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Negotiating Order in State-Funded Care: Examining the Salience of Sponsoring Agencies in Maine's School-Based Health Centers

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Negotiating Order in State-Funded Care:
Examining the Salience of Sponsoring Agencies in
Maine's School-Based Health Centers

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Honors Thesis
Department of Sociology
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ABSTRACT

The rising costs of healthcare and increasing awareness about poor health outcomes in the United States has brought the issue of access to primary and preventative care to the forefront of the national public health agenda in recent years. While still a relatively small part of the U.S. health care delivery system, the integral place of school-based health centers is becoming increasingly apparent, particularly in low-income, medically underserved communities. Previous scholarship that using quantitative measures demonstrates that school-based health centers are effective and address the stark racial and socioeconomic health disparities that persist. Yet, this work neglects many of the local, contextual factors that impact care. The purpose of this study is to gain perspectives of those working on the ground in the field of school-based health in Maine to supplement the plethora of quantitative data on school-based health outcome measures. Data from in-depth, semi-structured interviews explores the perspectives of those working in school-based health care in Maine. Through the framework of “negotiated order,” this paper unpacks the workings of school-based health centers in Maine in order to uncover the structures shaping organizational relations and the provision of school-based health services. Differences reflected at the level of sponsoring agency were the most salient factors shaping care- the ways in which these differences mattered is the focus of this paper. Findings presented illuminate the salience of the centers’ sponsoring agency in shaping organizational arrangements and how decisions are made regarding issues of stability, value negotiations, sustainability, and best practices.

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INTRODUCTION

Increased awareness about health outcomes and rising health costs in the United States has catalyzed the rise of primary and preventative care on the national public health agenda along with the implementation of the Patient Protection and Affordable Care Act (PPACA) in 2010. The healthcare landscape has changed in recent years, along with the PPACA, and school-based health centers (SBHCs), initiated in the 1960s, have increased greatly in numbers. They have also evolved; initially focused primarily on medical services, mental and behavioral health services have become more prominent (Chamberlin 2009).

Although they have not gained much traction at the federal level, previous research demonstrates that SBHCs may be one of the most effective ways to address the stark racial and socioeconomic health disparities that persist among youth. Yet, since school-based health is relatively small, a number of myths still surround the centers. Common myths are that SBHCs are only for low-income students or that they exist to provide contraception. The circulation of incorrect information may prevent parents from enrolling their children in the health center program. Moreover, without quality state-level research on school-based health across the country it is unlikely that the federal government will establish oversight or funding, which could elevate the presence and impact of school-based health and improve prospects for long-term sustainability.

A deeper understanding of the organizational relations and policies around school-based health care in Maine can elucidate state-level challenges and successes. For example, the layers of accountability in the local context from the school board to the community members creates a unique healthcare setting when compared to other primary care centers. The purpose of this study is to add to the insights provided by existing research on SBHC outcomes to examine the

qualitative factors shaping the centers' provision of care. Through the lens of negotiated order, this paper explores the most salient factors that shape the negotiations both internal and external to the individual centers.

Drawn from the insights of institutional ethnography, this research seeks to privilege the perspectives of those working in school-based health, a perspective that the literature has largely ignored due to the focus on quantitative research. Evidence-based policies aim to close the gap between what research demonstrates is effective and which policies are actually enacted. Research on policy implementation focuses on three theoretical approaches to policymaking, the "top-down" approach, the "bottom-up" approach, and the combined approach (Cerna 2013:18). This paper draws on the work of "bottom-up" theorists, which focuses on the role of local actors and target groups, establishing a network to link the concerns of local actors to policymakers (Cerna 2013:18). Local actors, including direct service providers, Michael Lipsky (2010: *xii*) coined as "street-level bureaucrats," play a vital role in policy implementation as they carry out policy objectives through daily interactions with clients. Likewise, this qualitative project elevates the perspectives of administrators, allowing them to articulate the challenges and successes of their particular health centers. The participants I spoke with reflected a diversity of perspectives from within the school-based health system in Maine. Bridging the "bottom-up" theoretical approach of policy implementation research with qualitative methodologies to study SBHCs in Maine will provide a new perspective on the school-based health system. This research builds on these insights by applying a negotiated order framework to questions about how policy shapes practices through complex networks of inter-organizational negotiation to examine the factors that shape how the same policy translates in different ways to local health centers.

Review of Existing Literature

There is consensus within research that SBHCs are an integral part of the health care system, particularly for adolescents, a hard to reach group with regard to primary care. Some studies suggest that the school-based health model can address the underutilization of health services by adolescents and provide patients with a means of accessing their provider on their own. Only thirty-eight percent of adolescents had a preventative care visit over the course of a year (Irwin et al. 2009). Of those who had visits, only forty percent of adolescents had time alone with their providers, and these figures are lower for low-income and Hispanic patients (Irwin et al. 2009). A study in Denver of low-income students comparing SBHC users and non-SBHC users, for instance, found that although only thirty-seven percent of SBHC users were insured (compared to seventy-three percent of non-users) they were more likely to have had fewer than three primary care visits and more likely to have received a health maintenance visit and vaccines (Allison et al. 2007). This suggests that SBHCs address health disparities that arise due to insurance status. Adolescents are ten to twenty-one times more likely to seek mental health services at an SBHC than at community health centers and this can lead to decreased absences and fewer school discipline referrals (Juszczak et al. 2003; Kaplan et al. 1998; Hall 2001).

Other research on SBHCs illustrates outcomes attributed to this model of care provision. Use of SBHCs among high-risk students has been associated with improved academic performance including increases in attendance rates and grades and reductions in early dismissals (e.g. Walker 2010:256; Van Cura 2010:375) and emergency department use (e.g. Key 2002:276). SBHC users are more likely to access mental health services and those receiving services have notable decreases in absenteeism and tardiness (Brown 2006: 187; Amaral et al. 2011; Gall et al. 2000). SBHC usage also correlates with academic retention, with African-American male SBHC

users three times more likely to stay in school when compared to their non-user peers (Walker et al. 2010). A growing body of research demonstrates that SBHCs are cost-beneficial to Medicaid and reduce health disparities (Guo 2010; Fleming 2009; Parasuraman 2015).

Despite the array of quantitative data, qualitative research on SBHCs is lacking. However, qualitative research done in other related areas illustrates the potential for such work to illuminate important aspects of school-based health care. Sherryll Kleinman's (1982) work on health center negotiations, for example, provides a reason to examine more nuanced factors, noting turnover at the board level, stability of staff positions, availability of funds, and practitioners on contracts belong to different organizations. Additionally it shows how the complexity of organizational arrangements shapes conversations about applying rules. There can be confusion over who should negotiate as well as uncertainty about when and how to apply certain rules (Kleinman 1982: 325). The Kleinman study is a single case study of a holistic health center while this paper is a multi-site study of SBHCs, but there are some comparable findings.

There is no existing scholarship that takes seriously the perspectives of the variously situated actors participating in the practice of school-based health. Research on SBHCs has focused primarily on academic impacts, access to care, and health outcomes. Yet, there is a demonstrated link between health and educational outcomes, and SBHCs have proven to have positive results at addressing disparities in both. Furthermore, research published on SBHCs came before the implementation on the PPACA when the context of the healthcare landscape was different than it is today. My research aims to fill a gap in the literature through qualitative methodologies and varied perspectives at the level of program administration.

Context

School-based health is a relatively small part of the U.S. healthcare landscape with only 2,315 centers nationwide. Formally, SBHCs are health clinics that are located in or near a school facility, are administered by a sponsor, provide primary health services to children, and are organized through school, community, and health provider relationships (HRSA). SBHCs offer comprehensive health services either in the school building or in a building on school grounds. Nurse practitioners, physicians, clinical counselors, and athletic trainers may staff the centers. The size and staff composition of centers varies based on location. Some sites offer dental services as well. These centers do not replace the school nurse, as all students have free access to the school nurse and parents must enroll their students in SBHC services because they are billable medical, mental, or oral health visits.

Dr. Phillip J. Porter of Massachusetts established SBHCs in the late 1960s as a means of providing healthcare for underserved children (Massachusetts 2014). Then, in the 1970s, the St. Paul Maternal and Infant Care Project opened in some public high schools in Minnesota to address the needs of teenage mothers (Keeton 2012). The success of this program at the secondary school level led to the expansion of school-based services and a broadening of services to serve both male and female students (Keeton 2012). In the following decades, SBHCs expanded dramatically in numbers, largely attributable to private funding investments, chief among them from the Robert Wood Johnson Foundation (Keeton 2012). By 2014, there were 2,315 known SBHCs nationwide, over three-quarters of which were located in Title 1 schools that serve high percentages of children from low-income families (School-Based Health Alliance). Between 2011 and 2014, 385 new centers opened, representing a twenty percent increase during this time (School-Based Health Alliance).

Presently, out of the total number of SBHCs nationwide, roughly two-thirds are located in traditional public schools. As Figure 1 indicates, the federally qualified health center (FQHC) sponsoring agency model is the most common, accounting for forty-three percent of centers with nineteen percent sponsored by a hospital or medical center, twelve percent sponsored by a school district, ten percent sponsored by a private or nonprofit organization, and eight percent sponsored by a local health department (School-Based Health Alliance 2016). As I show later, of the sixteen Maine SBHCs in this study, seven are FQHC sponsored, a local health department sponsors four, three are sponsored by a hospital, and two are school district-sponsored.

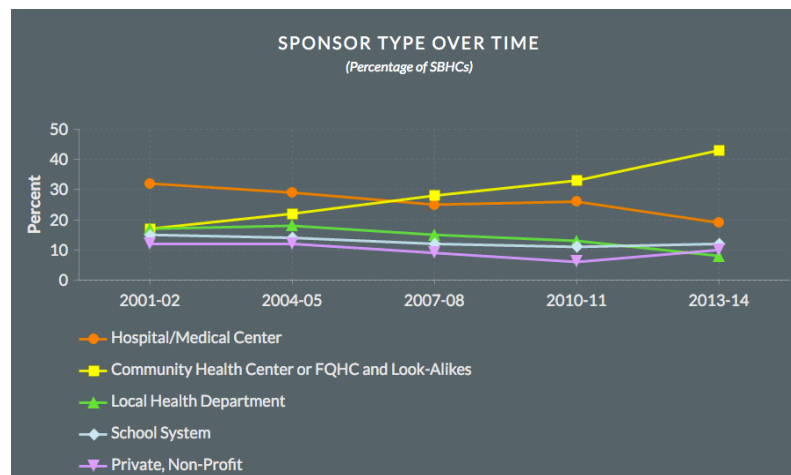


Figure 1. SBHC Sponsor Type Trends.

Federal Policy and School-Based Health

As of 2016, there is no oversight of SBHCs from a federal agency. There is also no consistent source of federal funding, although there were some one-time grants made available through the PPACA in 2010. However, there are still a number of factors at the federal level that impact the status of SBHCs. Increasing concern at the federal level over children's health care over the past decade resulted in the introduction of legislation, demonstrating the rise of SBHCs on the federal agenda. In 2007, Senator Gordon Smith (R-OR)

introduced the School-Based Health Clinic Establishment Act of 2007 (U.S. Congress).

Concurrently, Representative Darlene Hooley (R-OR-5) introduced the School-Based Health Clinic Act of 2007 in the House (U.S. Congress). While neither of these bipartisan bills made it beyond the committee stage, these efforts mobilized advocates and built congressional support for school-based health at the federal level.

In addition, the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) defined SBHCs as a provider of services, establishing a legal basis for reimbursement, which is vital to the financial sustainability of the centers (APHA 2010). CHIPRA provided the first definition of SBHCs in federal insurance law.

The PPACA of 2010 also included two provisions that have directly affected SBHCs: a federal grant program and an emergency appropriation to provide \$200 million to SBHCs over four years ((P.L. 111-148), Title IV, Section 4101) (Holmes 2010: 5). The grant program was short-term and directed for infrastructure development, not the provision of services. The PPACA also requires U.S. Citizens and legal residents to have qualifying health coverage, which in addition to Medicaid expansion, results in fewer uninsured people than in the past. The rate of uninsured children dropped from 8.2 percent to 5.5 percent from 2009 to 2014 (Cohen 2015: 10).

In fiscal year (FY) 2011, the Health Resources and Service Administration (HRSA), an operating division of the federal Department of Health and Human Services, awarded \$95 million in grants to 278 SBHCs across the country. An additional \$14.5 million was appropriated in FY 2012 to support an additional forty-five centers (HRSA 2013). In 2013, HRSA awarded \$75 in grants to SBHCs across the country. The PPACA authorized the School-Based Health Center Capital Program in order to address the capital needs of SBHCs. This federal law identified "sponsoring facilities," synonymous with sponsoring agencies, as: hospitals, public

health departments, community health centers, nonprofit health care agencies, local educational agencies, or programs administered by the Indian Health Services, Bureau of Indian Affairs, a tribe, or tribal association. The purpose of this program was to provide SBHCs with funding for construction, renovation, and equipment. In FY 2011, two sponsoring agencies in Maine received a combined total of \$698,629 and in FY 2012, one sponsoring agency in Maine received \$225,000. FY 2013 brought in a total of \$1,640,097 in federal funding to six sponsoring agencies in Maine that administer sixteen individual centers (School-Based Health Alliance 2013).

The inclusion of SBHCs in “The Community Guide” in 2015 reflects the heightening status of SBHCs and the recognition that SBHCs are an effective, evidence-based model of health care delivery. The Guide to Community Preventative Services is a collection of findings and reviews on interventions that improve community health. Produced by The Community Preventative Task Force, “The Community Guide” identifies SBHCs as an effective intervention to promote health equity (2015). Their review of forty-six studies found that SBHCs in low-income communities improve health and educational outcomes and reduce disparities. It also revealed that use of SBHCs can lead to net savings for both users and Medicaid.

Previous Research in Maine

As mentioned previously, this paper seeks to complement and update some of the findings from previous research. Maine is one of the leaders in SBHC quantitative data collection, and input from the state’s SBHC evaluator was recently integrated into the development of a national standardized measures pilot program (12/7/15 18:7). In addition, while a large majority of research on SBHCs is drawn from quantitative data, Maine’s SBHCs

illustrate a notable exception. Previous qualitative research, the “Maine School-Based Health Center Sustainability Study” was published in 2004, which included interviews with SBHC coordinators and three in-depth case studies of SBHCs in Maine (Shaler 2004). Four of the coordinators interviewed in this previous study were at the same sites included in this research and two of the case study sites are included. The centers now all have different coordinators than in 2004. The author found nineteen sustaining factors that contribute to the long-term outlook for an SBHC, resulting in a presentation of a number of recommendations for improving school-based health in Maine (Appendix). The purpose of this research was not to replicate this study, but to revisit some of the sites that were included in the original study, to update some of the findings, and to provide a new angle from which to conceptualize school-based health in Maine.

Theoretical Framework

School-based health centers are not as numerous or well studied as other healthcare organizations, particularly through qualitative methodologies. This research draws principally on negotiated order in addition to theories of standpoint and policy implementation. Sociologist Anselm Strauss’ pioneering work in “The Hospital and Its Negotiated Order” (1963) inspired the theoretical framework for this research. The purpose of Strauss’ approach is to reveal, “how a measure of order is maintained in the face of inevitable changes (derivable from sources both external and internal to the organization)” (Strauss 1963: 148). This framework emphasizes the “temporal clause” and that hospitals are “where persons drawn from different professions come together to carry out their respective purposes” (Strauss 1963: 148, 150). School-based health centers, like hospitals, are complex organizations, as Strauss would say, with a number of varied actors. Strauss, in his research on psychiatric hospitals, unpacks the negotiations and division of labor that create an ongoing sense of order. Strauss, unlike his

predecessors doing research, highlights the importance of the interactional features of the organization, finding that when there are personnel trained in different occupations there will be differences in philosophies and values. A number of theorists have adopted his work and applied it to different settings. The negotiated order approach to the study of organizations focuses on the perspectives of actors within the organization (Fine 1984: 239). The core of this approach is “the way in which interactants perceive the structure in which they are embedded” (Fine 1984: 243). There are three concepts through which scholars originally examined negotiated orders: negotiation, negotiation context, and structural context (Maines 1982: 270). I draw primarily on negotiation context and structural context, focusing on the meso-structural level, as well as larger circumstances that affect negotiations rather than the direct types of interaction among individual actors (Maines 1982: 278). I take these insights along with the “bottom-up” approach to policy implementation. Twenty-first century policy scholars contend that a more democratic approach to policy analysis, one that considers local contexts rather than the statistical “top-down” approach, is the direction in which policy scholarship should move (deLeon 2002: 478). Increasingly, scholarship in this area highlights that contexts, in addition to individuals, are actively involved in shaping policy outcomes (Nilsen 2013: 9). To be sure, Strauss acknowledges that negotiation takes place within a specific structural context based on institutional patterns within a specific sphere, which includes legal frameworks and local contexts. Like the hospitals Strauss describes, SBHCs are locales where varying professions coalesce. However, they are also sites where distinct organizations intersect and establish order, much as different professionals do at the intra-organizational level.

Strauss’ grounded theory methodology and negotiated order apply to school-based health centers because they are individually complex organizations with professionals trained in

different occupations. This approach emphasizes the importance of doing research in the field, grounding theory in data, and a focus on process and structure (Strauss and Corbin 1998). The three foci of organizational structure, according to negotiated order, are the types of employees, their treatment ideologies, and the institution's relationship to outside communities (Fine 1984: 241). At the meso-level, there are contracts, negotiations, and information sharing that occur among different school-based health centers, the state government, and other actors. Studying these processes through the lens of negotiated order reveals how social order emerges from complexity and uncertainty.

Following in the direction of others who have adopted this, here I expand the theory to inter-organization order in addition to intra-organization order. Gary Alan Fine suggests that the critical features of inter-organization order are: the segmentation of the market, network relations among organizations, and temporal-historical relations (1984: 253). This application of negotiated order allows for the study of the larger system, consisting of a variety of individual organizations. A main component of successful inter-organizational relations is communication; individuals must know whom to contact and how (Fine 1984: 254). School-based health in Maine is a complex network of government agencies, health systems, and schools, and Strauss' negotiated order theory provides a framework for understanding the factors that shape how divergent organizations negotiate funding agreements and contracts across the system and the impacts that has on more local negotiations within each center.

While previous studies have drawn on negotiated order research to inform managers on how to best control their environments, others apply this framework with a larger structural context, determining how varied organizational arrangements facilitate unique processes of

negotiation. Hall and Spencer-Hall, in their study of two school systems, identify seven factors that influence negotiated order, which are:

The nature and organization of operation tasks, organizational size and complexity, the distribution, use, and effectiveness of power, leadership and administrative style, the degree of organizational change, the nature and relationships of organizational personnel, and the number and significance of organizational problems (Fine 1984: 255; Hall and Spencer-Hall 1982: 328, 344).

These findings inform my study of SBHCs by pointing to possible areas that are most salient and impactful at the local level of care. Other scholars, in highlighting the continual process of negotiations have drawn on a more interactional and discursive practice within organizations, which I reflect by employing the phrase “negotiating order.”

METHODS

Drawing on the theoretical frameworks of institutional ethnography, standpoint theory, and negotiated order, qualitative methodologies elevate the perspectives of those working in school-based health in Maine. Strauss' open-ended approach to his study of the negotiated order in hospitals paired with the institutional ethnographic approach of uncovering power relations informed the methodology for this research.

Institutional Ethnography

Institutional ethnography is a method of inquiry that explores the social relations organizing institutions from the perspectives of people participating in them (Smith 2005). Feminist standpoint theory proposes that with patriarchal relations of power women occupy a social location providing them a privileged access to social phenomena (Longino 1993: 201). I extrapolate this approach to my study of SBHCs, arguing that the administrators of the programs hold a perspective that researchers have underprivileged. Seeing perspectives as “partial” highlights the importance of particular social locations from which people perceive the system. Dorothy Smith's seminal work on institutional ethnography advocates for a sociology that “begins with ‘insiders’ knowledge” (Smith 2005; Longino 1993: 203). Similarly, feminist scholar Donna Haraway argues, “feminist objectivity is about limited location and situated knowledge, not about transcendence and splitting of subject and object” (Haraway 1988: 583). These perspectives can then be translated to policy recommendations through the bottom-up approach to policy implementation.

Sampling and Data Collection

I used both purposive and convenience sampling. In an effort to include as many standpoints as possible, participants included school-based health center coordinators, a school nurse, a mental health provider, a school-based health advocate, a state government employee, and a school-based health data evaluator. The coordinators are employees of the sponsoring agency who oversee the management of the school-based health programs. School nurses are school employees and not officially affiliated with the SBHC, although some schools integrate the school nurse into the same space as the SBHC. I selected this sample strategically in order to cover a majority of the school-based health centers under the state grant in Maine and to gain an overview of the system as a whole outside of the individual centers. This sample allowed for an analysis of the relations between the state government, the sponsoring agencies, and the sponsoring agencies and the individual centers, revealing the negotiations that shape the provision of services and the sustainability of the programs.

I found all of the participants' contact information online or met them at the school-based health meeting. I emailed all participants in the study and provided a brief memo about the purpose of the research. All participation was voluntary. Participants selected interview times and locations, and all interviews took place at the workplace of the participants. Two interviews were at school-based health centers while the others were in office spaces off-site. The Colby College Institutional Review Board approved this research, and all participants provided informed consent.

This research project employed qualitative techniques of data collection. Semi-structured in-depth interviews afforded participants the agency to steer the direction of the interview and to provide responses in their own words. This method of inquiry provided participants the

opportunity to discuss salient topics that I as a researcher could not have anticipated. After my first interview, I narrowed the research topic to SBHCs in the state of Maine funded through the state grant, which the Maine Center for Disease Control (CDC) administers. This includes sixteen SBHCs in 2016 overseen by eight sponsoring agencies. This research includes qualitative data from four sponsoring agencies, which oversee eleven school-based health centers in Maine.

While data collection continued as patterns changed during my analysis, new coding schemes shifted the focus from policy implementation to stability and sustainability. From November 2015 to February 2016, I collected data. My main source of data was five individual interviews and two two-person interviews. I also attended a full-day Maine Assembly on School-Based Health Care meeting. The meeting and all but one of the interviews were audio recorded. The other interview was a more loosely structured informational interview over the phone, which provided background and contextual information in preparation for the meeting. In addition, I drew on several other sources of data for this study, including the meeting, the School-Based Health Alliance online mapping tool, and ongoing correspondence with some participants outside of the interviews.

Data Analysis

After conducting interviews and attending the meeting, I transcribed the recordings and coded the transcripts using Dedoose, a mixed-methods research program. My analysis uses a theoretically grounded approach starting with open codes, which identifies the dimensions of different concepts in the data (Strauss and Corbin 1998: 101). My coding focused on the content of the interviews rather than the tone or diction. Subsequently, I used a second round of coding to relate categories to subcategories to link concepts and selective coding to refine the theory

(Strauss and Corbin 1998: 123, 143). As I sorted through my findings, I rearranged the codes into categories that fit conceptually with those findings. I also received center-level data on a variety of indicators that SBHCs report on as a stipulation of the state grant. I referenced these data to better understand the contexts in which the centers are situated and the services that they provide. From these data, I used a bottom-up approach to elevate the perspectives of individuals working in school-based health in Maine.

Limitations

A number of limitations are worth addressing. This paper addresses only SBHCs in the state of Maine that receive funding from the state government. Other centers in Maine do not receive state funding; this study is not a comprehensive overview of all SBHCs in Maine. Moreover, there are eight sponsoring agencies in the state, and I only present four in this paper, accounting for eleven of the sixteen centers under the state grant. While a comprehensive look at the systems from every perspective would have been ideal, I conducted interviews primarily with program coordinators, so the perspectives of medical, mental health, and dental providers are not represented thoroughly. Additionally, there is no cross-state comparison included in this paper, but that is an important next step for school-based health research. Although I worked to reduce bias in my research, as an advocate for equitable access to quality health care, the lens of my own personal and professional values and ambitions inspired this work and there is no way of eliminating bias entirely.

The State of Maine

While not all SBHCs in Maine receive state funding, most do, and these centers are the focus of this research. The first SBHC in Maine opened in 1991. For the 2015-2016 school year, there are 21 SBHCs in Maine, but this number fluctuates over time due to the opening of new centers and the closing of other centers. The Maine Assembly on School-Based Health Care, the state affiliate for the national School-Based Health Alliance, meets every two months during the school year in Augusta, Maine to discuss different aspects of the programs and to present their quality improvement projects. Central to the ongoing success of Maine SBHCs is the sponsoring agency. Each SBHC has a “sponsoring agency,” the organization tasked with the administration and sustainability of the school-based health program. The sponsoring agency serves as the fiscal agent for the centers, managing funding and program operations. In Maine, sponsoring agencies include school districts, health systems, federally qualified health centers (FQHCs), and a local public health department. This range of sponsoring agencies, I demonstrate below, has implications for the delivery of services and the sustainability of a given center. Moreover, the particular networked relations of the sponsoring agency, the educational bureaucracy, and the healthcare system creates relations unique to school-based health centers and the community contexts in which they are situated. This paper considers those relations through the lens of negotiated order.

During the 2014-2015 school year, there were 185,767 public school students in Maine. The sixteen centers that are the focus of this study served 10,457 students (5.6 percent). At these schools, 39 percent of the students (4,112) were enrolled in the SBHC. At individual centers, enrollment ranged from 76 percent to 16 percent of students, so there is notable variation. Across the state, 54 percent of enrollees accessed SBHC services that year. Of the 12,764 total visits in

2014-2015, 54 percent were for mental health care, illustrated in Table 1 (Aubut 2011). Students with MaineCare, Maine's Medicaid program, accounted for 57 percent of the visits. Of the total enrollees, 47 percent had MaineCare and 41 percent had private insurance. Table 2 summarizes this insurance information (Aubut 2011).

Table 1. Behavioral Health Trends in Maine SBHCs.¹

	2011-12	2012-13	2013-14	2014-15	Average
Behavioral health users	561	357	483	480	470
Behavioral health encounters	4,506	4,503	5,974	6,870	5,463
% of all encounters to behavioral health	37%	45%	51%	54%	47%
Behavioral health visits per user	8.0	12.0	12.4	14.3	11.6

Table 2. Insurance Status of Students in Maine SBHCs.

Insurance Type	Encounters	Users	Enrollees
MaineCare	57%	53%	47%
Anthem (Private)	12%	13%	14%
Other Private	22%	24%	27%
No Insurance or Self-Pay	2%	3%	3%
Unknown	7%	7%	7%

¹ The Muskie School of Public Service at the University of Southern Maine evaluates the school-based health programs under the state grant.

FINDINGS

As I conducted my research, I found that the sponsoring agency type was the most salient factor in shaping how individual SBHCs negotiated order in the provision of health care services. These findings focus on the differences between sponsoring agency types and the experiences of administrators situated in these different organizational structures. Drawing on the perspectives of school-based health administrators and their everyday realities of the programs, this section addresses four salient areas of negotiation in which the type of sponsoring agency was directly implicated. They are: stability, values, sustainability, and best practices. I developed these areas of negotiation based on the most prominent themes that emerged from my analysis of participants' narratives as well as my observations of the school-based health programs that I visited.

Federally qualified health centers

The ability to bill both public and private insurance for services is vital to the financial sustainability of the centers. In Maine, the state CDC treats all sponsoring agencies equally with regard to the distribution of grant funding. However, key differences exist between sponsoring agencies that directly impact the workings of the SBHCs, including internal policies and reimbursement rates. For instance, all of Maine's SBHCs that receive state funding bill for the services they provide. Maine's largest health insurers, Anthem Blue Cross and Blue Shield, Harvard Pilgrim Health Care, Inc., Aetna Health, Inc., and CIGNA HealthCare, Inc. reimburse SBHCs for eligible primary care services and do not require preauthorization for these services (Goldberg 2002). Medicaid similarly recognizes SBHCs as a provider type in Maine and does not require preauthorization.

While services provided by all Maine SBHCs are eligible for public and private reimbursement, the distinction as a “federally qualified health center” (FQHC) qualifies the center for higher reimbursement rates from Medicare and Medicaid in addition to other benefits. As Figure 1 demonstrates, FQHCs are the most common sponsoring agency type nationwide, and the same holds true for Maine. FQHCs are defined under Section 330 of the Public Health Service Act. To be considered an FQHC, centers must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have a quality assurance program, and have a governing board of directors. In the case of SBHCs, the FQHC is the sponsoring agency, which qualifies the school centers for the FQHC rate of reimbursement, but, for example, the board of directors is for the sponsoring agency as a whole, not the individual SBHCs.

The variable impacts of the sponsoring agency’s type can also be seen by the mediating impact it has on the salience and role of school boards in negotiating the order of care in local schools. SBHCs, no matter what kind of sponsoring agency, are integrated components of schools. As such, they are overseen by and accountable to school boards. In Maine, local elections decide who sits on school boards.² In theory, school boards, as popularly elected entities, are representative of local populations and reflect the general will in their decisions. With regard to SBHCs, school boards, as well as the superintendents they select, have the ability to determine which services are available to students- embedding local political concerns in the services provided. In some communities, the superintendent may catalyze the opening of a new SBHC while in others a lack of support from the top educational official may hinder the long-term outlook of a center.

² This is similar to most states in the United States, although in some states government officials appoint members of certain school boards.

Obstacles to Standardization

External structural contexts set the framework within which order is negotiated in Maine's SBHCs. While some states do define SBHCs in state law, there is no legal framework, or even definition, for SBHCs in Maine. Moreover, there is no standardized set of requirements for centers to have credentials or certification. Centers funded by the state grant do adhere to state operating standards so there is oversight and accountability in that regard. This distinction is important contextual information, particularly as researchers and policymakers consider national efforts to establish standards or secure federal funding. Under state Medicaid law in Maine, SBHCs are a provider type and preauthorization is waived for some SBHC services. Preauthorization is a decision made by insurance companies that require that a service is medically necessary to be eligible for reimbursement.

A primary consideration for all SBHCs (and Maine is no exception) is the availability of funding. Sixteen SBHCs in Maine receive funding from the state government. The Maine CDC Adolescent and School Health program oversees school-based health programming in the state. Not all states run their school-based health programs through the state government in this way. Maine is one of eighteen states that provide state funding for SBHCs. During the 2013-2014 school year, the state government allocated \$699,700 to school-based health. Every five years, the state CDC releases a competitive request for proposals (RFP). Sponsoring agencies then apply for this state grant funding, which, if approved by the CDC, they receive for five years until the next RFP. In Maine, the majority of the funding for school-based health (\$480,410) comes from the Fund for a Healthy Maine. These funds come from tobacco manufacturers under the Master Settlement Agreement in the late 1990s. Another \$219,130 comes from the state

general fund and the remaining portion comes from the state portion of the Maternal and Child Health Block Grant.

The state determines funding levels based on a formula, which includes school size, utilization, hours of operation, and services provided (12/7/15 4:19). Sponsoring agencies, some of which oversee multiple centers, have the jurisdiction to allocate those funds as they see fit across the individual centers. The state grant system requires, most significantly, that centers report on certain quantitative indicators semi-annually, that they establish youth and adult advisory boards, and that they complete quality improvement projects known as “project charters.” This source funding is the only point of standardization across the centers, which is why this project focuses on the group of sixteen centers that have some commonality due to this central source of funding. Agencies cannot use state funds for capital improvements. In addition to insurance reimbursement for services, other sources of funding may include school districts, community partners, health systems, additional outside grants, and insurance reimbursement for services. Funding mechanisms for SBHCs in Maine differ across centers, dependent on the sponsoring agency. Funding is precarious, so financial planning is important in ensuring the long-term sustainability of the centers.

In addition to funding, there are also several legal barriers to standardizing the practice of healthcare for Maine’s SBHCs. First, as a stipulation of the state grant in Maine, SBHCs must have both a youth advisory board and an adult advisory board. This further embeds the health center in the local community and ensures that they act with not only the patients’ (students’) interests in mind, but also that they are accountable to parents, teachers, and other community members. Maine state law also requires that for legislators to access state employees for programmatic information, they must go through the executive branch to gain permission

(12/7/15 16:11). This deters the flow of information between state policymakers and those working at the programming level, directly impacting the negotiated order at this level of administration.

Maine state law mandates that minors can consent to confidential contraceptives and pregnancy testing, emergency contraception, sexually transmitted infection (STI) tests, and mental health and substance abuse care. If the minor requests confidentiality, funding from the state grant is used to cover the costs of these services, which are non-billable because of their confidential nature. These legal structures play a part in framing the discussions taking place, and, as I show in the following sections, directly impacted the perspectives of those working at the level of policy and program implementation.

Table 3. SBHC coordinators who participated in interviews.³

Participants	Sponsoring Agency Type	# of School Districts	# of SBHCs
Denise	FQHC	2	4
Luke	School District	1	1
Jane	FQHC	1	2
Mark	Local Public Health Department	1	4

Stability

A key area that emerged from participant narratives was the issue of organizational stability. The role of individual actors within these organizations, particularly when they may be the only one situated within their occupation in a diverse group of health professionals, is salient. While the centers range in size, they all have fewer than ten staff, making the question of how to ensure routinized, regular care a central concern. As previously mentioned, each center does things differently due to the type of sponsoring agency, the available resources, and the local

³ All names of participants have been changed to protect confidentiality.

context. In a space where everyone is the de facto expert in what they do by default of being the only one, establishing order poses a challenge as individual personalities and philosophies are prominent. For Mark, whose centers are sponsored by local public health department, the differences among actors complicated the process of establishing order. He said, “obviously when you have this system where there’s a lot of different actors, you know, nobody is in full control of the process” (2/11/16 15:15). The effect of sponsoring agency type on the bureaucratization of the centers is salient particularly with regard to working relations. For Denise at an FQHC, “relationships” tend to “ebb and flow,” which influences “how things should go, so you know, for example, should everything triage through the nurse, or should people be able to access us freely on their own accord. I think that’s been one question on the table in terms of philosophy and how that might conflict amongst providers” (11/23/15 20:14). SBHC and school staff members negotiate these decisions. The size and structure of the organization is salient with regard to the negotiation of order and organizational change. Mark, the coordinator of the most bureaucratic of the programs at the local health department, echoed some of Denise’s sentiments, expressing concern over the issue of determining “where is my effort best focused.”

Yeah it’s quite a little conundrum and lots of different actors and mostly everybody has good intentions, but certainly a lack of I guess like collective you know will or accountability to like how would we all really push this in a good direction you know what I meant there’s not really that (2/11/16 19:7).

For him, the coalescence of a variety of actors was sometimes a hindrance to progress because there are different views on what the process should be.

Yet, this concern was not prominent in the narratives of all participants. The long-time school nurse at a school district-sponsored center, Sherry, who is collocated with the SBHC although not an SBHC employee, provided a divergent perspective of her center, saying “we

really are a team. We're a great team, the athletic trainer, the counselors, the nurse practitioners, you know [the coordinator], myself, I don't think people have egos. Like we just work together, like you do this, it's really good" (12/9/15 17:8). This agency has only one center at the local high school, while Denise and Mark each manage four centers, reflecting the differences caused by the level of bureaucratization within the programs.

Negotiating Values

The ways in which values are negotiated inter-organizationally, and which organization's values become represented in the provision of care was prominent in the narratives of my participants. Reproductive health is a contentious area of negotiation that involves a variety of actors including school boards, advisory boards, sponsoring agencies, and the community, which elucidates the salience of local contexts. The example of reproductive health illustrates the intricate balance among the community, sponsoring agency, and SBHC. While the negotiations occurring in the school-based health setting are paralleled by changing public opinion and nationwide dialogue on more controversial issues such as reproductive health, these issues vary by sponsoring agency type. Figure 2, representing only SBHCs nationwide that do not dispense contraceptives, illustrates the complexity of policies surrounding reproductive health at SBHCs nationwide. This represents the actors who have a stake in shaping the provision of care- and the sponsoring agency type determines how these negotiations occur and which organization holds the most power.

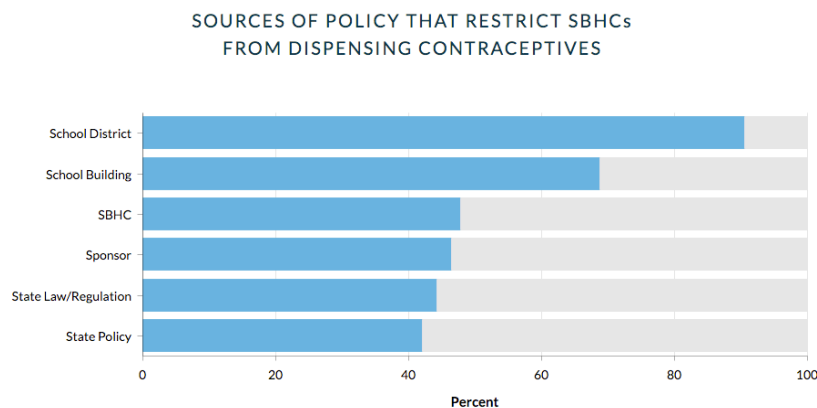


Figure 2. Sources of Policy that Restrict SBHCs from Dispensing Contraceptives.

Sherry, a school nurse at the school district-sponsored site (not an SBHC staff, but collocated with the center) recounted how reproductive health services became a component of the SBHC a few years after the center's opening:

And then a few years after that we said we wanted to have full reproductive health in our health center, but it was still early on. It was very early on. And so we went to the advisory board, and I remember the woman who was chair of the board...said, I think it's too soon, you know you opened up, you had the condoms, she said I would wait a couple of years. And, I think we took it to the students too, so we did wait a couple of years, so we did the whole focus groups again and once again went through one hundred percent without a glitch. And so, those advisory boards, you know, are great (12/9/15 5:15).

In this particular community, the school board provides a significant amount of funding and support, which increases the voice of community members in decisions about best practices. The open dialogue facilitated by the advisory boards and focus groups prevented the center from acting unilaterally in a way that may upset the community, and in the end, students were given access to reproductive health services and the SBHC involved the community in the decision-making process. Other healthcare institutions independent from schools do not have to go through this process and can act autonomously without community feedback. Sherry, the school

nurse at the school district sponsored site, shared the following anecdote, which may also reflect the relatively small, tight-knit community in which the center is located:

It's been very well received. It really has been. You know I'm not saying, once in awhile a parent will come in and express concerns. I remember one of our bus drivers in the district about ten years ago came in and said, you know, I want to talk to you, I'm really concerned about the birth control services here, I just don't think it's a good thing for students. And I said to her, "you know that's a dilemma" So do you give students birth control or you know, are they going to have unwanted pregnancy, it's a real dilemma. And she was like well that's, so it wasn't even, you know it wasn't even that hard (12/9/15 6:1).

The following example provides insight into one potential outcome of an SBHC-grounded model of community health, a model of care that is most closely attuned to the voices of local community and school board members. Sherry recalled:

I just would say as time goes more kids are talking to their parents say about birth control services. I mean... and we encourage that. And the state of Maine law says after you're 14, 14 years and older, they have a right to confidential services for reproductive and substance abuse services. But we certainly encourage them to talk to their parents and it seems like more and more are (12/9/15 14:27).

While the school-based health model uses focus groups to facilitate community negotiations, the sponsoring agency type shapes the overall access that youth have to reproductive health care. This can be seen most vividly within other communities in Maine that are not as open to the notion of reproductive health care in the schools. The student and adult advisory boards uphold the centers as accountable to the local community, which, in turn, reflects the local differences in the provision of reproductive health. When asked about the reproductive health services offered at the centers sponsored by an FQHC, Jane, the coordinator, responded that it was kept "under the radar." She explained:

It's not publicized. The superintendent's office when we first started, because we did focus groups before this was even put here and that was one thing the community did not want here is reproductive. So, the superintendent before basically told our provider if the kid is your patient we're not going to tell you how to do your job, but you are not going to advertise (1/28/16 15:25).

Although the school district and local community were not in favor of reproductive health services, as an FQHC the SBHC had greater control over the provision of services as compared to the previous example of a school district sponsored center. For Jane, it was a “game changer” that “kids can also choose us to be their primary care provider.” She elaborated:

Because if you’re my primary care provider and I want you to give me birth control, then that’s my right, like that’s the relationship. But a student just can’t walk in here and say can you put me on birth control, the answer would be no (1/28/16 15:29).

The sponsoring agency type shapes whether students can access their right to birth control in the school. At an FQHC sponsored SBHC, students can elect to have the agency as their primary care provider (PCP). If the sponsoring agency is a school district or public health department, they cannot serve as the students’ PCP because they are not open for the requisite number of hours or days. Since the centers sponsored by FQHCs are integrated into the larger local network of healthcare, they have the opportunity to serve as the PCP and provide that unfettered access to contraception.

While Jane, like Luke, alludes to how negotiating multiple voices can become complicated by the relative balance of power between stakeholder groups, the outcome in this SBHC was different. One of the practitioners at the same FQHC sponsored center noted, “We do all the screenings. Pregnancy tests, STI screenings, HIV if they want it. And that’s all under the confidential billing part” (1/28/16 16:6). This participant emphasized the perception in the center that the community would not be open to providing reproductive health services, saying, “I don’t think this community would ever go for it. You know people will say, try you never know, ehhe. I’m thinking that it would never go” (1/28/16 16:11). From her perspective, the community would not change their minds about reproductive health, demonstrating the embeddedness of

SBHCs in local contexts and the salience it has when students do not have the ability to name the SBHC as their primary care provider.

Yet, local school districts, I discovered, can also collude with sponsoring agencies in shaping the availability of services. For instance, Denise coordinates four centers sponsored by an FQHC under a Catholic health system. While sponsoring agencies shape the reimbursements, as previously mentioned, the structure of values within sponsoring agencies also plays a central role. Denise explained how reproductive health services work within her system:

Obviously being part of a Catholic organization, we, and also given that both the... school districts do not allow for prescription of birth control or handing out of any sort of prophylactics of any means, our providers often make referrals when necessary, to the local family planning, and assist students in terms of linkage to that if needed (11/25/15 10:8).

As was the case in the former example, the SBHCs do not ignore the issue of reproductive health, but there are differences in how much the centers can do. Not only are centers embedded in the communities through the residents, but they also engage in many partnerships to provide services outside of what they offer on school grounds. The SBHC facilitates the connection to local family planning services, which students may not have had information about or access to without the center. Denise emphasized, “But I mean we do pregnancy testing, we talk to them about what their options are, we give them a lot of health information about prevention and things of that matter” (11/25/15 10:16). While in this particular community some of the services offered are shaped by the type of sponsoring agency, the school districts share a similar, more conservative value structure. Denise stated, “there’s certainly some controversy in terms of reproductive health and our ability to do that. However, both school districts are against it as well, so even if there was that opportunity, their boards would have to be in approval of that” (11/25/15 15:18).

There are varying levels of negotiation that occur surrounding reproductive health services, and decision-makers can influence the provision of services based on their situatedness with the organization's relations of power. In one community, reproductive health was chief among the factors for the initiation of school-based health. A long-time practitioner from a center sponsored by a local health department recalled:

Our focus was primarily STI prevention, HIV was relatively new and scaring a lot of people then. Opening the SBHC's in schools was a comfortable way to provide access to preventive measures, condoms (including education on how to use), without school personnel, i.e. teachers, feeling like they needed to consider providing that service to keep their students safe (2/25/16 2:2).

Mark, the program coordinator at the same agency, described the available services:

So if somebody is, you know, worried that they might have an STI or that they might be pregnant or somebody is abstinent but they're thinking about becoming sexually active. So we would you know prescribe contraceptives, give out condoms, and obviously have conversations with people about their reproductive and sexual health (2/11/16 2:9).

In this community, there are SBHCs at the middle and high school level. Reproductive health services are available at the high schools but not the middle school due to a controversy around the provision of contraception to students at those grade levels. Mark recounted:

Yes, it's always been part of what we've done and when they had the controversy at [the middle school] I think they fielded it pretty much fine, you know the support from the superintendent and the school board didn't really falter. What did seem to have happen, just between [the family planning partner organization] and the [sponsoring agency] they did make a decision not to have [the middle school] be a family planning site anymore. So that just means in terms of like discount contraceptives or whatever it's not participating in that program. Now what I understand from staff is that over the years rates of sexual activity, but over the years, rates of sexual activity among middle schoolers has dropped in general. So it's not to say that no students at that school are sexually active but it's just to say that there may be fewer than before, and what I know from our data is that we have very few or perhaps no students coming to the health center that are sexually active. (2/11/16 4:20).

The availability of resources, in this case sub-grants from a partner organization, also shape the provision of services. These examples illustrate the continuously negotiated and dynamic nature of school-based health. There is no single model in every local context or within every organizational structure. Here, the sponsoring agency cooperates with the school board to establish an arrangement that satisfies the community's preferences while also balancing the need for quality health services for students who may or may not see another provider.

Sustainability

The type of sponsoring agency was also a salient theme shaping participants' concerns about long terms issues of sustainability. With the state grant as a central form of funding, centers must supplement the funds with additional funding while also understanding that the legislature could cut the state grant. Since the funding is part of the state budget, it is not guaranteed from year to year, which reflects the temporal nature of grant funding and the need for ongoing negotiations. The point person for the Maine state affiliate of the national School-Based Health Alliance explained:

Every couple years as of late there have been some recommendations or some proposals that are brought forth to either reallocate some of the funds from the Fund for Healthy Maine, questions as to how to justify the programs within the Fund for Healthy Maine, and I won't make a judgment call on why folks do that, but I think the general trend of tightening budgets, reducing waste, and really looking at effective programs have led to more and more questioning (11/16/15, 10:16).

I asked coordinators what they would do without the state funding, and my findings suggest that there are differences between sponsoring agency types with regard to this question. Luke, the coordinator at the site sponsored by the school district, provided the following excerpt:

So if the Fund for Healthy Maine goes away, well that was sort of going to happen in March, and we were kind of scared, so we went to the school board and

asked them if they would write in a contingency for the amount of money that would be missing, which we estimated would be \$24,000 because they said it would be two-thirds of the state money that we received. So the school board was willing to kind of put a reserve for us for the money that we would be missing in the event that it was taken away, umm, when it wasn't, that money is still sort of hanging out there, so I guess we would be looking for alternate sources of funding. And you know, we would probably look to the district, but also look out there for other ways of getting some money to cover (12/9/15, 2:17).

The embeddedness of the center in the community, because the local school district manages it and it started as a grassroots effort, may be a reason for this outlook. The district already provides funding for the center, so the state grant is not the only major source of funding. Luke believed that the support from the community and the school district would buttress the center's financial circumstances if needed. Denise, the coordinator at four SBHCs sponsored by an FQHC, provided a similar perspective with regard to her centers' longevity. Her centers, like the others, receive state funding from The Fund for a Healthy Maine, which she described as being "in jeopardy over the summer." Yet, as she explained:

And what I will say is that given our affiliation we felt a little safer than the majority of the other health centers in the state who function solely on what they recoup for insurance and the grant. We're lucky enough that our larger system supplements us at times when we are below budget. And, you know, we would have had to change probably our practice significantly had that fallen through (11/23/15, 5:22)

For her, being a part of a larger health system acts as a safety net and a means of financial security at least in short-term situations. Even so, she expresses a lot of uncertainty. Jane, at another FQHC, expressed similar thoughts. She said, "I don't think [the sponsoring agency] would want to pull our program because they are supportive. But financially we would probably... dramatically reduce our hours or we would be cut completely" (1/28/16, 19:14). Even in the centers with FQHC sponsors that are part of larger health systems and receive higher rates of reimbursement are unsure of what would happen without the state grant. From the

perspective of Mark at the local public health department, he thought that the financial problems were less of an issue of sponsoring agency type and more of an inherent characteristic of the SBHC model:

And obviously that's part of the sustainability conversation too. Although you know apparently even at that rate [FQHC sponsored SBHCs] don't, they can't necessarily break even, but you know. And part of that is because of, it's because you have a finite school population (2/11/16, 9:12).

The precarious nature of funding for SBHCs transcends sponsoring agency type, but the major difference is where the centers would turn for financial support in the case of funding cuts. The question of sustainability influences other aspects of the programs, according to Mark. He discussed how finances frame other aspects of the program:

So essentially the project has been put on hold, which is probably related to our larger sustainability issues because I think essentially what you have is like a little bit of a catch 22 maybe where you need to make some infrastructure investments to improve your program, but then of course that costs money and the reason your program is kind of unstable in the first place is because you have some stability of funding issues and so it's kind of a, kind of a vicious cycle (2/11/16, 7:11).

Unstable financial circumstances, for him, shape the ability for quality improvement, which, as described, is a required component of the state grant. This cycle, framed by funding and budgets, creates a precarious situation for the centers. The state coordinator provided her perspective on how this issue might be resolved, pointing to the safeguard that an FQHC or health system provides:

And, again, sort of connecting them to potentially some of kind of community care networks that are already based around improving health access like a federally qualified health center or another health system that would be able to sort of kind of incorporate them into the overall mission of a larger organization that could protect them a little bit. (12/7/15, 16:12).

There is space for negotiation with other local agencies for funding or other means of support. However, even the coordinators at the FQHC sponsored centers expressed their concerns about

funding, so although the sponsoring agency type may influence some aspects of sustainability, the SBHC model, from the perspectives of my participants, presents challenges for financial sustainability.

Best Practices

The last of the principle areas of negotiated order to emerge from my analysis was the practice of care and decisions about what constitutes best practice. The philosophies and values of actors involved in school-based health shape the provision of services. For Denise, who coordinates centers sponsored by an FQHC, triage practices were a point of negotiation. She oversees centers at four schools in two school districts, which presents variations in policies. She provided the following commentary:

Relationships...ebb and flow and a lot of it from what I recall is kind of based on sometimes personalities between the major players, philosophies and values about, you know, how things should go, so you know, for example, should everything triage through the nurse, or should people be able to access us freely on their own accord. I think that's been one question on the table in terms of philosophy and how that might conflict amongst providers

You know, policies around kind of working through both systems. So we may have our own policy about things, but the school may have a policy you know. (11/23/15 20:14).

There are institutionalized avenues for negotiation with regard to the relationship between the school and the centers for these FQHC sponsored centers. Denise explained that there is a “memorandum of agreement with each school. And that outlines sort of what to expect from them and what to expect from us, in terms of what we’ll provide and what they’ll do for us. Part of that is that they house us” (11/23/15, 6:19). This outline of expectations is one mechanism through which the sponsoring agency and the schools negotiate order.

Another area of negotiation within school-based health can be seen in participants' narratives of best practice with respect to methods of communication. Specifically, the type of sponsoring agency influences what platforms are at the centers' disposal for sharing health information. From the perspective of the head of the Maine state affiliate of the national School-Based Health Alliance, centers should have agreements in place for the sharing of data. She shared the following:

And they would have written agreements, a written agreement or other formal agreement so that they can share the personal data. They do have electronic systems that capture, to often capture, the patient visits at school-based health centers, but it's most of the time not interoperable with other electronic medical records. Especially if your students are from various different primary care providers, they're not on the same platform anyways. So, it would have to be a fax or a letter or something low-tech.

I think setting up, encouraging school-based health centers to set up more of those formal agreements, and standardizing the way they reach out and the periodicity, so how often am I contacting that primary care provider or other provider. (11/16/15, 4:18).

For her, there should be formal agreements and a system in place to facilitate communication among SBHC providers and other providers outside of the school. Luke, from the school district sponsored site, reflected on his own challenges of determining best practices, noting that the state meetings were places of information sharing and that the coordinators have collegial relations.

He shared:

And speaking for myself, I feel like I have good relationships with my cohort. We aren't as frequently in contact as maybe I'd like to be. Whenever I do reach out to them it's electronically usually or by phone and it's to ask a question, but we provide information for each other like if someone wants information about how we started our health center, for instance, or a policy that we've had in place. We share and that's all fine, like there's no issue with that. Or if someone did a project charter that I'm looking at doing I might ask them if I could see it and we share and that's fine because everybody's data is different. And we all kind of do things a little bit differently. There are nuances. So the meetings are great because we'll share something that we're doing and then someone will say well we're doing it this way have you considered that and an idea comes (12/9/15 10:29).

I then asked about the most challenging part of the meetings. He replied:

I'd say mostly for me I'll hear somebody say that they're doing things a certain way, and then I'll think well gosh we do it differently, is the way we're doing it okay. And then like who is the person that says whether or not it's okay because obviously we all want to be doing things the right way. So, [the coordinator] at the CDC is the person that I feel is, you know, the person that would, basically, say if what we're doing is okay. And we can read our grant and see, you know. So for me being new I guess that's the biggest thing. But it really isn't that big because usually there's a million different ways of doing it and most of them are fine. So we just kind of discuss it (12/9/15 11:11).

While this area of negotiation does not relate directly to the sponsoring agency type, the larger structure in which SBHCs are situated shapes the organization of the individual programs. Luke, at the school district sponsored center, noted that the avenues for negotiation are not always clear because he it can be unclear what the hierarchy of decision-making is when it comes to best practices. The state-level coordinator noted that, "The thing that's interesting about school-based health I would say in general is that, I mean, you know, every one of our sites does things a little differently, every state seems to do school-based health centers differently, it's crazy" (12/7/15 17:1). She does not suggest whether this is positive or negative, but the above statements suggest that those working in school-based health recognize the variation in programs.

DISCUSSION

One purpose of this research is to educate people about school-based health in an effort to increase awareness of this model of healthcare delivery. To this end, a number of factors unique to the school-based health model present locally specific challenges and opportunities for both programming and the provision of care. The legal context within which health care is provided in the United States sets the major structural framework for any discussion of health services. SBHCs, like other healthcare providers in the United States are a business. They must meet sufficient levels of reimbursement in order to stay afloat financially, which can be a challenge given the finite nature of a school's population. The embeddedness of SBHCs in local contexts is salient when compared to other primary care centers in a given community because if the SBHC were to go against the community's wishes, they would alienate the parents of their students. This would likely decrease the number of enrollees, and in turn, decrease income from billable visits. The institutionalized space for negotiation through the advisory boards and focus groups serves to ameliorate community concerns and reconcile the values of different actors. Negotiating the relationship with the community effectively is a financial necessity. The model of healthcare in the United States makes this so, and demonstrates that although SBHCs are a unique model of care, they are still bound by the larger system.

There are current efforts underway to standardized school-based health practices and develop the means to report the collective impact of the centers nationwide. In Maine, the state grant serves as the only source of standardization for the SBHCs in this study by requiring that centers fulfill certain requirements. The lack of institutionalized organization for school-based health leads to the great diversity in the negotiated order of authority. This presents challenges as centers try to employ best practices and remain sustainable in the long-term. The School-Based

Health Alliance, a national school-based health advocacy organization founded in 1995 advocates for the SBHC model at the federal, state, and local levels. The organization has undertaken a number of initiatives with the goal of improving the capacity of SBHCs. These initiatives currently include the areas of oral health, substance abuse, health system transformation, health care finance, and quality-improvement. A number of grant-funded projects are ongoing as well. The two quality-improvement pilot projects focused on standardizing performance measures and establishing sustainable business practices are most relevant to my findings. The rationale behind these projects is that the data collected at the state level varies tremendously, which does not allow for easy comparison nationwide. Standardized measures may allow for comparisons across centers and states, which could lead to large-scale quality improvements and long-term sustainability of the SBHC model nationwide.

I found reproductive health to be the area of greatest controversy; it revealed the layers of decision-making and the various actors involved in the negotiations surrounding the provision of services in school-based health programs. If the sponsoring agency is opposed to providing contraceptives and a school district felt strongly about providing that service, they could seek a sponsoring agency that would allow for it. However, if the school district is against the provision of contraceptives, the balance of power only favors the sponsoring agency if it is an FQHC. The organization of SBHCs is not static, and every five years with the release of a new RFP from the state, program restructuring can occur. This reflects the process of continual negotiations that occurs in order for organizations to maintain their working relations because the programs are flexible in their arrangements, as demonstrated by the variation across the state of Maine.

SBHCs serve as a valuable resource not only to the students, but also to the school community as a whole. The presence of an SBHC allows educators to focus on academic

instruction, knowing that down the hall, medical and mental health practitioners can meet the comprehensive health needs of students. This relieves some of the pressure on teachers so they do not feel as though they must counsel their students on issues not directly related to the classroom. Teachers spend a majority of the day with students and may recognize a medical or mental health problem that no one else may notice in a student.

Moreover, SBHC provide youth with the agency to access health services, if their parents have enrolled them, which may reduce some of the stigma of seeking care, particularly in centers where everything is in one location so no one can tell why a student is entering that space. Arguably, services for mental health and infectious diseases are crucial, but if young people feel as though they must conceal certain conditions and not seek care, then they go untreated. The school-based health model serves to reduce stigma and provide agency to youth to make decisions regarding their own health and wellness when compared to other health care providers.

SBHCs have proven effective at addressing health and educational disparities despite many challenges to sustainability. The school-based health model reflects an ongoing process of negotiations among a number of actors to shape the provision of care. My findings suggest that the sponsoring agency type is the most salient feature of an SBHC in shaping the provision of services and the sustainability of a center. Local contexts are also salient, and as nationwide efforts at standardization continue, there must be recognition of what aspects should be negotiated at the state or local levels. Further state-level research allowing for cross-state comparisons would elucidate best practices at the state level, including research on the level above the sponsoring agency. As not all state governments are involved in school-based health, research comparing the differences between states with and without government support would provide a comparison beyond the scope of the sponsoring agency. As SBHCs continue to

increase in numbers across the country, schools and potential sponsoring agencies should be cognizant of the ways in which the programs are structured and what the implications are for different organizational arrangements.

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Appendix. Sustaining Factors for SBHCs in Maine.

1. Staff leadership and rapport
2. Positive student perceptions of the center
3. Favorable school/community perceptions
4. Staff continuity
5. School support
6. Active involvement of the sponsoring medical agency
7. SBHC integration within the school
8. SBHC personnel work closely with school nurses
9. Partnerships with community organizations
10. Providing mental health services
11. High quality of care
12. Regular hours of operation
13. Diversified funding sources
14. Use of board members and volunteers
15. Having marketing plans
16. SBHC co-location with other services
17. Expanding services
18. Billing for services
19. Productive relationships with area providers