



**SCHOOL-BASED
HEALTH ALLIANCE**

Redefining Health for Kids and Teens

**School-Based Health Care Initiative
Readiness Assessment**

Adapted from the Colorado Health Foundation

PART I: ABOUT THE ORGANIZATION

Please provide the following information about the organization:

1. Name and address:

2. Basic organizational information:
 - a. How many employees does the organization have?
Full-time Part-time
 - b. What is the organization's annual budget?
 - c. What are the organization's major sources of funding?
 - d. How many years has the organization been in operation?

3. Please describe the organization's vision, mission and goals:

PART II: ABOUT THE SCHOOL-BASED HEALTH CARE PLANNING GROUP

It is an expectation that planning for school-based health care (and completion of this Readiness Assessment) will be accomplished by a steering/planning group and that group members should include, at a minimum, the following: the school principal, a representative from the school district, a representative of the medical sponsor (if identified), a representative of the local medical community (such as a pediatrician or family practice physician, mental health professional or dental health professional), a public health professional, the school nurse, a community representative, a representative of the parent group and/or PTA and, when age-appropriate, a representative of the student body to be served by the project.

Please list all members of the steering/planning group for this project, including the name, title and organization for each. Use additional lines if needed.

Name	Title	Organization

PART III: ABOUT THE MEDICAL SPONSOR

This section asks for information about the medical sponsor. If you are not the medical sponsor (i.e. you are a school district or other community-based organization), please either have the medical sponsor complete this section or answer the following questions on behalf of the medical sponsor.

1. Name and address of medical sponsor:

2. Please indicate the current children’s health services provided by the medical sponsor. Check all that apply.

- Medical services
- Mental health services
- Oral health services
- Substance abuse treatment
- Prevention services and education
- School-based health care programs
If checked, please indicate the number currently operated.
- Other services
If checked, please specify.

3. What other groups or organizations does the medical sponsor currently work with in providing services, programs or activities in the community? For each partnership, please include the name of the partner, a brief description of the activity or program, the role of each partner, how long the partnership has existed and the name of the lead person in the partnership. Use additional lines as needed.

Name of partner	Activity/program	Role of partner	Years in partnership	Lead person

4. What new projects or programs have the medical sponsor launched within the past 5 to 8 years and which of these projects has been sustained over time? Please list and give a brief history (no more than four sentences) of each.

5. Please provide a brief overview of the organization’s history of accessing and sustaining funds for programs and projects (including school-based health care programs), with a focus on the past 5 to 8 years of operation. Please include information about all sources of funding.

Source of funding	Brief description of organization’s history of accessing and sustaining these funds
<input type="checkbox"/> In-kind contributions from parents, community members, businesses	
<input type="checkbox"/> Financial support from local or regional foundations	
<input type="checkbox"/> Financial support from local and/or regional businesses	
<input type="checkbox"/> Local fundraising activities	
<input type="checkbox"/> Contributions from local charitable groups	
<input type="checkbox"/> Revenue generation from billing and collecting for services	
<input type="checkbox"/> Political activities (To what extent has organization leadership worked with local and state policymakers to build support for community activities?)	
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	
<input type="checkbox"/> Medicaid, including any state specific programs for schools and youth	
<input type="checkbox"/> State Tobacco Funds	
<input type="checkbox"/> Nurse Home Visitors Program funds	
<input type="checkbox"/> Chronic Disease Prevention funds	
<input type="checkbox"/> Funding from Children With Special Health Care Needs	
<input type="checkbox"/> Coordinated School Health funding	
<input type="checkbox"/> Other – please specify:	

6. Please describe the medical sponsor’s technology capacity, including its current use of Health Information Technology (HIT).

PART IV: GENERAL INFORMATION ABOUT THE SCHOOL AND SCHOOL DISTRICT

Please provide the following information about the school district and the school(s) chosen for the school-based health care project:

1. Name and address of school district:

2. Name and address of school(s):

3. Please provide the following general information for both the school and the school district you are proposing new school-based health care services for:

	School		School District	
	Number/rate/percentage	Year and data source	Number/rate/percentage	Year and data source
Current student population				
Average yearly attendance				
Students receiving free or reduced meals				
English language learners				
Migrant students				
Homeless students				
Gifted and talented students				
Economically disadvantaged students				
Students with IEP or 504 plan				
Annual drop-out rate (high schools)				
Student mobility rate				

4. Please provide the following race/ethnicity information for both the school and the school district.

	School	School district
African-American		
American Indian or Alaska Native		
Hispanic or Latino		
Asian or other Pacific Islander		
Caucasian		
Other		

5. Please provide information about the health status of currently enrolled students:

Health Indicator	Number/rate/percentage	Level of data (national, state, county, school district, school), source and year
Immunization compliance rates		
Hearing and vision screens – percent of referrals		
Asthma		
Diabetes		
Obesity		
Tobacco use among 9 th -12 th graders		
Alcohol use		
Other drug use		
Abstinence		
Sexually active		
Allergies		

6. Please provide information about students' access to health care services:

Indicator	Number/rate/percentage	Level of data (national, state, county, city, school district or school), source and year
Private insurance		
Medicaid or CHP+		
Uninsured		
Physical exams and preventive care		
Dental services		
Reproductive health care		
Mental health services		

7. Does the school currently have physical space to accommodate the school-based health care services being considered?
 - Yes
 - No

8. Do you anticipate a request for capital funding to support renovations or other capital improvements?
 - Yes
 - No

9. If adequate space is a concern, what are the plans for resolution?

10. Please list any questions/data elements for which you are unable to provide information and give a brief explanation of why.

PART V: DETAILED INFORMATION ABOUT THE SCHOOL COMMUNITY

Evidence shows that the most successful school-based health care programs are those that are located in a supportive school environment with the support of the school staff and leadership. Successful programs also build on the foundation of and integrate with existing services and actively involve parents and communities. The following questions and data elements provide baseline information about the school, its staff and leadership, the kinds of services offered and the school climate.

1. Please indicate the type of school being considered for school-based health care services. Check all that apply:
 - Head Start
 - Preschool
 - Elementary school
 - Middle school
 - Elementary/middle school
 - High school
 - Middle/high school
 - K-12
 - Charter school
 - Magnet school
 - Other – please specify

2. Are there other schools co-located in the building or on the campus?
 - Yes
 - No

3. If yes, do you plan to offer services to these schools as well?
 - Yes
 - No

(If yes, please complete a Readiness Assessment for each school.)

4. Please provide the following information about the school leadership and staff.

- a. Name of Principal
- b. Number of years the principal has been at this school
- c. Total number of years this individual has been a principal
- d. Number of staff in school Full-time _____ Part-time _____
- e. Number of paraprofessional staff
- f. Number of school support staff
- g. Number of administrators
- h. Number of counselors
- i. Average student-to-teacher ratio
- j. Average number of years of experience of teaching faculty
- k. Teacher turnover rate

5. Please provide information about the student support team/services.

	Full-time	Part-time	Available to all students	Available to specific student population
<input type="checkbox"/> Psychologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> School guidance counselor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> School social worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> School nurse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> School health aide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other. Please specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Please indicate the school's No Child Left Behind status and current work on Every Student Succeeds Act.

- Adequate yearly progress
- In need of improvement (If checked, how many years of this designation?)
- In need of improvement – restructuring phase.
(If checked, how many years of this designation?)

7. Please provide information about the school's strengths/challenges

- a. Student programs available to all students
 - Organized after-school program
 - Organized extracurricular sports
 - Music programs
 - Drama/theater/arts programs
- Clubs
 - Student Government Association
 - Gay-Straight Alliance
 - Girl/Boy Scouts of America
 - Future Farmers of America
 - Other. Please specify:

- b. What percentage of students participates in one or more of these programs?
- c. Parent and family participation
- Organized PTA
 - Parent-led special events
 - Parent-led fundraising events
 - Volunteer activities – mentoring, classroom aides
- d. Community partnerships to support schools
- Community organizations bring programs to schools
 - Community organizations invite students into their space
 - Community organizations serve on school committees and participate in planning events
- e. What do students say are the best features of your school?
- Commitment of school leadership to students
 - Great teachers
 - Organized sports
 - Other students
 - Good learning environment
 - School spirit
 - Great education
 - Other – please specify
- f. What do students say are the three biggest problems/challenges for your school?
- g. What do students say are the three biggest health problems they face?
- h. What do teachers like best about the school?
- Supportive leadership
 - Dedicated students
 - Supportive parents
 - Opportunity to grow professionally
 - Dedication to student achievement
 - Positive school climate
 - Good working environment
 - Team approach
 - Dedicated fellow teachers and staff
 - Other – please specify
- i. What do teachers say are the biggest problems/challenges for your school?
- j. What do teachers say are the biggest health challenges faced by the students in the school?

8. How safe do your students and other members of the school community feel? Please rate the school on the following issues.

	Very safe	Somewhat safe	Not very safe	At risk	Great risk
Staff in the school building	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Students in the school building	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff when outside school in immediate neighborhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Students when outside school in the immediate neighborhood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Student exposure to alcohol and drugs in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Student exposure to gangs in community or school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Was a survey used to collect the information in this section?

Yes

No

- a. If yes, please describe who was surveyed (e.g. students, parents, teachers)
- b. If yes, please note how many surveys were distributed and collected.
- c. If yes, please describe how the survey was publicized, distributed and collected.

10. Using data from the last full school year, please give the number of:

- a. In-school suspensions
- b. Out-of-school suspensions
- c. Expulsions
- d. Referrals for safety/disciplinary problems
- e. Students referred to law enforcement

11. Please indicate what other services are being provided in the school by outside partners/agencies and provide information about them.

	Full-time	Part-time	Available to all students	Available to specific student population
Social services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Juvenile services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
After-school programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mental health counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Substance abuse counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Health promotion/health education (e.g. Planned Parenthood)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Please list any questions/data elements for which you are unable to provide information and give a brief explanation of why.

PART VI: ABOUT THE COMMUNITY

Research shows that the social determinants of health (the economic, social and environmental conditions in which people live) can have a long-term impact on the health and well-being of children. This section asks for information about some of the indicators of healthy communities and neighborhoods, such as employment opportunities, stability of the neighborhood, and access to safe and affordable housing, health care, healthy food choices and recreational activities, as well as traditional health data. Knowing more about the community, its health problems and the social determinants affecting it will assist in developing and targeting future prevention strategies.

1. Please define the geographic area of the community to which the school belongs (e.g. city, county, neighborhood.)
2. What is the total population of the defined community?
3. How many children and young people ages 21 and younger reside in the community?
4. What is the racial/ethnic breakdown (use percentages) of the community population?

African-American	
American Indian or Alaska Native	
Hispanic or Latino	
Asian or other Pacific Islander	
Caucasian	
Other	

5. Please provide some information about access to services in the community.
- a. What stores are available in the community?
 - Grocery stores
 - Corner stores/small markets
 - Farmers' markets
 - Large retail stores
 - Small, locally owned shops
 - No accessible shops/stores (i.e. must leave community to access these stores)

 - b. Is public transportation available?
 - Yes
 - No

 - c. What forms of transportation are most accessible?
 - Car
 - Bus
 - Rail
 - Walkable community
 - Shuttles

 - d. What recreational spaces/facilities are available?
 - Parks
 - Sports fields
 - Town square
 - Community center
 - Community gardens
 - Community pools
 - Other, please specify:

 - e. What community resources are used by the school or might be used by students and staff?
 - After-school program
 - Community parks and recreation programs
 - Community-based sports leagues
 - Immigrant/refugee community organizations
 - Volunteer organizations
 - Faith-based organizations
 - Youth employment programs
 - Other, please specify:

6. Please provide some information about the following health indicators in your community.

a. What community resources are available to provide physical and mental health services?

Provider	Number/percentage/rate	Data source, year
Private physicians		
Specialists (e.g. dermatology, child psychiatry, cardiology)		
Community health centers		
Community mental health centers		
Private mental health providers (psychologists, LCSW, psychiatrists)		
Health professionals who accept Medicaid and CHP+		
Health professional who serve the uninsured with a sliding fee scale		

b. Please indicate which of the following designations, if any, your community has:

- Health Professional Shortage Area (HPSA)
- Medically Underserved Area (MUA)
- Medically Underserved Population (MUP)

c. Where possible, please provide information on the following health indicators for your community.

Community health indicators	Number or rate	Level of data (state, county, city)	Data source, year	No information available
Depression				<input type="checkbox"/>
Suicide				<input type="checkbox"/>
Infant mortality				<input type="checkbox"/>
Obesity				<input type="checkbox"/>
EPSDT compliance				<input type="checkbox"/>
Dental health visits				<input type="checkbox"/>
Asthma				<input type="checkbox"/>
Cardiovascular disease				<input type="checkbox"/>
Stroke				<input type="checkbox"/>
Diabetes				<input type="checkbox"/>
All cancers				<input type="checkbox"/>
Immunizations				<input type="checkbox"/>

Teen birth rate				<input type="checkbox"/>
STDs				<input type="checkbox"/>
HIV/AIDS				<input type="checkbox"/>
Substance abuse				<input type="checkbox"/>
Accidents				<input type="checkbox"/>
Injuries				<input type="checkbox"/>
Drug arrests				<input type="checkbox"/>
Crime rate				<input type="checkbox"/>
Violent crime				<input type="checkbox"/>
Child abuse and neglect				<input type="checkbox"/>
Crimes committed by juveniles				<input type="checkbox"/>
Juvenile arrests				<input type="checkbox"/>

7. Please describe any major changes (e.g. gentrification, population shifts, etc.) that have recently influenced your community and how the community has responded to the identified changes.

8. Please list any questions/data elements for which you are unable to provide information and give a brief explanation of why.