HEALTHCARE GEORGIA FOUNDATION
SCHOOL BASED HEALTH CENTER PLANNING GRANT
EVALUATION REPORT

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Background

The Emory University School of Medicine's PARTNERS for Equity in Child and Adolescent Health (formerly known as the Urban Health Program) was created to increase access to and improve the delivery of healthcare for underserved children and adolescents throughout the state of Georgia. Our vision is to '*reduce health disparities, ensuring that all Georgia Children are happy, healthy, and productive members of society'.* It is our intent to partner with stakeholders throughout Emory University, affiliated health systems, the philanthropic community and community agencies and organizations to maximize the health outcomes and improve the academic achievement for children state-wide.

The goal of the School Based Health Center project developed by Partners for Equity in Child and Adolescent Medicine is to:

- Increase access to quality health care (physical, behavioral, oral), improve the delivery of health services and improve the overall health of the children of Georgia.
- Improve the academic achievement of Georgia's children through increased school attendance.
- Facilitate the expansion of school-based health centers throughout the state.
- Establish a state alliance for school-based health centers – Georgia Alliance for School-Based Health Centers (GASBHA).

Through the expansion of school-based center services, children in Georgia will benefit from improved access to primary health care, improved health outcomes, and improved school attendance. The state will benefit from reduced costs to the Medicaid system through the reduction in inappropriate emergency room visits; hospitalizations for chronic illnesses (i.e., asthma, diabetes, etc.) and transportation costs.

Evaluation Methodology

The purpose of the evaluation of the planning grantees work is to document and describe the steps in the planning process that are necessary to successfully implement school based health centers. Multiple methods of data collection were employed as a part of this evaluation. Both qualitative and quantitative methods were used to collect data on partner engagement, community awareness and support, capacity building and plans for marketing, recruitment, and resource development. Five primary methods of data collection were planned: (1) Meeting minutes, (2) Grantee Progress Reports, (3) Quarterly Evaluation Phone Calls, (4) Community Readiness Model (CRM) Interviews and (5) Survey. Meeting minutes were completed from the monthly conference calls with grantees; community readiness interviews were conducted at the beginning and end of the grant year, and a community partner survey was completed at the end of the grant year. Given that the focus of the grant was on planning, no health outcomes data were collected. The modified measurement model is included in Appendix A.

Findings presented below were drawn from these data collection methods and are organized by evaluation question.

Evaluation Questions

1. What actions were taken to identify key partners and engage missing partners who are key to developing the SBHC?
2. What is the community perception/readiness for the SBHC?
3. What actions were taken to garner community support for the SBHC?
4. What challenges or barriers were identified and addressed in order to develop a SBHC?
5. What is the capacity for clinic development in the school and what delivery model is planned?
6. What is the plan for marketing and patient recruitment?
7. What is the capacity/plan for resource development to support implementation and sustain the SBHC?
8. What is the impact of the support from Emory in planning and implementing the SBHC?
9. What is the capacity/plan for data collection and utilization?

Evaluation Results

Evaluation Question: What actions were taken to identify key partners and engage missing partners who are key to developing the SBHC? (Meeting minutes)

A key requirement of the planning grant was that grantee bring together potential partners as part of an advisory committee to develop plans to improve the health of school students in their communities. PARTNERS provided guidance around the types of partners that should be engaged and included, but were not limited to:

- Local planning organizations
- School systems
- Medical service providers and 3rd party payers
- Medical and Training programs
- Public Health Departments
- Behavioral and Mental Health Providers and organizations;
- Community leaders
- Parents and PTA members
- Local businesses

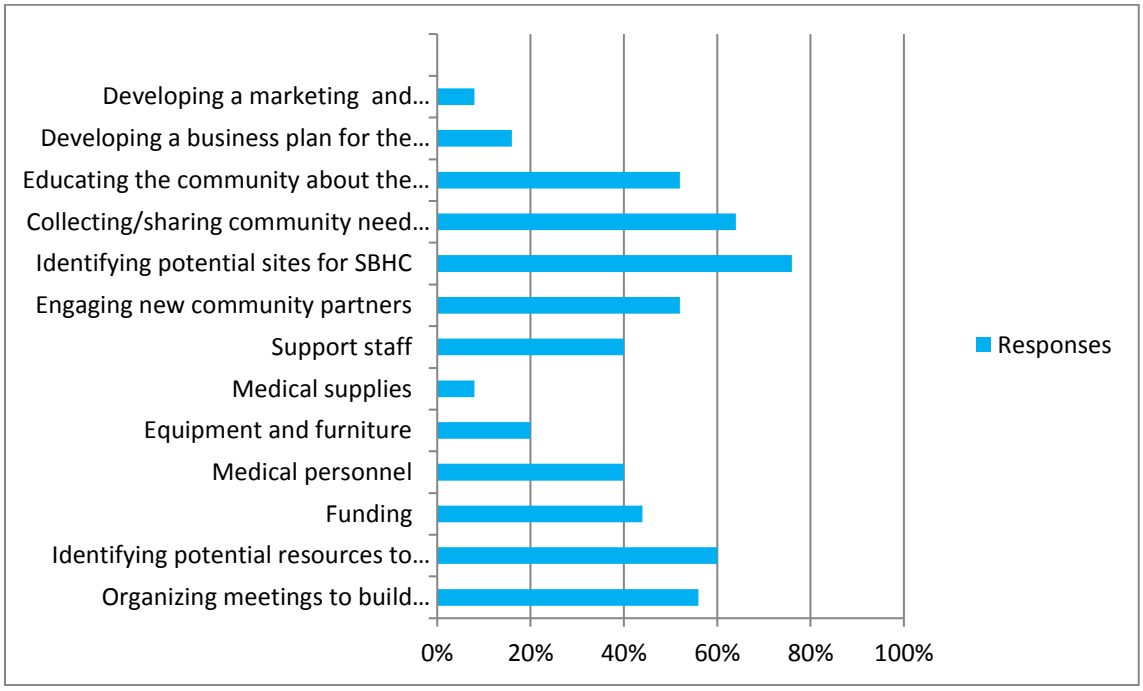
In addition, as part of the grant application process, grantees were required to submit letters of support from key planning partners such as school superintendent, school board, local health department, community leaders, community medical providers and parents or PTA representatives. Therefore, the infrastructure for the advisory committees were in place at the onset of the grant year.

Three of the 5 grantees, Charlton, Cook, Floyd, were Georgia Family Connection Partnership (FCP) collaboratives and were able to draw upon their existing community partnerships to create the SBHC advisory committee and work with partners to identify and include missing key stakeholders. The remaining two grantees, Gordon and Madison, represented Federally Qualified Health Centers (FQHC) and both engaged their local Family Connection collaborative and other key stakeholders in the SBHC planning process. One grantee, Gordon, also had the benefit of having previously established two school based health centers in surrounding counties and based on these previous experiences were able to identify and engage necessary partners.

Despite existing connections and partnerships, most of the grantees had to work to engage missing partners. For example, in Charlton and Cook counties, a relationship with local medical providers and organizations was lacking. In Charlton, the collaborative had a relationship with Public Health but did not have a relationship with the local FQHC. Advisory committee members reported that the community had limited knowledge about the services available at the FQHC. Charlton encountered significant difficulty engaging and garnering support from the FQHC and medical community. They did, however, have buy-in from the school system and other community partners. The inability to partner with the FQHC or another medical entity ultimately led Charlton to stop the planning process. Cook County, where there is not a FQHC present in the local community, established a relationship with Southwest Georgia Healthcare and hosted an advisory committee where Dr. Johnson shared information about the benefits of SBHCs. This new relationship helped to build support for the SBHC.

Two grantees, Madison and Gordon, represented FQHCs and therefore, demonstrated the support for SBHCs from a medical perspective. Both grantees were able to garner the support of their respective school system over the course of the planning. Madison also included local medical providers on their advisory committee. Respondents were asked to indicate what type of activities they were engaged in as advisory committee members. More than half reported that they participated in identifying resources (60%), organizing meetings (56%), engaging new community partners (52%), and educating the community about the role of SBHCs (52%).

Figure 1. Advisory Committee Activities



Evaluation Question: What is the community perception/readiness for the SBHC? (CRM interviews and Partner Survey)

Community Readiness Model interviews were conducted at the beginning and end of the project using the model developed by the Tri-Ethnic Center at Colorado State University. This tool is used to assess key stakeholder's perceptions about a community's readiness to address a specific need or issue. Each

grantee identified three to four key partners in the community who were engaged in interviews at the beginning and end of the grant period. Data from the original interviews were discussed with each of the grantees to inform their planning activities. The repeated interview was designed to identify key informants' perceptions of changes in the community related to the six constructs of the CRM. One county was unable to provide contact with the same individuals interviewed at the beginning of the year. For this county their comparison scores were limited to the two repeated interviewees. Across the five grantees, a total of 17 individuals were interviewed and 15 completed both interviews.

The CRM interview has six constructs to define the level of community readiness to address the issue of health care access. Each construct is defined by interview questions specific to the issue of interest.

- Existing Community Efforts
- Community Knowledge of Efforts
- Leadership
- Community Climate
- Community Knowledge about the Issue
- Resources

Data collected from the interviews allows for a rating of each construct on a scale of 1 being "no awareness" to 9 being "high level of community ownership". Data presented below provide the comparison of scores from the initial to final interviews for each of the five grantees and an overall comparison score for the project. Findings are provided by county and for the project.

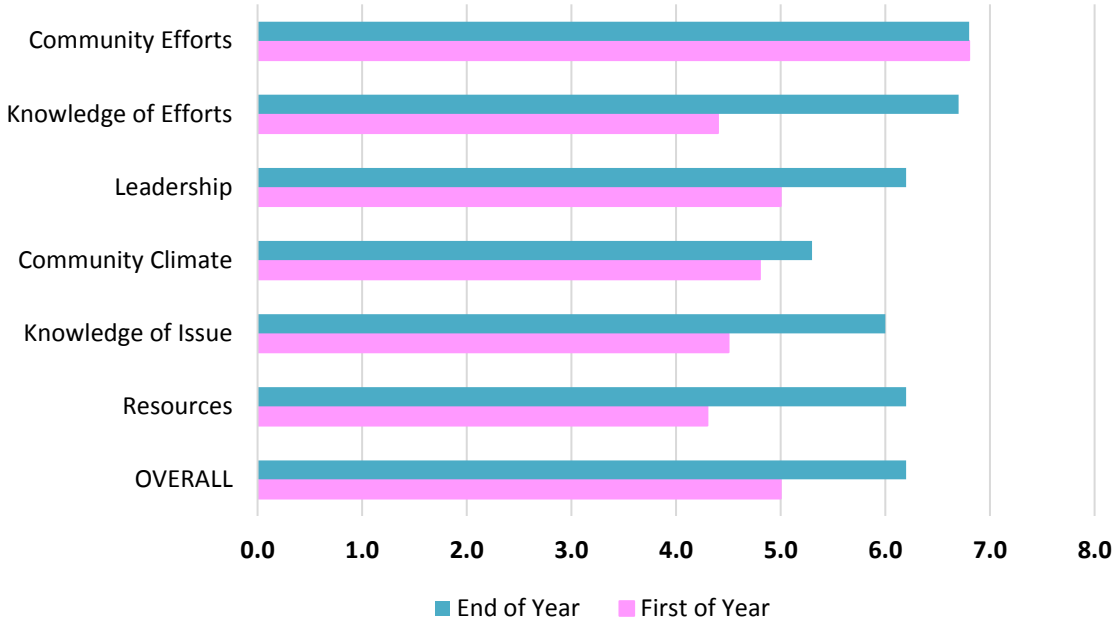
Table 1: CRM Stages of Readiness

Score	Stage of Readiness
1	No Awareness
2	Denial / Resistance
3	Vague Awareness
4	Preplanning
5	Preparation
6	Initiation
7	Stabilization
8	Confirmation / Expansion
9	High Level of Community Ownership

<u>Cook County Community Readiness</u>

Cook County is a rural farming community with just over 17,000 individuals and 24% living in poverty. Three key informants were identified by Cook County and included the Family Connection Collaborative Coordinator, the county Public Health nurse manager, and the county school assistant superintendent. All three were interviewed at the beginning and end of the grant period. Figure 2 below shows changes in community readiness.

Figure 2: Cook County CRM Interviews Comparison of Stage of Readiness



In Cook County, significant changes were seen in five of the six constructs and in the overall score of community readiness. The only construct that did not show any progress is "community efforts". During the planning year for the SBHC, a key medical partner thwarted any efforts to increase the number of locations for healthcare access including the school-based health center. This opposition was primarily based on the perception that the school-based clinic would create competition in an area with a small population. Nevertheless, significant progress was made in community engagement, knowledge of healthcare access issues, increasing leadership in the community who are concerned about healthcare access and increasing resources focused on community-wide improvement. The overall readiness increased from 5.0 to 6.2, showing movement from preparation to initiation.

> *"I'm proud that these things are taking place – they will be great for our kids and our community. Things were tense for a while, but it was worth the pain."*

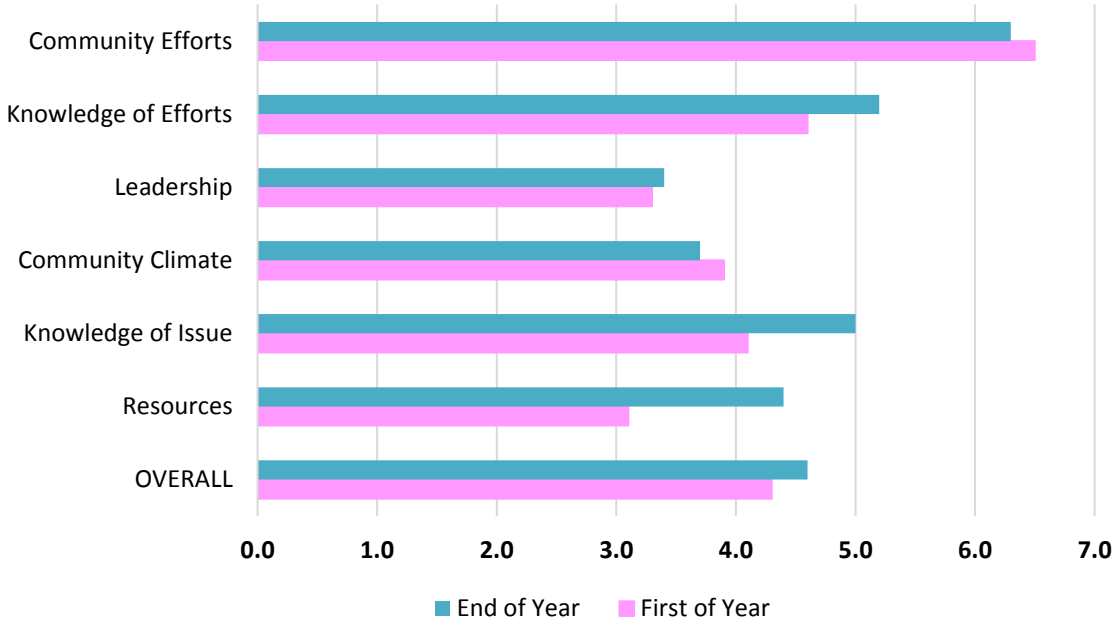
During the year, Cook County received a "Two Georgia's" Healthcare Georgia Foundation that is focused on improving the overall health and well-being in the county. Although, the school-based health clinic is currently not moving forward, key informants reported that the focus on healthcare access throughout the year significantly influenced their interest and ability to apply and receive additional funds. In addition, the federally qualified health center in a nearby county is helping to support a *"telemedicine clinic"* that will open in the near future at the Cook County Primary School. Finally, informants reported that the planning year has opened the door to new partnerships and a stronger community-wide understanding of the importance of healthcare access.

<u>Charlton County Community Readiness</u>

Charlton County has a small population of just under 13,000 with 33% living in poverty. In addition, it is a large county of just under 800 square miles bordering Florida. Many in the county work and play in Florida and go across the border for many services, including healthcare. Three key informants were identified by Charlton County and included the Family Connection Collaborative Coordinator, the county

Public Health nurse manager, and the county school superintendent. All three were interviewed at the beginning and end of the grant period. Figure 3 below shows changes in community readiness.

Figure 3: Charlton County CRM Interviews Comparison of Stage of Readiness



In Charlton County, significant changes were seen in three of the six constructs and slight growth in the overall score of community readiness. The three with significant growth, "knowledge of efforts", "knowledge of issue" and "resources", reflect the work of partners to better inform community members about resources in the community and to bring new resources to the most rural part of the county. Little change was seen in the "leadership", "community climate", or "community effort" constructs. During the planning year for the SBHC, partners were unable to rally the county leadership and commitment from medical provider needed to move toward the creation of a school-based health center. Nevertheless, key informants reported some improvement in healthcare access due to the schools now each having a school nurse, plans for telemedicine at rural school, a new doctor in the county, as well as primary care expansion at a clinic that previously provided only urgent care. The overall readiness increased from 4.3 to 4.6, showing only slight movement within the preplanning stage.

> *"The perception here is that we are close enough to quality care."*

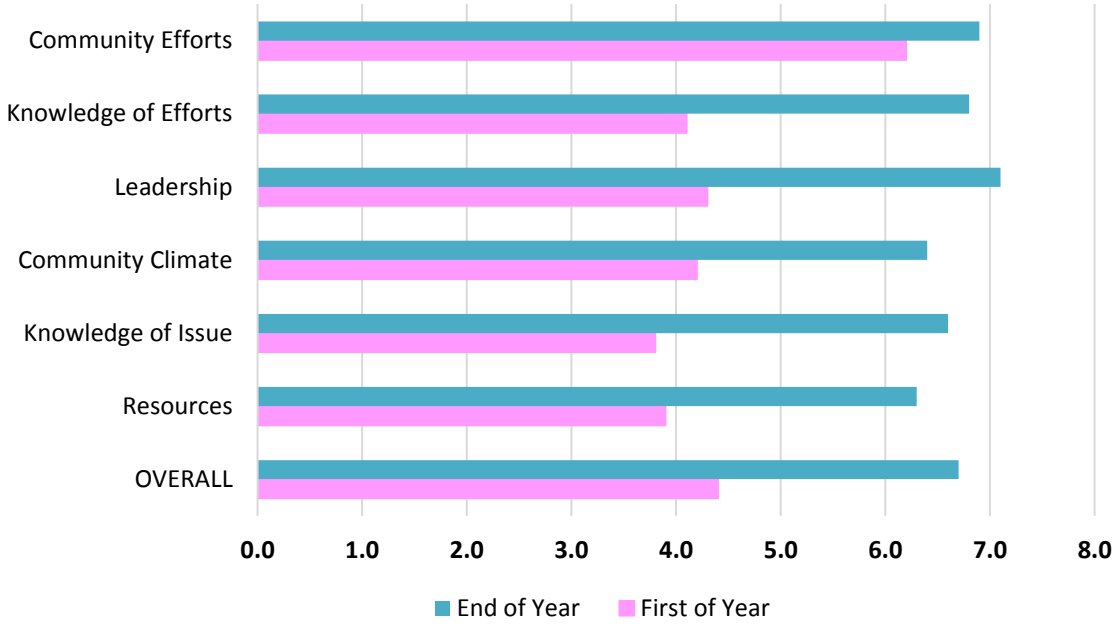
Regardless of the lack of progress in getting a school-based health center in Charlton County, the planning grant did draw attention to the needs in the county, especially in the most rural area with an underserved elementary school. This rural school is planning a renovation in the next couple of years and is hoping to build in space for telemedicine to operate with the support of the federally qualified health center (FQHC) in the neighboring county. Planning year conversations also highlighted the lack of mental health and emergency services and increased awareness of services available out of Jacksonville,

Florida. In addition, informants reported that conversations are taking place regarding how to better serve the rural population, as well as the uninsured and underinsured.

Gordon County Community Readiness

Gordon County has a population of slightly over 55,000 with 18% living in poverty. Three key informants were identified by Gordon County and included a director at the Primary Health Care Center, elementary school principal, and the county school lead nurse. All three were interviewed at the beginning and end of the grant period. Figure 4 below shows changes in community readiness.

Figure 4: Gordon County CRM Interviews Comparison of Stage of Readiness



In Gordon County, significant changes were seen in all six constructs and in the overall score of community readiness. Of the five grantees, the Gordon site showed the greatest improvement across all six constructs of community readiness with greater than 10% growth in each construct. During the planning year for the SBHC, this grantee greatly increased community awareness and engagement, leadership buy-in, and resources to address their healthcare access needs. They were able to go beyond planning to begin implementation with efforts focused on *"medical outreach and education at the school*" and telehealth capacity at one elementary school with plans for a second one to open early in 2018. Together these efforts have put them on a solid path toward a *"brick and mortar"* school-based health center and this is reflected in their overall readiness increased score from 4.4 to 6.7, showing significant movement from preplanning close to stabilization.

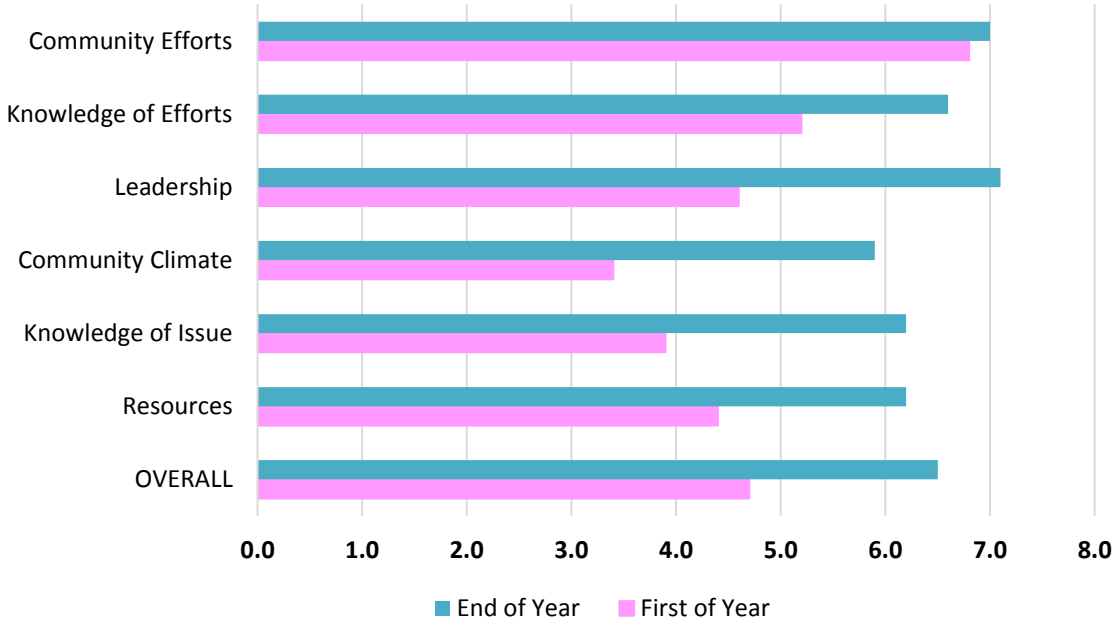
> *"We are just waiting for the release of federal funding – it will be a real blessing for our community."*

The Primary Healthcare Center that is the lead in Gordon County serves five surrounding counties. They have been in the area for over 40 years and have a well-established reputation and trust with the communities they serve. Together with their school partners, they successfully built the telehealth program and begun intensive communication with parents. Outreach to numerous community partners through the Family Connection Collaborative also helped to inform and engage the broader community and key leadership. Finally, key informants reported that they recognize there is still a significant need for adult healthcare access and are continuing to search for funds to serve *"whole families"* in the community, but for now are limited to telehealth serving students and their siblings.

Floyd County Community Readiness

Floyd County has a population of over 96,000 with 20% living in poverty. It is a county with a wealth of resources yet 27% of children live in high-poverty areas. Four key informants were identified by Floyd County and included superintendents from both school systems, the hospital administrator, and Family Connection Collaborative Coordinator. All four were interviewed at the beginning and end of the grant period. Figure 5 below shows changes in community readiness.

Figure 5: Floyd County CRM Interviews Comparison of Stage of Readiness



As in Gordon County, Floyd County saw significant changes in all six constructs and in the overall score of community readiness. The area with the least growth is "community efforts" to address healthcare access. The two constructs with the greatest growth were "leadership" and "community climate". This demonstrates the great success in Floyd around increasing engagement among community member and key leaders to address healthcare access needs. Floyd County saw a greater than 25% increase in all the constructs of readiness other than "community efforts". Key informants reported no new efforts were in place in

"We are revamping our plan – we have a new team – currently in wait mode."

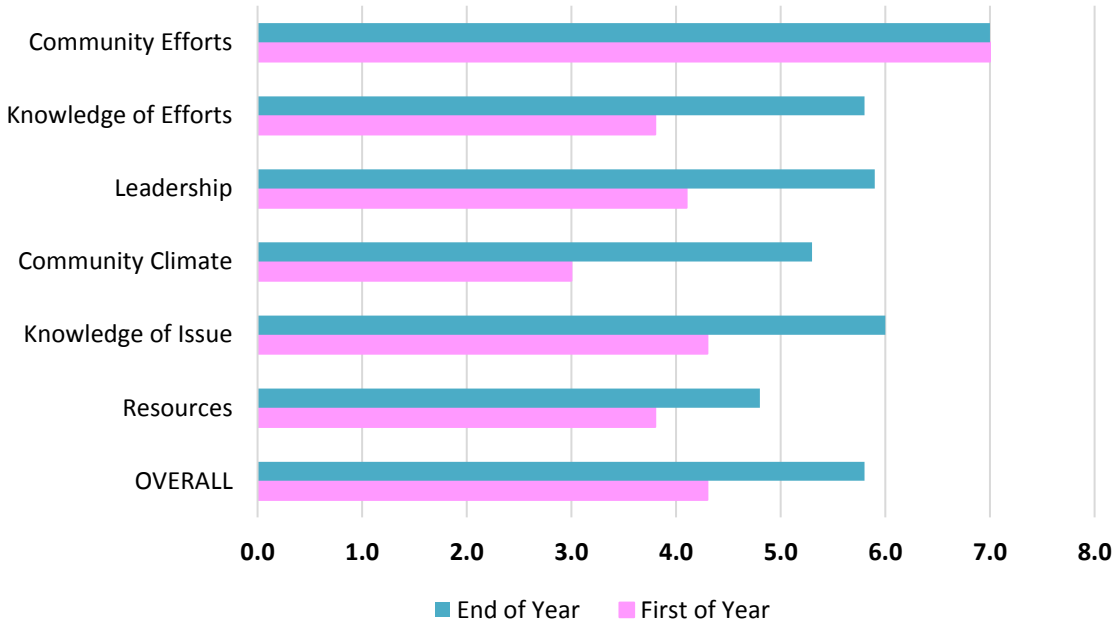
the community, however the SBHC planning year had greatly increased community awareness and engagement and leadership buy-in. Their needs assessment helped to identify barriers for parents, including inability to take time off work to access care. As with Gordon, there is a high rate of factory workers who cannot take time off work without losing pay. They are continuing to work toward developing a school-based health center and this is reflected in their overall readiness increased score from 4.7 to 6.5, showing significant movement from preplanning to close to stabilization.

Key informants agreed that progress has been made and that the planning year has raised awareness of community healthcare services as well as the barriers to receiving preventive care. They are working with partners, including CMOs to apply for funds to support the development of the SBHC and in the meantime, are planning to begin with telehealth in one school system with plans to expand to the second school system. Partners agree that more community education is needed, especially with parents, to increase their health knowledge and the importance of preventive care. Although significant progress has been made, Floyd County still has work to do with business leaders and community member to build the understanding and community will to address the barriers to healthcare access in their communities.

Madison County Community Readiness

Madison County has a population of just under 28,000 with 15% living in poverty. It is a county with a wealth of resources yet limited access to healthcare facilities. Four key informants were identified by Madison County and included the Family Connection Collaborative Coordinator, two pediatricians from MedLink, and the MedLink Special Services Director. Two of the four were interviewed at the beginning and end of the grant period. The two with repeated interviews represent the Family Connection Collaborative Coordinator and one pediatrician. Figure 6 below shows changes in community readiness.

Figure 6: Madison County CRM Interviews Comparison of Stage of Readiness



Madison County saw significant changes in five of six constructs and in the overall score of community readiness. The area with no improvement was "community efforts" and the area with the least growth was "resources". The two constructs with the greatest growth were "community climate" and "knowledge of efforts". This demonstrates the great success in Madison around increasing engagement among community members to address healthcare access needs. As with Floyd, Madison County saw a greater than 25% increase in all the constructs of readiness other than community efforts. Key informants reported no new efforts were in place in the community, however the SBHC planning year had greatly increased community awareness of need for improved healthcare access and knowledge of existing services. They are continuing to discuss how to better engage parents in preventive care and address the transportation barriers in the community. Their overall readiness increased score from 4.3 to 5.8, showing growth from preplanning to preparation.

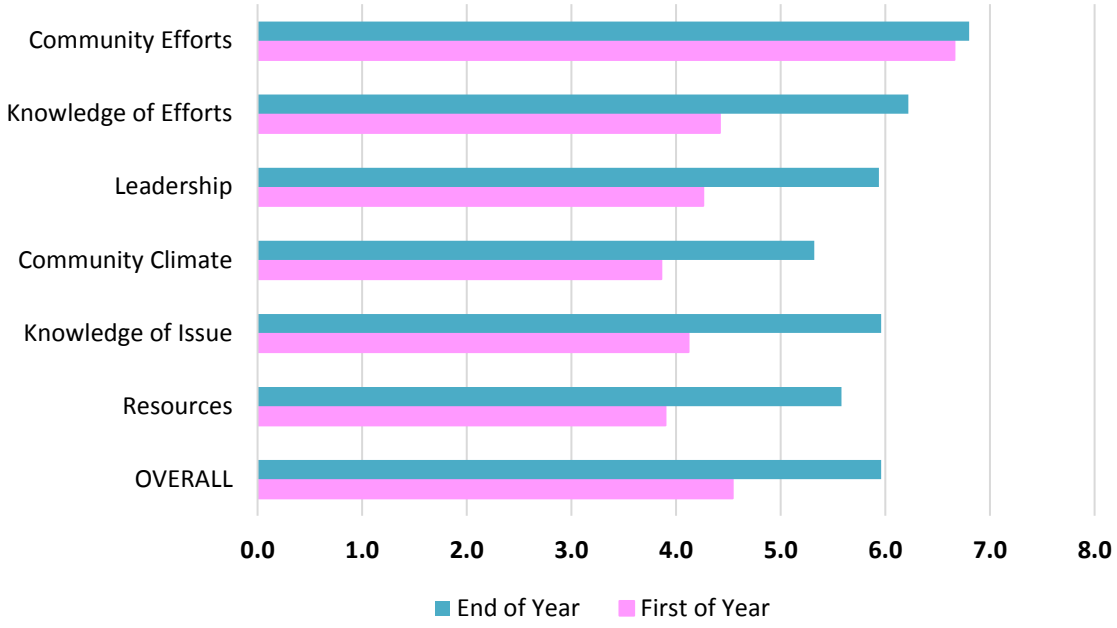
"SBHC would definitely increase access, but we still have things to work out to get full support."

Key informants agreed that the planning year has helped increase community awareness as well increased the understanding of healthcare access barriers for key leadership. Community leaders, including the school system, are fully engaged and they plan to continue their efforts to build support and resources to establish a viable SBHC in the county. This work includes applying for grants, hosting health fairs that include health screenings, and other activities to increase community education of healthcare and the importance of preventive care. Although progress has been made, informants agreed that the lack of resources remains the primary barrier to SBHC in the county.

SBHC Grantees Community Readiness

As shown in Figure 7 below, collectively grantees saw improvement in all six constructs of community readiness. The construct with the greatest percentage change was "knowledge of issue" followed by "resources", "leadership", and "community climate" respectively. Not surprisingly, "community efforts" was the construct with the least amount of growth. These data reflect grantees in which the planning year was productive for community growth, even in those cases in which SBHC facilities were not able to be established or fully funded. As one key informant noted, *"I think we are going to see some important changes in the next few years because now there is such high interest in healthcare."* This change in community awareness and willingness to work toward solutions is a real success.

Figure 7: Planning Grantees CRM Interviews Comparison of Stage of Readiness



Evaluation Question: What type of community engagement activities occurred to build support for the SBHC? (Meeting minutes, Partner Survey)

The SBHC Planning Grant Advisory Committee Survey was distributed to advisory committee members as identified by the grantee in each county. A total of 48 surveys were sent to members across four counties and 32 were returned for a response rate of 67%. The response rates differed by site: Floyd, 73%, Cook, 91%, Gordon, 67% and Charlton was 20%. The Madison site did not provide any names for distribution. The majority of the 32 responses were provided by Cook and Floyd grantee members; Cook accounted for 10 (31%), Floyd for 16 (50%), Gordon for 4 (13%), and Charlton for 2 (6%). Respondents represented a variety of community sectors including school system (36%), local planning organizations (16%), medical providers (16%), community leaders (12%) and medical training organizations (8%), public health (4%), behavioral/mental health (4%) and local businesses (4%). Several respondents did not identify which community sector they represented (21%).

Grantees reported a variety of activities designed to engage the community in addressing the issue of health care access, including community meetings, need assessment surveys, and stakeholder meetings. Thirteen respondents,41%, from three grantees reported being involved in activities “educating the community about the role of SBHCs”. Table 2 below summarizes the community engagement methods as reported via the survey and meeting minutes.

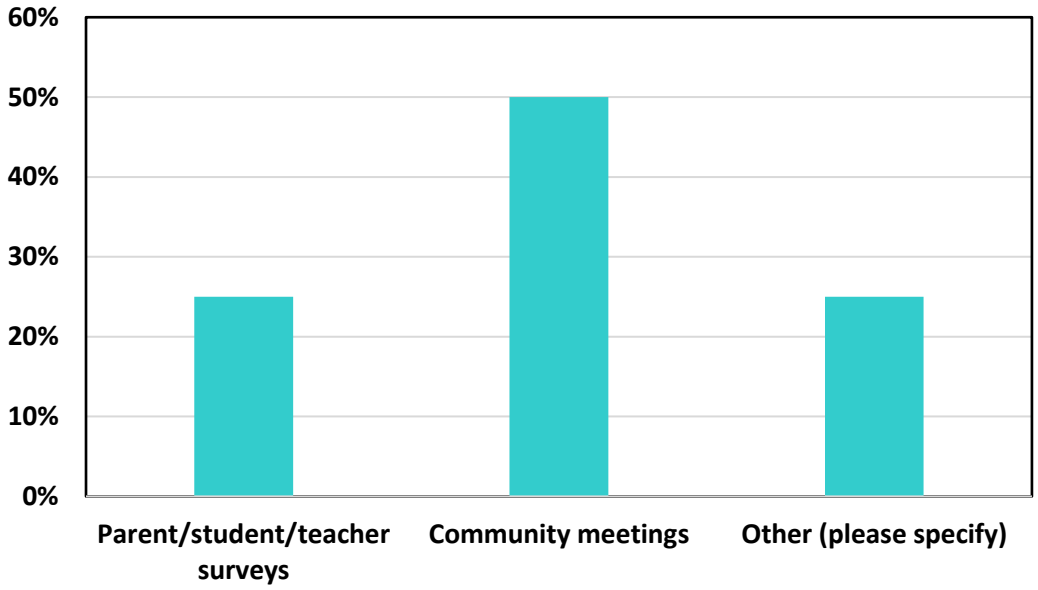
Those counties with the greatest progress in SBHC planning reported the greatest variety of community engagement methods. Detailed data regarding the number or frequency of events, number of participants, or number of survey responses is not available. Nevertheless, it is expected that those sites with multiple methods of engagement reached the greatest number of individuals in their communities. CRM analyses support that the three counties with the most effort toward community engagement also showed the greatest increase in “knowledge of issue”.

Table 2: Community Engagement Activities

Grantee Site	Community Meeting	Stakeholder Meeting	Needs Assessment Survey	Newspaper Articles / Media	PTO or other specific group meetings
Charlton					
Cook	X	X		X	X
Floyd		X	X	X	
Gordon	X	X			X
Madison					

As part of the year end satisfaction survey, grantees were asked to identify which activities were more successful in garnering support for the SBHC. The data (presented in Figure 8 below) show that community meetings were viewed as most successful in building support for the SBHC (50%), followed by parent, student, or teacher surveys.

Figure 8: Which activities were most successful in garnering community support for the school based health center? (N=5)



Evaluation Question: What challenges or barriers were identified and addressed in order to develop a SBHC? (Partner Survey, Community Readiness Interview)

Over the course of the planning year, several challenges to implementing a SBHC were identified. The five primary challenges were:

- Lack of information about the role of SBHC,
- Lack of buy-in and resistance,
- Funding,
- Logistics, and
- Multiple needy locations.

A primary challenge during the planning process was the lack of information about SBHCs. Many people, including medical providers, were unfamiliar with the SBHC delivery model and had concerns about available services, patient privacy and parent involvement. For example, there were concerns expressed about maintaining patient privacy, obtaining parental consent and the ability to engage parents when students are seen at the health center during the school day. Another challenge that arose was the resistance and lack of buy-in from the medical community. Some grantees received a negative response from the professional medical community who felt that the SBHC might impact their patient census. One grantee reported experiencing public opposition from the local hospital and their doctors, and some resistance from the health department. Another reported that the local hospital and a few local physicians were powerful opponents to the SBHC. In another county, politics and medical "turf" conflicts created a barrier to implementing the SBHC.

> *"Our only barrier was powerful opposition from the local hospital and private physicians. They are aggressively opposed to a SBHC for fear it would affect their walk-in clinic. They fought hard to undermine the effort."*

Advisory committee members from every grantee identified funding as a challenge to implementing the SBHC, even those community where plans to implement are underway. For example, in Floyd County where there is significant support from the hospital to implement the SBHC, there was still some concern shared about their ability to sustain the SBHC through billing. Other grantees reported that they were still seeking funding to support implementation and/or develop a plan to sustain the SBHC once it is operational. Logistics was another challenge identified during the planning process. Logistics includes identifying a site to implement the SBHC and planning with local health care providers to either provide services and/or avoid conflict and duplication. Gaining the support of local medical providers was a primary concern for some grantees. Finally, the vast need for a SBHC in the community presented a challenge. For example, some grantees identified multiple needy communities within the county that could benefit from the SBHC but a lack of resources to plan and implement more than one. In Floyd County, for example, both school systems were eager to implement a SBHC from the onset of the planning grant.

Evaluation Question: What is the impact of the support from Emory in planning and implementing the SBHC? (Grantee Satisfaction Survey)

At the end of the grant cycle, grantees were asked to complete a survey about their satisfaction with the planning. Grantees were asked to rate, using a 5-point Likert scale, the extent to which they agreed with statements about the planning grant and how helpful they found the support that they received from PARTNERS. Higher scores indicate higher levels of agreement; see Table 3 below. Four of the 5 grantees (80% response rate) completed the survey. The data show that grantees felt that the RFP clearly described expectations (m=4.5), communication was sufficient to support their efforts (m=4.75) and that funding was adequate to accomplish the grant objectives (m=4.0).

Table 3: Grantees Experience with the SBHC Grant

	Mean (Average) Score	% Agree / Strongly Agree
The RFP sufficiently described what was expected of applicants.	4.5	100%
The funding you received was adequate to accomplish the planning grant goals and objectives.	4.0	75%
Communication was sufficient enough to support your endeavors.	4.75	100%
Membership in the National Assembly of School-Based Health Care (NASBHC) was helpful.	4.25	100%

All grantees participated in training provided by PARTNERS about developing business plans, marketing, patient recruitment and potential delivery models for the SBHC. When asked to rate how helpful the support from the Emory team was, grantees reported that they found their support helpful in nearly every aspect of the planning process. For example, all grantees reported that the orientation workshop, support developing a business plan, and technical assistance received during the monthly conference calls was helpful or very helpful. See Table 4 below.

Table 4: Grantees Rating of Usefulness of Support from PARTNERS

	Mean (Average) Score	% Helpful / Very Helpful
Orientation workshop	5.0	100%
Support to develop a business plan	4.25	100%
Support to conduct a needs assessment	4.5	100%
Site Visit	4.25	75%
Technical Assistance during monthly conference calls and/or meetings.	4.75	100%

When asked what additional support was needed during the planning year, grantees reported that help identifying funding sources would have been beneficial. Grantees were also asked what support they needed to move forward in establishing a SBHC. Here again, grantees identified help with funding sources as a future need. Others indicated that help engaging community partners, quarterly meetings and establishing a network to access information would help them moving forward.

Evaluation questions 5, 6, 7 and 9 specified earlier in this report specifically address the implementation of the SBHC and were not addressed during the planning year.

Successes

Advisory Committee members also identified several successes that occurred as a result of the SBHC planning grant. They were:

- Partner Engagement,
- Increased community awareness and knowledge, and
- Increased access to healthcare.

Advisory committee members reported that their ability to engage community decision-makers in the planning process was a big success. The opportunity to bring the school system, medical community, and other key stakeholders to the table to discuss community needs, resources, and plan to address those needs would not have occurred without the planning grant. Even those communities that are not yet ready to implement reported that as a result of the planning grant, there were unprecedented discussions about health issues and community needs that has mobilized the community. Advisory committee members viewed the meetings as a positive step in stressing the importance of school based service and opened the discussion about potential healthcare options. In addition, the advisory committee meetings, focus groups and community meetings helped to increase community knowledge about needs, health care options and the potential benefits of SBHCs.

"The benefits were that our community learned about the concept of School Based Health Centers and quickly saw the ways that having them in our community would be beneficial. Another benefit was to connect with resource people at Emory School of Medicine and the other communities attending the meetings this year. I see no drawbacks to the SBHC planning grant."

"While we were not able to fully implement a SBHC, the planning process moved our community leaders forward and sparked new discussions/actions around child health. As a result of our work, a new telehealth program is being implemented in our primary school (the first telehealth project in our county). We also played a role in working with our state representative to establish a new FQHC scheduled to open in our community by February 2018."

The development and plans to increase access to healthcare through SBHCs or telehealth in four of the five communities are a major success of the planning grant. In Gordon County, plans are underway to utilize telehealth until a SBHC can be fully implemented. Plans are also underway to open SBHCs in both Floyd and Madison counties. In Floyd, the decision was made to implement two sites in the Fall of 2018; one for Rome City and one for Floyd County. In Cook County, a new telehealth clinic is being implemented at the primary school funded by Tift Regional Hospital as an alternative option to getting health services to elementary students in the county.

Conclusions and Recommendations

The goal of PARTNERS School Based Health Center project is to facilitate the expansion of SBHCs throughout the state. The planning grants supported through HCGF enables grantees to identify key stakeholders, build community support and develop plans to implement SBHC in their communities. The data from this evaluation show that the objectives of the planning grant were met and that grantees were successful in engaging partners and increasing community knowledge about the benefits of SBHC.

Most grantees (n=3) were also successful in garnering enough support for SBHC to begin the implementation process for either telehealth or a SBHC during 2018. The planning grant was beneficial to all grantees in identifying the healthcare needs of their communities, creating more community readiness to address healthcare access needs, and exploring the possibility of ways to address those needs. As with any planning process, there are recommendations that may help future grantees and PARTERS move the SBHC effort forward.

Recommendations for future grantees include:

- Engage a wide-variety of community partners to obtain their full support
- Educate community members and community partners, especially the. medical community, about the benefits of SBHC
- Identify perceptual barriers to SBHC and address them as early as possible during planning
- Provide clear and specific logistical and financial need information to all partners
- Increase communication efforts to inform community members about the importance of preventive care and availability of health care services in their community
- Seek additional resources, including in-kind and funding, to support SBHC work

Recommendations for PARTNERS include:

- Consider extending the planning process to allow more time for grantees to secure a facility and identify resources to support the SBHC
- Assist grantees in identifying resources, including in-kind and funding, to support SBHC work
- Provide marketing materials and other information to help inform the community about the structure and benefits of SBHC

Appendix A

Evaluation questions	Indicators	Data sources	Data collection methods	Timeline & person(s) responsible
1. What actions were taken to identify key partners and engage missing partners who are key to developing the SBHC?	• Number/type of partners and organizations engaged • Representativeness of community stakeholders • Advisory committee membership • Number of advisory committee meetings & participation	• Meeting minutes • Survey	• Document review • Survey	• Meeting minutes - Designated health center staff and evaluators - - quarterly • Evaluator conducts survey at end of the project

2. What is the community perception/readiness for the SBHC?	• Readiness scores for each of 6 constructs:
	  • A) Community efforts,
	  • B) Community knowledge of efforts,
	  • C) Leadership,
	  • D) Community Climate,
	  • E) Community knowledge of issue,
	  • F) Resources available.
	• Responses to community readiness interview
		• Community Readiness Interview	• Interview	• Evaluator -Community Readiness Interview - At the beginning and end of the 18-month planning cycle

3. What actions were taken to garner community support for the SBHC?	• Number/type of community engagement activities • Number of participants engaged in community activities • Representativeness of community participants.	• Meeting minutes • Evaluation conference calls • Survey	• Document review • Survey	• Designated health center staff and evaluators – quarterly • Evaluator conducts survey at end of the project

Evaluation questions	Indicators	Data sources	Data collection methods	Timeline & person(s) responsible
	• Community support (e.g. advocacy, participation, shared resources) for implementation of SBHC			
4. What challenges or barriers were identified and addressed in order to develop a SBHC?	• Types of challenges/barriers • • Challenges/barriers eliminated or resolved	• Meeting minutes • Survey • Community Readiness Interview	• Document review • Survey • Interview	• Designated health center staff and evaluators - quarterly • Evaluator conducts survey at end of the project • Evaluator-Community Readiness Interview - At the beginning and end of the 18-month planning cycle
5. What is the capacity for clinic development in the school and what delivery model is planned?	• School site identified • MOUs with school system and key partners • School support (e.g., staff, space, coordination) of SBHC • Infrastructure available or obtained	• Evaluation conference calls • Meeting minutes • Survey	• Document reviews • Survey	• Designated health center staff and evaluators - quarterly • Evaluator conducts survey at end of the project

Evaluation questions	Indicators	Data sources	Data collection methods	Timeline & person(s) responsible
6. What is the plan for marketing and patient recruitment?	• Marketing plan developed • Patient recruitment plan	• Meeting minutes • Evaluation conference calls • Survey	• Document reviews • Survey	• Designated health center staff and evaluators - quarterly • Evaluator conducts survey at end of the project
7. What is the capacity/plan for resource development to support implementation and sustain the SBHC?	• Number of potential funding sources identified/applied for • Resources, personnel, funding, etc. obtained • Business plan developed	• Meeting minutes • Evaluation conference calls • Survey	• Document review • Survey	• Designated health center staff and evaluators - quarterly • Evaluator conducts survey at end of the project
8. What is the impact of the support from Emory in planning and implementing the SBHC?	• Types of technical support utilized • Usefulness of TA provided	• Survey	• Survey	• Evaluator conducts survey at end of the project
9. What is the capacity/plan for data collection and utilization?	• Data collection plan developed • Data collection system in place	• Evaluation conference calls • Meeting minutes	• Document review	• Designated health center staff and evaluators - quarterly

Appendix B

SBHC Planning Grantee Community Readiness Interview

A. COMMUNITY EFFORTS (programs, activities, policies, etc.)
AND
B. COMMUNITY KNOWLEDGE OF EFFORTS

1. **Using a scale from 1-10, how much of a concern is access to healthcare in your community (with 1 being "not at all" and 10 being "a very great concern")? Please explain.** (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

2. **Please describe the efforts that are available in your community to address this issue.**

3. **How long have these efforts been going on in your community?**

4. Using a scale from 1-10, how aware are people in your community of these efforts (with 1 being "no awareness" and 10 being "very aware")? Please explain. (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.) (B)

5. **What does the community know about these efforts or activities? (B)**

6. **What are the strengths of these efforts? (B).**

7. **What are the weaknesses of these efforts? (B)**

8. Who do these programs serve? (Prompt: For example, individuals of a certain age group, ethnicity, etc.) (A) Are there people who need the service but are left out?

9. Is there a need to expand these efforts/services? If not, why not? (A)

10. **Other than the SBHC planning work, are there efforts currently underway in the community to increase access to healthcare?**

11. **How long have these efforts been going on in your community?**

12. Using a scale from 1-10, how aware are people in your community of these efforts (with 1 being "no awareness" and 10 being "very aware")? Please explain. (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.) (B)

13. **What does the community know about these efforts or activities? (B)**

14. **What are the strengths of these efforts? (B).**

15. **What are the weaknesses of these efforts? (B)**

16. Who do these programs serve? (Prompt: For example, individuals of a certain age group, ethnicity, etc.) (A) Are there people who need the service but are left out?

17. Is there a need to expand these efforts/services? If not, why not? (A)

C. LEADERSHIP

18. Who are the "leaders" specific to this issue in your community?

19. **Using a scale from 1 to 10, how much of a concern is this issue to the leadership in your community (with 1 being "not at all" and 10 being "of great concern")? Please explain.** (NOTE: this figure between one and ten is NOT figured into your scoring of this dimension in any way – it is only to provide a reference point.)

20. **How are these leaders involved in efforts regarding this issue? Please explain. (For example: Are they involved in a committee, task force, etc.? How often do they meet?)**

21. **Would the leadership support additional efforts? Please explain.**

D. COMMUNITY CLIMATE

22. Describe the population you think does not have access to healthcare.

23. **How does the community support efforts to address this issue?**

24. **What are the primary obstacles to efforts in your community?**

E. KNOWLEDGE ABOUT THE ISSUE

25. **How knowledgeable are community members about this issue? Please explain. (Such as: dynamics, signs, symptoms, statistics, effects on family and friends, etc.)**

26. **What type of information is available in your community regarding this issue?**

27. **What local data on this issue is available in your community?**

28. **How do people obtain this information in your community?**

F. RESOURCES FOR PREVENTION EFFORTS (time, money, people, space, etc.)

29. To whom would an individual affected by this issue turn to first for help in your community? Why?

30. Do community members, including local business' support efforts to address this issue, with people volunteering time, making financial donations, and/or providing space?

31. How are current efforts funded? Please explain.

32. Are you aware of any proposals or action plans that have been submitted for funding that address this issue in your community? If yes, please explain.

Appendix C

School Based Health Center Planning Grant Advisory Committee Survey

School Based Health Center Planning Grant Advisory Committee Survey

1. Please select your school based health center grantee.

- ◯ Rome/Floyd
- ◯ Madison
- ◯ Gordon
- ◯ Cook
- ◯ Charlton

Which of the following best describes the community sector that you represent?

- ◯ School System (administrators, teachers, school nurse, social worker etc.)
- ◯ Parents or Parent Organization Member (PTA, PTO etc.)
- ◯ Community Leader
- ◯ Faith Based Organization
- ◯ Medical Service Provider and/or 3rd Party Payer (ex; hospitals, community health centers, private physicians, Medicaid managed care organizations, private insurers etc.)
- ◯ Medical and Training Organization (ex; academic centers)
- ◯ Local Planning Organization (ex; Georgia Family Connection Partnership)
- ◯ Public Health Department
- ◯ City or County Government
- ◯ Local Business
- ◯ Behavioral and Mental Health Provider
- ◯ Other (please specify)

Over the last year, how often did you meet to discuss the school based health center?

- ◯ Weekly
- ◯ Monthly
- ◯ Quarterly
- ◯ Other (please specify)

What activities were you involved in as an advisory committee member? (select all that apply)

- [ ] Organizing meetings to build community support for the SBHC
- [ ] Identifying potential resources to develop and implement the SBHC (specify below)
  - [ ] Funding
  - [ ] Medical personnel
  - [ ] Equipment and furniture
  - [ ] Medical supplies
  - [ ] Support staff
- [ ] Engaging new community partners
- [ ] Identifying potential sites for SBHC
- [ ] Collecting/sharing community need assessment data to support the need for a SBHC
- [ ] Educating the community about the role of SBHCs
- [ ] Developing a business plan for the SBHC
- [ ] Developing a marketing and recruitment plan for the SBHC
- [ ] Other (please specify)

What type of community engagement activities occurred to build support for the SBHC?

Please select the choice that best describes how well the advisory committee completed the activities of the SBHC planning grant?

	Very poor	Poor	Neutral	Good	Excellent
Conduct a needs assessment.	○	○	○	○	○
Develop a business plan	○	○	○	○	○
Identify a target school	○	○	○	○	○
Galvanize community support	○	○	○	○	○
Identify funding to support the SBHC	○	○	○	○	○
Apply for funding to support the SBHC	○	○	○	○	○

Are plans underway to open a SBHC in your community during the 2017-18 school year?

- ◯ Yes
- ◯ No

If yes, where will the SBHC be located?

- ◯ Elementary school
- ◯ Middle School
- ◯ High school

If not, where are you in the implementation process?

- ☐ Identifying a school
- ☐ Securing funding
- ☐ Establishing agreements
- ☐ Finalizing contracts
- ☐ Determining a start date
- ☐ We have decided NOT to open a school based health center

What barriers to implementation were identified during the planning process?

What were the major successes during the planning year?