elementary schools;
- 10% in middle schools; and
- 25% are "school linked" or mobile medical vans.

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 health care 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 construction of a 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 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 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, sponsor of the bill, notes "The SBHC Program has existed in statute since 2007 yet has never been implemented due to a lack of funding. It is time for this program to be updated and funded to address the state's goals to improve educational outcomes and improve health outcomes at a reduced cost. School-based health centers provide quality, age and developmentally appropriate comprehensive health care and other support services on or near a public school campus. School-based health centers are primarily located in areas where children are underserved, experience health and education disparities, and face significant barriers to care. Including a school-based health center on or near a school campus increases a student's access to care, reduces health disparities, and provides potential savings through better preventative care and reduces emergency department utilization, drug utilization, and inpatient treatment services. Children do better in school if they are healthy and have received all of their immunizations and preventive annual exams. School-based health centers support educational achievement, help increase attendance rates, and address the whole-child needs of students. Despite the effectiveness of school-based health centers and the awareness that students are best supported with access to health care and supportive services in schools, California has never provided state funding for school-based health centers. Given the growing recognition to address student health needs, now is the time to invest in a proven strategy."

Arguments in opposition. The Right to Life League writes, "The bill modifies aspects of the Health and Safety Code to authorize these school-based health centers to provide primary medical care that includes reproductive health services…through mobile health or telehealth." Reproductive health services is code for abortion. Accordingly, this bill will provide direct state funding for school-based health centers providing abortion and birth control services to children on school campuses throughout the state. For these reasons we oppose AB 1940 unless amended to remove the phrase "reproductive health services" throughout the bill."

Related legislation. 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 the1999-2000 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 also would 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

California School-based Health Alliance (Sponsor)
Access Reproductive Justice
Association of California Healthcare Districts
Bustest Express by Storer

California Dental Association
California School Nurses Organization
Children Now
Community Clinic Association of Los Angeles County
Fred Finch Youth Center
National Center for Youth Law
The California Children's Trust
The Los Angeles Trust for Children's Health
One individual

Opposition

Right to Life League

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