



# FINDINGS FROM THE 2022 NATIONAL CENSUS OF SCHOOL-BASED HEALTH CENTERS

## Background

### What is the School-Based Health Alliance?

Since 1995, the School-Based Health Alliance (SBHA), a 501(c)(3) nonprofit corporation, has supported and advocated for high-quality health care in schools for the nation's most vulnerable children. Working at the intersection of healthcare and education, SBHA is a recognized leader in the school-based health care field and a source of information on best practices for philanthropic, federal, state, and local partners and policymakers.

For over 25 years, SBHA has worked with SBHA State Affiliates and national organization partners, advocates, health care providers, and school-based health centers (SBHCs) across the nation to:

- Set the national policy and legislative agenda for the field.
- Advocate for increased support and funding for SBHCs.
- Promote high-quality clinical practices and standards.
- Support data collection, reporting, evaluation, and research.
- Provide training, technical assistance, and consultation.



### What are School-Based Health Centers?

SBHCs complement existing school health services by facilitating access to primary care and often behavioral health, vision, dental, and other services through school-community partnerships for children and youth nationwide who experience barriers to accessing care because of systemic inequities, their family income, or where they live. SBHCs operate through partnerships between health care organizations, school communities, community-based organizations, families, and youth. This collaboration, care coordination, and youth engagement improves student, school staff, and community health literacy and outcomes and contributes to positive educational results, including reduced absenteeism, decreased disciplinary actions, and improved graduation rates.

## What is the National Census of School-Based Health Centers?

SBHA has conducted the National Census of School-Based Health Centers (Census) for more than 20 years, capturing the growth and evolution of SBHCs nationwide. The COVID-19 pandemic prompted a pause in the Census scheduled to launch in spring 2020. The 2022 Census is the first Census conducted since the 2016-17 school year and the first to capture SBHC data since the pandemic. As SBHA advocates for national policy and legislative action, we use the findings from the Census to tell the story of how SBHCs across the country are meeting the needs of their communities.

### Methods

The 2022 Census was administered online from April to November 2022 to all known SBHCs in the United States. SBHA used information from SBHA's State Affiliates, State Program Offices within state health or education departments that fund or support SBHCs, SBHC sponsor organizations, and news alerts to maintain and update a national directory. SBHA actively recruited Census respondents from directory contacts through email, newsletters, social media, and website postings. State Affiliates also promoted the Census to their networks directly. Between August and November 2022, non-responders were contacted by email and phone to confirm contact information and whether the SBHC was still operational. Early responders and SBHA State Affiliates with high response rates received fiscal incentives in the form of cash or gift cards. Survey topics included schools and populations served, services and staffing, funding, sustainability, and collaboration with other school health providers.

The final sample included 1,518 SBHCs from more than 500 sponsoring organizations across 47 states and the District of Columbia, accounting for approximately 40% of the roughly 3,900 SBHCs nationwide known to SBHA.<sup>1</sup> The sample excludes any respondents who indicated they did not provide primary care in 2022 as they do not meet SBHA's definition of an SBHC. The 2022 Census response rate was significantly lower than prior administrations, likely due to pandemic-related staff turnover, outdated contact information, staff burnout, survey fatigue,<sup>2</sup> and competing demands. Unlike previous Census administrations, multiple individuals could respond on behalf of the same SBHC. While this approach aimed to reduce barriers to participation, it also resulted in some duplicate submissions with divergent responses. In these situations, the research team conducted outreach to respondents to determine which response to include.



<sup>1</sup> There were no responses from SBHCs in North Dakota, South Dakota, or Nebraska. However, SBHA confirmed that each of these states has at least one SBHC.

<sup>2</sup> SBHCs (n=1,122) reported experiences during the COVID-19 pandemic and salient operational information as part of the [2021 National Survey of SBHCs](#) in 2021.

# School-Based Health Center Delivery Models, Sponsorship, and Funding

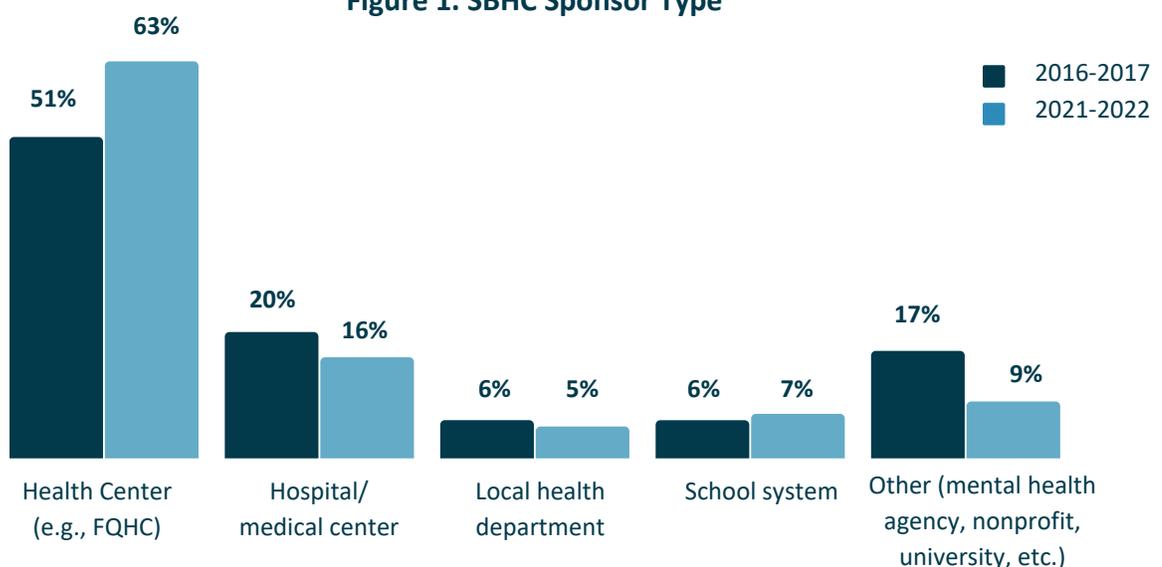
## Delivery Models

The dominant model for responding SBHCs was a traditional school-based approach (92%, n=1,394) where patients access care in a fixed facility on campus. Only 4% of respondents (n=60) reported using a school-linked model that leverages relationships with a designated facility near the school campus to provide care to students, and 3% (n=38) provided care through a mobile model, parking a specially equipped vehicle on or near a school campus. Traditional, school-linked, and mobile models can supplement in-person care with telehealth services. Only 2% (n=25) of respondents used a telehealth-exclusive model that linked students from a designated school location to offsite providers.

## Sponsorship and Funding

Lead sponsor organizations oversee SBHC clinical and fiscal operations, including staffing and other necessary supports. **Health Centers emerged as the dominant sponsor model in 2022, accounting for 63% of responding SBHCs (n=954), an increase of 12% from 2016-17 (51%, n=1,181).** Hospitals and medical centers sponsored 16% (n=244) of SBHCs in 2022, decreasing from 20% in 2016-17 (n=464). Less common were sites sponsored by school systems (7%, n=105) and local health departments (5%, n=74), remaining similar to 2016-17 levels. Other sponsor types, including tribal governments, universities, nonprofits, and mental health agencies, accounted for 9% of respondents collectively (n=141), down from 17% (n=166) in 2016-17 (Figure 1). While these values represent reported responses, it is important to note that sponsorship roles and responsibilities vary due to subcontracts and legal and fiscal arrangements. For example, a school district reporting as a sponsor may receive state funding and act as the fiscal agent while subcontracting clinical services to a Health Center.

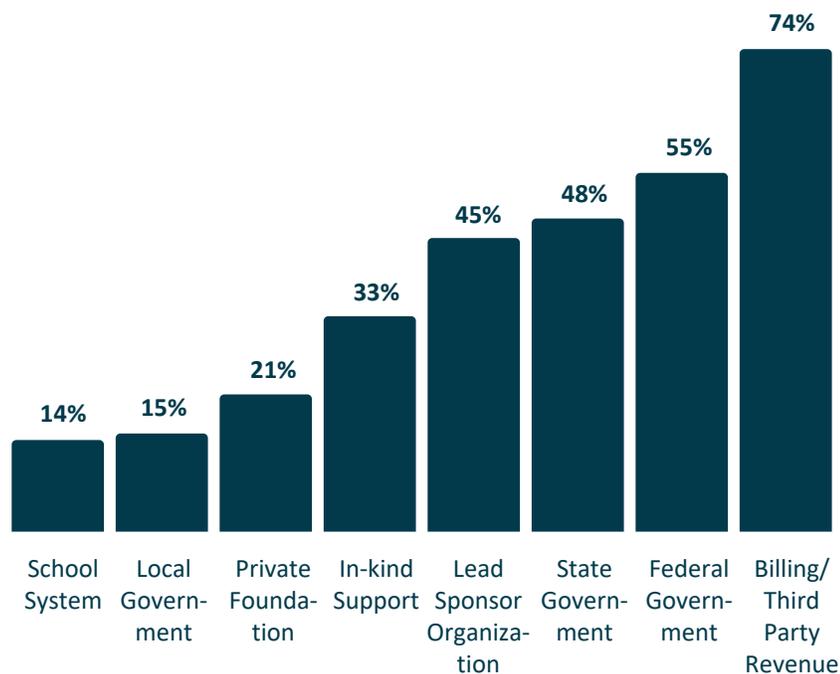
Figure 1. SBHC Sponsor Type





**Billing and third-party revenue from insurance claims is an integral funding source for SBHCs**, supporting 74% of responding sites (n=1,117; Figure 2). More than half of respondents indicated that they received federal funding (55%, n=838). Federal sources included Health Resources and Services Administration Telehealth Network Grant (28%, n=216), Title X Public Health Service Act (23%, n=177), Section 330 Public Health Service Act (20%, n=157), Title V Social Security Act (6%, n=48), Substance Abuse and Mental Health Services Administration (6%, n=48), rural health center (10%, n=75), and U.S. Department of Education (6%, n=46) funding. Nineteen percent (n=150) of respondents reported receiving funding from other federal sources. State government funding supported 48% of responding SBHCs (n=722). SBHCs also received in-kind support (33%, n=507), private foundation funding (21%, n=319), local government funding (15%, n=230), and school-system funding (14%, n=211). Lead sponsor organizations dedicate funds directly to their SBHCs, often through startup costs or regular subsidies. An example is the dispersal of Community Benefits by nonprofit hospital organizations required by federal tax law to spend a portion of their profits to address a community need.

**Figure 2. SBHC Funding Sources**



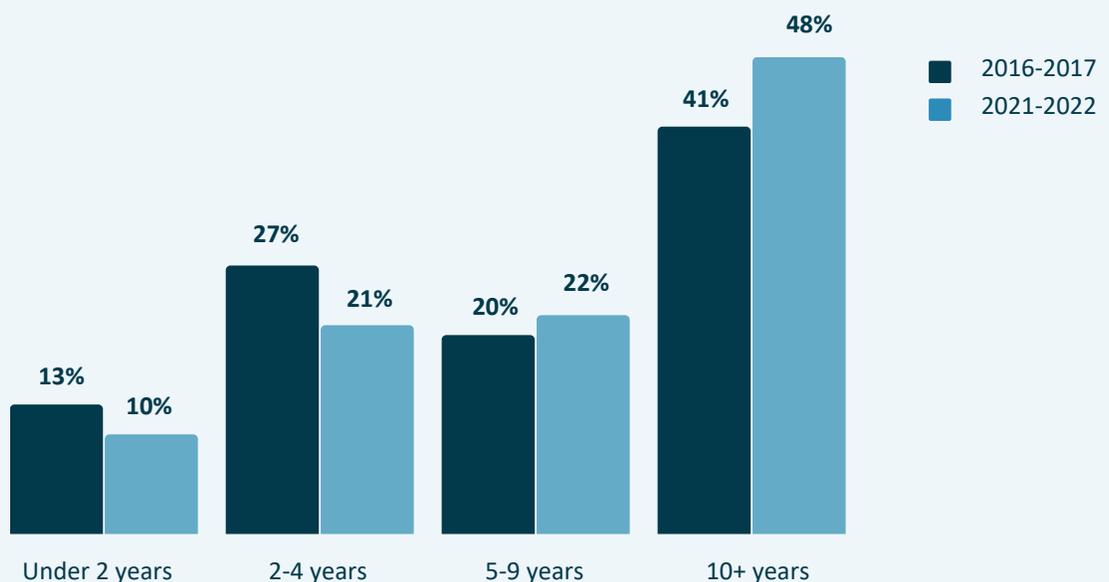


## SBHC Operations

### Years in Operation

Of the respondents who indicated the year their SBHC opened, 48% (n=606) had been open for 10 or more years, 22% (n=277) between 5 and 9 years, and 21% (n=265) for 2 to 4 years. Ten percent (n=123) opened within the last two years. These percentages are consistent with 2016-17 (Figure 3). Although the COVID-19 pandemic delayed the opening of some SBHCs, it also brought attention to the intersection of health and education. It created funding streams to support the development of new SBHCs and the expansion of service offerings among existing SBHCs. Though SBHA and SBHA State Affiliates monitor the establishment of new SBHCs, newer SBHCs, or those with new sponsors and staff, may not have connected to the larger SBHC field in time for Census administration and would not have received direct outreach for participation and may therefore be underrepresented in the 2022 Census.

Figure 3. SBHC Years of Operation

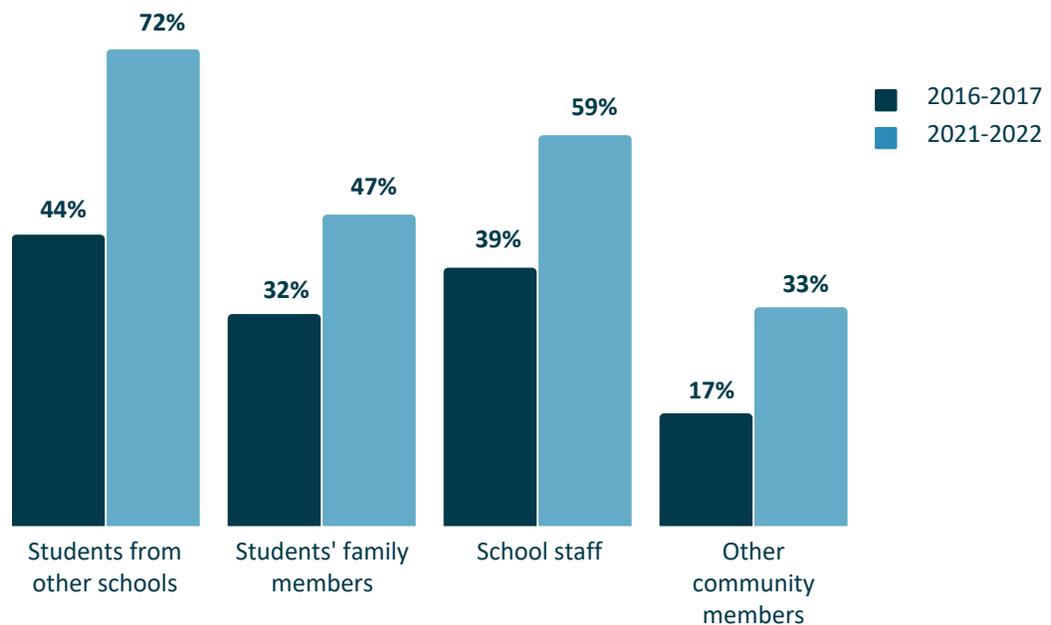


## School Communities Served

The 2022 Census shows that growth occurred in all categories of types of school communities served compared with the 2016-17 Census. Three out of four SBHCs represented in the current Census (75%, n=1,142) reported that they provide care to populations other than students enrolled in their schools, compared with only 62% (n=1,442) in 2016-17 (Figure 4). Seventy-two percent (n=828) now serve students from other schools, a notable increase from 44% (n=1,010) in 2016-17. Fifty-nine percent of respondents (n=678) indicate they serve school staff (previously 39%, n=904), 47% (n=542) serve students' family members (previously 32%, n=740), and 33% (n=375) serve other community members (previously 17%, n=399). Although these changes could be because of the sample of SBHCs that responded to the Census, it is likely that the pandemic altered priorities for care delivery and reduced barriers to seeing patients beyond the immediate student population.



Figure 4. SBHC Populations Served



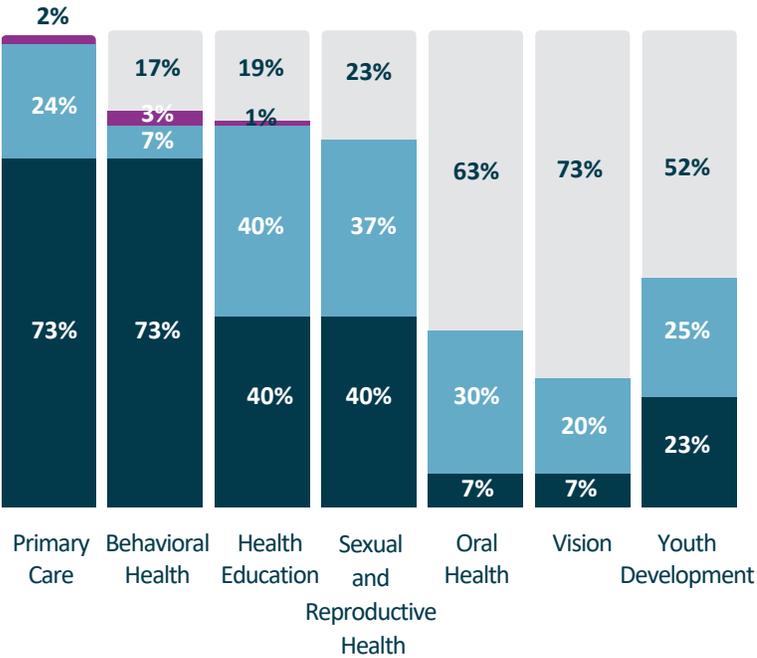
Nearly half of the SBHCs in the Census served elementary schools, while 18% served high schools, 14% middle schools, and 21% represented other school models, such as kindergarten (K) through eighth grade, K-12th grade, and seventh-12th grade. About 8 out of 10 schools served by SBHCs were Title 1 schools, which receive federal funding to support high percentages of children from families with low-incomes. About 7 out of 10 students in schools with access to SBHCs were youth who were Black, Indigenous, and People of Color.



## Services and Staffing

By definition, SBHCs provide primary care services. In-person services remain a principal facet of SBHC delivery models, with **the majority of SBHC respondents (73%, n=1,113) offering primary care both in-person and through telehealth and 24% (n=369) offering in-person primary care only** (Figure 5). Only 2% (n=36) reported that primary care services are telehealth exclusive. In addition, 83% of SBHCs (n=1,259) offer behavioral health care, with most (73% n=1,103) offering these services in person and through telehealth. Eighty-one percent (n=1,223) provide health education. And 77% (n=1,174) of responding SBHCs provide reproductive health services including contraceptive provision or counseling; pregnancy testing; or sexually transmitted infection prevention, testing, or treatment, respectively. Nearly half (48%, n=734) indicated they provided youth development services, 37% (n=561) provided oral health care, and 27% offered vision services (n=402).

**Figure 5. SBHC Service Offerings by Delivery Mode**



All bars might not add to 100 due to rounding.

- In-Person and Telehealth
- In-Person Only
- Telehealth-Only
- None

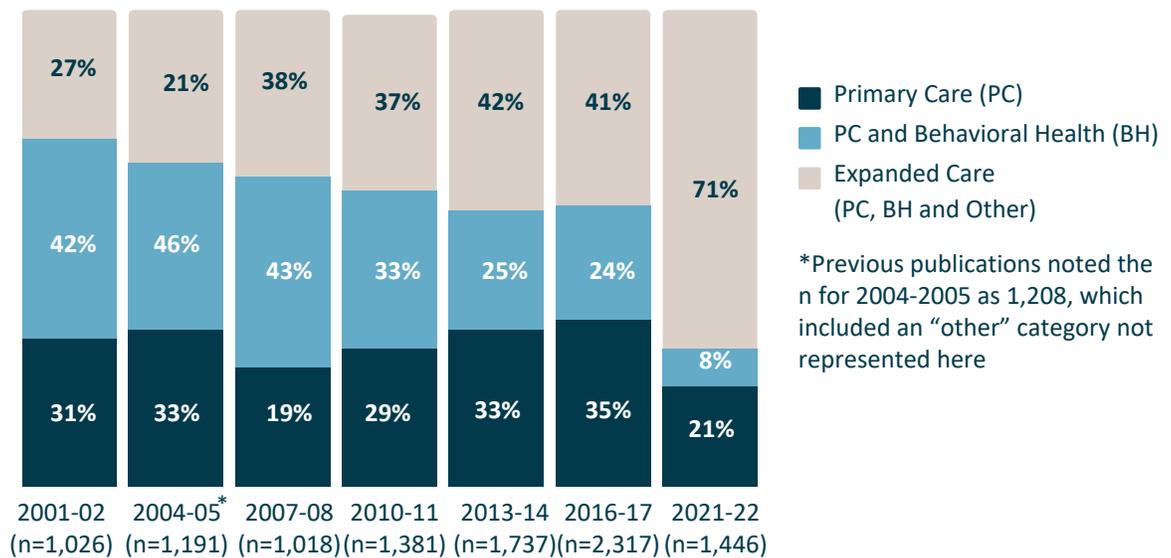
In the 2022 Census, a majority of SBHCs' staffing supports an expanded care model (71%, n=1,025), offering behavioral health and at least one "other" service (oral health, vision care, health education, sexual and reproductive health, and/or youth development) in addition to primary care. Twenty-one percent (n=304) of responding SBHCs are staffed only with primary care providers, and 8% (n=117) have primary care and behavioral health providers but no other provider types. This trend has shifted from prior years when only about a third of SBHCs offered expanded care models (Figure 6).

90%



of responding SBHCs provide some services via telehealth (n=1,370) compared with 19% in 2016-17 (n=434). SBHCs are most likely to offer primary care and behavioral health services through combinations of in person (73%, n=1,113) and telehealth (73% n=1,103). Among the 72% of SBHCs that reported barriers to providing telehealth (n=1,023), the most widely reported barrier is a lack of client interest (44%, n=454). SBHCs also indicated challenges obtaining consent (36%, n=365), purchasing equipment (31%, n=316), receiving reimbursement for services (24%, n=250), and staffing services both with tele-presenters (15%, n=154) and remote providers (10%, n=107).

Figure 6. Trends in SBHC Staffing



All bars might not add to 100 due to rounding.

According to the 2022 Census, primary care services are typically provided by a nurse practitioner (86%, n=1,298), though some SBHCs are staffed with physicians (20%, n=307) or physician assistants (18%, n=268). About three-quarters engage a licensed social worker, counselor, or therapist to provide behavioral health care (76%, n=1,158). Less common are behavioral health-focused case managers or care coordinators (21%, n=321); psychiatrists (11%, n=172); unlicensed social workers, counselors, or therapists (8%, n=124); psychiatric nurse practitioners (8%, n=127); and psychologists (5%, n=83). Other SBHC staff include medical assistants (59%, n=774), registered nurses (38%, n=504), community outreach workers (22%, n=336), dental hygienists (21%, n=326), dentists (19%, n=289), health educators (19%, n=243), and nutritionists (13%, n=168).



Almost all SBHCs support clients and their families in obtaining services related to their social needs (90%, n=1,375).

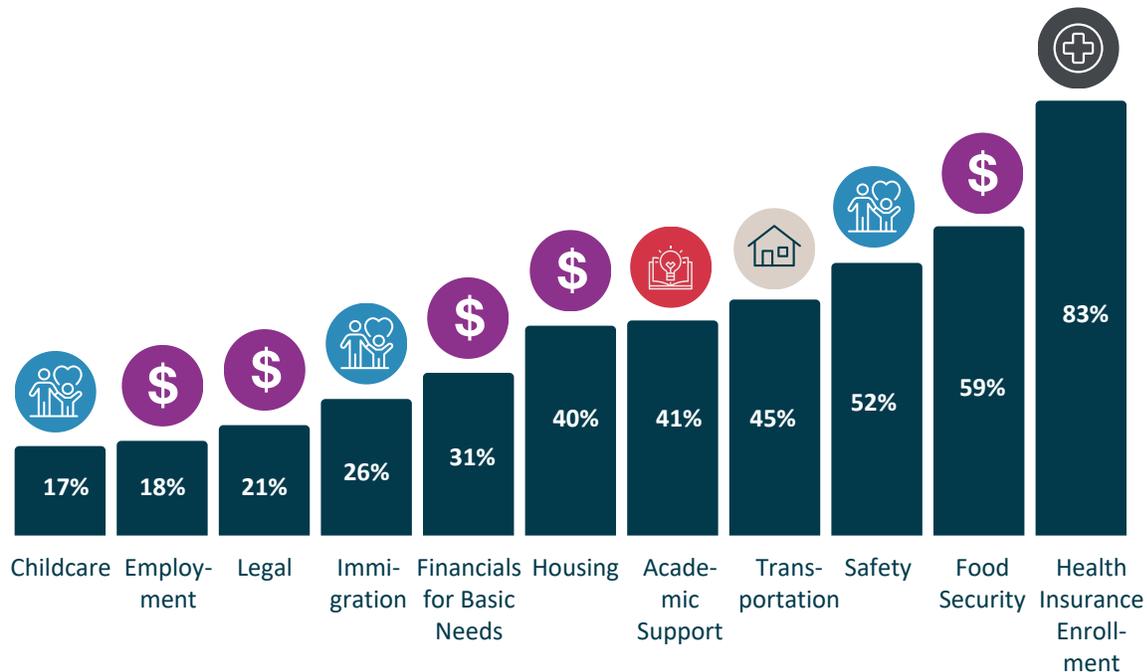


### Social Determinants of Health

In addition to addressing health care access and quality directly, more than 4 of 5 SBHCs responding support health insurance enrollment (83%, n=1,136; Figure 7).

SBHCs support economic stability for their clients and families by addressing food security (59%, n=810), housing (40%, n=554), financials for basic needs (31%, n=422), legal concerns (21%, n=286), and employment (18%, n=245). SBHCs also address the social and community context by facilitating access to interpersonal relationship and safety services (52%, n=719), immigration or acculturation support (26%, n=363), and childcare support (17%, n=238). Forty-five percent of responding SBHCs (n=621) support their clients and families with transportation-related neighborhood and built environment challenges, and 41% (n=565) support students accessing academic support services.

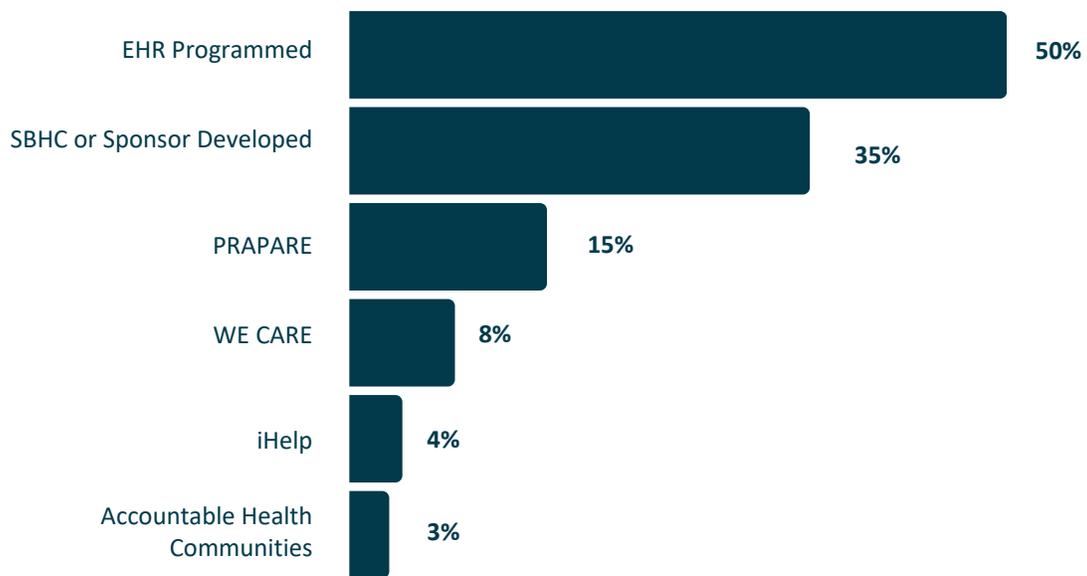
Figure 7. Supports Provided to Clients and/or Their Families to Obtain Social Needs Services



**Almost all responding SBHCs use standardized tools to screen clients for health and social needs (98%, n=1,483).** These include tools to screen for depression (86%, n=1,269), social needs (81%, n=1,175), substance use (52%, n=777), adverse childhood experiences or trauma (31%, n=457), and social determinants of health (30%, n=441). Only 6% of SBHCs that use standardized tools screen clients for resilience (n=94).

Among respondents who indicated which standardized screeners are used to identify social needs, the most common approach was using questions pre-programmed in the electronic health record (50%, n=582). Other SBHCs reported using a screening tool developed or modified by the SBHC or sponsoring organization (35%, n=407), or standardized tools, such as PRAPARE (15%, n=172) or WE CARE (8%, n=99;<sup>3</sup> Figure 8).

**Figure 8. SBHC Social Needs Screening Tools**



<sup>3</sup> SBHA does not recommend or endorse the use of any particular standardized screening tool for social needs.

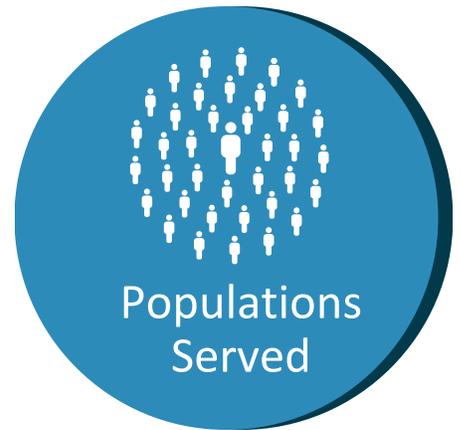


# Main Takeaways



The COVID-19 pandemic brought attention to the intersection of health and education and created funding streams to support SBHCs. The dominant model for SBHCs responding to the Census remains a traditional school-based approach (92%) where patients access care in a fixed facility on campus. In the 2022 Census, Health Centers emerged as the dominant lead sponsor model that oversees SBHC clinical and fiscal operations (63%). Billing and third-party revenue from insurance claims remained an integral funding path for SBHCs, supporting 74% of 2022 Census responding sites. More than half of the respondents (55%) receive federal funding and 48% receive state support, demonstrating the importance of dedicated governmental funding sources to the sustainability of this health care delivery model.

**SBHCs are available to populations that traditionally face barriers to care.** About 8 out of 10 schools served by SBHCs were Title 1 schools, and about 7 out of 10 students in schools with access to an SBHCs were youth who were Black, Indigenous, and People of Color. Compared with 2016-17, the 2022 Census shows that growth occurred in all categories of school communities served, including populations other than students enrolled in their schools (75% in 2021-22 vs. 62% in 2016-17). This growth may be a direct result of the pandemic and expanding services to support students' and families' basic needs.



**SBHCs are providing expanded comprehensive care, with more sites offering behavioral health and other services, such as vision, health education, and dental care, in addition to primary care.** While all SBHCs provide primary care, among Census respondents, 73% offer primary care both in person and through telehealth. Four out of five Census respondents offer behavioral health care in addition to primary care, with 73% offering behavioral health care through a combination of in person and telehealth. **There was also a large expansion of the provision of telehealth services.** Ninety percent of responding SBHCs provide some services via telehealth, compared with only 19% in 2016-17.

**SBHCs also address non-medical needs to support student and community well-being.** Almost all SBHCs support clients and their families in obtaining services related to their social needs (90%). In addition to directly addressing health care access and quality, 83% support health insurance enrollment. SBHCs support economic stability for their clients and families by addressing food security (59%), transportation (45%), housing (40%), financials for basic needs (31%), immigration or acculturation support (26%), legal needs (21%), and employment (18%).



## What's Next

SBHA uses Census findings to advocate for federal legislation and administrative agency policies that support SBHCs, support state and local advocacy and relationship building, and highlight the powerful work of SBHCs across diverse communication platforms. These data help convey how SBHCs operate and reduce barriers to health care for students nationwide. SBHA, with our partners, advocates for increased funding to grow the number and expand the services of SBHCs nationally and the need for an SBHC workforce pipeline to ensure that SBHCs have the staffing to meet student needs.



## How you can help

1. Share this report with your colleagues to launch dialogue and inform decision-making.
2. Connect with [research@sbh4all.org](mailto:research@sbh4all.org) to confirm your SBHC's current contact information.
3. Sign up for SBHA's Digest to stay current on news and offerings on our [website](https://www.sbh4all.org).

## Acknowledgements

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## Get Involved

SBHA is committed to strengthening and expanding SBHCs nationwide. Learn about how you can contribute at [www.sbh4all.org](https://www.sbh4all.org). Follow us on Twitter (@sbh4all), Facebook (SchoolBasedHealthAlliance), and LinkedIn for our latest updates.

### Recommended Citation

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