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Pathways and Sustainability: Comparing FQHC-Affiliated and Independent School-Based Health Centers in California

With the insurgence of Medi-Cal enrollment across California for children (0-18), there must be an equitable and accessible avenue for students to receive support (DHCS). Currently, over 5 million students aged 0-18 are enrolled in Medical, representing 54% of the state's youth population (California Department of Health Care Services 2015). Therefore, the expansion and rise of popularity in School Based Health Centers (SBHC) is the perfect solution to reducing inequality and expanding Medical service delivery. A School Based Health Center is defined as health clinics that reside on high school campuses and provide counseling (behavioral health), medical care and health education. The target population for these SBHCs is students with Medi-Cal, specifically in areas with poor geographical access to health centers. There has been sustained research on the effects/benefits to these students, both with behavioral health and access to medical procedures. Therefore, the research gap I want to focus on in this paper is the funding side of SBHCs. The main funding and operational source that supports these centers is the Federally Qualified Health Center (FQHC). In 2022, 63% of all SBHCs were sponsored by FQHCs (Soleimanpour 2023). Given this high percentage of coverage, there is an assumption that this sponsorship style leads to the most efficient output of services offered. This research paper attempts to answer this assumption and dive into the difference between independently sponsored SBHCs vs FQHC sponsored.

How does affiliation with Federally Qualified Health Centers relate to the comprehensiveness of services provided by School-Based Health Centers in California? I will specifically be looking at 34 counties across California that had at least one qualifying SBHC from the School Health Resources Center 2022 SBHC census. With this collected data, I aim to

look at whether or not these FQHC sponsored SBHCs are more effective at providing a comprehensive quality of services compared to independently supported.

Context

August Österle, an Austrian professor, framed this issue of administering Long-Term Care (LTC) of publicly provided services into three main categories: what is being distributed, who receives it and how resources are allocated. The resource being distributed in this case is access to medical, behavioral, and dental care in the form of an accessible clinic on high school campuses across California. The main recipient of these services would be students (age 0-18) who attend public schools and are enrolled in Medical. Resources are allocated at the school campus level with individuals directly receiving services. To think about SBHCs in this context might provide further clarity to what it is and the purpose it serves. This policy area of School Based Health Centers is important to research because it directly affects the majority of people in California age 0-18 (California Department of Health Care Services 2015). Having School Based Health Centers on school campuses would allow for everyone, regardless of income, to access quality health education and mental health services. For those students who are eligible for Medi-Cal this would allow them to access barrier free medical care. While there may be some children in high school that are covered by their parents' health insurance, this communicates that access to health insurance is a human right and allows young adults to have choice in their health care matters.

Most of the current research on School Based Health Centers is on the impact, like increasing the amount of students on Medical receiving services. However, there is a potential research gap in the funding, more specifically the breakdown of funding streams for SBHCs and

what financially keeps them sustainable. There is also no current research focused on Federally Qualified Health Centers and their impact when compared to independently or locally operated SBHCs.

Literature Review

School Based Health Centers are increasingly growing in California as an equitable and effective solution to provide access to medical and behavioral health services for Medical students. In the year 2000, there were 108 SBHCs, as of 2022 there are 245 fully functioning health clinics spread out across the state. SBHC are widely recognized as crucial access points for students especially in underserved communities, because of the removal of barriers. There is a growing body of research from academics looking at the increased rate of access and overall positive effects of expanded services. However, less is known about the financial and organizational challenges that affect SBHCs from being implemented and their sustainability. This literature review analyzes the existing research across three core areas: Implementation and Sustainability, SBHC Impact, and Sponsorship methods. The identified gap in research is determining the role funding models have on the quality and depth of services provided by SBHCs. The review highlights that research on improved access and sustainability in general is important, but few directly look at specific sponsorship types and the comprehensiveness of services offered as a result.

Implementation and sustainability should be the starting place for research on School Based Health Centers. Before the impact of funding models or depth of services offered can be looked at, there needs to be evidence showing the prolonged investment in these clinics. Navarro, Zirkle, and Barr (2017) contribute to this discussion on sustainability by analyzing three San Diego based SBHCs, with the goal of creating a research based model for

effectiveness. Their work indicates that there is an over-reliance on state-funding and not enough diversity of funding types. The framework they created highlights the importance of diversification of sponsorship type, with local and federal funding streams generalized to be subject to volatility outside of just San Diego. A key finding was the year-to-year fluctuations in cost for health clinics that make it difficult for a single rigid funding source to cover these changes. This study out of San Diego would challenge my hypothesis because I anticipate that federal funding from the FQHC would cover yearly fluctuations, but there may need to be further research on the variety of funding models.

Johnson, Ellis, and Hutcherson (2020) expand on this research surrounding implementation by looking at community context and stakeholder involvement. The results from their various case studies showed that community-buy in and a stable funding model were two of the biggest factors in the implementation of a SBHC. This research calls attention to the necessity of having stakeholders involved in the decision making process. These findings further prove that implementation and sustainability are interconnected. Therefore, being able to show continued support for these clinics, both organizationally and financially, will lead to greater likelihood of a school acquiring a health center. This coincides with my hypothesis that support from FQHCs, which has demonstrated quantitative data driven sustainability, could lead to greater support for implementation. Measuring sustainability for independently funded health centers is difficult because there are a variety of local factors that can affect their validity, preventing them being seen as transferable across counties.

The majority of the research found through this review was centered on the impact for Medical students of having a School Based Health Center on their campus. Coble and McDaniel (2023) establish the positive outcomes associated with SBHCs like increased health equity for

children. This means that health centers remove barriers to access medical services like poverty, discrimination, and lack of resources. Therefore, leveling the playing field and allowing for all students to have equal access to receiving health care. There are other barriers that these health clinics also work to bridge the gap, like education on the importance of behavioral, dental and physical health. Their review also notes that over half of SBHCs are sponsored by FQHC, which underscores the importance of this federal funding model. However, there is not a continued exploration into how these sponsorship models affect the depth and quality of services provided. This article was the inspiration to explore this gap in the literature and shed light on an important facet to the School Based Health Center conversation.

The last thematic area of research was centered around local financial environments and funding models. Valdez (2022) fosters this discussion on the impact local financial environments can have on the sustainability of SBHCs. The author limited her geographical scope to Orange County as a case study to interview local non-profits that help fund these health clinics. This study identified an over reliance on short-term state grants that hurt long-term sustainability and the lack of transparent funding from independent agencies. She argues that increased financial transparency is an indicator of greater organizational stability. This makes logical sense, because if the local organization that provides funding is dysfunctional, then it will be difficult for the SBHC to maintain structure and efficiency. Promoting this paper's hypothesis, organizational stability from FQHC could influence the long-term success of these sponsored health clinics.

Broadening the geographical scope, Eisenberg (2025) looked at the new California statewide initiative that is aimed at improving the financial stability of SBHCs. A new funding model, Child-Youth Behavioral Health Initiative, in collaboration with CalAim seeks to solve the transparency in funding problem. This initiative would start with a state-wide budget analysis to

properly reallocate the existing funds and determine which centers are most in need. Their work highlights the long-standing gap in financial information, especially from independent SBHCs, that is necessary to properly distribute financial support. They also use Alameda county as a case study to analyze a specific county, predominantly independently sponsored, that has benefited from this increased availability of financial transparency. This research raises questions about how funding allocation is initially determined and how often re-assessments are conducted to meet yearly fluctuations in operating costs, services available, and number of students served.

The literature review uncovers three consistent themes that are found across the literature: Sustainability is dependent upon transparency and diversification of funding models, SBHCs are effective at increasing access for Medical students, and implementation depends on funding stability and local context. Despite recognizing the importance of stability in funding, there is an identified research gap in how different funding models, particularly FQHC vs Independent, impact the scope and quality of services offered. Existing studies tend to define sustainability as the number of students serviced, staff retention rates, and years of service. Alternatively, this paper attempted to link implementation to outcomes from funding structures. This would be measured as range of services, depth of care, and integration into school function. This paper attempts to bridge this information gap by analyzing which SBHC funding model leads to a more comprehensive scope of services. There is more data needed, specifically in California, to conduct a statewide budget analysis to make funding environments more transparent and properly allocate resources.

Theoretical Framework

My conceptual hypothesis is: School Based Health Centers across California that receive funding support from Federally Qualified Health Centers are more likely to provide comprehensive (full-scope) services than independently operated SBHCs, due to stronger funding and administrative infrastructure. After data collection FQHC-sponsored SBHCs provided a full scope of services at a higher rate (32%), when compared to independently (18%) sponsored centers. My operational hypothesis is: SBHCs affiliated with FQHCs will have a higher average number of service types offered (≥ 10 clinical, behavioral, and dental services) than independent SBHCs, as measured by the 2025 National School-Based Health Alliance survey. My null hypothesis is: There is no difference in the comprehensiveness of services provided between FQHC-affiliated and independent SBHCs. The casual mechanism is: Affiliation with the Federally Qualified Health Center will lead to a more stable source of funding and infrastructure support. This infrastructure support, in combination with financial support, will lead to more staff and therefore a greater scope of services offered. I will be using the Resource Dependent Theory by Jeffrey Pfeffer and Gerald Salancik to hypothesize that School based Health Centers sponsored by FQHC will deliver a larger scope and greater quality of services because of their federal support and replicable infrastructure. Federally Qualified Health Centers will be better insulated from any potential changes of political leadership or other focusing events that could affect independent organizations' support. This was evident in the research, specifically Valdez (2020), where organizations in Orange County struggled with lack of local financial transparency.

Research Design & Findings

My independent variable is the proportion of SBHCs affiliated with FQHCs. I will be measuring this variable by aggregating from the comprehensive list of all SBHC per California county (School Based Health Alliance 2022). To maintain cohesiveness in my definition of School Based Health Centers, I only included SBHCs that offered both medical and behavioral health services. This eliminated the majority of “SBHC” across the state that just offered behavioral health services, classifying those as wellness centers. Therefore, for definition purposes a Wellness Center would be a school-based clinic that only offers behavioral health services and not standard medical procedures. My dependent variable is the proportion offering full-scope services, medical, behavioral, and dental, for each sponsorship type. This data for the dependent variable will be measured by aggregating each individual SBHC from the complete list of all FQHC per California county (Health Resources and Service Administration 2025). Data collection yielded 245 qualifying School Based Health Centers across these 34 counties with 128 (52%) being vs 117 (48%) being Independently sponsored. I will cross reference the School Based Health Alliance list to determine if each SBHC offers a full scope of services. I will then find the percentage of full scope offerings for both FQHC and Independent SBHC, into a simple ratio. I conducted an independent sample t-test to compare the percentage of SBHCs offering full services between FQHC-sponsored and Independently-sponsored. My control variables will be the percentage of children (age 0-18) enrolled in Medical (Georgetown University 2023), and population per county in California (Population Reference Bureau 2023). These were selected as control variables because counties with similar size and Medical population can be cross-examined, isolating potential local environmental conditions.

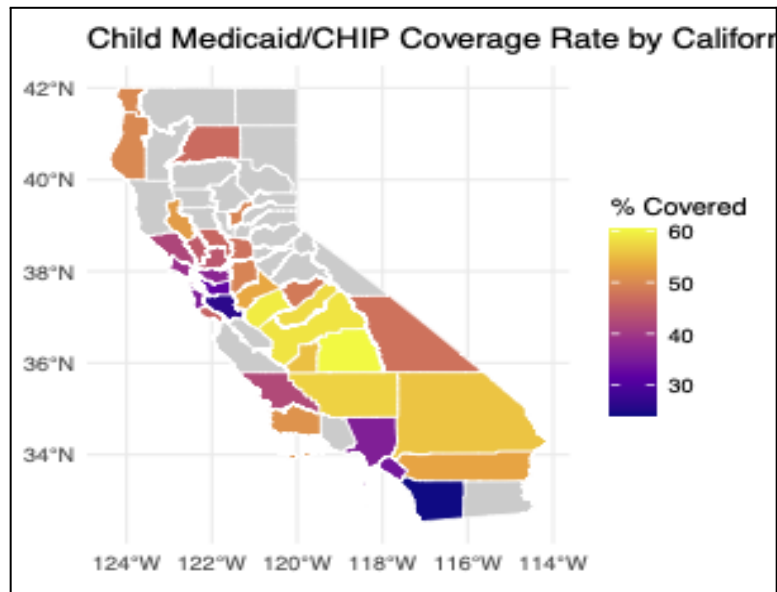
Research Methods & Limitations

County	# of SBHC	# Sponsored by FQHC	# Independent	# of FQHC with full services	# of Independents with full services	Child Medicaid/CHIP Coverage Rates	Child Population

There will be 8 variables being analyzed in the dataset. The research question was limited to 2022 due lack of reliable data outside of this census. Counties are limited in geographic scope to California. SBHCs are defined as health centers that offer medical and behavioral health services. Federally Qualified Health Centers are organizations that receive grants under section 330 of the Public Health Service Act. Independent sponsors are hospitals, local health departments, school systems, and non-profits. Full services are medical, behavioral health, and dental care. Percentage of students enrolled in Medical is people actively enrolled, not percentage of those who qualify. This is an area for further exploration because by increasing overall access for students to obtain Medical, there would be more students who would benefit from School Based Health Centers. Child Population is extended to 0-18 because there is not reportable data on only high school population(14-18) across counties. Additionally, in order for a SBHC to have a qualifying medical classification there are 6 main core sets of services that must be met. These include: Comprehensive health assessments/well-child exams, Screenings (vision, hearing, behavioral health, substance abuse), Diagnosis and treatment of minor, acute, and chronic medical conditions, Age-appropriate preventive care and immunizations, Referrals

and follow-up for specialty care and community resources, and Mental health services (School Based Health Alliance).

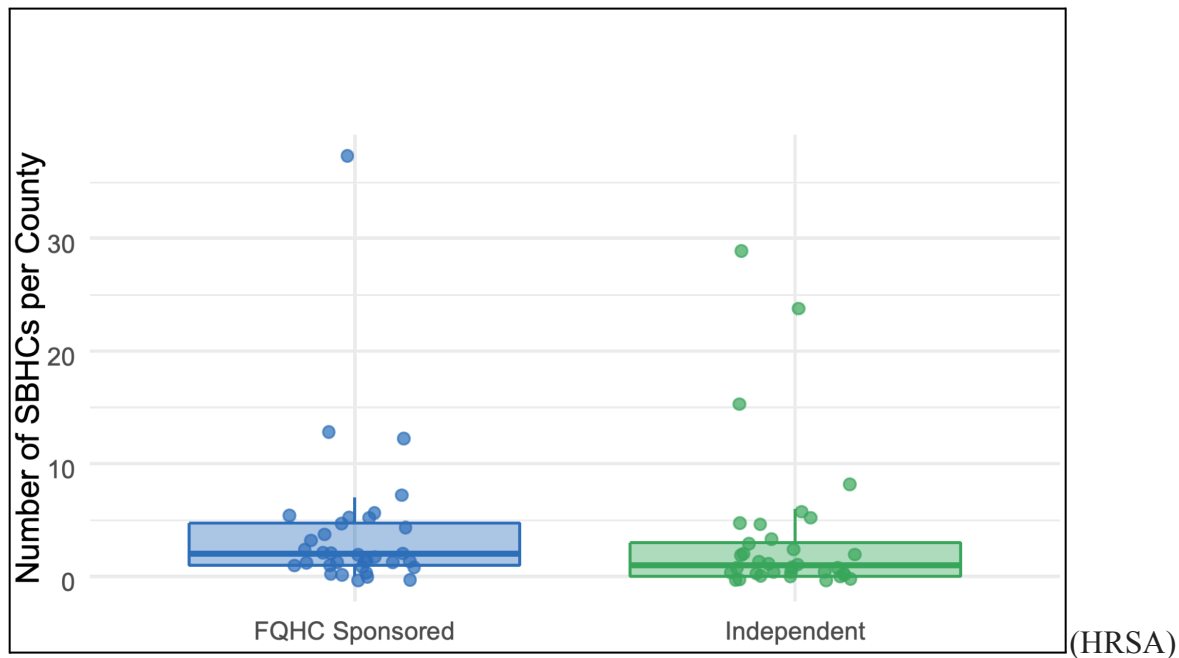
Figures & Results



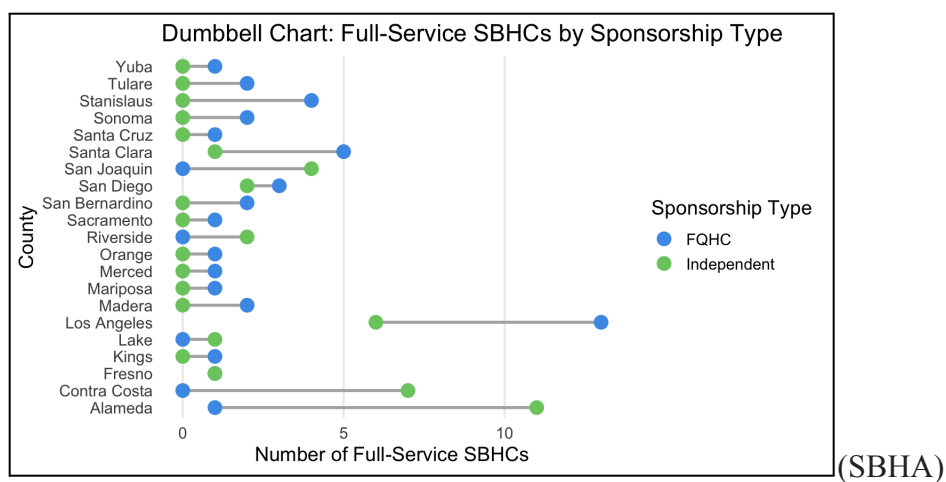
(SBHA)

This first plot is a choropleth map that looks to analyze medical coverage vs SBHC Density across key counties in California. Countries that have a lighter color (yellow) have a good ratio of percentage of Medical Coverage to number of SBHCs per 1,000 individuals. The goal was to look at counties across California and see if high-impacted counties, like the Central Valley, have a greater number of SBHCs to match demand. This graph shows that the greatest disparities are in Southern California and the Bay area.

Distribution of SBHC Counts by Sponsorship Type



This second plot is the distribution of SBHCs between the two sponsorship types. This box and whisker plot is a good visualization to show how the majority of counties have less than 10 SBHCs usually limited to one predominant sponsorship type. The major outlier for FQHC was LA county and the outlier for Independently sponsored was Alameda county.



This last graph is the most complicated but also tells an important story. It looks at the breakdown of SBHCs per county and how many of each sponsorship type offer a full scope of services. The green dot indicates Independently sponsored and blue represents FQHC. This shows that LA county has the greatest number of full service FQHC sponsored SBHCs. While Alameda county has the greatest amount of full service independently sponsored SBHCs. Further analysis into the local environment of Alameda county and what contributes to the success of independent sponsors is an area for further research. This figure suggests sponsorship alone doesn't fully predict the depth of services offered.

Implications & Conclusions

The data shows that there are counties (like Alameda) that are extremely successful at implementation of SBHCs and a full scope of services offered without being FQHC sponsored. However, an interview with Kale Jenks, the former director of School Based Health Centers in Alameda clarified this outlier because these SBHCs were implemented before FQHCs were popular. Therefore additional data on when SBHCs were implemented would be helpful in assessing if the mass FQHC sponsor model was adopted later. There are gaps in the data that hurt the quality of this research, like years of activity for each SBHC and further information on the quality of ties with Independent organizations sponsoring these clinics. Ultimately, 32% of FQHC-sponsored SBHCs offered full scope of services, compared to only 18% of independently-sponsored SBHCs. Therefore there is statistically significance that FQHC-sponsored SBHCs will lead to a more comprehensive range of services. However, there needs to be more research on each individual School Based Health Center in relation to their funding model and how it inevitably impacts sustainability and implementation.

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