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School-based Health Centers in High Poverty Schools

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School-based Health Centers in High Poverty Schools

by

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A graduate project report submitted in partial fulfillment
of the requirements for the degree of
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ABSTRACT

This capstone project was part of a team project completed by two school principals in Hillsborough County, Florida. The project began because of our passion for meeting the needs of our students in urban high poverty schools being supported by varying district turnaround initiatives. We looked at our district's previous and current attempts to increase student success in high poverty schools. We questioned the ways in which supports and resources were provided, and we explored ways through which success in high poverty schools might be increased by redefining the supports and resources provided. Our appreciative exploration of the topic was guided by the question, what successful examples of services and supports have contributed to an increase in success for students in high poverty schools? Considering that the majority of SBHCs exist in schools with high poverty rates, I was interested in what services were provided and how accessible they were. I looked for literature using the following keywords: wrap around services, school based health centers, health and student achievement.

School-Based Health Centers improve access to healthcare, which can help to identify and address health risk behaviors and contribute to more stable attendance at school. More instructional seat time can contribute to improved academic outcomes. The preventative role played by SBHCs can reduce barriers to learning, such as treating undiagnosed mental and physical illnesses. School-Based Health Centers provide wraparound services so that issues impacting students such as obesity or asthma can be addressed on a school's campus where key mental health, medical and school professionals can collaborate to meet the needs of students..

SECTION 1. INTRODUCTION

Children from low-income families who have their social-emotional needs met will be more likely to become proficient readers, succeed in other academic areas, and graduate from high school ready to succeed in college and in careers. The dropout rate for students who spend at least a year in poverty and do not read proficiently is higher for Black and Hispanic students (31% and 33%) than white students (22%).

Increasing the success rate of students (in urban high poverty schools) as evidenced by standardized testing data, discipline data and district level attendance reports is critical. In order to inspire action, principals need to see district leadership openness regarding time needed to implement change and autonomy from district level supervisors and personnel. They need to feel supported in decision making, allocation of resources, and delivery/instructional models.

This capstone project was part of a team project completed by two elementary school principals in Hillsborough County, Florida. The project began because of our passion for meeting the needs of our students in urban high poverty schools that were being supported by varying district turnaround initiatives. We looked at our district's previous and current attempts to increase student success in high poverty schools. We questioned the ways in which supports and resources were provided.

Our appreciative exploration of the topic was guided by the question, what successful examples of services and supports have contributed to an increase in success for students in high poverty schools?

Personal focus. I have been principal of an Elementary School since 2005. The school is a Title I school located in Seffner, FL. Its students come from surrounding neighborhoods, mostly low income apartment buildings, a few areas with standard homes, and several trailer parks. One trailer park development so large that it takes three busses to collect all of the students who reside there. There is also a small contingency of technically homeless students who live in a motel about two miles from the school.

The school's demographics have changed a lot over the last 10 years. In 2005, Hispanic students were less than 10% of the student population of the school, and the African American percentage was even smaller. Currently, Hispanics (40%) and African American students (24%) make up the majority of the student population.

I came to the principalship through many leadership roles as a teacher (team leader, writing resource teacher, Title I Lead Teacher, and Mentor Teacher) and then as Assistant Principal. I am a strong, black woman who believes that all students can be successful and that I am obligated to help them get where they need to be. Faculty and staff hear it constantly: "*If they don't get it here, they don't get out.*" If I don't ensure that my students get what they need while under my care, direction and leadership, they will never make it out. They won't make it out of the trailer parks, out of low paying jobs or unemployment, out of teenage motherhood, out of homelessness, out of criminal mischief - everything they see around them. In short they won't make it out of the cycle of poverty.

During my tenure at this elementary school, I have seen the school come within one point of being graded an A+ school by the state. Last year was one of the best years ever. The school was coming off its lowest grade (numerically an F in points, a D in grade). My staff and I were galvanized as a team; we raised the school grade to a C, about 20 points shy of a B, which was our

goal. I will be proud and fulfilled if our students are successful in life. I would love to have a high poverty school with positive, notable turnaround results, not just in student achievement, but also in student and staff culture. I would like our school to be a place where students, their families, faculty and staff WANT to be.

Considering that the majority of SBHCs exist in schools with high poverty rates, I was interested in what services were provided and how accessible they were.

School District Context

Hillsborough County Public Schools (HCPS) currently serves nearly 212,000 students, with over 15,000 certified teachers and 25,000 full-time staff. HCPS is the eighth-largest school district in the country with over 250 schools. The district is minority-majority: 21% Black, 33% Hispanic, and 36% White. Asian (4%) and Multi-racial (6%) make up the remaining 10% of the student population. Sixty-two percent of students are economically disadvantaged; 16% are English language learners; and 14% receive Exceptional Student Education. The district graduation rate for 2015 was 76% with over 14,000 students graduating.

Social service in the community. Hillsborough County, Florida has comprehensive social services. The Social Services Department “provides comprehensive case management programs as well as stabilization services to low-income residents of Hillsborough County. The Social Services Department's mission is to improve the quality of life of Hillsborough County's most vulnerable citizens by promoting self-sufficiency through interactive service delivery and strategic partnerships” (see <http://www.hillsboroughcounty.org/index.aspx?nid=281>).

To better guide parents of HCPS students to community support services, Hillsborough County Schools have an entire Student Services Department which includes: Attendance, Exceptional Student Education (Special Education), Guidance Services, Health Services, Multi-

Tiered System of Supports, Non-Traditional Programs K-12, Professional Development, Psychological Services, and Social Work Services.

School choice. HCPS School Choice provides parents and legal guardians with options such as Magnet schools, Career & Technical Education programs, School Choice (parents may choose from a list of schools with space available), Out of County options, and options for military families. School Choice has become increasingly popular in HCPS with several options available:

- *Charter schools* – independent public schools operated by a non-profit organization. According to a report printed February 29, 2016 by the HCPS Charter Office, 16,620 students are currently enrolled in Charter schools.
- *Home education* – defined by Florida Statute 1003.01 as "sequentially progressive instruction of a student directed by his or her parent in order to satisfy the attendance requirements of SS.1002.41, 1003.01 (4), and 1003.21 (1)."
- *John M. McKay Scholarship* – additional Choice options to students with an Individual Educational Plan (IEP) or a 504 Plan.
- *Partnership schools* – schools that have developed an innovative partnership between the public and private sector. Proof of employment in the partnership area is a requirement.
- *Hillsborough Virtual School (HVS)* – a school choice option for students entering grades K-12. HVS students are served by Highly Qualified Hillsborough County teachers for each class online.

Turnaround Schools

Hillsborough County Public Schools (HCPS) established its new 5-year strategic plan in November 2015. Its vision is “Preparing Students for Life.” The Message from the Superintendent and School Board at the opening of the plan focuses on commitment to “serving our students and

families” and making every decision “with our students’ futures in mind.” Four Strategic Priorities are the core of the plan: 1) increase graduation rates, 2) communicate with stakeholders, 3) build strong culture and relationships, and 4) financial stewardship (see <http://www.sdhc.k12.fl.us/doc/list/superintendents-office/about/>).

Our interest was in our district’s previous and current attempts to increase student success in high poverty schools. In the district high poverty schools are designated as those with over 75% of students living at or below poverty level. In turnaround schools, where we have low poverty levels and low achievement levels, we are faced with serious issues and acknowledge the far reaching impact they can have:

- Students – low self-esteem, leading to behavioral and social issues and continuation of the cycle of poverty
- Teachers – frequent “burn out” due to managing challenging students (academically, behaviorally, and socially), additional requirements for training, and extended work hours
- Schools – low teacher retention, inability to attract effective teachers
- District – increased scrutiny from the state, inability to recruit leaders for high needs schools, decreased graduation rates
- Economy – potential for higher unemployment rates, increase in minimum wage workers, and an increase on reliance of government subsidy programs

Recent Hillsborough County Public Schools (HCPS) district data indicate that of the 958 third grade students who scored below proficiency on FCAT (level 1) in their third grade year, only 60% graduated (in 2013-2014); 73% of those scoring a level 2 graduated. On the other hand, the percentage jumps to 85%, 94%, and 99% respectively, for those scoring proficient and above (levels 3-5).

Over the past 10 years, HCPS has engaged in many reforms in order to address low performance by schools with high poverty. Although the program/initiative names have changed, many of the strategies have been constant. Schools have been labeled fundamental or academy. Priority, STAAR, and Focus have all been used to identify low performing schools, and district supports were mandated. Examples of strategies include district oversight by assigned personnel to ensure that non-negotiables were in place such as bell to bell instruction, teacher planning, adherence to the core instruction models, best practices for instruction, data meetings, etc. Although some schools showed improvement from year to year after these supports are added, there is no clear example of a high poverty school with sustained success over time in this district. Simply put, change was needed.

Our new superintendent's vision and actions have demonstrated that he is open to change and is an advocate for all students. He has a strong focus on increasing the graduation rates for all students, as well as decreasing suspension rates for minority students. Barriers currently exist in allocation formulas for providing needed services to students and families in high poverty schools. And, the district has continually placed a higher emphasis on academic achievement versus the social-emotional needs of students and families in high poverty communities.

Elementary School Context

Currently, the school's majority is comprised of 40% Hispanic students, 29% white students, and 24% African American students. Multiracial and Asian students represent the remaining student population at 6% and 2% respectively. The student population is very close to evenly distributed as it relates to gender. Of the 837 students, 48% are girls represent and 52% are boys. Seventeen percent of the students are students with disabilities; 29% of our students are English Language Learners.

The school is a Title I school; 93% of students receive free or reduced price lunch with 85.4% receiving it through direct certificate, which indicates that they are currently living at or below the poverty level and receive some form of government assistance.

The median household income of our families is estimated at \$37,820. Males had a median income of \$29,040 versus \$22,950 for females. The percentage of the community population living below the poverty rate is 13%, and 20.1% of those were under age 18. We have many students who live in motels, with other family members, or doubled up with other families. We work closely with our school social worker and the district's social work services department to help identify those students who are technically homeless but may not be coded as such. Through the McKinney-Vento Act, they are eligible for certain services, and we want to ensure that they are given those in order to help them to be successful.

Good attendance is hard to maintain; currently, 21.5% of student have been absent 10 or more days this school year. We are a positive behavior supports (PBS) school, so we work hard to maintain positive discipline. Our district discipline data currently looks fantastic; we have less than 1% of students who have had an out of school suspension.

Community resources. Parent involvement continues to be an area of need. We host monthly events for families. Our parent involvement liaison works to keep our plan updated and uses it as a working document. Our most recent event (reading night) had only 120 participants, yet our math night at Publix had more. It's a work in progress.

We have several key partners in the community. Big Brothers Big Sisters is coordinated by our school counselor. 'Big's' visit with their assigned students weekly. They serve as mentors, sometimes help with classwork, have lunch with students, or just sit and talk with them. Several community organizations work with the school annually including Cynthia Pinckney Services,

ECHO, Brandon Jr. Women's League, and Kiwanis. They provide counseling services, holiday assistance, school supplies, food, clothing, financial assistance, and other basic necessities for our families. Although our students are needy, we try to teach them the importance of giving back and helping to provide for others in the communities through service learning projects. Students participate in an annual canned food drive to help sustain needed items for community food banks and holiday giving.

SECTION 2. PERSPECTIVES FROM SELECTED LITERATURE

Keeton, Soleimanpour, and Brindis (2012) reviewed the history of SBHCs and their impacts with the understanding that “[l]essons learned from the synergy of the health and school settings have major implications for the delivery of care for all providers concerned with improving the health and well-being of children and adolescents” (p. 132). This review of selected literature explores the impact of school-based health centers (SBHC) and their benefits. Considering that the majority of SBHCs exist in schools with high poverty rates, I was interested in what services were provided and how accessible they were.

Methods used to conduct the review. To prepare this literature review, the University of South Florida Libraries general keyword, title, and abstract searches were used to search a variety of databases including: Academic Search Premier, EBSCO, ERIC, Google Scholar, JSTOR, SAGE, and Web of Science. Searches included the following keywords: wrap around services, school based health centers, health and student achievement. Sources within selected texts were cross-referenced, resulting in additional searches by author or source. Sources were limited to the last 10 years, and the primary focus was on studies conducted in the United States.

Wrap-Around Supports in School

In 2004 the School-Based Health Care Policy Program (SBHCPP) was launched. Its purpose was to advance advocacy and policies that would sustain SBHCs in communities throughout the United States (Committee on School Health, 2004). The SBHCs were seen as a solution to the barriers facing disadvantaged children: low income, without health insurance, and as a result, exposed to environmental risks that cause poor health.

Census reports from 2005 indicate that there were thirteen million children living in poverty and eight million additional children living without health insurance (Wade, Mansour, Line, Huentelman, & Keller, 2008). Many more have limited access to health care because of other systemic and structural barriers to care.

Uninsured children also face hurdles to obtaining appropriate health care. Less than half (44.8%) of all uninsured preschool-aged children receive recommended well-child care. Uninsured children are 7 times less likely than insured children to have a regular place of health care. Not only is quality health care more difficult for them to obtain, but they are disproportionately exposed to the environmental and social conditions that contribute to poor health in the first place (Zimmerman, 2014).

School-Based Mental Health, Access and Enrollment

School-based mental health services generally means any mental health service delivered in a school setting, but as school settings have a varied range (neighborhood, public, private, DJJ facilities, etc.), it is necessary to be more specific. Schools also deliver mental health services and support through the special education program for students with emotional disturbance. In fact, efforts to deliver mental health services and manage challenging behaviors have been a mandate in special education for over 30 years (Kutash, Duchnowski, & Lynn, 2006). There are many programs that exist for preventing and treating mental health conditions, with the hope of helping to prevent emotional or behavioral challenges. As a result, confusion exists, as there is not a common definition for school-based mental health services.

Access. In 2012 the National Center for Health Statistics noted that the majority of youth who have mental health problems are living at or below the poverty level. Children from low-income households are at a greater risk for mental health problems (Bains & Diallo, 2015). In a

systematic review of mental health services in school-based health centers, Kutash et al. (2006) looked at the effectiveness of SBHCs in providing mental health services to children and issues that influence the use of mental health services in SBHCs. They reviewed 23 research studies on the provision of mental health services in elementary, middle and high schools. They found that 30% of total visits to SBHCs were comprised of mental health visits. They also found that students who experienced psychological issues were more likely to access mental health services in SBHCs. A review by Bains and Diallo (2015) also found that in elementary schools more students used the SBHC for mental health issues than for general medical issues and that when students had access to mental health services, they were more likely to use them.

In the *Empirical Guide for Decision Making*, Kutash et al. (2006) highlight what is known about the need for mental health services for children. They assert that we are slowly learning about the number of children who have some type of emotional disturbance and the nature of those disturbances. They state, “Estimates of the number of children with emotional disturbances are always more than expected, and their conditions are more diverse and often more long-standing than previously estimated” (p. 4). The authors are of the belief that we must provide mental health services in the school setting since schools have a long history of providing mental health and support services to children and can provide easy access for a large number of children.

Access and academic performance. SBHCs serve children regardless of their insurance status or ability to pay, thereby improving their access to care, but does it positively impact academic performance? Strolin-Goltzman, Sisselman, Melekis, and Auerbach (2014) sought to answer this question by studying the differences between elementary, middle and high school SBHC users and non-users on school connectedness. School connectedness was defined as “the belief held by students that adults and peers in the school care about their learning as well as about

them as individuals” (Centers for Disease Control and Prevention, 2009 as cited by Strolin-Goltzman et al., 2014, p. 84). Students who feel connected to school do better and are not as likely to behave poorly, thus adding to the possibility to have a stronger academic impact.

The researchers also wanted to test the pathways between SBHC usage and academic performance. Examining the relationship of SBHCs to academic indicators (attendance and performance), the researchers conducted in person surveys on SBHC usage, satisfaction, and school connectedness. Their findings showed that users of SBHCs, compared with non-users, had higher levels of school connectedness in each of the factors assessed.

Enrollment. Critical to the success of SBHCs is access and the ability to enroll children in health insurance, which reduces the number of uninsured children. When SBHC services are located on school campuses, students can receive immediate care including prevention and early detection of illnesses. Wade et al. (2008) bring to light some barriers that have prevented SBHCs from being available to all children in the United States. Some of the barriers noted are: absence of designated federal or state policies that authorize and fund SBHCs, insurance programs that do not reimburse all services provided in school based setting, lack of infrastructure and capacity to bill appropriate parties, historically weak network of SBHC associations, and other stakeholders organized to advocate for change.

Geographic patterns of enrollment. SBHCs are a critical piece of improving access to mental health care for students who have the greatest need: those living at the poverty level, those who are disadvantaged and/or uninsured. In a study of enrollment patterns and frequency of use in school-based health centers, Wade et al. (2008) used four rural and four urban school districts that were implementing SBHCs. The study specifically addressed four areas related to SBHC access and utilization: (1) how the utilization patterns varied across urban and rural schools,

characteristics of students, insurance status and chronic health conditions; (2) examining sources of referrals to determine if they differed across student characteristics and presenting health conditions; (3) how the SBHC assesses the most frequent resulting diagnoses for visits and how they may evolve over time; and (4) factors regarding if students are being sent back to class or being sent home after a visit to the SBHC.

The results of the study are in alignment with another review of literature by Wade et al. (2008) who found that the enrollment in SBHCs was greater in urban areas, but utilization was higher in rural areas. Black students, students with public or no health insurance, and students with asthma and ADD had higher enrollment and utilization. Notably, during the three years, the largest increase in the number of visits to SBHCs was for mental health issues (Wade et al., 2008).

Conclusion

Implementation of school-based health centers will impact student success. Most SBHCs are aimed at protecting and promoting the health of children and adolescents, helping to ensure that they are healthy in the classroom and ready to learn. School-based health centers provide a combination of primary care, mental health care, substance abuse counseling, case management, dental health, nutrition education, health education, and health promotion for students and families. Emphasis is placed on prevention and early intervention.

As primary clinics located on school campuses, SBHCs have the potential to reduce barriers to healthcare access for uninsured and disadvantaged groups of children and adolescents. Most school-based health centers report that the majority of their student population is eligible for the National School Lunch program, a common indicator of low socioeconomic status.

Usually, SBHCs operate as a partnership between school districts and community health organizations. Studies of SBHCs have documented improved appropriate health care access for this population and reduced hospital emergency department use by adolescents.

The number of SBHCs has grown, and the scope of services available at tSBHCs has also grown, now providing behavioral healthcare, risk/disease prevention, case management and coordination, and other community-wide services. Recognition of the need for mental and physical health services at the school level is the first step.

Implications

For school leaders. Looking at feasible models of providing physical and mental health care to students on campus will be beneficial to help impact student success. SBHCs help to assure that children are healthy in the classroom and ready to learn. Site-based leaders must fully maximize personnel in order to meet the growing health care needs of students in high poverty schools. Are school leaders utilizing opportunities within the community to address students' health needs?

Implications for district leaders. Current practices related to health needs include school-based health care professionals, site based mental health professionals, Full Service Centers, Dental Sealants, Buc's Vision Mobile, and Vision/Hearing Screenings. Where do we go from here? What partnerships (established/potential) can be leveraged to create SBHCs in the district? What can we learn from existing SBHCs in the Southeast? What resources (funds, grants, buildings, infrastructure) are available to support the implementation of SBHCs?

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