State Funding for School-Based Health Centers in Colorado

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Colorado Association for School-Based Health Care

Table of Contents

Overview

The Colorado Association for School-Based Health Care (CASBHC) has long been a proponent of investing state resources in school-based health centers (SBHCs). SBHCs play an indispensable role in providing care to thousands of Colorado children who may otherwise have difficulty accessing needed services.

CASBHC believes that SBHCs offer an efficient and effective model for delivering health services to children where they spend a great deal of their time – in school. Currently there are 41 school-based health centers in Colorado operating in 17 school districts. During the 2006 – 2007 school year, a total of 180,000 children had access to preventive and primary health services through enrollment in one of the schools where a health center is located (host school) or in a designated feeder school.

There are currently four sources of funding available through the State of Colorado for SBHCs:

- School-Based Health Center Grant Program
- Primary Care Fund (PCF)
- Comprehensive Primary and Preventive Care (CPPC) Grant Program
- Medicaid Extended School Health Program (MESH)

Detailed below are the history and legislative intent of each funding opportunity, the barriers encountered in obtaining the funding, and recommendations to reduce the identified barriers. The primary finding of this report is that, although the Colorado General Assembly has created funding opportunities intended for SBHCs since authorizing the Medicaid Extended School Health Program in 1997, very little money was actually provided by the State until the creation of the School-Based Health Center Grant Program in 2006. While many communities across Colorado have taken advantage of this grant program in the past two years, it does not supply sufficient support to proliferate the model in school districts that have a disproportionate number of children who do not have access to basic physical, mental and dental health services.

The recommendations made in this report are intended to guide the Colorado Association for School-Based Health Care, state legislators, child advocacy organizations, philanthropic foundations, and other partners in advocating for the wise investment of our public resources in improving health care access for our most vulnerable residents.

School-Based Health Center Grant Program

Created in 2006, the School-Based Health Center Grant Program is administered by the Colorado Department of Public Health and Environment (CDPHE).

Background and Legislative Intent: In 2006, the Colorado General Assembly passed legislation (HB 06-1396) creating a grant program specifically for SBHCs and appropriating $500,000 in General Fund dollars for State Fiscal Year 2006-2007.[1] The appropriation included support for staff (0.7 FTE or $40,519) within the Prevention Services Division of CDPHE. In 2007, a line item was created in the State budget that provided the same level of support as the previous year.

Grant criteria are intended to give priority to SBHCs that serve a disproportionate number of uninsured children, a low-income population, or both. Grants may be awarded to establish new SBHCs; to expand primary health services, behavioral health services or oral health services offered by existing SBHCs; to expand enrollment in the Children's Basic Health Plan (CHP+); or to provide support for ongoing operations of SBHCs. The statute specifies that the grants must supplement existing SBHC funding sources such as federal funds, patient fees, public and private insurance reimbursement, grants, and donations including in-kind support from school districts, hospitals, foundations, and local governments.

Definitions: "School-based health center" means a clinic established and operated within a public school building, including charter and State-sanctioned GED programs. SBHCs are operated by school districts in cooperation with hospitals, public or private health care organizations, licensed medical providers, public health nurses, community health centers, and community mental health centers. This definition includes clinics or facilities authorized to provide clinic services under the Medicaid program[2] or authorized to apply for and receive medical assistance payments under the Medicaid Extended School Health Program (MESH).

Application Process: Eligible applicants include existing SBHCs and communities interested in engaging in a planning process to create or expand a SBHC. The Prevention Services Division at CDPHE is responsible for establishing the procedures and timelines by which an operator of a SBHC may apply for a grant; determining the grant application contents; developing criteria for selection, reporting and evaluation; and determining criteria for the amount and duration of the grants. There is an annual application process, with planning grants typically being awarded for one year and implementation or ongoing operations grants for three years.

Opportunities Created: This is the first and only source of State funding that is exclusively for the support of SBHCs**.** In State Fiscal Year 2006-2007, grants supported 11 agencies operating 33 SBHCs and five communities planning new SBHCs. For the State Fiscal Year 2007-08, three planning grants and 14 implementation and ongoing operation grants (ranging from $8,333 to $100,000) were awarded.

[1] C.R.S Sections 25-20.5-501, 25-20.5-502, and 25-20.5-503
[2] C.R.S Section 25.5-5-301

Barriers Encountered: Health care providers, schools and communities that offer SBHCs are delighted to have a funding source specifically to support these services. However, $500,000 is an extremely limited amount, considering there are now 41 SBHCs in operation. If divided among them equally, after deducting the amount earmarked for CDPHE staff, the funding would supply only $11,200 to each SBHC per year. As the number of SBHCs grows, and as inflation in health care costs spirals, this source of funding will effectively shrink unless the budget line item is increased.

Recommendations:

1. Increase the amount of the line-item in the State budget that supports the School-Based Health Center Grant Program. Develop strategies to automatically increase the appropriation based on increases in the number of SBHCs, the number of students served by SBHCs, and/or the rate of inflation in health care costs.

2. Leverage private dollars to encourage increased State funding for SBHCs.

3. Create opportunities for SBHC administrative and fiscal leaders to share information, strategies and lessons learned related to maximizing the investment of State dollars to produce desired outcomes.

Primary Care Fund

Implemented in 2005, the Primary Care Fund (PCF) is administered by the Colorado Department of Health Care Policy and Financing (HCPF).

Background and Legislative Intent: In November, 2004, the people of Colorado voted to change the State's Constitution to increase Colorado's tax on cigarettes and tobacco products. The legislation became effective January 1, 2005, and created a cash fund designated for health-related purposes. House Bill 05-1262 divided the cash fund into separate accounts with specific uses, assigning 19 percent of the money to establish the Primary Care Fund, to be administered by HCPF. The PCF provides funding to "qualified providers" that make "comprehensive primary care" services available to residents of Colorado who are considered medically indigent. The money is allocated based on the number of medically indigent patients served by a provider in an amount proportionate to the total number of medically indigent patients served by all Colorado health care providers who qualify for this fund.

Definitions:
"Comprehensive Primary Care means the basic, entry-level health care provided by health care practitioners or non-physician health care practitioners that is generally provided in an outpatient setting. Comprehensive primary care, at a minimum, includes providing or arranging for the provision of the following services on ***a year-round basis***: primary health care; maternity care, including prenatal care; preventive, developmental and diagnostic services for infants and

children; ***adult preventive services***; diagnostic laboratory and radiology services; emergency care for minor trauma; pharmaceutical services; and coordination and follow-up for hospital care."[3]

A qualified provider must meet either of the following criteria:
(a) is a community health center as defined in section 330 of the federal "Public Health Services Act", 42 U.S.C. sec. 254b; or (b) At least 50% of the patients served by the qualified provider are uninsured or medically indigent patients, or patients who are enrolled in the medical assistance program…, the children's basic health plan, … or any combination thereof."[4]

Additionally, the statute states that a "qualified provider means an entity that provides comprehensive primary care services and that:

> (a) Accepts all patients regardless of their ability to pay and uses a sliding fee schedule for payments or that provides comprehensive primary care services free of charge;
>
> (b) Serves a designated medically underserved area or population, as provided in section 330(b) of the federal "Public Health Service Act", 42 U.S.C. sec. 254b, or demonstrates to the state department that the entity serves a population or area that lacks adequate health care services for low-income, uninsured persons;
>
> (c) Has a demonstrated track record of providing cost-effective care;
>
> (d) Provides or arranges for the provision of comprehensive primary care services ***to persons of all ages***; and
>
> (e) Completes initial screening for eligibility for the state medical assistance program, the children's basic health plan, and any other relevant government health care program and referral to the appropriate agency for eligibility determination."[5]

To be eligible for funding, a provider must meet this definition of "qualified provider", have a quality assurance program in place, and submit a completed application form according to HCPF guidelines.

Application Process: At a minimum, the statute requires that the application form include responses that:

1. Demonstrate how the provider meets the criteria of a "qualified provider"
2. Provide an Unduplicated User/Patient Count conducted at a specific point-in-time between the end of the applicable calendar year and prior to the submission of the

[3] C.R.S. Section 25.5-3-203
[4] C.R.S. Section 25.5-3-302
[5] C.R.S. Section 25.5-3-203

application which, at a minimum, includes the number of patients eligible for Colorado Indigent Care Program, CHP+, and Medicaid, and the number of patients considered to be medically indigent patients

3. Provide certification that the Unduplicated User/Patient Count has been verified by an outside entity

4. Provide documentation that the provider has a quality assurance program

Providers complete an application annually. They are notified within 45 days of the deadline whether or not they meet the requirements to become an "Eligible Qualified Provider." The determination is made on a State fiscal year basis and enables the providers to receive only those funds appropriated to the PCF for that same State fiscal year, subject to the tax amount actually collected for that State fiscal year. Payments are based on the number of Medically Indigent Patients in each Eligible Qualified Provider's Unduplicated User/Patient Count in an amount proportionate to the total number of Medically Indigent Patients from all Eligible Qualified Providers' Unduplicated User/Patient Counts. Disbursements of funds to Eligible Qualified Providers are made quarterly, based on actual tax collections for a three-month period and distributed by the end of the following month (e.g. tax collections for sales in July, August and September are distributed to eligible providers by the end of October).

Opportunities Created: The State Fiscal Year 2005-06 appropriation for this fund was $44,000,000 (which included tax revenues for 18 months, January 1, 2005 – June 30, 2006). Actual tax collections for that time period exceeded $44,000,000, but per statute, the payments to providers cannot exceed the appropriation. The Fiscal Year 2006-07 appropriation was $32,939,958. Actual tax collection for that year was $31,952,031, thereby reducing the disbursement by $987,927. The Fiscal Year 2007-08 appropriation was $32,365,298. Applications were due May 25, 2007 and awards were announced the following September 25. Awards were granted to 29 applicants, including Community Health Services, Inc., which operates six school-based health centers in Adams County School Districts 14 and 50. Two of the centers operate year-round. Community Health Services received 0.36% of the available funding.

In addition, four Federally Qualified Health Centers (Denver Health, Metro Community Provider Network, Peak Vista Community Health Center and Sunrise Community Health Center) serve as the medical sponsor of school-based health centers in their service areas. They may include students in their count of medically indigent patients served, and thereby receive some funding for their school programs from the Primary Care Fund.

The statute authorizing the PCF states that "not less frequently than annually, the State Department shall consult with representatives of Federally Qualified Health Centers, ***School-Based Health Centers*****,** Family Residency Directors, Certified Rural Health Clinics, other qualified providers and consumer advocates regarding the implementation and administration of

the allocation of moneys."[6] HCPF holds a stakeholder meeting annually so that providers can give input on the application process and program implementation. This meeting is an opportunity for SBHCs to have a place at the table. Including SBHCs in the statute indicates that the legislature intended for SBHCs to benefit from the funding. However, given the barriers described below, SBHCs have been able to claim only a very small sliver of the "pie".

Barriers for SBHCs: The requirement that services must be provided on a year-round basis is a significant barrier for those SBHCs that are open only during the school year. Also, providing adult preventive services, maternity care including prenatal care, and other services "to persons of all ages" is not within the scope of practice of SBHCs.

The available dollars in the PCF will shrink over time, as fewer Coloradans smoke and the tax revenue from tobacco products decreases. In addition, more eligible providers are learning about the fund, so the total amount available is likely to be split among more programs in future years.

Recommendations:

1. Provide input to HCFP related to changes in processes and rules within statutory parameters that would make these resources available to support more SBHCs.

2. Consider pursuing legislation that would remove the "year-round" and "all ages" provisions of the current statute or to exempt SBHCs from these requirements.

3. Provide opportunities for SBHCs that have been successful in obtaining these dollars to share their strategies with other SBHCs.

Comprehensive Primary and Preventive Care Grant Program (CPPC)

This program, established in 2000, is administered by the Colorado Department of Health Care Policy and Financing (HCPF).

Background and Legislative Intent: This grant program was created as a result of the Tobacco Master Settlement Agreement, the Smokeless Tobacco Master Settlement Agreement and the Consent Decree approved and entered by the District Court for the City and County of Denver."[7] The CPPC Grant Program was authorized by the Colorado General Assembly through the addition of Part 10 to the Medical Assistance Act, 26-4-1001 through 26-4-1007, C.R.S. This

[6] C.R.S. Section 25.5-3-301

[7] *State of Colorado, Ex Rel., Gale A. Norton, Attorney General V. R.J. Reynolds Tobacco Co.; American Tobacco Co., Inc.; Brown and Williamson Tobacco Corp.; Liggett Group Inc.; Lorillard Tobacco Company; Phillip Morris, Inc. United States Tobacco Co.; B.A.T. Industries, P.L.C.; The Council for Tobacco Research—U.S.A., Inc.; and Tobacco Institute, Inc.;* Case No. 97CV3432; www.chcpf.state.co.us/HCPF/cppc/CPPCEnablingLegislation.asp

program was established to provide grants to health care providers in order to expand primary and preventive care services to Colorado's low-income, uninsured residents. Beginning with FY 2000-01, the program was funded through the Comprehensive Primary and Preventive Care Fund, established pursuant to the tobacco litigation settlement referred to as the Master Settlement Agreement (MSA). At that time, six percent of the MSA, not to exceed $6 million, was the annual appropriation allocated to this fund.[8]

Definitions: The definition for "Comprehensive Primary Care" is the same as for the Primary Care Fund. The definition of "Qualified Provider" is also the same except that, under CPPC there is no requirement that a provider either be a Federally Qualified Health Center or have a case mix of at least 50% uninsured or medically indigent patients.[9]

Grants are to be used:

1. To increase access to comprehensive primary care services for uninsured or medically indigent patients
2. To create new services or augment existing services provided to uninsured or medically indigent patients
3. To establish new sites that offer comprehensive primary care services in medically underserved areas of the state or to medically underserved populations[10]
4. To maintain increased access, capacity or services previously funded by CPPC Grants[11]

The client to be served under this program is a person:

1. "Whose yearly family is income below 200 percent of the federal poverty level (FPL); and
2. Who is not eligible for medicaid, medicare, or any other type of governmental reimbursement for health care costs; and
3. Who is not receiving third-party payments." [12]

Legislative Revisions: The original bill creating the CPPC Program was HB 00-1388. Beginning in State Fiscal Year 2001, the program was authorized in statute to receive 6 percent of the MSA fund, not to exceed $6 million. Several bills enacted in 2003 impacted this program. Senate Bills 03-019 and SB 03-190 both reduced the appropriation. SB 03-013 clarified the

[8] www.leg.state.co.us/2000/inetcbill.nsf/fsbillcont/33261E7AAF4BAD6987256854007209aa?open&file=1388_01
[9] C.R.S. Section 25.5-3-302
[10] Ibid
[11] www.chcpf.state.co.us/HCPF/Pdf_Bin/CPPC_FY03_ANNUAL_REP.pdf
[12] C.R.S. Section 25.5-3-203

definition of comprehensive primary care, adding a provision that the services must be provided on a "year-round basis" and further defining "arranging for the provision" of comprehensive primary care services as demonstrating established referral relationships with health care providers for any of the comprehensive primary care services not directly provided by an entity.[13] This includes maternity care and adult preventive services. In addition, the bill specified that HCPF and the Advisory Council shall consider geographic distribution of funds among urban and rural areas when awarding grants under this Program. In 2004, HB 04-1421 changed the percent of the MSA devoted to the CPPC Fund from 6 percent to 3 percent with a maximum of $5 million per year.[14]

Application Process: The application process is developed and managed by HCPF. An Advisory Council is appointed by the Executive Director to review the application form prior to its issuance. An Application Evaluation Committee is established by HCPF for the purpose of reviewing the grant applications and recommending to the Executive Director which applications should receive awards. There is an annual application process, with a maximum amount of $5 million to be distributed. However, the amount available for awards is contingent upon the actual amount appropriated by the General Assembly and any pre-awarded multi-year contracts that are still in effect. In State Fiscal Year 2007-08, there is approximately $1,500,000 remaining and available for new awards. Eligible applicants are those who meet all of the criteria of a Qualified Provider.

Table 1: Appropriations by Fiscal Year and Primary Uses of CPPC Funds

Fiscal Year	Appropriation	Construction	Medical	Dental	Mental Health
2000-01	$4,751,488*				
2001-02	$5,156,532*	34.5%	62.0%	2.8%	0.5%
2002-03	$5,259,917	38.9%	50.5%	10.6%	0
2003-04	$5,419,045	36.8%	46.4%	16.8%	0
2004-05	$2,578,694	2.0%	59.0%	35.0%	4.0%

*combined for 15-month grant period Apr 01-June 02) of $9,730,381

Opportunities Created: In the first application cycle (FY 2001-2002), Parkview Medical Center in Pueblo received a one-year grant in the amount of $690,931 for developing three new SBHC sites in Pueblo District 60 high schools. No CPPC grants have been awarded to SBHCs since then.

[13] www.leg.state.co.us/2003a/inetcbill.nsf/fsbillcont/open&file=013_enr.pdf
[14] Comprehensive Primary and Preventive Care Grant Program, Health Care Policy and Financing, Performance Audit, May 2007

Barriers Encountered: The State Fiscal Year 2007-08 grant application specifically lists SBHCs among the providers who are encouraged to apply. However, the requirement of providing services on a year-round basis is a barrier for those SBHCs that are open only during the school year. Also, providing or arranging for services for all ages is not generally within the scope of practice of SBHCs.

CPPC is intended to support safety-net providers including SBHCs that serve a disproportionate share of "clients" in families below 200 percent of the Federal Poverty Level. However, in addition to the "year-round" and "all ages" requirements, the statute stipulates that, in order to be counted in the formula for disbursing CPPC funding, a client **must not be eligible** for Medicaid, CHP+ or any other government-supported health program. In other words, if a client is enrolled in a government-supported program, **or is eligible but not enrolled**, CPPC will not cover the services provided. Therefore, in order to benefit from CPPC, SBHCs have to financially screen each uninsured patient to determine his or her eligibility for Medicaid or CHP+, even if the patient's parents do not intend to enroll their child. This requires unusual parent cooperation. It also requires the hiring of additional staff, the cost of which diminishes the return expected from CPPC.

Another barrier is that these dollars are awarded as one-time grants and are not intended to be an ongoing funding source for an agency. Therefore, from a business and strategic perspective, many agencies are reluctant to budget these dollars to support ongoing staff. Instead, the funding is generally used for construction projects, equipment, infrastructure and other one-time needs.

Finally, program audits reveal a lack of equity in distribution of CPPC funds to rural parts of Colorado, something HCPF has attempted to address.

Recommendations:

1. Consider legislation to remove the "year-round" and "all ages" provisions of the statute (essentially reversing the language added in 2003) or to exempt SBHCs from these requirements.

2. Consider legislation to remove the language that requires CPPC clients to be **ineligible** for Medicaid, or CHP+, making it consistent with the Primary Care Fund.

3. Educate SBHC sponsors about this funding source and encourage qualified SBHCs to utilize it for capital construction, equipment and technology. Work with HCPF to get accurate information to SBHC providers.

Medicaid Extended School Health Program (MESH)

Established in 1997, this program is also known as the School Health Services Program. It is jointly administered by the Colorado Departments of Education (CDE) and Health Care Policy and Financing (HCPF).

Background and Legislative Intent: This program was created by the Colorado General Assembly in 1997, through SB 97-101, to help pay for health services for children in public schools.[15] This legislation allowed school districts providing Medicaid-covered health services to Medicaid-enrolled students to be eligible for federal matching funds for the dollars they expended on such services.

Application Process/Eligible Applicants:

"Any school district or Board of Cooperative Education Services (BOCES) is eligible to participate, based on the following:

- An assessment of the health needs of students enrolled in the district(s)
- Evidence of community input on the health services to be delivered to public school students
- A written Local Services Plan (LSP)
- Approval of the Local Services Plan by the Colorado Departments of Education (CDE) and Health Care Policy and Financing (HCPF)
- Receipt of a contract from HCPF for reimbursement of health services that are covered by Medicaid and are provided to Medicaid enrolled students"[16]

In order for the school district or BOCES to be reimbursed for services, parents of children enrolled in Medicaid must give permission to submit insurance claim(s) on behalf of their children. HCPF submits claims on behalf of the school district or BOCES, which then receives reimbursement for the federal share (currently 50%) of the amount spent in providing health services. The school district or BOCES may use the dollars to provide new or expanded health services identified in their LSP.

In 2004, the CDE began phasing in five-year LSPs. This allows school districts and BOCES to continue providing services and receiving reimbursement without the burden of submitting annual plans. The district or BOCES may choose to submit a revised LSP for approval on an as-needed basis.

The school district or BOCES must submit an annual report to CDE with a summary of expenditures incurred under MESH. The MESH Annual Report collects data summarizing health services and administration expenditures for the current and carryover fiscal years including a description of each service, units of service, amount expended, an unduplicated count of students receiving health services, and a summary of expenditures by category (health assistants/clinic

[15] www.state.co.us/gov_dir/leg_dire/sbills/SB101.htm
[16] www.chcpf.state.co.us/HCPF/school/intro.asp

aide, physician services, case management, dental services, health education, nursing services, mental health services, insurance outreach for CHP+ and Medicaid, and materials/equipment/supplies). The required reporting form does not include a separate category for services delivered by a SBHC. Some schools do report SBHC services by listing these in the "Other" category.

Opportunities Created: A new source of funding became available to support school health services with the implementation of this legislation. CDE and HCPF have forged a partnership to administer the program. Reimbursement of half the funds spent by school districts and BOCES comes from federal sources. School districts and BOCES have extensive flexibility in spending the federal dollars they receive to further address unmet health needs of students in their districts.

Colorado has 178 school districts. Approximately 80 percent of these (144) are currently participating in MESH. Since the beginning of the program until June 30, 2005, the school districts spent more than $55,000,000 to provide covered health services for Medicaid-enrolled children. Districts received federal reimbursement of approximately half that amount, or $27,500,000, through MESH. The school districts may use this reimbursement to provide new or expanded health services for any public school child in their district, regardless of Medicaid enrollment. Therefore, MESH reimbursement may be used to support SBHCs. However, in 2004-05, only one school district reported doing so. Most commonly, the districts use these funds to provide nursing services, health-related materials, equipment and supplies, mental health services, health assistant or clinical aide services, and case management.

Table 2: Investment in Health Services for Students

Fiscal Year	Number of Districts (including BOCES)	Dollars Spent on Health Services	Direct Amount and % spent on SBHCs
1997-2000	varied by year	$22,928,515	$0 reported
2000-2001	63 districts, 7 BOCES	$3,695,312	$0 reported
2001-2002	69 districts, 7 BOCES	$4,876,973	$0 reported
2002-2003	77 districts, 6 BOCES	$8,264,214	$109,716 (1.33%)
2003-2004	81 districts, 5 BOCES	$8,303,515	$127,385 (1.53%)
2004-2005	81 districts, 6 BOCES[17]	$7,189,263	$52,427 (0.73%)
Total spent on health services, 1997-2005		$55,257,792	$289,528

Barriers Encountered: While the utilization of MESH dollars is flexible, the competing demands of myriad student health needs have limited direct support of SBHCs. Also, because the dollars obtained are exclusively federal and subject to change with new federal legislation, program sustainability is an issue. In fact, through the current contentious federal reauthorization

[17] The six BOCES represent 63 school districts. Therefore, 144 out of 178 school districts in Colorado participated in MESH in 2004-2005.

process for the State Children's Health Insurance Program (SCHIP), there has been discussion that MESH could be eliminated or reduced. Because of this instability, some districts have chosen not to use MESH dollars to pay staff salaries. This creates barriers to building comprehensive programs that support student health needs.

Recommendations:

1. Encourage school district Medicaid Coordinators to include funding of SBHCs in their Local Service Plans.

2. Educate school districts and BOCES regarding the opportunity to utilize their MESH dollars to support SBHCs.

Conclusion

School-Based Health Centers are a proven model for increasing access to preventive and primary health care for our most vulnerable children. While the Colorado General Assembly has created four programs in the past ten years with the intent of providing support for SBHCs, none of the four has proved satisfactory. The most promising — the School-Based Health Center Grant Program created by the passage of HB06-1396 — is severely underfunded, providing on average only $11,200 for each of the 41 SBHCs currently in operation. As we are successful in replicating the model in schools where the need is greatest, this small "pie" will be divided into more pieces, making it even more difficult to sustain the centers over time.

The Colorado Association for School-Based Health Care envisions that Colorado's children will have quality, integrated school health services that improve health status, optimize academic achievement, and enhance well-being. To achieve this vision, we will continue to advocate for increased State investment in keeping children healthy, in school, and ready to learn. While a number of approaches should be explored as recommended in this report, increasing the line-item in the State budget that supports the School-Based Health Center Grant Program is the most simple and the most logical. We welcome your support.

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Keeping children healthy, in school, and ready to learn

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