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Financing School-Based Health Centers: Sustaining Business Operational Services

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Walden University

College of Management and Technology

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Ingrid Hayes-Burrell

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Walden University
2015

Abstract

Financing School-Based Health Centers: Sustaining Business Operational Services

by

Ingrid M. Hayes-Burrell

MBA, Trinity University, 2007

BA, Potomac College, 2004

Doctoral Study Submitted in Partial Fulfillment

Of the Requirements for the Degree of

Doctor of Business Administration

Walden University

September 2015

Abstract

School-based health centers (SBHCs) have faced challenges in securing adequate funding for operations and developing sound business systems for billing and reimbursement. Specifically, administrators often lack strategies to develop and sustain funding levels to support appropriate resources for business operations. The focus of this descriptive study was to explore best practice strategies to develop and sustain funding through the experiences of SBHC administrators. The conceptual framework included Elkington's sustainability theory, which posits that corporate social responsibility, stakeholder involvement, and citizenship improve manager's effect on the business system. Twenty full-time SBHC administrators working in separate locations throughout the state of Maryland participated in semistructured telephone interviews. The van Kaam process was used to cluster descriptive experiences in data analysis that resulted in the development of thematic strategies for implementing best practices relevant to developing and sustaining funding for SBHC business operations. Major themes provided by the participants were interagency communications, creating marketing plans, and disparities in the allocation of funding for programs and professional staff. Findings indicated SBHC administrators continue to face challenges in developing and sustaining adequate funding for operations in the state of Maryland. Suggestions for future research include how administrators can develop marketing plans and explore long-range funding for SBHC services. The findings in this study may contribute to positive social change by demonstrating to officials in the Maryland State Department of Education the significance of SBHCs, and the need to increase mental health services.

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Dedication

I dedicate this study to the memory of the 20 innocent children and six adult teachers of Sandy Hook Elementary School, Newtown, Connecticut.

Acknowledgments

I am grateful to my Lord and Savior Jesus Christ for sparing my life. I am forever indebted to Dr. Ify Diala, a remarkably gifted Chair, Dr. Anne Davis, my extraordinary Second Chair Member, Dr. Al Endres, an experienced Methodologist, and Dr. Yvette Ghormley, an accomplished educator.

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Section 1: Foundation of the Study

This study explored best practice strategies of administrators who develop and sustain the financial operations of school-based health centers (SBHCs) in the state of Maryland. Section 1 contains discussions of the approaches used by administrators to secure funding for approximately 2,000 SBHCs through implementation of federal and state policies and expansion of traditional sources of funding. School-based health center administrators described their ability to obtain private funding sources and community partnership agreements. Additionally, the administrators discussed legislation, known as the Patient Protection and Affordable Care Act (ACA) of 2010, and the School-Based Health Clinic Establishment Act of 2007. The procurement of funding enabled by these two legislative actions provided support for construction and continuous funding of SBHC operations through Medicaid reimbursements (Cleland, Peipert, Westhoff, Spear, & Trussell, 2011; Dynan, 2006).

The key points of these findings included business operations in SBHCs services, the need for adequate staffing levels of school nurses, physicians, social workers, and psychologists. These professionals shared the experience of developing and sustaining the financial operations of SBHCs in the state of Maryland. The conceptual framework discussion includes the theory of sustainability and connects to the continuation of SBHC business operations. Participant discussions provided the data for the analysis of the importance of the public healthcare workforce and shortages of 200,000 health care professionals required to meet the growing demands of business operational services.

Background of the Problem

Approximately 2,000 SBHCs, staffed by professional healthcare teams, meet the medical needs of children in the United States (Keeton, Soleimanpour, & Brindis, 2012; Policy Statement School-Based Health Centers, 2012). Administrators at the Cincinnati Health Department's Division of School and Adolescent Health Services operated certified SBHCs under the Federally Qualified Health Center (FQHC) rules and regulations. Through these facilities, healthcare professional teams offered a full range of public health preventive services (Hutchins-Goodwin, 2013). Developing and sustaining adequate funding to maintain business operational services was a problem for administrators (Keeton et al., 2012).

Private funding for SBHCs began in 1994 with the Robert Wood Johnson Foundation's multi-year $23.2 million initiative for state-level policies to advance the SBHC model (Keeton et al., 2012). Consistent with the vision and mission statements of SBHCs, these administrators used Title V funds to extend and improve health and welfare services for mothers and children throughout the United States (Keeton et al., 2012). With the passing of the School-Based Health Clinic Establishment Act of 2007, the approval of federal funding was useful for building acquisition, purchasing equipment, paying salaries, and modernizing existing buildings for clinical usage (National Assembly on School-Based Health Care, 2011). Additional funding sources included Medicaid and state-sponsored Children's Health Insurance Programs (CHIP); administrators used funds to acquire significant resources for the development of SBHCs. Keeton et al. (2012) reported administrators face challenges related to securing adequate

funding levels for different school structures, for funding operations, and for developing effective financial billing systems for reimbursement.

Legislators created funding resources found under Sections 4101 and 399Z-1 of the Patient Protection and Affordable Health Care for America Act and established grant-making opportunities specifically for school-based health centers (The Patient Protection and Affordable Care Act, 2010). These legislators mandated funding to address public health services for children in school-based settings. Since there were no guaranteed Congressional or state appropriations, financial stability to maintain adequate funding levels for construction, staffing, and sustaining operations remained uncertain (Hutchins-Goodwin, 2013). Developing and sustaining funding for SBHCs may support jobs for nurse practitioners, physicians, social workers, and mental and dental health professionals, which were necessary in a health care setting (Keeton et al., 2012; Stephan, Paternite, Grimm, & Hurwitz, 2014). The National Association of Pediatric Nurse Practitioners (NAPNAP) supported funding SBHCs so healthcare professionals and administrators could provide comprehensive business operational services (NAPNAP, 2013); specifically, benefactors used the association's funds to support the further development of pediatric nurse practitioner careers.

Problem Statement

Since 1973, through an interdisciplinary team of health professionals, school-based health centers have faced challenges in securing adequate funding for operations and developing sound business systems for billing and reimbursement (Hilliard & Boulton, 2012; Keeton et al., 2012). Beck and Boulton (2012) published the annual

national operating costs for a School-based Health Center as ranging from $90,750 to $400,000. The general business problem was the lack of stable funding systems to sustain and expand school-based health centers. The specific business problem was administrators often lack strategies to develop and sustain funding levels to support adequate resources for school-based health center operations.

Purpose Statement

The purpose of this qualitative descriptive study was the exploration of best practice strategies SBHC administrators used to develop and sustain funding for business operations in Maryland. I conducted semistructured interviews with 20 SBHC administrators. The key criterion for participation in this study was any administrator who was a subject matter expert on reimbursement policies with the ability to obtain resources for different student populations. Additional criteria included budget management expertise and financial acumen in SBHC funding policies.

The focus of this study was an exploration of participant's experiences in developing and sustaining the financial operations of SBHCs based on best practice strategies. The data from this study may contribute to new knowledge and insights for leaders within the state and federal government regarding the reimbursement policies and business practices of SBHCs. In addition, study findings might affect social change through the identification of multifaceted team approaches to the delivery of business services to students in the communities in which they live.

Nature of the Study

The qualitative methodology is an inductive approach exploring a complex

business problem by focusing on situations and people while emphasizing descriptions (Maxwell, 2013; O'Reilly & Parker, 2012). Using a qualitative method, I collected data from multiple sources, including interviews, handwritten notes, and member checking. The qualitative method was ideal for learning the contexts of participants' actions, influences, and events (Maxwell, 2013). Understanding occurred through the descriptive inquiry of the best practice strategies of SBHC administrators currently employed in the selected programs.

I did not choose the quantitative method because this method related to causal studies. The quantitative approach is a method of analyzing the relationships between two or more variables to determine cause and effect of one or more outcomes (Saunders, Lewis, & Thornhill, 2009). Quantitative researchers rely on mathematical and statistical modeling to establish relationships between variables (Saunders et al., 2009). The quantitative method was not suitable for this doctoral study because the use of this approach reduces the human experience to numbers, and does not disclose the conditions in which participants behave, relate to, or experience the phenomenon (Bernard, 2013). I did not use the quantitative method because it did not align with the business problem and was not effective in responding to the research question. Additionally, researchers who use mixed methods measure two types of approaches, quantitative and qualitative, producing diverse sets of data to answer the research question (Bernard, 2013). I also ruled out the use of a mixed research method on the following reason: a mixed methods study involves combining the theoretical aspects of quantitative research and the technical aspects of qualitative research techniques into a single study, which means that

when you quantitate qualitative data it loses its flexibility and depth (Small, 2011).

Descriptive research was the chosen research design for this study. Descriptive research involved gathering data that described events, systematic facts, and characteristics of a population within a contextual framework in business research across versatile disciplines (Kachele, Erhardt, Seybert, & Buchholz, 2013; Simon & Goes, 2013). I used descriptive design to explore the participant's position to discover conditions that define those experiences (Omair, 2015). The descriptive design was appropriate for this doctoral study because participants provided a broader viewpoint of their experiences in a narrative format; how they perceive, feel, and judge the ability to tackle this complex phenomenon (Marcinowicz, Abramowicz, Zarzycka, Abramowicz, & Konstantynowicz, 2014; Marshall & Rossman, 2011).

The phenomenological design was not appropriate for this study because the researcher focus is on persons who have shared the same experiences, eliciting commonalities and shared meanings (Bernard, 2013; Simon & Goes, 2013). The narrative research design was not appropriate because the approach was useful for discovering regularities in how people tell stories within and across cultures (Bernard, 2013). A theoretical lens guided narrative studies in which researchers follow informal processes to collect data. The grounded theory research design was not applicable because this analytical induction approach is useful for explaining a theory around a central theme that emerges from the data (Bernard, 2013; Salkin, 2010; Saunders et al., 2009). A researcher who uses the grounded theory seeks to generate the development of a new theory

(Bernard, 2013). The phenomenological, narrative, and grounded theory research designs did not align with the research question in this study.

The focus of this study relates to the best practice strategies of the participants in developing and sustaining financing in the business operation of SBHCs; therefore, the case study approach was not applicable. Yin (2009) and Macpherson (2013) used the case study design to develop answers to research questions that are extensive descriptions of the social phenomenon; social phenomenon included personal life cycles, small group behavior, neighborhood changes, international relations, and school performances. Yin (2009) and Simon and Goes (2013) both claimed case studies relate to how or why questions, exhibits little control over events, and the focus was a modern phenomenon within a real-life context.

Research Question

The research question for this study was as follows: What strategies can SBHC administrators use to develop and sustain funding for business operations?

Interview Questions

The following open-ended questions guided the study:

1. What significant challenges affect administrators in SBHC business services?
2. How do you build relationships with funders or potential funders?
3. What skills do SBHC administrators use to enhance the development of existing funding?
4. What SBHC program receives the least revenue, and which program receives greater funding support? Why?

5. How do you demonstrate to funders the return or practical outcome of the funds?
6. What was your perception of the funder's investment in your center?
7. How do SBHC administrators and Medicaid providers identify what business services provide revenue from fee-for-services?
8. How do you evaluate the marketing plan for continued SBHC implementation?
9. What other information would you like to add that I did not ask?

Conceptual Framework

The sustainability theory was the conceptual foundation of this study. Elkington (1998) is a leading world authority who developed the sustainability management theory. Elkington (1998) focused on corporate social responsibility and sustainable development to drive corporate leaders toward transformative sustainability. In 1987, Elkington and Hailes established sustainability during the same time as the Brundtland Commission publicized its definition of sustainable development (Elkington, 1998). Elkington championed the corporate responsibility movement, and coined the term *triple bottom line* in 1997 consisting of profit, people, and the planet (Elkington, 1998).

Sustainability is economic development that meets the needs of the present generation without compromising future generations' ability to meet their own needs (Elkington, 1998). In the business arena, sustainability includes corporate social responsibility, stakeholder involvement, and citizenship to improve managers' impact on the environment.

The sustainability theory was applicable to SBHC administrators' efforts to acquire and manage financing required for operational excellence. Managers' abilities to sustain services in the SBHC environment drives internal organizational focus on retaining space, medical professionals, social workers, and community partnerships, and funding alliances (Eilam & Trop, 2013; Keeton et al., 2012; Meier & O'Toole, 2011). External pressures that may affect the sustainability of financing SBHCs are federal, state, and private funding sources (Besel, Lewellen, & Klak, 2011; Kendall, 2009; Medicaid.gov, 2012). Included in the sustainability model were feedback loops for evaluation, testing, and improving corporate strategies (Bain, Walker, & Chan, 2011). This framework required customization based on industry, geographical location, and internal and external business context (Biro, Zsuga, Kormos, & Adany, 2012).

Tibbits, Bumbarger, Kyler, and Perkins (2010) defined sustainability as the program components developed and implemented in earlier stages maintained after the removal of initial funding. Organizational capacity sustains adequate funding levels, which also included appropriate staffing levels, effective funding management, and administrators working towards shared goals. Sustainability planning sessions described the financial future of community and school initiatives to determine how financial sustainability planning relates to the delivery of health care interventions (Tibbits, Bumbarger, Kyler, & Perkins, 2010). With broad support, administrators can sustain funding to align with the prerequisites of the schools and meet the immediate community needs.

Moseley (2011) defined sustainability as the means of donating local budget

investments to increase productivity for the next steps of implementation. Within the lifecycle of educational sustainability, a measurable venture for children is the ability to school track attendance and measure national graduation rates (Cogan, 2011). Another measurement of sustainability is program participants shared in the ownership of the methods and ideas incorporated (Moseley, 2011). At the heart of every program, the results should identify the ability to become self-sufficient due to the benefits of new funding, technology, or innovation. Sustainability planning includes fail-safe points to address failing issues; fail-safe points represented indicators for required changes in program direction, or management correction (Moseley, 2011). Moseley suggested sustainability requires the realization of a long term planning perspective to assess the benefits of new modeling, and lasting change measured for at least 10 years. This approach may lead to reasonable timeframe adjustments with outcomes for long-term success.

The supply and demand of healthcare costs threatens the sustainability of healthcare services (Biro et al., 2012). Biro found preventive healthcare reimbursements occurred in a closed system, whereas healthcare providers maintain budgets and use resources through micro distribution instruments. Since there are no incentives for improving patient care quality, production efficiency was a tool used to increase sustainability of healthcare services (Biro et al., 2012). The production efficiency tool provided healthcare professionals a context for understanding the impact on financial performance. Highlighting areas where variances existed gave administrators opportunities to cut costs or decrease funding gaps. The reality of SBHCs growth

continues to require adequate funding to meet the demands of its developing phenomenon for the need of health services in the public school systems (Knauer, Baker, Hebbeler, & Davis-Allbrit, 2015; Silberberg & Cantor, 2008).

The theory of sustainability fit with administrators' ability to monitor performance; by identifying what are measurable activities that provide a stable return on the investments from federal, state, private, and community partnership programs. Planning for the sustainability of SBHCs requires an understanding of how to operationalize and monitor financial activity over time (Shediac-Rizkallah & Bone, 1998). Sustainability is the capacity to maintain service coverage at a level that provided continuing control of a health problem (Shediac-Rizkallah & Bone, 1998). When financial, managerial, and technical assistance from external sources ended, program sustainability was a way for administrators and healthcare professionals to ensure the continuation of services for intended recipients. Sustainable health care is affordable when the community at large can independently support it, and enough resources provided adequate program deliverables to yield long-term success (Shediac-Rizkallah & Bone, 1998).

Definition of Terms

Medicaid: Enacted in 1965, Medicaid is a government-supported program that reimburses healthcare providers for services for qualified individuals and families who have low incomes and few resources (Dynan, 2006). Individuals must meet program eligibility criteria to qualify for coverage and enrollment into the program. Medicaid is the largest funding source for medical and health-related services for America's poorest

people (Dynan, 2006).

School-based clinic: A school-based clinic is a program that provides education, in-school reproductive health and family planning services, skills training, financial assistance, and social services to pregnant and parenting teens (Bear, Finer, Guo, & Lau, 2014).

School-based health center (SBHC): Staffed primarily by physician assistants and nurse practitioners, SBHCs practitioners provide care for underserved children in elementary, middle, and high school settings (Keeton et al., 2012).

The Patient Protection and Affordable Care Act (ACA): Under Section 2713 of the ACA, the available health plans must include coverage for preventive services without associated copayments or deductibles (Cleland, Peipert, Westhoff, Spear, & Trussell, 2011).

Assumptions, Limitations, and Delimitations

Assumptions

An assumption is an assumed truth, otherwise the study cannot progress (Simon & Goes, 2013). An assumption of this study was SBHC administrators could articulate their best practice strategies with honesty and truthfulness in their description of the business process. An additional assumption was the researcher was capable of capturing, analyzing, and understanding the responses of the participants.

Limitations

Limitations are potential weaknesses in a study and not controlled by the researcher (Simon & Goes, 2013). The limited number of SBHC administrators was a

limitation in this study because the generalizability of the research findings might not apply to a broader population. Limiting the research to the perspectives of SBHC administrator potentially restricted the findings' breadth. This study excluded individuals outside of the SBHC business structure. The use of a descriptive design limited the types of insights yielded from the study. The skills and expertise of the researcher as the main instrument for data collection limited the depth and richness of the data collected.

Delimitations

Delimitations of a study are those characteristics that arise from limitations in the scope of the study, and may result from specific choices made by the researcher (Simon & Goes, 2013). The population of this study was SBHC administrators located in the state of Maryland. The research population was limited to only 20 administrators. The use of telephone interviews as the main instrument for data collection excluded useful information that I could obtain through other means.

Significance of the Study

The findings of this study may provide information to SBHC businesses by developing a multifaceted team approach within school environments that coordinates financial resources (Manning, 2009). Furthermore, the SBHC model provides information about how state, federal, and private leaders could coordinate and acquire supplementary or permanent funding. The results of this study could contribute to understanding financial strategies implementation for SBHC business services in the state of Maryland.

I explored how SBHC administrators develop and sustain funding for business

operational services. Although administrators face sustainability challenges, the National Assembly of School-Based Health Centers (NASBHC) made progress in healthcare reform by recognizing these initiatives as federally authorized programs (Keeton et al., 2012). This federal recognition aided in the allocation of funds useful for the expansion of operations, as well as increasing administrators' participation in the implementation of the healthcare reform laws. Filling a gap in business practices on financing SBHC operations led to new decisions about program funding, reimbursement options, and SBHC program models (Basch, 2011; Guo, Kataoka, Bear, & Lau, 2014; Hutchins-Goodwin, 2013; Keeton et al., 2012). Identifying gaps among service providers, healthcare professionals, and schools may play a vital role in financing the access to these business services.

Contribution to Business Practice

The outcomes in this study contributes to business practices by identifying opportunities to sustain funding for professional staff and eliminating gaps in the business services provided by SBHC administrators (Hutchins-Goodwin, 2013; Keeton et al., 2012). These results are relevant to improving business practices for stakeholders to build initiatives addressing the need for SBHC formal marketing plans and the expansion of professional staffing positions in areas to meet critical business services. The conclusions in this study may contribute to building business practices by campaigning for the sponsorship of SBHCs on a private, state, and national level, and the statewide reimbursement business practice of Medicaid payments for all primary and mental health care services.

Implications for Social Change

Findings from this study may contribute to understanding successful business practices of SBHCs (Hutchins-Goodwin, 2013; Keeton et al., 2012). The results may recognize the innovative funding resources for SBHCs in the major cities throughout the state of Maryland. Additionally, the results may benefit social change by comprehending administrator's ability to obtain adequate resources to provide business services to students in the communities. The conclusions may contribute to positive social change by communicating the best practice strategies for administrators to obtain the financial sponsorship of SBHCs on a state level, and – most importantly – provide better services to children.

A Review of the Professional and Academic Literature

The following professional and academic literature review contains a concise summary of the key aspects for understanding the business processes associated with funding SBHC programs, business operations, and organizational structures. There are discussions in this review about funding sources, workforce staffing roles and shortages, and financial management. My literature review strategy incorporated Walden University's library databases PsycINFO, PubMed, ERIC, and Web of Science. Key search terms included *SBHCs, school-based health clinics, school-based health centers, adolescent health, third-party reimbursement, nursing workforce shortage, advancing nursing practice, granting institutions, funding, federal funding, state funding, fee-for services, private funding, and sustainability*.

Perusing peer-reviewed journals and seminal works provided insights on the

diverse aspects of SBHC operations and funding resources. Journals included *American Journal of Preventive Medicine, Journal of School Health, American Journal of Public Health, and Health Affairs*. The literature review includes the details of business operation requirements in health services, funding structures of SBHCs, public healthcare workforce roles, and community partnerships required for the development of funding SBHC entities. A thematic chronology provides the background of SBHCs, public healthcare roles required for SBHCs through nurse practitioners, counselors, doctors, social workers, mental health professionals, and management of funds to finance SBHCs. In selecting the concept of sustainability, I compared, contrasted, and delineated the distinctive characteristics previous researchers used to obtain continuing support of federal, state, and private funding to sustain the operation of SBHCs.

Sustainability Theory

Davidson (2011) restated the traditional definition of sustainability provided by the Brundtland Commission; sustainability is the development that meets the needs of the present without compromising the ability of future generations to meet their own needs. Sustainability described as the triple bottom line: comprised of economic, environmental, and social factors attributed to businesses or government activities (Davidson, 2011; Persons, 2012). Progressively, international and national educational systems are broadening sustainability initiatives and developing sustainability agendas within the partnerships of school districts funding sources, educators, parents, and community partnerships (Duncan, Morris, & Rodrigues, 2011; Eilam & Trop, 2013; Siddiqi, Kawachi, Berkam, Hertzmsan, & Subramanian, 2012).

A sustainability agenda defined the degree of importance and interests between parents, and the priority given to school programs on different higher education issues (Eilam & Trop, 2013; Hutchins, Lindenfeld, Bell, Leahy, & Silka, 2013). In comparison to the school agenda and parents' expectations, sustainability agendas have become the motivating dynamism for driving funding initiatives to transform the interaction of the broader audience to include community partnerships, media, and educational institutions. Eliam and Trop (2013) found no similarity between school program agenda and parents' sustainability agenda, indicating these two entities belong to two distinct populations about their financial commitment to school-related sustainability agendas. School environments are homogeneous about their sustainability agenda; an explanation derives from their organizational structure of uniformity, and the engagement of diverse viewpoints significantly influenced sustainability (Eilam & Trop, 2013; Hutchins et al., 2013). According to Eilam and Trop (2013) and Hutchins et al., (2013), the parents' view of the sustainability agenda differed from that of school administrators; geographical differences, community needs, educational background, and cultural experiences influenced parents' perspectives.

SBHCs required sustainable funding vehicles comprised of federal, state, and private entities, as well as school district policies that support related initiatives and reforms. As reported by Brown and Hamburger (2012) and Cohen (2012), sustainability principles integrate into the overall operational plan, mission statement, annual marketing plan, and staffing evaluation criteria. The principles of sustainability may guarantee long-term success by demonstrating to external funding sources that they have incorporated

principles for success, and annual goals are achievable (Dupuis & Ball, 2013; Hutchins et al., 2013). Brown and Hamburger also reported sustainability is a holistic concept similar to value creation, inspiring management to integrate sustainability into their strategic business plans. Understanding sustainable practice, process, and designs incorporated into the business model might assist organizations in redefining their organizational capacity and competitive advantage objectives (Eliam & Trop, 2013). The sustainability theory was applicable to this research in supporting the financial success of SBHCs in communities to meet the demands of business operational services (DuPuis & Ball, 2012; Hutchins et al., 2013). Sustaining revenue might become easier to obtain for its business operations, as SBHCs designation gain recognition as federally qualified health services entities.

Sustainable Funding

Ghaly (2011) described leaders' capabilities spread across multiple boundaries including personal, team, organizational, visionary, political, and ethics. Cullom and Cullom (2011) and Ghaly (2011) concurred these networks created dynamic opportunities for policy innovation derived from sociological, political, economic, technological, and ecological trends. Governments, businesses, and individuals in different sectors may work together to alleviate public problems (Cullom & Cullom, 2011). When leaders focused on sustainability, they facilitated the alignment of networks, created direct connections, and refined guiding principles towards an endorsable mission statement (Ghaly, 2011).

Besel et al. (2011) reported the qualities of leadership for sustainability funding

and conducted a survey with nonprofit boards of directors within the Mississippi River Delta. Effective directors continuously face challenges regarding the measurable effect on community members (Besel et al., 2011). Boards of directors' choices may include legacy issues; legacy issues challenge current business practices and might encourage business partners to seek new approaches to business for mutual benefit (Cullom & Cullom, 2011). When board members acquire responsibility they voice financial decisions, and are more likely to become involved in fundraising strategies (Besel et al., 2011).

Sustainability for a nonprofit is critical if the mission is going to make a major impact on a crisis (Besel et al., 2011; Cullom & Cullom, 2011). In light of the cutbacks in federal and state funding, strategies on sustainable funding for nonprofit organizations are necessary to avoid cutbacks in community services (Besel et al., 2011). Conversely, overall dependence on government resources may affect the service delivery strategies to include, but not limited to, biased mission, loss of independence, and increased bureaucracy (Besel et al., 2011; Maruthappu, Ng, Williams, Atun, & Zeltner, 2015). Major goals of sustainable funding are the ability to diversify the funding support and extend the operating budget over a 5-year period (Besel et al., 2011). A key connection between business and the government may challenge fundamental assumptions, trade-offs, quality, and cost. According to Besel et al. (2011), boards of directors might consider increasing their understanding of disruptive approaches to change corporate culture towards high performance, adapting solutions, and initiatives to sustain adequate resources. Cullom and Cullom (2011) concluded nonprofits must operate as businesses

selling consistent images of the mission, and senior leadership's knowledge management was a cornerstone for sustaining the organization into the future.

Kataria, Kataria, and Garg (2013) mentioned internal communication with all employees in managing sustainable funding is a primary link in the implementation of sustainability initiatives. It was essential for all employees to engage in the sustainability initiative to maximize value and use sustainability as a competitive advantage (Kataria et al., 2013). The perspectives of all employees are valuable because the success or failure of an organization depended on its employees' full contribution to the initiative (Cullom & Cullom, 2011). Moreover, Kataria et al. (2013) emphasized tailoring messages based on job relevance and cost-saving measures throughout organizations. Verbal communication between and from employees was helpful because this form of communication provided valuable suggestions. Open communication engaged all employees in plan development, sharing of ideas, and internal education (Kataria et al., 2013).

Bowman (2011) described two financial indicators affecting sustainable funding for nonprofits, long term and short term financial capacities. Long-term capacities are the ability of administrators to maintain adequate service levels while short-term capacity relates to the resiliency of the organization while meeting long-term forecasts (Bowman, 2011; Cullom & Cullom, 2011). An organization was sustainable if long-term financial capacity change rate was sufficiently adjustable to maintain assets and costs (Cullom & Cullom, 2011); organizations are at risk if sustainability falls below bottom quintile (Bowman, 2011). Bowman further defined the financial sustainability measurement as

the rate of change in capacity in each funding period compared to similar nonprofits that are active public charities without endowments.

Bowman (2011) and Cullom and Cullom (2011) cited financial capacity is the ability for an organization to avoid high debt. Debt impairs financial capacity against creditors' claims as the inability to pay causes asset forfeiture. Borrowing takes less effort than fundraising; however, nonprofit administrators must guard against overextension (Bowman, 2011). Administrators must have adequate short-term capacity to withstand external economic shocks. An organization might be sustainable in the long term, yet become unsustainable in the short term if cash runs out. Conversely, if the values of the organization's assets erode over time, administrators cannot maintain the quality of services without acquiring new assets (Bowman, 2011; Cullom & Cullom, 2011). Creating value was an objective for administrators focused on nonprofit survivability so that stakeholders, donors, and volunteers continue to see the contribution making a difference (Cullom & Cullom, 2011).

In order to create sustainable engagements toward funding community projects, the three dimensions addressed are internal, external, and personal relationships (Clifford & Petrescu, 2012; Cullom & Cullom, 2011). These engagements lead to creating value in the capacity building process and supporting the creation of successful community relationships. The formation of the internal dimension challenge administrators in balancing stakeholder expectations, managing continuous commitments, and building new partnerships. Maintaining the support of these relationships provided political placement in the community (Clifford & Petrescu, 2012; Cullom & Cullom, 2011).

Managing the organizational dynamics, structure, and culture between the community and partners helped administrators establish the external appearance of equity of contribution and the appearance of positive, cooperative returns between the partners (Clifford & Petrescu, 2012).

Formed by the psychological identity of oneself, personal relationships included making a choice between career advancement and the recognition of functioning effectively in the community (Clifford & Petrescu, 2012). When an administrator committed to improving the community, challenging issues like equity in funding distribution and career advancement persisted. Cullom and Cullom (2011) underscored long-tenured nonprofit employees possess tacit knowledge and exhibit passion for the cause, critical for the future of the organization. The core of building sustainability funding opportunities is building relationships with diverse organizations, people, and institutions (Clifford & Petrescu, 2012; Cullom & Cullom, 2011).

School-based Health Center Structures

Statisticians reported almost 2,000 SBHCs are in operation; 57% of SBHCs are in urban centers, 27% are in rural, and 16% are in suburban settings (Keeton et al., 2012; Pediatrics, 2012; Policy Statement School-based Health Centers, 2012). As identified on the next page in *Figure 1* by Lofink et al. (2013), 1,930 clinics provided business operational services in school-based, mobile, and linked health centers, reflecting a 2% increase in sustaining services throughout the nation. School-based health centers nationwide sponsored by school systems, hospitals, private nonprofit, health department, and community health centers served an estimated 2,000,000 students (Lofink et al.,

2013). Maryland (67) ranked high in the number of SBHCs (Lofink et al., 2013). The largest concentration of SBHCs locations are in New York (231), Florida (224), and California (172) (Lofink et al., 2013). The lowest concentration of SBHC states are South Carolina, Marshall Islands, Nebraska, Virgin Islands, and Wisconsin (Lofink et al., 2013). Populations also served by SBHC program sustainability and expansion included other people in the communities, out of school youth, faculty and school personnel, students from other schools, and family of student users (Lofink et al., 2013; Samdal & Rowling, 2011). Program managers have illustrated SBHC models vary across school demographics; whereas, elementary and middle schools are for treatment of illnesses, and high school students' uses are for reproductive health services (Luthy, Thorpe, Dymock, & Connely, 2011; NAPNAP, 2013; Soderback, Coyne, & Harder, 2011).

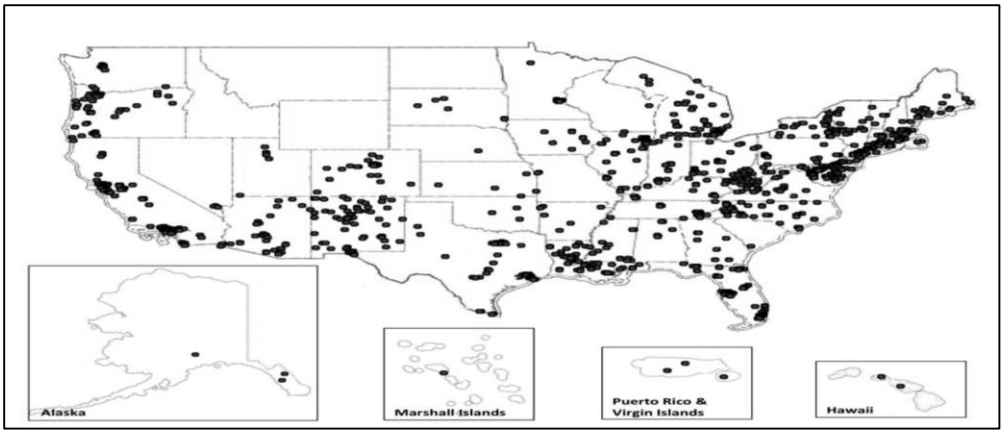


Figure 1. The School-Based Health Alliance conducted its 12th census, identified 1,930 clinics provided school-based, mobile, and school-linked primary and mental healthcare services across the nation. Adapted from "2010-2011 Census Report of School-Based Health Care," by H. Lofink, J. Kuebler, L. Juszczak, L. Schlitt, and J. Even, M. Rosenberg, and I. White, 2010-2011 School-Based Health Alliance Census Report, p. 11. Copyrighted 2013 by the School-Based Health Alliance. Reprinted with permission.

The business services provided by SBHC staff deliver preventive care; provide immunizations; manage chronic illnesses, such as asthma, obesity, and provide reproductive health services for adolescents in an environment to improve academic success (Clayton, Chin, Blackburn, & Echeverria, 2010; Engelke, Swanson, & Guttu, 2014; Keeton et al., 2012). School-based health centers brought healthcare services to school environments, acting as an entry point and source of primary care to children who lack traditional access to medical care (Daley, 2012; Keeton et al., 2012; NAPNAP, 2013). The access to healthcare improves the link between the student and the learning outcome. Analysis of records showed how the availability of healthcare services on campuses was conducive to meeting the needs of students. School health officials and policymakers examined the eight components of school health programs consistently (Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011; Policy Statement School-

based Health Centers, 2012). The eight components are (a) health education, (b) physical education and activity, (c) health services, (d) mental health and social services, (e) nutrition services, (f) healthy and safe school environment, (g) faculty and staff health promotion, and (h) family and community involvement (Anakwenze & Daniyal, 2013; Keeton et al., 2012; Policy Statement School-based Health Centers, 2012).

Using a multi-sectional model, SBHCs near local hospitals or community health centers, administrators operate within the public school and match the multi-sectional model to the needs of a specific community (Cummings, Wen, & Druss, 2013; Keeton et al., 2012). Different economic, political, and school district policies created societal opportunities that limit administrators' capabilities of meeting different health needs (Silberberg & Cantor, 2008). Although the administration of the health center was separate from that of a school, practitioners and clinicians understood the health maintenance needs of children. Assessing SBHCs effectiveness, Silberberg and Cantor (2008) recommended administrators understood the magnitude of the clinic impact and compared operations to alternative medical homes. Moreover, Silberberg and Cantor assessed different clinical models and considered the adoption of a hybrid model with a dual focus of school and community.

Structured services provided by the administrators follow one of three primary staffing models (Policy Statement School-based Health Centers, 2012). The primary care model comprised of a nurse practitioner, or physician assistant provided basic health services under the supervision of a physician (Lineberry, & Ickes, 2015; Parcei, & Pennell, 2012; Policy Statement School-based Health Centers, 2012). The most common

model was the primary-care mental model, which included a licensed clinical social worker or psychologist (Daley, 2012; Policy Statement School-based Health Centers, 2012; Wells & Gifford, 2013). The primary-care mental health plus model was comprehensive with primary care, mental health professionals, health educators, case managers, and nutritionists (Daley, 2011; Daley, 2012; Doll, Spites, & Champion, 2012; Hooper & Britnell, 2012; Policy Statement School-based Health Centers, 2012).

As Scutchfield, Howard, and Mayes (2012) asserted, public health departments continue to experiment with methods of reducing the cost of medical services while responding to budget and political changes. The selection of the appropriate model was an effective mechanism to provide public health services (Bear et al., 2014; Daley, 2011; Daley, 2012; Keeton et al., 2012; Scutchfield et al., 2012). Public health services delivered through collective efforts of government and private organizations vary widely based on the availability of resources, missions, and operations (Policy Statement School-based Health Centers, 2012). As stated, it was important to comprehend how these structures fit other elements of the health care system to improve the business operation processes and understand SBHC funding structures (Policy Statement School-based Health Centers, 2012).

Health Services

Manning (2009) reported legislators in each state establish policies and requirements for health promotion in schools. Health screenings for hearing, height, weight, oral health, scoliosis, tuberculosis, and vision are part of school districts' mandatory health assessments (Manning, 2009). As a result, one of the goals of Healthy

People 2020 is for an 80% human papillomavirus (HPV) vaccination rate (Kelminson et al., 2012; Peery, Engelke, Streater, Hausauer, Newman, & Vogel, 2014).

Hudson (2013) reported health services provided by SBHC practitioners tend to reduce emergency room visits and the associated expenses among children of the low socioeconomic status. After Hurricane Katrina, all but three of the 15 area hospitals remained closed for months, exacerbating a very difficult time for children to obtain health services (Hutchinson, Carton, Broussard, Brown, & Chrestman, 2012). Therefore, many residents previously relied on emergency room care for preventive and primary services, and this act of nature destroyed familiar clinical services. With the scarcity of services in high-risk urban environment, SBHCs measurable impact provided preventive and acute health care in schools replacing the emergency room stopover (Hudson, 2013; Hutchinson et al., 2012).

Ethier, Dittus, DeRosa, Chung, Martinez, and Kerndt (2011) reported a survey conducted by the National Assembly on School-Based Health Care stated business services vary from state to state, however reproductive and contraceptive health services are not consistently accessible. While business services like abstinence-counseling, pregnancy testing, counseling for birth control are available on site, there are restrictions on the dispensation of contraceptives. Juszczak and Ammerman (2011) reported on one New York City SBHC where healthcare practitioners reached 70% of the males in school and were able to connect the boys and young men with reproductive and mental health services.

One school district in Massachusetts demonstrated how SBHCs and communities

worked together. The town's health advisory council and school board members voted unanimously to implement a condom availability policy in September 2010 (Sayegh, Rose, & Schapiro, 2012). The policymakers limited the program to children over the age of 12, provided counseling with school nurses, and distributed information on abstinence. Parents who were averse to the plan had to sign waivers to exempt their children from the program. The author of the 2008 national survey reported 60% of SBHCs are in cities or towns where school district policies prohibited the dispensing contraception (Sayegh et al., 2012). Determining sound policy initiatives for providing reproductive health services in SBHC settings require the support of policymakers (Bains, Franzen, & White-Frese, 2014; Sayegh et al., 2012).

Daley (2011) cited administering contraceptive services within an SBHC environment is controversial, met with legal roadblocks, and lacks full public support. Daley (2011) reported school district policies limited the scope of services, and these policies were more restrictive than local or state health policies. Administrators who are successful in changing the policy for reproductive health services are those with operations older than 10 years. Daley found administrators and health practitioners achieve success by gaining the trust of patients, parents, school administrators, and the community.

SBHCs with business services that administered reproductive health services counsel youth in a trusted environment (Sayegh et al., 2012). Without significantly increased funding, staffing, or facilities, reproductive health services remained limited (Ethier et al., 2011). The Patient Protection and Affordable Care Act of 2010 provided

more than $50 million, over 4 years, to fund SBHCs that served Medicaid participants, increased the availability of contraception among youth, and supplied access to care for this growing population. School-based health centers provide connections to family planning services through community providers, and act as a conduit to healthcare services this population would otherwise miss (Ethier et al., 2011).

Children with special healthcare needs also require mental health services provided by SBHC business services (Manning, 2009). Mental health services in SBHCs targeted suicide, depression, attention deficit disorder, aggression, and violence. Manning (2009) showed how these issues may overlap in the life of a child, and discussed the linkage between mental health and academic performance. Across the United States, there are no state requirements for mental health screening in schools. Even though state legislators enacted policy requiring the identification of abused students, there are no stringent guidelines or requirements for providing counseling or intervention services (Manning, 2009).

Students who used SBHC mental health services reported paying for healthcare with private insurance (53%), government assistance (13%), cash (10%); 21% of students are not sure who paid for healthcare services (Amaral, Geierstanger, Soleimanpour, & Brindis, 2011). Initiatives to establish and expand mental health screenings and services remedied unmet needs by accommodating children at every school level. Amaral et al. (2011) found adolescents sought mental health services in SBHCs because traditional mental health practitioners or mental health service organizations did not exist within the community where adolescents reside.

Manning (2009) reported the delivery of school-based mental health centers was a model that linked physical health and mental health, with improved mental health as the primary result of referred SBHCs enrollees. The enrollees develop trust and confidence in the influential staff persons or three primary SBHC employees. The three primary SBHC employees are:

- The school counselors who provide vocational guidance; counselors' roles expand into problem solving for children.
- School psychologists who assess psychological needs, consults with teachers, and communicates with parents regarding behavioral modification strategies.
- School-based social workers who serve as liaisons between homes, school, and the community, providing case management assessments and delivering social services benefits.

Gampetro, Wojciechowski, and Amer (2012) claimed the findings in few studies explore the needs of adolescents with mental health disorders; however, the number of children affected by mental, emotional, and behavioral disorders continues to rise. Gampetro et al. (2012) claimed factors' increasing mental health disorders includes depression, exposure to violence, abuse, parental substance abuse, poverty, immigration, inadequate housing, and homelessness. The use of evidence-based intervention programs provided cognitive behavior therapy and medication, assertiveness training, family and group therapy, and social skills training (Dempster, Wildman, & Keating, 2013; Gampetro et al., 2012; Morgan et al., 2014). Unfortunately, if mental health issues remain untreated, these disorders reappear in adulthood (Gampetro et al., 2012; Schonert,

Richter, van der Gagg, & Bhutta, 2012).

As mentioned, after Hurricane Katrina, the Louisiana Office of Public Health allocated $1.6 million of state funding, with $2.9 million allocated to the Medicaid program for mental health services (Madrid et al., 2008). The W. K. Kellogg Foundation donated $8.7 million for SBHCs located in the metropolitan New Orleans area, and funding allocations were in response to increased patient volume after the hurricane (Madrid et al., 2008). Reported conditions among school age children included increased family disruption, domestic conflicts, fighting in school, truancy, and an increase in sexual activity (Madrid et al., 2008). School-based health center administrators used the funds to support training for school staff and families, in order to meet the mental health needs of students (Madrid et al., 2008). The hurricane event confirmed the need for school psychologists trained in clinical diagnosis and treatment of high-risk youth, trauma assessment, and intervention (Madrid et al., 2008). Following events like natural disasters, administrators who worked with mental health programs demonstrated their ability and financial shrewdness to keep SBHCs as self-sustaining entities during the stabilization of the community's infrastructure (Madrid et al., 2008).

Without early intervention, children may be unable to contend with emotional and behavioral issues or cope with life problems (Ebrahim, Steen, & Paradise, 2012; Taylor, Way, & Seeman, 2011). Accordingly, children are incapable of articulating their fears, anxieties, and worries (Ebrahim et al., 2012). Using techniques like play therapy, counselors presented children an alternative to talk therapy (Ebrahim et al., 2012). Although barriers prevented the implementation of this type of therapy, school counselors

forged novel approaches to overcoming such barriers including training, educating faculty and administrators, using of personal funds for play therapy materials, and creatively using treatment time (Ebrahim et al., 2012). School counselors assisted students in coping with severe stressors that might interfere with learning. Stressors include depression, grief, anger, physical or sexual abuse, school violence, and bullying (Ebrahim et al., 2012). The school counselor, as an early interventionist, may also be the only mental health professional school age children encountered.

As active players in the development of school age children opportunities exist to legitimize the school social worker to provide more visibility, viability, and value to the SBHC establishment. The social worker's role requires stronger internal coordination between the school's counselor and psychologist (Ebrahim et al., 2012). Improved certification standards developed for school counselors and social workers might equip public health workers to manage students with mental health problems and complex family structures (Graham-Jones, Jain, Friedman, Marcotte, & Blumenthal, 2012).

Maryland's SBHCs

Rich (2011) reported that 68 SBHCs provided healthcare access to more than 28,000 students during the Maryland school year 2010-2011. Rich also found demonstrating the importance of healthcare services availability and prevention; parent's enrolled 27,729 students in Maryland SBHCs. Visits captured by the Maryland State Department of Education in the categories of 2010-2011 visits were:

- 41,069 visits for somatic care;
- 24,163 visits for mental health services;

- 1,579 visits for oral healthcare, and
- 1,279 visits for substance abuse treatment (Rich, 2011).

The Maryland SBHC Policy Advisory Council adopted standards for the operation of SBHCs and implemented the current application process for SBHCs execution jointly between Maryland State Department of Education (MSDE), the Maryland Department of Health, and Mental Hygiene's Medical Assistance Program (DHMH) (Maryland State Department of Education, 2014). Maryland State Department of Education reported applications consisted of eligibility for state grant funding, DHMH and MSDE application standards, billed insurance carriers, a licensed health care provider, and participant in a statewide network of SBHCs for technical assistance (Maryland State Department of Education, 2014).

A Maryland SBHC complied by hiring health professionals who are trained and experienced in community health services for school-age children, possess knowledge of health promotion and illness prevention, certified for the population to be served, and currently licensed or certified under the guidelines in the Health Occupations Article, Annotated Code of Maryland (Maryland State Department of Education, 2014). The organizational structure supports adequate clinical supervision of staff as required by law, having designated individuals who are responsible for the management of the center, maintained a staff of one advanced nurse practitioner, physician assistant, or a physician onsite for the delivery of primary health services (Maryland State Department of Education, 2014). The Maryland State Department of Education reported in Maryland SBHC enforced policies ensuring confidentiality in the data collection, retention, and

storage of medical records and client demographics (Maryland State Department of Education, 2014).

Through the School-Based Health Centers Capital Program (HRSA-11-127), four organizations received awards of approximately $934,435 (Rich, 2011). Awards were for construction, renovation, and equipment at Choptank Community Health Systems, Dorchester County Health Department, Montgomery County, Maryland Government, and the Baltimore County Department of Health (Rich, 2011). The School-Based Health Centers Capital Program is the most recent federal funding mandated to come from legislators supporting the construction of SBHCs (National Assembly of School-Based Health Centers, 2011; Rich, 2011). These awards illustrate the continuous need to expand the construction of medical space in school settings in the state.

Business Processes

Schmiedel, vom Brocke, and Recker (2014) described business process management (BPM) as methods of increasing the efficiency and effectiveness of organizational processes. BPMs evolved through the series of improvements and innovations. The BPM process originates from the division of labor in Taylorism, focusing on departmental boundaries, and building on aspects of total quality management and business process reengineering (Schmiedel et al., 2014). Stating business processes explains how an organization operates and differentiates between the customers, employees, partners, and systems (Singh, 2012).

A business process is a collection of structured activities or tasks that produce a particular product for a customer, which may increase efficiencies and cost the company

less (Singh, 2012). Managers used business processes to define inputs and outputs, structure for action, acquire critical process efficiency, execute management, and operational processes (Schmiedel et al., 2014; Singh, 2012). Senior managers set goals for the business process by solidifying the foundation to the implemented technology (Singh, 2012). Overall, managers' responsibilities ensured linkages between business projects so that projects align with the organization's overall strategy and business concept (Schmiedel et al., 2014; Singh, 2012).

Since 1994, SBHCs managed fee-for-service activities in a variety of school settings. Holweg and Pil (2012) cited the nature of outsourcing traditional activities as external enterprise partnerships. The fee-for-service organization worked well for routine and standardized processes such as payroll and loan application processes; however, the enterprise structure did not work well if the corporation was complex, customized, or infrequently operational. Holweg and Pil (2012) described infrequently operational functions as belonging to recruiters, benefits advisers, or managers of developmental activities. The outsourcing model is beneficial when organizations have expensive processes and services (Holweg & Pil, 2012). Traditionally, successfully outsourcing services reduce costs by 20-40% of baseline costs (Holweg & Pil, 2012; Keehan et al., 2011). School-based health center practitioners are providing medical care, screenings, and interventions for children who might otherwise not receive care (Gifford, Wells, Bai, & Malone, 2015; Sisselman, Strolin-Goltzman, Auebach, & Sharon, 2012; Veith, 2012). Providing services to children decreased absences by providing treatment for minor illnesses (George & Shocksnider, 2014; Halfon, Wise, & Forrest, 2014; Sisselman et al.,

2012). Future research might focus on evaluation of programs to develop objective information related to the effectiveness in managing illnesses, risky behaviors, and chronic health matters. Developing this type of information might be useful for creating SBHC manuals of operation to guide effective operations (Sisselman et al., 2012).

SBHC administrators work with network providers to offer medical services including human papillomavirus vaccinations and adolescent health screenings (Rickert et al., 2014). Other services described training and consultation procedures implemented to pilot modular psychotherapy for therapist to treat youth with depression and anxiety (Lyon, Charlesworth-Attie, Stoep, & McCauley, 2011). Module selection and adaptation decisions are data driven to increase compatibility with SBHC environments (Lyon et al., 2011).

Therapists who train for 1 year have the ability to select students for treatment, track the use of module treatments, and administer standardized measures to monitor changes (Lyon et al., 2011). System related issues included inconsistencies in timelines, methodological considerations, and interpretations of value for money, stakeholder engagement, and accountability for reasonableness (Svensson & Hvolby, 2012). The need to create this framework came from decision-makers requests; decision makers understood a one-size fits all approach was inappropriate and needed a support tool that would not produce pre-defined restrictive answers. The framework included a checklist of the elements useful for improving processes and decisions. Users' responses to questions provided verification of information required by the experts, board members, and executive committee members to revise existing funding processes (Svensson &

Hvolby, 2012). The objective was to establish a reference model, improve process quality, and reduce administrative burdens on budgets (Svensson & Hvolby, 2012; Waitkin, Yager, & Santos, 2012).

McCann et al. (2011) discussed Small Business Innovation Research and Small Business Technology Transfer Research programs as excellent sources of funding for nurse researchers who could capitalize on small businesses obtaining seed money for high risk projects to attract venture capital. Venture capital is an underutilized pool of money that nursing faculty members, who have sustained intellectual property they own with other people and academic institutions, can access (Granger et al., 2012; McCann et al., 2011). These commercialized products might benefit society and other funding sources, as well as establish the usefulness in research by furthering the development of nurse practitioner opportunities.

Koepp, Manohar, McCrady-Spitzer, and Levine (2011) discussed the scalable office-based healthcare opportunity created in the culture of healthcare delivery. The return on investment for wellness strategies is positive, ranging from $3 to $6 for each $1 invested (Koepp et al., 2011). By 2020 or sooner, most individuals working for small businesses may purchase insurance on their own or through state exchanges (Keehan et al., 2011; Martin, Lassman, Whittle, Catlin, & the National Health Expenditures Accounts Team, 2011; Miller, 2011). The responsiveness of nurse practitioners changed healthcare delivery by leveraging clinical, intellectual, and financial resources to generate new knowledge of innovative patient care practices (Granger et al., 2012; Jokelainen, Turunen, Tossavainen, Jamookeeah, & Coco, 2011; Poronsky, 2012). Nursing knowledge

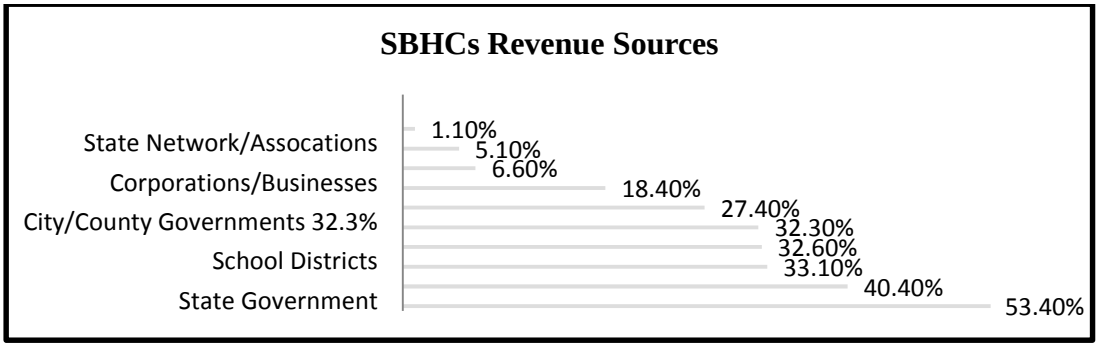
products entered practices quickly and efficiently creating a synergy between business and educational goals that feed scholarly and financial success (De Nicola, Missikoff, & Smith, 2012; McCann et al., 2011). Nurse researchers positioned themselves to balance the demands of practicing healthcare in an environment that also values financial efficiency (Granger et al., 2012; Im & Chang, 2012; McCann et al., 2011). Nurse researchers documented the process developing intervention and training modules creating best practices to meet the needs of the population served (Lyon et al., 2011).

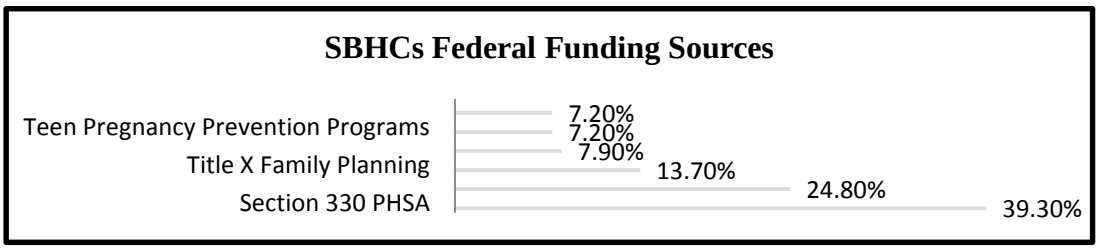
Funding Sources of SBHCs

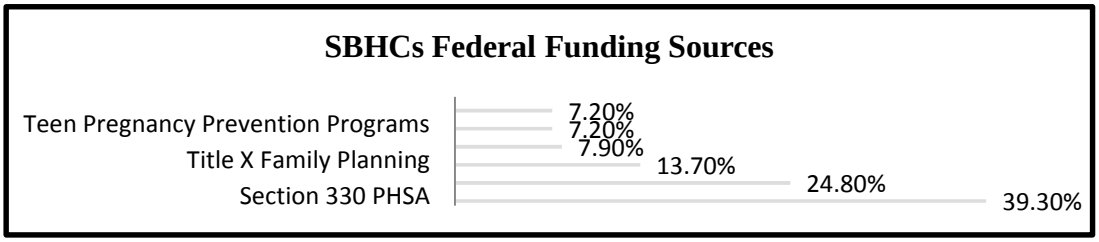
The Patient Protection and Affordable Care Act (2010) incorporated Medicaid legislation to cover millions of individuals and provide the eligibility for the Children's Health Insurance Program (CHIP). There are four funding sources for SBHCs, federal, state, third party billing, and private foundation funding (U.S. Department of Health and Human Services, 2012). Recipients of federal funding must meet eligibility guidelines before they received grants of approximately $200,000 per year (U.S. Department of Health and Human Services, 2012).

Competitive grants from the Centers for Disease Control and Prevention and the Maternal and Child Health department fund programs are available for SBHCs located in low-income communities (U.S. Department of Health and Human Services, 2012). Grant recipients understand the limitations associated with these funding sources, as most grants are term limited (American Public Health Association, 2012; Cogan, 2011; Jannone, 2011). Administrators combined federal grants with other revenue resources; state funding varied by budget and other grant program priorities (National Assembly on

School-Based Health Care, 2011). Typically, program grants provide funding for SBHCs based on the federal and state's interest in health, education, and youth development opportunities.







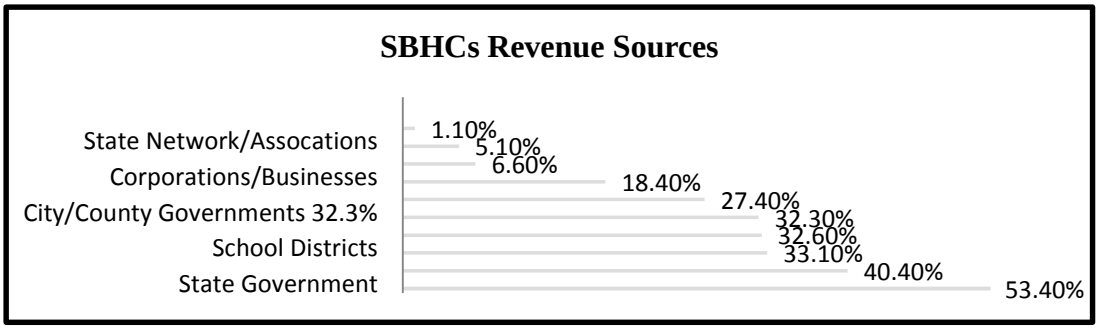


Figure 2. **School-based health centers** bill associations, corporations, and state and federal governments for direct payment for health center visits. Effective billing of insurance and increasing family enrollment policies sustain SBHC services. Adapted from "2010-2011 Census Report of School-Based Health Care," by H. Lofink, J. Kuebler, L. Juszczak, L. Schlitt, J. Even, M. Rosenberg, and I. White, 2010-2011 School-Based Health Alliance Census Report, p. 7. Copyrighted 2013 by the School-Based Health Alliance. Reprinted with permission.

With the passing of the School-Based Health Clinic Establishment Act of 2007, federal funds may be used for acquiring and leasing buildings, equipment, training, managing the health clinic, paying salaries, and modernizing existing buildings for clinical usage (National Assembly on School-Based Health Care, 2011). For example, *Figure 2* illustrates financing of SBHCs, and the sources of funding received from corporations, and state and federal governments (Lofink et al., 2013). The ACA included a mandate that requires the Secretary of Health and Human Services to establish a program to award entities to support federal funding and expansion of the operation of SBHCs (American Public Health Association, 2012; Cogan, 2011; Jannone, 2011). The primary goal of the policymakers who designed the ACA was to improve access to healthcare services through insurance system reforms (Gable, 2011; Hardcastle, Record, Jacobson, & Gostin, 2011). In relationship to SBHCs, the Affordable Care Act provisioned the creation of job training and educational opportunities to expand the primary care workforce in support of new doctors, nurses, nurse practitioners, and physician assistants (Thompson & Bucher, 2013; U.S. Department of Health and Human Services, 2012).

The funding built into the ACA supports the opportunity to coordinate health services, improve health outcomes for uninsured children, and efficiently use federal resources (Thompson & Bucher, 2013; U.S. Department of Health and Human Services, 2012). The funding of core services includes physicals and mental health treatment, dental health prevention programs; providing these core services target large populations of underserved youth (Jannone, 2011). When the federal funding authorization under the

ACA expire, SBHCs will no longer have this level of designated federal funding; requiring new sources of revenue for sustaining business operational services at the state and national level. The remaining appropriated $50 million per year for fiscal year 2010 through 2013 may provide a final resource to SBHCs that serve children eligible for medical assistance (Jannone, 2011).

The Children's Health Insurance Program Reauthorization Act (CHIPRA) acknowledged SBHC practitioners as medical providers of services (American Public Health Association, 2012). In 2013, the ACA required Medicaid, a joint state and federal public health insurance program for the poor, to cover preventive services, immunizations, and to pay each state an additional 1% in Medicaid matching funds (Cogan, 2011). This opportunity allows state providers to gain recognition as agents for reimbursement of medical services, and the provision expands the services of managed care plans for recipients of the CHIPRA program. Under CHIPRA, 6.5 million children became eligible for coverage by government-sponsored programs (American Public Health Association, 2012).

The expansion of Medicaid and Children's Health Insurance Programs (CHIP) contributes significant financial resources to the expansion of SBHCs nationwide. Legislation authorizing health centers through Section 330 of the Public Health Service Act provided primary health care for underserved populations through community health centers (Keeton et al., 2012). The health centers received reimbursement through Medicaid for FQHCs, and funding offset the cost of uncompensated care for uninsured children (Keeton et al., 2012; Seiber, 2014). The FQHC authorization established federal

laws and regulations ensuring SBHC regulation by the federal government, while laying the foundation for the federal grant for SBHCs (American Public Health Association, 2012).

The enactment of the Public Health Service Act legislation guarantees the opportunity to expand the medical services footprint to school and community environments where none existed previously (American Public Health Association, 2012). As a result, funding provided the opportunity to buy licenses for electronic medical records, which helps SBHCs comply with the technological need for electronic recordkeeping and patient confidentiality of medical records (American Public Health Association, 2012). The expansion of access to new business procedures provided SBHCs with influence viewed as a *meaningful use provider* in the implementation of health care reform's electronic medical records and information insurance exchanges (American Public Health Association, 2012). By expanding the footprint of SBHC, the healthcare reform financed the challenges to deliver health care business services (American Public Health Association, 2012).

As stated by Medicaid.gov (2012), in the state of Maryland, 960,915 of the persons enrolled in Medicaid received healthcare services through managed care organizations; this reflects 79.52% low-income persons enrolled. All state legislators must ensure fund availability to cover the state's portion of Medicaid payments (Medicaid.gov, 2012). The federal and state governments fund the Medicaid programs using per capita formulas set the Federal Medical Assistance Percentage payment (Medicaid.gov, 2012). Information available on the Medicaid.gov website showed

average state disbursement payments are 57%; 50% for wealthier states; and up to 82% for lower per capita states (Medicaid.gov, 2012). Opportunities for state funding included legislative appropriations to state agencies, inter-governmental transfers, permissible taxation, and private donations.

States have the discretion to establish their own Medicaid provider payment rate within the federal guidelines, and generally pay for services through fee-for-services or managed care arrangements (Medicaid.gov, 2012). Fee-for-service arrangements are costs, rates in the private sector, and a percentage of the Medicare equivalent services (Medicaid.gov, 2012). Through a network of service providers, 70% of Medicaid enrollees derived care from services paid on a monthly capital expenditure plan (Medicaid.gov, 2012). The Medicare payment rates derive from specific trending factors, like Medicare Economic index or trend factors based on state-determined inflation adjustment rates (Medicaid.gov, 2012). Changing the way Medicaid providers received payments; state officials must submit a State Plan Amendment for review, approval, and public notice for comment (Medicaid.gov, 2012). Amendments to the reimbursement methodology must be consistent with the Social Security Act, other federal statutes, and regulations (Medicaid.gov, 2012).

Also administered by the states, the federal and state governments jointly fund the Children's Health Insurance Program (CHIP) (Medicaid.gov, 2012). The federal matching rate for state CHIP program was approximately 15% higher and set at a rate of 65% (Medicaid.gov, 2012). Information available on the website details how the ACA of 2010 maintained the eligibility standards through 2019, and the law extended CHIP

funding through October 2015 with additional provisions to bring the average federal matching rate to 93% (Medicaid.gov, 2012). As reported by Medicaid.gov (2012), these provisions added $40 million in federal funding to promote the enrollment of Medicaid and CHIP. Several states received allocations from Child Health Services Title V Block Grant funds to support centers that deliver the mission to extend and improve the health and welfare services for mothers and children (Keeton et al., 2012). The awarding of these competitive grants reflects the classification criteria of low-income communities, federally designated medically underserved areas, health professional shortage areas, and uninsured among school-aged youths (Booker, Schluter, Carrillo, & McGrath, 2011).

Private funding for SBHCs began in 1994 with the Robert Wood Johnson Foundation's multi-year $23.2 million initiative to support the creation of state-level policies to advance the SBHC model (Keeton et al., 2012). Limited research exists in the area of private funding; however, managers of these funding sources are particularly interested in the evidence-based program effectiveness to reduce chronic illness or target a specific demographic of the community. The W. K. Kellogg Foundation subsidized nine state SBHC associations and the NSBHC, with 6 years of financial, advocacy, and technical assistance to advance local, state, and federal health and education (Richardson & Wright, 2010). Additionally, Kaiser Permanente expanded its oral health services grants and provided over 30 opportunities for capital projects (National Assembly of School-Based Health Centers, 2011). This organization recognized the unmet need among children and recognized SBHC business operations unique positioning for meeting the dental health needs in the lives of uninsured children (National Assembly of

School-Based Health Centers, 2011).

Community Partnerships

Establishing an SBHC in the community, guiding principles clearly articulate maintaining a stable business relationship (Grant & Greene, 2012). Community partnerships typically occur between the school district, local medical association, public health services, community hospitals, social services, mental health authorities, parent, teacher and student associations, university health-related programs, and the business community (Grant & Greene, 2012). Communities of practice share people who express a domain of interest and share competencies in the business operations of the health care system (Grant & Greene, 2012; Merrill, Keeling, Wilson, & Chen, 2011). Recommendations for the community to be involved in the development, expansion, and sustainability of SBHCs are:

- Serving on an organizing committee to establish a SBHC.
- Serving on the board of the current SBHC.
- Serving on a multidisciplinary team that staffs SBHC clients.
- Becoming a liaison between the school and the SBHC team; and training SBHC personnel about the school, resources, and school organization/climate (Merrill, Keeling, Wilson, & Chen, 2011).

The SBHC business plan, with funding sources from the local, state, and federal government, provide comprehensive information resulting in the ability to receive payment from Medicaid, and approval by managed care organizations for reimbursement (Raelin, 2011). Accountability audits for funding partnerships may provide stakeholders

with valuation data supporting the growth of the SBHC for future partnership expansion and community involvement. Raelin (2011) acknowledged the Robert Wood Johnson's Foundation had continued commitment to collaborate with the Hitachi Foundation to advance the skill and career development of healthcare workers by creating the Jobs to Careers Program. Consequently, the initiative addresses the career plight of healthcare workers by providing work-based learning opportunities through the partnerships with SBHCs. This program includes didactic instruction and fieldwork that support the attainment of both bachelor and master degrees (Raelin, 2011).

Nursing Roles

The school nurse facilitates the development of business services at SBHCs (Borrow, Munns, & Henderson, 2011). The school nurse incorporated a new vision for school health to collaborate, communicate, and cooperate toward a common goal (Borrow et al., 2011; Nelson, Kendall, & Shields, 2013). The school nurse's services integrated with SBHCs to develop the systems and policies required to deliver quality and confidential healthcare of every student (Gapinski & Sheetz, 2014; Haffke, Damm, & Cross, 2014). As reported by Maughan and Troup (2011), the National Association of School Nurses, in conjunction with the Standards of School Nursing Practice, recommend one school nurse for every 750 students. Business services offered by the school nurse are too numerous to mention, but the major focus was on implementing wellness and disease prevention programs to improve student health. This position ensures the school nurse was an active participant in the SBHC's structured mode, providing case management and treatment care, and support referral agencies to develop

a productive business outcome for the student population.

The school nurse fills the gap by investigating and diagnosing health needs of the SBHC student population. The school nurse is fully aware of the medical needs; school administration procedural issues; markets the services to parents; teachers, and community for support; assists the staff with the implementation plan of care, and provided partnership with neighboring health centers for possible referral opportunities (Hill & Hollis, 2012; Mehta, Lee, & Ylitalo, 2013; Veith, 2012). School nurses are unique to the educational environment, and positioned to solve complex medical issues while delivering primary and mental healthcare services (Biag, Srivastava, Landau & Rodriguez, 2015).

A cost analysis conducted by Baisch, Lundeen, and Murphy (2011) calculated the annual savings in time spent on student health concerns when a school nurse was on site; Baisch et al. (2011) estimated cost savings at $133,000 annually. The average salary and benefits package of a school nurse was $74,450 (Baisch et al., 2011). Nurses supported the administrative mission by maintaining electronic records, following highly mobile students when the need for health information was critical in the transfer process. Without the documentation of immunizations by school nurses, Baisch et al. (2011) stated some students would not meet the minimum statutory requirements for admission; students would be ineligible for enrollment, and this would result in extended absences. Moreover, these students would remain vulnerable to preventable illnesses (Baisch et al., 2011).

Larson, Clark, Colborn, Perez, Engelke, and Hill (2011) completed a Guideline

for Adolescent Preventive Services assessment of fifth and sixth graders to determine if student participation in SBHC programs was an effective strategy for utilizing preventive health services. Administrators used this tool to assess individual and population level public health nursing interventions to include screening, referral and follow-up, case management, delegated functions, health teaching, collaboration, and counseling (Chan, 2013; Larson et al., 2011). The evaluation gave school nurses a better understanding of the needs of the population and barriers that prevent the facilitation of health outcomes (Ford, Tesch, & Carter, 2011; Larson et al., 2011). They found the consistency in supervision to be important at the clinical site, which developed relationships with community partnerships and built trust and confidence in the success of the collaborative work of the SBHC (Larson et al., 2011). As a result, communication strategies are more effective between the partnership of school, nurses, and students because they are equally involved in monitoring the progress and challenges of the SBHC business operations (Larson et al., 2011).

Ribas, Dill, and Cohen (2012) examined the relationship between different jobs, occupational mobility patterns, and wages for nurse aides. The focus of their study was to determine when the transition from nurse aide to higher paying nursing opportunities occurred, and who took advantage of these opportunities. The transition was noticeable for those who left the nurse aide category and moved into the registered nurse field, but most obvious was the lack of mobility for *Black* workers who continued in low-wage labor markets contributing to high turnover (Ribas et al., 2012). *Whites* are more likely to transition into better paying occupations; *Blacks* would particularly move into the bottom

of the low wage service area health care for personal aide care (Ribas et al., 2012). Researchers recommend further studies to determine if nurse's aides are former manufacture workers and if so, the job classification provides the financial upward mobility to eliminate the high turnover by *Blacks* in the field (Ribas et al., 2012). The sustainability of SBHCs employing school nurses provides the trajectory to create career ladders for frontline healthcare workers (Biag et al., 2015; Kleinman & Doughtery, 2013; Ribas et al., 2012).

With the demographics of the U.S. public school system changing, nurse practitioners developed close relationships with students by providing direct care to those who are uninsured requiring skills that can diagnose and assess specific populations served (Bobo, Carlson, & Swaroop, 2013). School nurses determine the business needs of minority children, serve as the front line resource to provide administration of SBHC budgets, and develop cultural sensitivities enabling children to receive the access to care (Biag et al., 2015; Bobo et al., 2013; Veith, 2012). Recommended findings suggest ACA funding might achieve the goal of financing SBHC services and public health nursing roles (Hutchins-Goodwin, 2013). These findings highlighted misconceptions about the roles and services school nurses provide, and may contribute to the lack of funding. Therefore, the ability to use SBHC models with the traditional school nurse role produced evidence of a good return on investment (ROI). The ACA funding policy could be integral to establishing partnership strategies and new reimbursement opportunities (Hutchins-Goodwin, 2013).

Healthcare Worker and Nurse Shortages

Beck and Boulton (2012) conducted a systemic review on the role of the public health workforce, and its association between organizational staffing levels and health outcomes on the underinsured. The challenge to advance public health workers may require the elimination of financial and organizational barriers, and the strengthening of public health workforce classifications. Sumaya (2012) recommended a comprehensive classification data system provide trend projections and policies that are critical to the future workforce. As reported by Beck and Boulton, the ACA included a funding provision to increase the healthcare workforce. The ACA provisions offers opportunities for healthcare workers to participate in loan repayment programs, participate in workforce grants for state and local programs, public health fellowships, and preventive medicine training grants (Beck & Boulton, 2012). An emphasis on quality measurements would require the collection of workforce data on worker recruitment, training, and employment under this federal program (Beck & Boulton, 2012). An additional measurement supported by federal funding is to create a monitoring system of public health workers to understand the supply of workers accurately assessing where the shortages exist to inform and educate policymakers (Beck & Boulton, 2012; Sumaya, 2012).

The goals of health care reform have increased demand for physicians, advance practice nurses, and physician assistants (Sargen, Hooker, & Cooper, 2011). Driven by the efforts associated with the Affordable Care Act, the medical profession may expand upon the physician shortages. Sargen et al. (2011) identified these three medical

professionals as advanced clinicians who administer a broad spectrum of care, and who meet the demand for healthcare services. The research is limited to these professionals because they are involved in the delivery of care recognized as physician services, constitute about 7% of the entire health care labor force, and 90% regulated and licensed as first-contact clinicians (Sargen et al., 2011).

Public healthcare faced a critical workforce shortage, according to Hilliard and Boulton (2012), who emphasized the need to understand who will keep the American citizens healthy. Hilliard and Boulton proposed the opportunity to increase the diversity of the health workforce requires the recruitment of highly skilled workers, credentialing and certification programs, competitive salaries, and career advancement opportunities that generate high levels of job satisfaction in the delivery of required services (Hilliard & Boulton, 2012). Hilliard and Boulton reported 7.4% of public health doctoral graduates in the United States are minorities in 2004; however, the minority population was 25.7% that same year. An effort to increase minority participation in public health at academic institutions is minimal, which provides an opportunity to bridge the education gap and eliminate the disparities by developing a diverse group of business professionals to serve the growing diverse, demographic population base.

Equally important to managing the shortage of health professions was the estimation that, by 2020, there could be a deficit of 200,000 physicians in the public health field (Sargen et al., 2011). Based on the federal estimates of future spending and historical relationships of healthcare, there will be a nationwide shortfall of physicians by 2025 (Newhouse et al., 2012). In the absence of physicians, Newhouse et al. (2012)

offered a solution; according to Newhouse et al., 240,460 Advanced Practice Registered Nurses (APRNs) would be capable of delivering equivalent patient care. This alternative might sustain the workforce of the advanced practice nurses and physician assistants in areas where physicians' presence was lacking. Newhouse et al. (2012) acknowledged this recommendation would not compensate for shortages in all areas.

Newhouse et al. (2012) recommended designing reimbursement systems that maximize efficiency by structuring payment models that support interdisciplinary teams, and independent practices of APRNs. Changes may develop lower billing costs to Medicaid because they are not physician-directed services contributing to healthcare (Newhouse et al., 2012). Challenges within the current healthcare environment indicate the need for advance nurse practitioners who can utilize their skill, knowledge, and competencies to address the workforce shortages in the coming decade (Turale, 2011). A revision to the educational curricula nurses use would prepare students to act in the capacity of advance medical proficiency practitioners (Turale, 2011). If shortages persisted, specific training in mental health may initiate the development of the next generation of mental health nurses, ensure ethical dimensions of care, and overcome gaps in specialized areas of the public health workforce (Reinke, Stormont, Herman, Prui, & Goel, 2011; Turale, 2011).

Sustaining a viable public health workforce is vital for building capacity (Juraschek, Zhang, Ranganathan, & Lin, 2012; Turale, 2011). Organizational attributes studied support public health nursing as a broad examination requirement, and community involvement in Canada (Juraschek et al., 2012; Turale, 2011). Attributes

examined are program planning, promotion and value of public health nursing practices, commitment to learning, professional environment, effective human resources, adequate staffing goals, supportive public health partnerships and community, effective communication, and workplace policies (Turale, 2011). Policy makers and healthcare stakeholders sought to develop national strategies to encourage an effective retention plan for experienced nurses to endorse all nursing professions. Endorsements from experienced nurses could strengthen the diminishing supply as projected (Coyne & Kirwan, 2012; Juraschek et al., 2012). The identification of successful practices require a shared business enterprise and public health agenda clearly linked to goals and objectives based on business operational needs (Juraschek et al., 2012). Due to the complexity of public health, specific business goals must be adaptive and creative, and must include sound financial planning.

Fee-for-Services and Managed Care Organizations

When coverage shifted from the fee-for-services model to the managed care model, its development was a means of controlling costs in healthcare delivery (Koppelman & Lear, 1998). The primary care provider acted as a gatekeeper for hospitalization, specialty services, emergency room care, and other health services that are outside of the network (Koppelman & Lear, 1998). Due to the size of the Medicaid population, the transformation of a fee-for-service to a managed care model required a financial organization with managed care plan holders (Koppelman & Lear, 1998). Without prior approval from the primary care provider, participants could not receive services from a coordinated system of preventive care (Koppelman & Lear, 1998).

Managed care organizations and SBHCs share common goals to increase health accesses and services to keep participants healthy.

Previous Health Maintenance Organization (HMO) contract goals are to create a linkage with SBHC (Koppelman & Lear, 1998). States using managed care arrangements expected to serve enrollees with SCHIP and Medicaid (Koppelman & Lear, 1998). Issues regarding duplication of services, financial costs of SBHCs, and enrollment used patterns relating to the delivery of coordinated services. HMO administrators selectively eliminated coverage for services provided at SBHCs specifically; disallowed programs included treatments related to chronic care, nutrition, and sports medicine (Koppelman & Lear, 1998). Establishing continued relationships, SBHCs had to prove valuable, measure impact on outcomes of importance to HMOs, and control costs on the delivery of preventive services. Through this initial investment and contractual agreement with HMOs, SBHCs opted to manage their Medicaid population and turn its efforts to improve health care based on community needs and its ability to obtain financial resources (Koppelman & Lear, 1998).

Monson et al. (2012) claimed problems in fee-for-service systems are common, and stakeholders must work on existing problems within this billing system to allow for bundling services, higher reimbursement for team-based care, and incentives for improved health outcomes. For example, Denver Health is a FQHC focused on behavioral health care service (BHC) with a payer composition of 52% Medicaid, 32% uninsured discount programs, 9% Medicare, 3% commercial insurance plans, 2% children health plan, and 2% other (Monson et al., 2012). The compositions of the

clinical staff are physicians, nurse practitioners, and two resident family medical staff persons per year (Monson et al., 2012).

Establishing financial value and generating revenue is difficult at best. Staff may not know how to bill for an SBHC service or how to establish a billing protocol immediately (Monson et al., 2012). Administrators and office staff track billing and use pilot meetings to review results against the Medicaid system guidelines to ensure compliance (Monson et al., 2012). Through these methods, administrators and office staff establish standards for organizing patient care, optimized billing so that reimbursements for depression screenings would receive Medicaid approval (Monson et al., 2012). Since 2011, Medicaid officials set a standard of reimbursement; in the 2011 standard, officials emphasized inclusion of behavioral health and proposed multiple payment models (Monson et al., 2012).

Fee-for-service reimbursement methods did not meet the expectations of SBHC administrators (Schlitt et al., 2008). The reimbursement practice of basing remittances on underutilization of care from physicians in a private setting did not support a broad, coordinated system such as the SBHC environment. Medicaid reimbursement methodologies are adequate for primary services, and these funds apply directly to the SBHC model (Schlitt et al., 2008).

Federally Qualified Health Centers

Alvarez, Walsh, Valentine, Smith, and Carlson (2013) defined Federally Qualified Health Centers (FQHCs) as the safety net medical provider for the uninsured population. Federally Qualified Health Centers act in principle with the guidelines

established by the Affordable Care Act (ACA) integrating mental health services with primary care in SBHCs (Alvarez et al., 2013; Hacker, Chu, Arsenault, & Marlin, 2012). The mission of the FQHC is the reimbursement vehicle for the U.S. Department of Health and Human Services to increase access to high quality services for all (Alvarez et al., 2013; Grogan, 2011; Hacker et al., 2012; Sefton, Brigell, Yingling, & Storgjell, 2011). Regardless of the patient's ability to pay, practitioners at FQHCs provide service to all; services include mental health, dental care, urgent care, pharmacy service, referrals, and substance abuse services (Alvarez et al., 2013; Grogan, 2011). The structure and contemporary business model of these centers stemmed from their status as nonprofit operations. Each facility has a board of directors composed of 51% participation from the community (Alvarez et al., 2013; Grogan, 2011). School-based health center administrators allow expansion and growth of these centers because in order to receive federal funding; administrators must adhere to federal accounting reporting requirements. This opportunity provides revenue growth to meet operational needs directly tied to community needs and available resources (Alvarez et al., 2013).

With the FQHC designation, a Medicaid qualified provider expanded opportunities for strategic partnerships with general internists and nurse-managed centers (Grogan, 2011; Sefton et al., 2011). General internists viewed this impact favorably by practicing in facilities who served in SBHCs because it removed barriers for reimbursement, provided the opportunity to expand primary care workforce and infrastructure capacity, and changed the service delivery model (Grogan, 2011). The availability of the Medicaid payment increased for primary care physicians to 100% of

Medicare (Grogan, 2011). The Affordable Care Act (ACA) provided bonus payments to primary care physicians and eliminated the distinction between Medicaid and Medicare plans (Fiscella, 2011). Additionally, the distinction provided an added bonus to physicians who operate in low income areas reducing medical disparities (Grogan, 2011). State fee increases had little effect on physician participation, and Medicaid reimbursement was the most crucial factor for influencing physician participation in the program (Grogan, 2011).

Sefton et al. (2011) reported nurse-managed centers previously funded by universities, grants, and third-party payers sought to achieve sustainability and increase services for patients through the designation of FQHC. The financial benefit of FQHC status required compliance with federal policy, procedure, and equipment requirements (Broussard, Howat, Stokes, & Street, 2011; Sefton et al., 2011). This center operated within a SBHC, accomplished its mission, and determined the benefits to include six areas (a) mission support, (b) financial consideration, (c) collaboration with other partnerships, (d) primary service model, (e) quality improvement measurements, and (f) ownership and control of the business operation (Sefton et al., 2011). With the support of a university partnership, the group embraced obtaining FQHC designation with the goal to increase revenue and develop a marketing plan to make the general practice known to the community (Sefton et al., 2011). A significant benefit of FQHC status is the enhanced opportunity to create a business model to serve the public regardless of the number or types of patient visits to the center (Kuo, Frick, & Minkovitz, 2011; Sefton et al., 2011). Because the FQHC business model is a flat rate reimbursement structure, regardless of

services provided by a physician or nurse practitioner, there is an added appeal for status achievement.

Reported by Broussard et al. (2011), obtaining FQHC status identified the need to have the school nurse consultants in Louisiana partner with FQHCs to generate revenue employing a State School Nurse Consultant (SSNC) within the Department of Education. SSNC assisted school nurses with technical issues, policy practices, and implementation of medical recordkeeping. School administrators benefit from SSNCs with information regarding the reimbursement procedures and legislation on health policy initiatives to develop partnerships with FQHCs and billing of Medicaid for school nursing services (Broussard et al., 2011). State School Nurse Consultants (SSNCs) also possessed the expertise to develop partnerships with FQHCs and billing of Medicaid for school nursing services (Broussard et al., 2011). Budgetary limitations called for new investment approaches at the federal, state, and local level to focus on innovative funding opportunities to expand the development of FQHCs business operational services in SBHC environments (Broussard et al., 2011; Kuo, Houtrow, Arango, Kuhlthau, Simmons, & Neff, 2012).

Calman et al. (2013) established a patient-centered medical home model utilizing the FQHC designation. Similarly, McCord et al. (2011) developed strategic partnerships to provide sustainable mental health services via teleconference services. These two innovative services are examples of implementing a FQHC as a business operational model. The key characteristics of these models included a physician, team-based care, advanced health information technology, and practical payment methods (Calman et al.,

2013). Sites selection is typically in medically underserved communities and the model components include two primary care clinics, one family medical model, and two teaching facilities for clinical training for students (Calman et al., 2013; Fox, Hodgson, & Lamson, 2012). Telehealth services increased mental health professionals' access to individuals who may otherwise remain untreated (McCord et al., 2011). Low-income communities experienced disparate availability of transportation, socioeconomic services, and lack insurance coverage (McCord et al., 2011; Monson, Sheldon, Ivey, Kinman, & Beacham, 2012).

Over a 9-year period, McCord et al. (2011) monitored the operations of large FQHC networks as administrators of these facilities implemented practice changes. The emphasis was on enhancing psychosocial health services, instituting staff model changes, and deploying patient registry electronic portals. Having the federal designation helped administrators sustain operational processes and partnerships (McCord et al., 2011). The establishment of an FQHC was an indication that administrators had the ability to increase revenue, sustain business operational services, and increase physician and nurse leadership in communities that do not have medical facilities (McCord et al., 2011). The result was a functioning organization in which staff and practitioners became the safety net providers of healthcare for uninsured patients (McCord et al., 2011).

Management of Funds for SBHC Operations

Cohen and Syme (2013) measured funds for SBHC business operations by conducting a cost benefit analysis. Cohen and Syme suggested public health researchers combine cost benefit analysis with health impact assessments to assess how policies and

programs relate to the school day and the school year, and apply these analyses throughout the life course of students from Head Start through 12th grade. Their rationale related to the longer students stay in school, raising their educational attainment their wage earnings potential might also increase (Cohen & Syme, 2013). Similarly, lowering the dropout rate linked to better health outcomes, which also affected future learning and employment paths (Cohen & Syme, 2013; Tai & Bame, 2011).

Specifically targeting childhood asthma management through SBHC business operations, Tai and Bame (2011) conducted a cost-benefit analysis of SBHC programs in managing childhood asthma nationwide for the reduction of medical costs and emergency room visits. Although SBHCs may not affect the increase of childhood asthma, Tai and Bame (2011) found ongoing prevention monitoring, and reducing the severity of parents work loss, realized savings in medical costs and a reduction in the number of emergency room visits. Most students identified during the screening experienced psychiatric conditions, and immediate referral provided the opportunity for early intervention and successful treatment options (Aldrich, Gance-Cleveland, Schmiege, & Dandreaux, 2014; Benson, Baer, & Kaelber, 2011; Rodriguez et al., 2013).

The literature review included a comprehensive review on federal legislation, Medicaid and Title V grant programs, community partnerships, and private foundations continuation to fund and sustain SBHC business services. Through the qualitative descriptive approach and thematic responses to the research question, administrators' best practice strategies may provide strategies to develop and sustain funding for statewide business operations. This literature review was a presentation of empirical data regarding

the business operational topics that related to identifying resources, sustaining funding, business processes, organizational structures, nursing roles, and shortage projections of healthcare professions. Additionally, there were discussions regarding legislator enactment of the Patient Protection and Affordable Care Act (ACA) of 2010 and the School-Based Health Clinic Establishment Act of 2007.

Transition and Summary

In Section 1, I presented the foundation of the study, background of the problem, problem and purpose statements, nature of the study, research question, the conceptual framework, and significance of the study related to SBHC business operation and funding requirements. Section 2 begins with a review of the purpose statement. The role of the researcher, participants, research method, research design, population, and sampling provide justification for the specific research method selected and those not selected. Section 2 concludes with detailed discussions about the processes for conducting ethical research, data storage, analytic techniques, data organization, determining reliability and validity of the instruments, and processes for this study. Section 3 includes the presentation of findings, application to professional practice, implication for social change, recommendations for action, and recommendations for further study.

Section 2: The Project

The objective of this qualitative descriptive study was the exploration of SBHC administrators in the state of Maryland who develop and sustain funding levels, and provide adequate resources to support business operations. Section 2 includes a restatement of the research purpose, and descriptions of the role of the researcher, participants, research method and design, population and sampling, ethical research, data collection plan, and data analysis procedures. This section provides information regarding the consent form, research and interview questions, and an explanation of reliability and validity in data collection.

Purpose Statement

The purpose of this qualitative descriptive study was to explore strategies SBHC administrators used to develop and sustain funding for business operations in Maryland. I conducted semistructured interviews with 20 SBHC administrators. The key criterion for participation in this study was an administrator who was a subject matter expert on reimbursement policies with the ability to obtain resources for different student populations. Additional criteria include budget management expertise and financial acumen in SBHC funding policies.

The focus of this study was an exploration of participants' perceptions of developing and sustaining the financial operations of SBHCs based on best practice strategies. The data from this study contributed to new knowledge and insights for leaders within the state and federal government regarding the reimbursement policies and business practices of SBHCs. In addition, study findings might affect social change

through the identification of multifaceted team approaches to the delivery of business services for students in the communities in which they live.

Role of the Researcher

My role as the researcher was to use the qualitative method of inquiry to develop an understanding of the perceptions of administrators who develop, manage, and sustain SBHC business operations. The primary role of the researcher is data collection to evaluate the phenomenon (Maxwell, 2013). I selected participants, established working relationships, conducted semistructured interviews, and analyzed the data collected. Understanding the staff and activities was critical to obtaining reliable qualitative data. Demonstrating the requisite expertise and readiness to conduct qualitative inquiry included understanding seminal and extant literature, accounting for the professional and personal experiences of the participants, and appropriately interpreting the data (Bernard, 2013). Prior to this study, I have never collected data on this topic, and I have no previous relationship with the participants or knowledge of the requirements for financing SBHCs.

Participants

The participants were administrators and full-time employees in the state of Maryland SBHC with a work history of more than 1 year or a full school year funding cycle. A current public list posted on the MSDE SBHC website provided all email addresses and telephone numbers for administrators (Maryland State Department of Education, 2014). Based on the above criteria, from this population, I determined who was eligible for participation.

I contacted all participants by email communications (Appendix C), and followed

up with telephone calls to discuss their participation in this doctoral study. During this conversation, participants received information regarding the purpose of the study and background material to begin the development of a working relationship. All participants had opportunities to receive answers to their questions before scheduling one-on-one telephone interviews with me. Gaining access to the participants required constant negotiation of the relationship to obtain the data required answering the research question, and I developed a cogent working relationship with the participants by demonstrating honesty and integrity. The development of a trusting relationship began by treating the participants with respect, by honoring their time, and by protecting the information provided about their best practice strategies (Bernard, 2013; Maxwell, 2013; Padgett, 2008). Maxwell (2013) noted gaining access is necessary for a successful study, which builds relationships to gain the information needed to answer the research question. Padgett (2008) stated retaining solid participation is a key element of study success. Bernard (2013) concluded conducting a science of human behavior is not selecting the right sample size; it is doing everything ethically, in order to live with the consequences of your actions. Once agreed, all participants received a consent form and interview questions prior to the interview with a request to return by emailing their replies *I consent* to my personal email address. The consent form outlined the information regarding ethical protection for the participants, and participation in this doctoral study did not embarrass the SBHC participants (see Appendix C).

The population for the doctoral study was administrators of SBHCs in the state of Maryland; this included primary staff administrators from various agencies located in the

city and counties around the state responsible for both financial and budget operations served as (a) program managers, (b) advanced nurse practitioners, (c) doctors, (d) social workers, (e) counselors, and (f) psychologists. These individuals had experience and knowledge of Medicaid reimbursement plans, contracts with managed care organizations, and contributed to an understanding of the objectives required to develop and sustain funding.

The sampling method for this doctoral study was purposive. Saunders et al. (2009) and Michaelson, McKerron, and Davison (2015) defined purposive sampling as a non-probability sampling procedure to select participants who can respond to the research question adequately, meet the intended purpose of the research, and collect sufficient data to document the uniqueness of the phenomenon. Rich detailed data resulted from the participants' primary knowledge of their best practice strategies related to the phenomenon (Greenwald, 2013). In this study, the transcripts of the administrator's best practice strategies derived from the recorded interviews and themes developed by using Dedoose software.

All interview questions remained consistent for reliability (Maxwell, 2013). As each administrator agreed to participate, I assigned a participant number (Participant 1 through Participant 20). The names of organizations in this study remained confidential, and Yin (2009) recommended using numeric identifiers to replace participants' names in the data. I used the 256-bit algorithm encryption software to preserve all electronic documents for 5 years. An external hard drive stored in a locked container, only accessible by me, was the device, which secures the data for 5 years. When this retention

period expires, I will destroy all hard copy data by fire.

Research Method and Design

The research method and design section included the method chosen to use the inductive approach in the exploration of a complex business problem. The research design chosen was the descriptive design. The descriptive design is useful for researchers who seek to understand problems through the best practice strategies of others (Marshall & Rossman, 2011; Maxwell, 2013). Understanding the business problem of financing and sustaining the business operational services of SBHCs took place through the qualitative method of inquiry. Collecting data using the qualitative method allows for gaining an understanding of participants' experiences in their natural environment (Miles et al., 2014). The following research method and design discussion includes explanations and rationale for utilizing the qualitative method and the descriptive design to explore a complex business problem inductively.

Method

I chose the qualitative method to generate multiple constructed realities, focus on an individual's experience, and explore little-known phenomena (Maxwell, 2013). Using the qualitative methodology, a researcher gains a deeper understanding about personal experiences through a participant's natural surroundings, settings, and environment (Denzin & Lincoln, 2005; Major & Savin-Baden, 2011; Padgett, 2008; Salkind, 2010). There is justification for using this method because it was an inductive approach; in this approach, information evolves through a process of developing meaning from a thorough analysis of raw data (Bernard, 2013; Maxwell, 2013; Padgett, 2008). Using the inductive

approach provided the opportunity to explore data from the *bottom up*, with an open mind, and without any predetermined ideas (Bernard, 2013). Qualitative studies seek to represent subjective meanings and question the existence of a single objective reality (Padgett, 2008). The methodology provides an opportunity to describe a complex phenomenon and discover deeper understanding of the phenomena (Bernard, 2013; Gibson, Santelli, Minguez, Lord, & Schuyler, 2013).

In contrast, the quantitative method is an application of the scientific method to study human interactions, transform behavior into numerical data, and test hypotheses (Rivkina et al., 2014). A goal of the quantitative methodology is to verify relationships between independent and dependent variables (Hanson, Balmer, & Giardino, 2011). The quantitative method reduces the human experience to numbers, and does not disclose the conditions in which participants behave, relate to, or experience the phenomenon (Bernard, 2013). I did not use the quantitative method because it did not align with the business problem and was not effective in responding to the research question.

The mixed methods is a collection and analysis of qualitative and quantitative data in the same project and involved combining the methods to answer the question of interest (Bernard, 2013; Rivkina et al., 2014; Tapp et al., 2011). Using the mixed methods approach would not support an explanation of the problem statement, identify concerns found in the nature of the study, or address the issues in the research or interview questions. Integrating techniques from quantitative and qualitative paradigms to tackle the research question would become divisive because the study's findings sought to

provide descriptive data on how administrators sustain and develop sources of financing already in place.

Research Design

The research design for this study was the qualitative descriptive design. The qualitative descriptive design may enable participants to describe rich details, and focus on the individual's perceptions and experiences (Polit & Beck, 2012). Researchers use facts, identified characteristics, and reflect on the experiences of participants to draw conclusions (Bohman & Borglin, 2014; Kridli, Ilori, & Verriest, 2013). Descriptive research involves gathering data that describes events, systematic facts, and characteristics of a population within a contextual framework in business research across versatile disciplines (Simon & Goes, 2013). The use of the descriptive design is appropriate when researchers ask participants to describe events and experiences in rich detail to expose individual perspectives and interpretations (Miles et al., 2014).

I used the descriptive research design approach to collect data on the participants' best-practice strategies, through open-ended questions, and the analysis of transcribed data (Denzin & Lincoln, 2005; Moss, Gibson, & Dollarhide, 2014). The reflection was retrospective and related to a person's job, program execution, position in the organization, or culture; each factor influenced a person's experiences of an event. Perception is essential to the experience, and inductive interpretation provides insights into the participant's reality (Padgett, 2008). The qualitative descriptive research design was appropriate to explore participants' experiences of the nature of the business process.

The phenomenological design is not appropriate because researchers investigate

and focus on persons who have shared the same experiences and shared meanings (Simon & Goes, 2013). Narrative and ethnographic research designs were incompatible with the business problem because these designs lend to the development of social constructs. When conducting narrative studies, the focus relates to the collection of chronological stories from individuals (Denzin & Lincoln, 2005). The narrative strategy does not establish authenticity but creates a self-reflective and respectful distance between researcher and participant voices (Denzin & Lincoln, 2005). A goal of the narrative research design was to bring the story to the public, and not to engage in the interpretive process (Denzin & Lincoln, 2005). Ethnography relies on direct observation or the insider perspective that stands in contrast to the outsider perspective assumed by many researchers (Padgett, 2008). Ethnography research design implies understanding a culture's perspective on their terms, not judged by the beliefs and values of others and focuses on a cultural system with identifiable features (Padgett, 2008). I did not choose the ethnographic research design because this approach was useful for observing behavior from the natives' points of view. Ethnographic research may also require the examination of artifacts and the use of video cameras (Denzin & Lincoln, 2005; Maxwell, 2013; Padgett, 2008; Yin, 2009).

Finally, the case study design was not appropriate for this study. Case studies require the incorporation of various data sources including (a) interviews, (b) observations, (c) document analysis, and (d) surveys (Yin, 2009). Case studies consist of detailed inquiry into a bounded entity and an examination reveals phenomena taking place in a social or cultural context (Macpherson, 2013; Morse & McEvoy, 2014). Using

a case study design is preferential to assess small group behavior or neighborhood changes, and was not appropriate for describing individual or organizational best practice strategies (Morse & McEnvoy, 2014; Yin, 2009).

Population and Sampling

The populations contributing to this study were SBHC administrators who develop and sustain adequate funding for SBHC business operations (Maryland State Department of Education, 2014). Under the funding of a managed care organization, administrators may be health professionals (pediatrician, nurse practitioner, or physician assistant) who managed the budget and diagnose children illnesses (Maryland State Department of Education, 2014; Veith, 2012). Administrators provided services to prevent children from missing school due to illness and proven effective in managing chronic health conditions for children in schools with SBHCs (Maryland State Department of Education, 2014; Veith, 2012). These services ranged from maintaining immunization records and referring children to appropriate medical and mental health providers (Maryland State Department of Education, 2014).

The sampling method I used was purposive. Purposive sampling is the deliberate selection of individuals in a specific population who possess topic specific information. Purposive sampling provides the opportunity for participants to contribute their knowledge or experience about the phenomenon (Eller, Lev, & Feurer, 2014; Petty, Thomson, & Stew, 2012; Suri, 2011). The five objectives of purposive sampling are (a) achieving representation from the selected population, (b) capturing uniformity in the population, (c) selecting individuals who articulated what was happening in the

environment, (d) establishing a basis for comparisons between settings and individuals, and (e) selecting individuals who could answer the research question (Maxwell, 2013). The justification for this sampling method was the participants' ability to respond to the research question adequately, they met the criteria for the purpose of the research, and provided a sufficient collection of data regarding the business strategies for developing and sustaining funding for SBHCs.

Answering the research question necessitated selecting participants who possess knowledge regarding the financing of SBHCs, and who articulate what their experiences are in developing and sustaining funding for business operations and activities (Salkind, 2010). An eligibility requirement for inclusion in the population was any administrator who works in a selected SBHC. Participants were full-time employees who have a work history of more than 1 year or a full school year funding cycle. These participants provided rich information regarding the business strategy and able to give detail on how financing affects operations (Salkind, 2010).

The principle of data saturation indicated 10-20 knowledgeable people were a sufficient number to provide core categories for studying best practice strategies (Bernard, 2013). If the data did not clearly indicate saturation, then I interviewed additional participants, and continually reviewed the data for saturation. Data saturation occurred when no new information arose from the in-depth review of the data and no new codes or themes developed in the data analysis process (Padgett, 2008). I reviewed 20 participant transcripts of data to confirm reaching a point of data saturation. Data saturation occurred when the collection of participant data produced no new information,

which did not take place prior to the 16th participant. However, confirmation of saturation occurred through the analysis and comparison of transcripts from Participants 17, 18, 19, and 20. These respondents did not add new evidence or resources and repeated statements echoing experiences of the previous respondents.

The participant criteria were appropriate because administrators had tenure in their positions, were familiar with medical reimbursement policies, and understood the geographical, political, and financial structures associated with business development (Maryland State Department of Education, 2014). Specific for this study, telephone interviews were the interview setting. Conducting private, confidential interviews with participants in their natural environment provided security and comfort for the participants, and allowed them to elaborate on rich descriptions. Participants articulated their experience in developing sustainable activities to accomplish this task (Padgett, 2008).

Scholarly debate exists about how discussing sensitive topics leads to lackluster and uncomfortable discussions; in Trier-Bieniek's (2012) study, women claimed telephone interviews provided ease and flexibility. The interview atmosphere and communication style was reassuring to participants when compared to face-to-face interviews (Trier-Bieniek, 2012). With the limited interaction that occurs in the email and virtual conversations, Trier-Bieniek suggested telephone interviews yield the potential for reliable dialogues because of the anonymity-allayed participants' doubts and fears. The interview technique was ideal for this study since technological advancements have generational appeal and participants were more likely to engage the research and lend

their voices to data collection (Maxwell, 2013; Padgett, 2008; Trier-Bieniek, 2012).

Ethical Research

To conduct ethical research, each participant received written instructions and a consent form before participating in this study (see Appendix C). After participants agreed to take part in the study, I emailed the consent form for their review with a request to return the form by email. By replying to the email with the words *I Consent*, they were agreeing to participant in the study. At any time during the study, if participants wished to terminate their participation and withdraw, they advised me of their choice verbally or in writing. None of the participants withdrew their consent to participate.

The use of individual names or organizations in this study was not permissible (see Appendix C). Yin (2009) recommended using numeric identifiers to replace the participants names in the data (e.g., Participant 1 through Participant 20). Therefore, the label format was Participant 1 through Participant 20, and labeled in electronic folders.

As stated by Saunders, Kitzinger, and Kitzinger (2014), a researcher must take full responsibility for determining factors to maintain and protect the confidentiality of the participants. Confidentiality refers to all information hidden from everyone except the primary researcher (Knight et al., 2012; Saunders et al., 2014; Saunders, Kitzinger, & Kitzinger, 2015). Saunders et al. (2014) cited anonymity as one form of confidentiality that maximizes the protection of participants' identities and maintains the value and integrity of the data.

Ethical considerations in this study included: (a) the nature of the study, (b) participant contributions, and (c) institutional guidelines, (d) telephonic communications,

(e) emails, and (f) the consent form contain no offer of payments or incentives for participation in this study. I protected the rights and privacy of the participants by including a data retention plan to secure all documents in a confidential location. The consent form outlined information regarding ethical protection for the participants, and participation in this doctoral study did not embarrass the SBHC participants (see Appendix C). Securing electronic records occurred through the application of 256-bit algorithm encryption software, TrueCrypt™ (2013). I secured data on an external hard drive stored in a locked container, only accessible by me for a period of 5 years. After 5 years, I will destroy all hard copy data by fire.

Data Collection

Marshall and Rossman (2011) discussed four methods for gathering information, which included: (a) participating in the environment, (b) direct observation, (c) in depth interviews, or (d) analyzing documents. The instrument for data collection for this study was semistructured interviews with open-ended questions. I recorded responses from the interview questions with a hand held digital device. As recommended by Marshall and Rossman (2011), I organized and labeled the data by unique identifiers, Participant 1 through Participant 20. I provided a summary of individual transcripts to each participant to review for data accuracy in the descriptions and explanations (Miles et al., 2014; Onwuegbuzie et al., 2012).

I conducted member checking by asking the participants if the results were plausible – diminishing the threat of misinterpretation (Morse & McEnvoy, 2014). In addition, member checking minimized biases and the guiding principle is to seek the truth

(Koelsch, 2013; Maxwell, 2013; Onwuegbuzie et al., 2012). The benefit of conducting member checking is the verification of the findings, which helped to increase the validity and accuracy in the development of codes and themes (Harper & Cole, 2012; Koelsch, 2013). I conducted both member checking and transcript review to ensure complete accuracy in the interpretation of the participants' data. The purpose of transcript review consisted of distributing transcript results to the participants to provide feedback and conduct a follow-up discussion with the participants on the accuracy of the information provided (Reilly, 2013). I provided instructions to the participants asking them to confirm if the transcribed data was truthful and accurate. Some transcripts returned accurately recorded; a few participants edited transcripts, and others introduced additional data further explaining their experiences. Participants commented on the accuracy or omission of statements, reflected on the data, and clarified content that deepened my understanding (Barusch, Gringeri, & George, 2011; Irving et al., 2012). Edited transcripts became the new data used in the data analysis process.

Instruments

Semistructured interviews with open-ended questions comprised the instrument for this doctoral study (see Appendix D). As the sole researcher, I was the main instrument, who collected the research and interview questions data (Maxwell, 2013). Using semistructured interviews, I obtained detailed information leading to a deeper understanding of the perspective of the participants (Maxwell, 2013; Padgett, 2008; Petty et al., 2012). Semistructured interview guides prepared by researchers capture the deep meaning of the experience in the participant's words (Marshall & Rossman, 2011). The

interview instrument best served this sample because there was an opportunity to record the perspective of each participant (Marshall & Rossman, 2011). Scheduling 1-hour telephone meetings provided sufficient time for participants to complete the semistructured interviews (Triek-Bieniek, 2012). The participants' use of the semistructured interview was helpful to them in responding to questions to develop and sustain funding for SBHC business operations.

A reliable instrument facilitated reproducible results in a similar setting (Hanson et al., 2011). Equally, assessing results indicated consistency, applicability, and accurately represented the trustworthiness of the study sample (Miles et al., 2014). Reliability provides evidence that researchers achieve similar results by repeating procedures in similar settings, and the findings confirm significant parallels across data sources (Hanson et al., 2011; Miles et al., 2014). Validity determines whether the researcher achieved the research objective, exhibited truthfulness in the research results, and delivered confidence in the findings (Salkind, 2010). Validity involves the participants' verification of themes, interpretations, and findings (Marshall & Rossman, 2011). I produced consistent documentation, and the transcription of the audio recordings established reliability and validity of the instrument, which helped to safeguard against researcher bias (Irving et al., 2012).

The participants' willingness to engage in a thoughtful dialogue demonstrates their interest in the use of the information and exhibited their level of involvement in the research (Marshall & Rossman, 2011). A key objective is that each participant completed the interview process, and I maintained control and consistency with all participants. To

strengthen reliability and validity, I implemented member-checking certifying all data was an accurate representation of participants' perceptions. In addition, I provided a summary of individual transcripts to each participant to review for data accuracy, ensuring that each member checked on the accuracy of descriptions, explanations, and interpretations of the data. Each participant validated their responses and confirmed the accuracy of the transcription derived from the TrueCrypt website. A copy of the instrument appears in Appendix D.

Data Collection Technique

The data collection process began by contacting the participants by email to solicit participation in the doctoral study. Using e-mail addresses and telephone numbers published in the Maryland State Department of Education's public website directory ensured the identification of appropriate individuals. My first conversation described my background, introduced the study, and answered questions and concerns about the processes to conduct the doctoral study. Next, I coordinated schedules with each participant and set a time to conduct a telephone interview. After scheduling telephone interviews, as indicated on the consent form, returning the executed form demonstrated the administrators' commitment to participate in the study (see Appendix C).

At the start of each telephone interview, I greeted the participants in a friendly and cordial manner. As recommended by Yin (2009), engaging in active listening helps a researcher to remain unbiased by preconceptions. Participants informed me if they required further clarification of the interview procedures. Each participant confirmed if the interview atmosphere was conducive to privacy and suitable for confidential

participation before activating the recording device. A test of the sound level ensured both voices were clear and audible. I used a timer to monitor the interview timeframe, composed of a semistructured interview with an open-ended research question and interview questions.

Handwritten notes supported the development of accurate transcriptions. As stated by Ihantola and Kihn (2011) and Onwuegbuzie et al. (2012), inaccurate transcriptions may be a possible threat to validity. This threat to validity was manageable through careful transcription of the audio recordings, preventing inaccurate interpretations (Fey, Scrandis, Daniels, & Haut, 2014; Ihantola & Kihn, 2011; Onwuegbuzie et al., 2012). At the close of the telephone interview, I asked each participant if he or she would like to add additional information. The instructions provided to the participants included procedures for data collection and data analysis, and included contact information should questions have arisen.

I conducted follow up phone calls with participants to take part in member checking to verify the transcriptions, perhaps clarify data for further analysis, as well as generate additional information for interpreting the participants' best practice strategies. The opinion of the participants was valuable and provided additional input and more data (Padgett, 2008; Reilly, 2013). The participants reviewed individualized interview transcripts for accuracy, description, and explanation. Transcript review provided the opportunity to revisit responses determining if participants had second thoughts or a desire to clarify points for consideration. Member checking provided the opportunity for

participants to add new data for further interpretation to produce well-founded conclusions (Miles et al., 2014; Morse & McEnvoy, 2014; Onwuegbuzie et al., 2012).

A significant milestone was the collection of the participants' responses until data saturation occurred (Bernard, 2013). Reaching data saturation occurs when comparison of new data to previous data identifies similarities or differences, and no new concepts emerged from interviews (Greenwald, 2013; Malterud, 2012). Data saturation occurred when the collection of participant data produced no new information; data saturation did not take place prior to the 16th participant. However, confirmation of saturation occurred through the analysis and comparison of transcripts from participants 17, 18, 19, and 20 against previous participants. These respondents did not add new evidence or resources, but repeated statements and echoed experiences explained by the previous respondents. I will write letters of thanks and include a summary of the findings to share with the participants emphasizing their best practice strategies to sustain and develop funding for business operational services.

Data Organization Techniques

The system I used for keeping track of data was electronic folders. The label format was Participant 1 through Participant 20; storage was on a hard drive of a secured computer. The creation of strong passwords restricted access to this data and ensured confidentiality. The construction of a reflexive journal was useful for me in documenting accomplishments and milestones, new learning, and personal reactions. This journal was ideal for storing new knowledge and challenges encountered; Heller et al. (2011) claimed as an important practice, journaling provided context, rigor, and depth to qualitative

research. Maxwell (2013) suggested creating memos and journaling as a means of getting ideas down on paper to facilitate reflections and analytic insights.

Using the data organization techniques, provided guidance for me to catalogue the milestones and achievements accomplished. The process provided the opportunity to articulate methodological issues and organization in a systematic retrievable format. I used the 256-bit algorithm encryption software to preserve all electronic documents for 5 years. An external hard drive stored in a locked container, only accessible by me, was the device, which secures the data for 5 years. When this retention period expires, I will destroy all hard copy data by fire.

Data Analysis Technique

I used the Dedoose software program to analyze qualitative data. The benefit from using this software was the reduced timeframe to organize, code, and analyze large amounts of data. Qualitative analysis software was useful for searching words and phrases within the text, resolving similarities between themes and categories, and hyperlinking relevant data. Padgett (2008) reported using qualitative data analysis software provides a smooth interface between the transcriptions, allowed the input of large data files, and gave the researcher the ability to select files for hard copy printing. Padgett reported software allowed for the central functions of storing, coding, and analyzing data.

The data analysis processes included the eight steps of the modified van Kaam method of analysis espoused by Moustakas (1994):

1. Listing and grouping: Using each participant's transcript, listing every

expression relevant to the experience (Horizonalization).

2. Reduction and elimination: Determination of invariant constituents by checking for (a) does the statement contain a necessary experience for full understanding? Then checking for (b) can it be labeled? If so, it was a horizon of the experience. Eliminated expressions are ones that overlap, repetitive, and vague. Those that remain were invariant constituents.
3. Clustering and thematizing: The clustered invariant constituents became the core themes (Themes).
4. Final identification of the invariant constituents and themes by application (Validation).
5. Individual textual description: Using the validated invariant constituent and themes construct for individual textual description of the experience, and including the verbatim transcript.
6. Individual structural description: Constructing individual structural description of the experience based on the textual description and imaginative variation.
7. Textual structural description: Constructing individual textual structural description of the meaning and essence of the experience, incorporating the invariant constituent and themes.
8. From the individual textual structural descriptions, develop an overall composite description of the meanings and essences of the experience as a representation of the whole.

The data analysis process provided support to systemically evaluate and read between the lines of textual data (Padgett, 2008). I utilized Dedoose software to analyze and provide explanation of the best practice strategies of the participants associated with sustaining SBHC operations. Allowing the participants to describe their external world in everyday language promotes the development of an interpretative process (Padgett, 2008).

The sustainability theory served as the basis for the conceptual framework. I presented the findings through the lens of the sustainability theory. Economic sustainability development for SBHC meant using present resources to continue to meet future needs. Planning for sustainability of SBHCs requires an understanding of financial monitoring activities over a long period, and required administrators to maintain business services after financial assistance from external sources ended (Shediac-Rizkallah & Bone, 1998).

Reliability and Validity

Maxwell (2013) found reliability ensures the research design was credible, and validity refers to the truthfulness of all descriptions, conclusions, and interpretations of an account. Modern expressions of credibility, dependability, confirmability, and transferability supported the analyses of reliability and validity in qualitative research (Maxwell, 2013). In this study, I applied consistent practices to collect data to establish credibility and dependability. Recording interview responses and member checking assisted in demonstrating the validity in a research study (Marshall & Rossman, 2011; Maxwell, 2013; Onwuegbuzie et al., 2012). Ensuring reliability and validity,

semistructured interviews, member checking, and rich, descriptive writing were effective procedures in building a scholarly qualitative, descriptive study.

Reliability

Following a consistent approach to ensure reliability in qualitative studies may result from using the same semistructured interview instrument (Maxwell, 2013). Bernard (2013) further stated reliability refers to whether or not a researcher obtains the same answer by using an instrument more than once. In this qualitative, descriptive study, all participants received identical research and interview questions. Semistructured interviews were useful in gaining in-depth information regarding the best practice strategies of the participants, and provided an opportunity to obtain dependable, trustworthy qualitative data (Bernard, 2013; Petty et al., 2012). Furthermore, I used an audio-recording device accurately capturing the participants' responses, obtained the description of events, and acquired explanations of a phenomenon (Maxwell, 2013).

Maxwell (2013) recommended four steps to ensure reliability procedures; the steps were (a) transcribe data accurately, (b) use qualitative software for coding, (c) use consistent codes throughout data analysis process, and (d) verify coding against raw data for accuracy. The development of codes by using the Dedoose software supported data analysis. The advantage to using this software was the ability to analyze data, code, and organize lengthy interview transcriptions. Additionally, using software simplified the identification of similarities between themes and categories, and allowed for the hyperlinking of relevant data. Following a consistent approach to ensure reliability in qualitative studies resulted from using the same semistructured interview instrument

(Maxwell, 2013).

Marshall and Rossman (2011) posited dependability accounts for a researcher's ability to demonstrate how the study design, data, and interpretations will be strong and credible. Miles et al. (2014) suggested dependability stems from demonstrating whether the process of the study was trustworthy, stable over time, and consistent across researchers and method. Additionally, a researcher accounts for dependability by defining a clear research question, collecting data consistently, routinely assessing bias, and regularly reviewing the data (Miles et al., 2014). The dependability construct addresses issues of reliability and integrity in the interpretation of the data and confirms the researcher conducted the study with unbiased attention (Miles et al., 2014). Using consistent semistructured interview questions increased reliability and illustrated a scholarly approach in conducting this study.

Validity

In qualitative research, Maxwell (2013) reported credibility, confirmability, and transferability are equivalent to validity in qualitative research. With reference to the researcher's trustworthiness, validity determines whether the researcher's discoveries accurately report and reflect the findings measured by the respondent's data (Saunders et al., 2009; Zohrabi, 2013). To the extent that data collection methods must accurately describe the research observations and findings, the ability to generalize the application to other research settings was essential (Morse et al., 2014; Zohrabi, 2013). I ensured the validity of the findings through the accurate transcription of the participants' interviews, by using member checking, constructing themes, interpretations, and findings solely

based on the collected data. Marshall and Rossman (2011) further describe *transferability* as occurring when the findings are useful to others in similar situations; applicability of transferability depends on the existence of similar research questions, and the use of similar research methods. Houghton, Casey, Shaw, and Murphy (2013) stated transferability of original research occurs when other researchers can make informed decisions about the applicability of the findings to other settings. The participants' thick, rich descriptions provided information for readers to evaluate the applicability to other settings (Barusch et al., 2011; Hanson et al., 2011). Precision in execution and clarity in describing findings is expected to enable those who review the study to determine if these results would likely transfer to a new environment (Goffin et al., 2011; Hanson et al., 2011).

Furthermore, Hanson et al. (2011) described external validity as the establishment of transferability in qualitative research studies. I paid close attention to the methods to determine transferability to the description of the sample collection and results; enabling those who review the study to determine if these results would likely transfer to a new environment with different participants (Goffin et al., 2011; Hanson et al., 2011). Enabling the determination of external validity facilitated answering the research question through rich descriptions, developing a transparent story of the participants best practice strategies to determine if statements transferred to similar environments. The use of repeatable methods and procedures lends to the production of credible research.

Hanson et al. (2011) established internal validity as the formation of credibility in qualitative research studies. Internal validity implies that the conclusions accurately

describe the evidence; articulating the approaches, steps, and actions that transpired throughout the research process are dependable findings and increases the potential of reassessment by other researchers (Salkind, 2010; Zohrabi, 2013). Judging for trustworthiness in credibility, data collection occurs from more than one source – participation in focused interviews, handwritten notes, and member checking (Harper et al., 2012; Hanson et al., 2011; Padgett, 2008; Wainwright & Sambrook, 2010).

Padgett (2008) found debriefing participants after interviewing them helped to guard against researcher bias. I verified if the interview transcripts accurately represented the experiences of participants (Hanson et al., 2011; Onwuegbuzie et al., 2012; Pavletic, 2011). Transcript review involved participants' review of a summary of the transcripts of their interviews to ensure accurate recordings and acknowledge their words (Houghton et al., 2013; Onwuegbuzie et al., 2012). I used member checking by requesting authentication of the interpreted data from participants to validate the data.

The process of member checking provided a broad confirmation of the best practice strategies of the participants, and led to the development of a consistent and objective representation of administrators' experiences (Fey et al., 2014; Hanson et al., 2011; Maxwell, 2013; Onwuegbuzie et al., 2012). Therefore, transcript review and member checking provided an opportunity to solicit feedback, rule out the possibility of misinterpretation, and minimize biases and misunderstandings (Maxwell, 2013; Nottingham & Henning, 2014). Following reassurance and discussion with participants, clarifications provided interpretation or agreement that the transcription should remain unchanged (Houghton et al., 2013; Koelsch, 2013). I continued interviewing from the

participant pool until data saturation occurred. Data collection did not stop until additional data collection resulted in more of the same findings, and reaching data validity when no new insights occurred (Marshall & Rossman, 2011).

Transition and Summary

In Section 2, I reiterated the purpose of the proposed study, identified my role, the participants, qualitative research method, and descriptive design I chose to provide the inquiry of the administrators best practice strategies to sustain and fund SBHC business operational services. Also in Section 2, discussions covered data collection instruments, data collection and data organization techniques, data analysis, reliability, and validity. Section 3 includes the presentation of findings, application to professional practice, implications for social change, recommendations for action, and recommendations for further study.

Section 3: Application to Professional Practice and Implications for Change

Section 3 includes discussions of the outcomes of this study. This section begins with an overview of the study, presentation of the findings, and recommendations for action. Section 3 concludes with recommendations, reflections, a summary, and conclusion of the study.

Overview of Study

The purpose of this qualitative descriptive study was to explore strategies SBHC administrators use to develop and sustain funding for business operations. The research question was as follows: What strategies can SBHC administrators use to develop and sustain funding for business operations? All participants responded to the research question and eight open-ended interview questions (see Appendix D); each participant gave descriptive statements related to their best practice strategies with sustaining operational funding of a SBHC.

The findings in this study confirmed SBHC administrators continue to face challenges in developing and sustaining adequate funding for operations in the state of Maryland. Collectively, administrators suggested that personal contacts were important; for example, knowing who the funders were and positioning the agency to receive funding was vital for the continuous flow of capital. School-based health center administrators need to create, develop, and maintain strong marketing plans to improve collaboration between the school and community partnerships. Administrators' abilities to attract grant or philanthropic funding was crucial to the continued success of SBHCs organizations' continuing operations.

Funding allocations varied depending on the type of service administrators offered at their facilities; for example, dental programs received the least funding, whereas somatic and mental health services received greater amounts. The SBHC administrators lacked professional staff and technical assistance for reimbursement payments, billing, and coding (Hutchins-Goodwin, 2013; Keeton et al., 2012). Minimizing the gaps between service providers and adequate staffing of healthcare professionals was vital to financing the access to these business services. Finally, the task of sustaining funding for professional staff, social workers, and nurse practitioners is an ongoing challenge for administrators who frequently play dual roles in the business operation of SBHCs.

Presentation of the Findings

Research Question

From their experiences, administrators collectively agreed that developing and sustaining funding was difficult. Participants contrasted SBHC funding with the funding of general education services, claiming that working with government agencies indirectly was challenging because of the lack of personal relationships with agency representatives. The primary strategic challenge was navigating the governments' bureaucracy to communicate funding requirements and voice their (administrators') opinions. Verbal communication between and from employees was a source of valuable suggestions. Open communication engaged all employees in plan development, sharing of ideas, and internal education (Kataria et al., 2013).

According to Participant 10, focusing on sponsors and leaders in the county's health department was one strategy for securing funding. Participant 10 stated, "… impress upon them the value of school based health so that they can act on my behalf because I can't be the direct spokesperson in a lot of these situations." Direct contact with the people in control of funding streams within *a governmental structure* was an invaluable resource for this participant. Personal contact was how this administrator could send the message about "how it (funding the SBHC) can impact the community that we are serving." Participant 11 commented:

> They have sustainability plans in place – financial and other wise. They are delivering services that are appropriate which these days; they are evidence-based programs. The main strategies that administrators could use making sure all the ingredients are in place so that when a funder does come around they are attracted to what you are delivering.

Participant 12 and Participant 20 claimed funders sought people who had "done their homework".

Participants in this study advocated for engaging community members (parents, students, etc.) on different levels to raise awareness of the need for the programs; administrators believed the awareness and self-advocacy translated into needed capital. According to Participant 2, "They have to be the spokesperson, and basically empower them to do that. Looking particularly at serving their families and the leadership they both need to be the voice." The six participants (30%) who mentioned public awareness and developing personal relationships with funders agreed that SBHC providers should

deliver evidence-based programs. The evidence-based service delivery model was a useful tool for attracting and sustaining funders and their capital.

Findings Addressed by the Evidence Collected

Twenty full time SBHC administrators who worked in multiple, separate locations throughout Maryland provided descriptive data and narratives that related to the semistructured interviews with open-ended questions. Participants had work histories of more than 1 year and up to 20 years of service in a school year funding cycle. The assignment of a participant number (Participant 1 through Participant 20) replaced the use of individual names in the data and the labels for electronic folders. I sent the individual transcripts, for transcript review, to the respective participants so that they could review for accuracy, and requested feedback or comments to eliminate the possibility of misinterpretation, bias, and misunderstandings (Maxwell, 2013). The process of member checking provided a broad confirmation of the best practice strategies of the participants, and led to the development of a consistent and objective representation of administrators' experiences (Hanson et al., 2011; Maxwell, 2013). Therefore, member checking provided an opportunity to solicit feedback, rule out the possibility of misinterpretation, and minimize biases and misunderstandings (Maxwell, 2013). These processes of transcript review and member checking assured the accuracy of descriptions, explanations, and interpretations of the data.

I used member checking by requesting the participants to validate the data. I transcribed the interview verbatim, labeled each transcription Participant 1 – Participant 20, and emailed transcripts to participants anonymously without participant number

assigned. Instructions provided asked participants to review a summary of the transcript to confirm if the transcription was complete, truthful and if interpretations presented an impartial representation. Some transcripts returned as accurately recorded, a few participants used this opportunity to make grammatical edits to their transcripts, and others added more data to questions for further explanation of their experiences. Edited transcripts matched in the participant folder became the new data used in the data collection process. Following reassurance and discussion with participants, clarifications provided interpretation or agreement that the transcription should remain unchanged (Houghton et al., 2013).

I continued interviewing from the participant pool until data saturation occurred. Data collection did not stop until additional data collection resulted in more of the same findings, and reaching data validity when no new insights occurred (Marshall & Rossman, 2011). Data saturation took place when the collection of participant data produced no new information; data saturation did not occur prior to the 16th participant. However, confirmation of saturation occurred through the analysis and comparison of transcripts from participants 17, 18, 19, and 20 against previous participants. I developed themes from the responses semistructured interviews and open-ended research question and interview questions. Four themes emerged interagency communication, creating marketing plans, disparities in the allocation of funding for programs, and funding for professional staff.

Theme 1: Interagency Communications

The administrators exposed the necessity for improved communication with funders to build interagency relationships with MSDE and county officials. Participants aspired to sustain and create personal contacts to ensure funders were aware of available services. Within the narratives, participants explained the potential benefits of maintaining face-to-face contact with agency officials. Participants also identified problems associated with the lack of personal contact; these problems affect current and future funding opportunities.

Participants' responses to the research question and two interview questions based on their best practice strategies expressed difficultly in answering the question to compare to funding general education services, because working indirectly with governmental entities does not provide direct, personal relationships with the main source of funding. Participant 11 commented:

> They have sustainability plans in place – financial and other wise. They are delivering services that are appropriate which these days; they are evidence-based programs. The main strategies that administrators could use making sure all the ingredients are in place so that when a funder does come around they are attracted to what you are delivering.

Interview Question 2 responses regarding building relationships with funders coincided with the overall Research Question and respondents agreed that making your presence known was a strategy that brought value and awareness of the business services provided by SBHC in the state of Maryland. Participant responses echoed the importance

of using contacts to apply for grant funding and working with the state organization, Maryland Association of School Based Health Centers (MASBHC), to identify potential funding sources. Participant 3 stated, “I think maintaining those relationships with legislators when you are talking about state dollars is very important to use known contacts.” Additionally, Participants 1, 7, 9, 14, 15, 6, and 19 confirmed the importance of using metrics and data to report and demonstrate the success of SBHC business operations. Participants articulated they provided examples of the importance of SBHC services, which enabled children to maintain healthy outcomes, staying in school and reducing absenteeism.

Interview Question 5 responses to the demonstration of funders return or practical outcome of the funds resulted in participants continuing the dialogue through collected stories, keeping good data, and providing face-to-face opportunities to demonstrate impact of SBHC business operations. Participants who were Nurse Practitioners suggested they write and publicize success stories for the funding entities. Finally, Participants 1, 4, 9, 10, 14, 15, 16, reiterated having face-to-face contact provides the opportunity to ask for feedback to tell the story from the consumer’s perspective. Participant 13 provides electronic reports to MSDE demonstrating the return on investment. Participant 1 reiterated documentation received from the clinician’s perspective is important; however, reporting good data results derive from providing actual consumer feedback.

Theme 2: Creating Marketing Plans

SBHC administrators discussed the absence of marketing plans. Administrators revealed business operations functioned in the absence of publicity and providers delivered services without recognition. Representatives of SBHCs used forums like *Back to School Night* to stimulate interest in available services. Parents and guardians received information about the availability of immunizations and physicals for team sports. Administrators agreed that periodic assessments of the billing processes could add value to marketing efforts. Financial documentation of the efficient and adequate use of existing funding could be an effective tool for demonstrating the continued value and need for funding. One opportunity to increase existing funding was evident in the narratives. Participants believed that collaboration between the school system and the county health department could foster the development and allocation of additional grant funding.

The assigned Program Manager of MSDE distributes funding annually; however, MSDE officials have little interaction with the SBHC service providers. Because SBHC administrators do not communicate with MSDE except during the annual check in, the impression is that officials are supportive of the business operations and services because they (officials) allocate funding year to year. There are no requirements for creating or implementing marketing plans for SBHCs; the MSDE officials use the annual applications only to monitor the availability and delivery of health-related services to children.

The participants in this study agreed the hiring of permanent staff would

contribute to the sustained continuity and expansion of professional staff and business services. When I asked question eight, SBHC administrators immediately mentioned they did not have a marketing plan, could not describe how they evaluate the marketing plan, and did not have a problem with marketing the SBHC business services. Participant 3 said:

> We don't have a local marketing plan. It is day-to-day operation and reaching out to our community partners when we need to. Making sure our advisory board is aware of what we are doing. Making sure our local management board is fully invested and they are, but's not a formal marketing plan. So kids are enrolling throughout the year. And at the end of the school year when report cards go home we send out notices that we can do sports physicals before the beginning of the fall sports season for families who are interested.

Participant 11 remarked, "The marketing plan is conducted by word of mouth." Participants 1, 4, 6, 8, 9, 2, 13,14,15,16, and 18 stated they do not have a marketing plan. The SBHC administrators thought there was no need to have a local marketing plan because their business activity is day-to-day operations and reaching out to the community is needs based. Additionally, the participants reported, the number of people determines baseline marketing for services, they are looking to the school system to provide marketing services, considered marketing something the service provides work on with MSDE, and the creation of a formal marketing plan is the next step.

Interview question 3 supported the need for marketing and SBHC administrators want better collaboration between the school system and county health department.

Participants reiterated the need to develop better communication plans, having an advocate communicate business service needs, and conducting billing assessments to market overall businesses to obtain additional funding. For example, Participant 8 mentioned, “If the community and everybody is serious about it the school base clinic must demonstrate the professional running the business side, and I think if we don’t see a lot of kids they may close us down.”

Participant 11 stated, “I think one of the keys here in [this county] is to build better collaboration between the school system and the county.” SBHC administrators considered comprehensive assessments as an opportunity to market SBHC services to current and potential funding sources. Participant 15 stated, “I really don’t want to underestimate the significance of demonstrating of the need for the services, and the administrator can be the person who helps facilitate a more comprehensive needs assessment; and finding the data where it is.” Participant 15 stated, “One of the other ways that we have positioned ourselves, we’ve helped school system to position itself for additional funding has been by conducting assessments of its current service delivery system.”

MSDE was supportive of school-based health as restated by Participants 4, 9, 14, 15, and 16, and they think officials realize the need and benefit for services. Participant 8 claimed:

> I think they believe it will make a difference. Our goal truly, with any school-based health program whether it be just the health center or health offices or a school-based wellness center truly can help the child stay in the classroom as

much time as possible. That is the goal of any school-based health program. Therefore, with the wellness center we have the opportunity to interact with children to prevent them from having to be picked up or burdening a parent who can't afford to miss a day's work to come get their child to take them to the doctor's so they can be cleared to get started on antibiotics.

Since the officials at MSDE did not require a marketing plan, SBHC administrators repeated the need to demonstrate the success and positive outcomes for business operation services throughout the year when seeking opportunities for additional funding sources.

Theme 3: Disparities in the Allocation of Funding for Programs

School-based health center administrators agreed that dental programs received the lowest funding statewide. The costs associated with providing dental care exceeded the budget limitations of most SBHC operations. Administrators could not sustain the costs of maintaining a dentist on staff to provide consistent and dependable levels of care. State funding was not sufficient to support dental services; administrators chose to reallocate funding to address the growing needs of somatic and mental health services. Billing for somatic and mental health services is a priority in Maryland (Rich, 2011). The existence of FQHCs attracted SBHC administrators to apply for recognition as federally supported entities. Under the FQHC designation, SBHCs qualify for federal funds and full reimbursement for services provided. With these supplemental funds, administrators can obtain inclusive rates and substantiate the costs of all business services offered.

The SBHC administrators' response to the identification of least and most funded

services received separate responses because the participants illustrated why they think funding is least targeted for specific programs (Participants 1, 4, 20). For example, Participant 10 described dental programs as least funded stating:

> The one that receives the least funding have been our dental services. Why? For the reason that I mentioned, I think it was in the first one dentist come at a price. Dental equipment is expensive. So folks basically say well, if we have to have our druthers what are we going to focus on. So we focus on mental health and the somatic health.

Participant 14 commented, "The dental program receives the least funding as compared to the medical program. It's mostly related to the fact that dental insurance is just not as good as medical insurance." Other observations included, "dental probably receives the least state dollars" (Participant 17), and a "dental program receives the least funding compared to medical programs" (Participant 16).

A noted area of least funding was also staffing sizes at SBHC. In the area of social work, SBHC administrators noted organizational structures had shortages of Social Workers to handle the increase of caseloads for their business operations. Participants 2, 11, and 13 repeated the least funding is the actual staff of the school based Social Workers. Somatic and mental health services reportedly receive the most funding in the state of Maryland (Rich, 2011; Vernberg, Nelson, Fonagy, & Twemlow, 2011). Participants 3, 10, 16, 18, 19, and 20, echoed similar responses that these areas receive the most funding and their centers share the responsibility for somatic and mental health because both are required to maintain the health of a child. Participant 2 stated:

> The area that receives the most funding is the concrete services, which comes out of DHR, which is very consistent. If you have medical assistance, you can pretty much get any service you need. If you have private insurance that is another story, because private insurance really doesn't cover behavioral services or mental health services to the extent that medical assistance does.

Interview question 7 addressed revenue from fee for services support for somatic and mental health services (Participants 3, 17, and 18). One center is a full service clinic, which bills for all services (Participant 7). Federally Qualified Health Center designation allowed four centers to cover all costs of services and carry an all-inclusive rate for billing (Participants 4, 14, 15, and 16). Participant 9 stated, "We only generate from Medicaid. We only bill Medicaid and that's who we receive funding from this point for us for somatic care." Because the FQHC business model is a flat rate reimbursement structure, regardless of services provided by a physician or nurse practitioner, there was an added appeal for status achievement.

Theme 4: Funding for Professional Staff

Sustaining funding for professional staff is a fundamental challenge. School-based health center administrators encounter budgetary constraints that affect their ability to staff their operations. A common tactic used to manage this problem is requiring staff to function in dual capacities; for example, a nurse practitioner might also act as a budget administrator. In the state of Maryland, the size of the grants provided by the Department of Social Services resulted in the elimination of social worker positions in SBHCs (Maryland State Department of Education, 2014). The elimination of the social worker

positions occurred at a time when mental health illnesses among children are increasing, and there is increased need for family support services. The participants in this study also highlighted another unmet staffing need; there was a need for technical and billing professionals who could ensure the timely processing of insurance submissions for reimbursements.

School-based health center administrators responding to challenges faced in sustaining funding for SBHC business services appeared eager to answer – the need for professional staff. Participants 10, 14, 19, and 20 emphasized, "the most significant challenged is acquiring and sustaining professional staff." Participant 19 stated:

> Funding, because we have to be able to pay people what they are worth. I am dealing with that right now. We have had a tremendous time trying to get people who want to come to work here and we always get people who want to because they understand what the population is and what they need. But they are not coming here to volunteer.

Other administrators illustrated the challenges to include university funds are limited (Participant 7), possibility of grant funding going away (Participant 4), and challenge to sustain funding is often dictated by the Board of Education (Participant 5). Paying professional staff and having a standard payment model is a major challenge in sustaining funding for staff.

Another challenge to sustain funding is the lack of support in the area of technical assistance to support billing, coding, and reimbursement for SBHC business services. Participant 3, 17, and 18 similarly reported:

> I don't know that I have anything. Although any kind of education or technical assistance around the billing issue is always, welcome. We have a half time person that does all of our billing for all of our centers as well as a couple of other mental health clinicians who work in the elementary schools and we may need to increase that staffing at some point. Any kind of technical assistance is always welcome.

Related Findings to a Larger Body of Literature on the Topic

The W. K. Kellogg Foundation's leadership subsidized nine state SBHC associations and the NSBHC, with 6 years of financial, advocacy, and technical assistance to advance local, state, and federal health service delivery and education (Richardson & Wright, 2010). The foundation's leaders made an investment in Kindergarten to 12th grade programs. This investment was an example for policymakers on how a properly placed investment could provide a healthier workforce and have a positive net social benefit for the population (Flaspohler, Meehan, Maras, & Keller, 2012). According to a 2011 survey conducted by W. K. Kellogg Foundation, eliminating health disparities remains a monumental challenge (Siruta, Simmer-Beck, Ahmed, Holt, Villalpando-Mitchell, & Gadbury-Amyot, 2013). Most programs are not self-sustainable based on Medicaid reimbursement alone, and a continuous external source of funding is necessary for long-term sustainability of dental programs in SBHC business environments (Siruta et al., 2013). ACA funding provided medical services funding through Medicaid and continue to target school-based programs (Mathu-Muju, Friedman, & Nash, 2013; Siruta et al., 2013; Wang & Stewart, 2012).

As mentioned in the narratives of the SBHC administrators', the least funded services were dental programs and repeated throughout the interviews as the least targeted program for pools of funding. School-based health center administrators noted publicizing, expanding, and coupling the funding sources could provide dental services expansion, however; reportedly, throughout the state of Maryland dental insurance coverage was not prominent as medical insurance programs. Based on the findings of this study, the SBHC administrators continue to require private foundation and state level assistance to ensure adequate service continuity to meet the needs of school age children. MSDE provides an annual service payment, and participants provide electronic reports to MSDE demonstrating the return on investment. Since program managers do not require a marketing plan for current or new funding sources, SBHC administrators stressed the demonstration of successful outcomes through demographics on services provided yearly to continue and sustain its current funding levels. Limited research exists in the area of private funding; however, managers of these funding sources are particularly interested in the evidence-based program effectiveness to reduce chronic illness or target a specific demographic of the community. For example, Kaiser Permanente expanded its oral health services grants and provided over 30 opportunities for capital projects (National Assembly of School-Based Health Centers, 2011). This organization recognized the unmet need among children and recognized SBHC business operations unique positioning for meeting the dental health needs in the lives of uninsured children (National Assembly of School-Based Health Centers, 2011).

Staffing arrangements in SBHCs have contrasting financial models; service providers do not require a single business process, and operate in a variety of settings at each location (Davis, Honacker, Jones, Williams, Stocker, & Martin, 2012; Policy Statement School-based Health Centers, 2012). School health officials and policymakers examined the eight components of school health programs consistently (Policy Statement School-based Health Centers, 2012). Of the eight components, the SBHC administrators demonstrated effectiveness in addressing health services, ineffective in the areas of mental health and social services, and faculty and staff health promotion. School-based health center administrators highlighted two components that were necessary for sustaining business operations, social services and staff health promotion (Keeton et al., 2012; Policy Statement School-based Health Centers, 2012). Within the participants' narratives, the requirement to meet adequate staffing levels of social workers and nurse practitioners to ensure service delivery was evident. Administrators described the inadequacies for more professional staff for social work in the area of mental health, further evaluation of funding for dental and mental health programs, and sustaining adequate funding for future school-based business operations will help SBHCs continue its examination of the eight components of school health programs.

The descriptive data and narratives of the participants in this study revealed their best practice strategies on how they develop and sustain adequate funding to support the business operations. Keeton et al. (2012) claimed developing and sustaining funding for SBHCs may support jobs for (a) nurse practitioners, (b) physicians, (c) social workers, (d) mental, and (e) dental health professionals. The findings in this study corroborate the

findings of Hilliard and Boulton (2012) and Keeton et al. (2012), who claimed SBHC administrators continued to encounter challenges when securing adequate funding to support business operations, professional staffing, and consistent billing systems for reimbursement.

Findings Related to the Conceptual Framework

I used the sustainability theory for the conceptual framework to explore the best practice strategies of SBHC administrators. The descriptive data indicated SBHC administrators' strategy to sustain business operations aligned with the definition of Elkington's theory on sustainability. Sustainability is economic development that meets the needs of the present generation without compromising future generations' ability to meet their needs (Elkington, 1998).

In Theme 1, SBHC administrators described the need for better communication between funders to build relationships with the primary funding source (MSDE), county health department affiliations, and private foundations. Participants addressed the need to sustain and create personal contacts to ensure funders were aware of available services. Sustainability planning sessions described the financial future of the community and school initiatives to determine how financial sustainability planning relates to the delivery of health care interventions (Tibbits, Bumbarger, Kyler, & Perkins, 2010). These major focuses had a cumulative impact on (a) corporate finance, (b) benefits of actions, (c) social impact, and (d) long-term sustainability through measured performance. Included in the sustainability model were feedback loops for evaluation, testing, and improving corporate strategies (Bain, Walker, & Chan, 2011). The viability of this

framework required customization based on industry, geographical location, and internal and external business context (Biro, Zsuga, Kormos, & Adany, 2012). MSDE program managers do not require a marketing plan for current or new funding sources. Therefore, SBHC administrators stressed the demonstration of successful outcomes through demographics on services provided yearly to continue and sustain its current funding levels.

SBHC administrators' responses in Theme 2 indicated MSDE provides an annual service payment. However, there was no in-depth evaluation, assessment, or feedback requirement, and little interaction with the SBHC service providers. Kataria, Kataria, and Garg (2013) mentioned internal communication with all employees in managing sustainable funding was a primary link in the implementation of sustainability initiatives. Internal communications were essential for all employees to engage in the sustainability initiative to maximize value and use sustainability as a competitive advantage (Kataria et al., 2013). Emphasized throughout organizations were job relevance and cost-saving measure messages (Kataria et al., 2013). Open communication engaged all employees in plan development, sharing of ideas, and internal education (Kataria et al., 2013). Within the narratives, participants explained the potential benefits of maintaining face-to-face contact with agency officials. Participants also identified problems associated with the lack of personal contact; these problems affect current and future funding opportunities. Verbal communication between and from employees was helpful because this form of communication provided valuable, continuing suggestions. School-based health center administrators reiterated the need to create and sustain permanent personal contacts to

ensure funders know the model differences in SBHC centers and maintaining face-to-face contact affects the sustainability of current and future funding opportunities. School-based health center administrators suggested hiring and retaining a permanent MSDE staff person who may prescribe the conceptual framework of sustainability planning to meet current needs, and implement concepts on retaining services to sustain future SBHC business operations.

As found in Theme 3, billing for somatic and mental health services was a priority in the state of Maryland. Planning for the sustainability of SBHCs required an understanding of how to operationalize and monitor financial activity over time (Shediac-Rizkallah & Bone, 1998). Without adequate funding, SBHC administrators continue seeking opportunities to maximize existing funding by developing additional grant funding by collaboration between the school system and the county health department. Sustaining revenue might become easier to obtain as SBHCs designation gain recognition as federally qualified health services entities (Alvarez et al., 2013; American Public Health Association, 2012; Hutchins-Goodwin, 2013). School-based health center administrators have business practices and funding achievements in the operation of FQHCs, which cover all-inclusive rates to help supplement the costs of all services of activity provided. School-based health center administrators were knowledgeable in receiving reimbursement through Medicaid for FQHCs sustaining services for uninsured children and operations remained viable sustaining adequate funding to meet the demands of the health services in the public school system.

Finally, in Theme 4 a challenge SBHC administrator faced was sustaining funding for professional staff. In a business environment, sustainability includes corporate social responsibility, stakeholder involvement, and citizenship to improve manager's effect on the company system. The literature indicated creating sustainable engagement toward funding community projects addressed three dimensions internal, external, and personal relationships (Clifford & Petrescu, 2012; Cullom & Cullom, 2011). These engagements led to creating value in the capacity building process and supporting the creation of successful community relationships. Managing the organizational structure and culture among the partners helped administrators establish the external appearance of the equity of contribution and cooperative returns between the partners (Clifford & Petrescu, 2012).

The narratives of the SBHC administrators discussed the need for professional staff and the cost associated with trying to hire and retain staff with limited funding. The findings related to the conceptual framework support Cullom and Cullom's (2011) claim that sustainability builds relationships with organizations, personnel, and invests in the community in which the SBHC delivers the business services. Participants in this study confirmed how developing and sustaining funding for SBHC business operations were critical because of limited resources and lack of contact with MSDE sources. Emerging themes from this study reinforced the application of sustainability theory to explore how SHBC administrators adjust current and future business operational services to meet the needs of student populations in the centers in which they live.

Findings Related to Existing Literature on Developing and Sustaining Funding

School-based health center structures. The SBHC administrators confirmed the business operational services in school-based, mobile, and linked health centers reflected a 2% increase in sustaining services throughout the nation. School-based health centers nationwide sponsored by school systems, hospitals, private nonprofit, health department, and community health centers served an estimated 2,000,000 students (Lofink et al., 2013). The state of Maryland increased the number of SBHC units from 68 to 70 in 2013. The SBHC administrators participation in this study, confirmed operating in different SBHC models. NAPNAP (2013) illustrated SBHC models vary across school demographics; whereas, elementary and middle schools were for treatment of illnesses, and high school students' uses were for reproductive health services.

Findings confirmed the business services by SBHC staff delivered preventive care; provided immunizations; managed chronic illnesses, such as asthma, obesity, and provided reproductive health services for adolescents in an environment to improve academic success (Keeton et al., 2012). Participants repeated SBHCs deliver services to school environments, acting as an entry point to children who lack traditional care (Daley, 2012; Keeton et al., 2012; Korenblum, Vandermorris, Thompson, & Kaufman, 2013; NAPNAP, 2013). The participants confirmed their centers are comprised of a nurse practitioner or physician assistant providing basic health services under the supervision of a physician (Policy Statement School-based Health Centers, 2012). Secondly, the most common model is the primary-care mental model, which included a licensed clinical social worker or psychologist (Daley, 2012; Policy Statement School-based Health

Centers, 2012). This model was ideal for the SBHCs located in the state of Maryland, and described by the SBHC administrators corresponds to one of the business operations that receive the most funding.

Health services. The participants in this study expressed feelings about the importance of children with mental health issues and the need for SBHCs to provide required mental health services (Manning, 2009). Mental health services in SBHCs targeted (a) suicide, (b) depression, (c) attention deficit disorder, (d) aggression, and (e) violence. Manning showed how these issues may overlap in the life of a child, discussed the linkage between mental health and academic performance, and there are no state requirements for mental health screening in schools. Even though state legislators enacted policy requiring the identification of abused students, there are no stringent guidelines or requirements for providing counseling or intervention services (Cummings et al., 2013; Manning, 2009; Stephan, Connors, & Brey, 2013). The SBHC administrators described programs based on delivery mental health services, and the three components comprised of a social worker, linkages to mental health services, and concrete services. Most importantly, concrete services provide additional support to children and families through community-based behavioral health agencies. Services provided include: (a) eviction prevention, (b) energy assistance, (c) food, and (d) clothing.

Additionally, Manning (2009) and Klontz, Bivens, Michels, and Tom (2015) recommended employing school-based social workers who serve as liaisons between (a) homes, (b) school, and (b) the community to provide case management assessments and deliver social services benefits. School-based health center administrators described

working with the University of Maryland Center for School of Mental Health leveraging a half a million dollar grant for 4 years to train all front line staff in mental health first aide. Obtaining this funding occurred after a shooting at a local high school. Billing for mental health services has become a priority, and SBHC administrators are finding success in the operation of Federally Qualified Health Centers (FQHCs) to cover all-inclusive rates for business services.

Findings in this study also aligned with those of Atlshuler and Webb (2009) and Weist et al. (2014), that supported social workers needs to address of the most vulnerable and disenfranchised students by addressing environmental barriers and easing access to care. In the development of school age children, opportunities exist to legitimize the school social worker's visibility, viability, and value to the SBHC establishment. Atlshuler and Webb stated the most pervasive public health worker was the school psychologist. Certification standards developed for school counselors and social workers might equip public health workers to manage students with mental health problems and complex family structures (Graham-Jones, Jain, Friedman, Marcotte, & Blumenthal, 2012; Hadjstylianos, 2014; Kerr, Price, Kotch, Willis, & Fisher, 2012; Lizano & Barak, 2015; Weist et al., 2014). The basis for the need for more social workers was that children in the state of Maryland have seen extreme violence in their homes, and they bring this trauma into the classroom. According to the SBHC administrators in this study, there will never be a shortage of students requiring the need for two social workers serving at schools with significant risks for mental health interventions.

Maryland SBHCs. School-based health center administrators were outspoken

about the lack of support received from MSDE. School-based health center administrators felt there was no real communication and personal contact with MSDE, which demonstrates a lack of commitment to ensure continued, effective business operations in SBHC environments. Leaders of the Maryland State Department of Education (MSDE) have not changed the application, does not require evaluations, or the development of marketing plans (Maryland State Department of Education, 2014). Participants in this study all confirmed that MSDE does not have dedicated staff to oversee business service activities with a view to determining expansion needs in Maryland SBHC business operations. Although SBHC administrators admitted receiving annual funding, there was no accountability, evaluation, or feedback provided to SBHC entities in the state of Maryland.

Funding sources of SBHCs. Since MSDE does not require a marketing plan to seek additional opportunities for new funding sources, SBHC administrators stressed the need to demonstrate successful outcomes through demographic data on services provided throughout the year. As reported by the SBHC administrators, the main funding sources for SBHC in the state of Maryland are MSDE, county health departments, and Department of Hygiene and Mental Health (DHMH). Participants agreed the least funded program was the dental program, and the most funded programs are somatic and mental health services. Administrators confirmed that health centers received reimbursement through Medicaid for FQHCs, and funding offset the cost of uncompensated care for uninsured children (Keeton et al., 2012). Additionally, administrators confirmed all state legislators ensured fund availability through the state's portion of Medicaid payments

(Medicaid.gov, 2012). The findings in this study correspond to SBHC administrators' continued challenges to ensure proper billing was taking place and reimbursements received at the highest due rates.

Although private funding began in 1994, one administrator mentioned beginning to develop new relationships with philanthropic organizations (Keeton et al., 2012). An opportunity to learn of new funding revenue potentially exists with Maryland Association of School Based Health Centers (MASBHC). As reported by two administrators who work closely with this state association, maintaining professional connections will allow them to gain information that provides a bigger picture of private funding resources.

Nursing roles. Borrow, Munns, and Henderson (2011) accurately described the school nurse facilitates the development of business services at SBHCs. The findings indicated by the nurse practitioners suggested, SBHC administrators' write and publicize success stories and gather data for the funding entities in the state of Maryland. The SBHC administrators operate in dual roles, develop reports, create metrics regarding the number of SBHC visits, and develop surveys for feedback and self-evaluation. Additionally, SBHC administrators mentioned the care provided to keep children in school by providing minimum immunization requirements for admission (Baisch et al., 2011); otherwise, children would be consistently absent.

Ribas, Dill, and Cohen (2012) examined the relationship between different jobs, occupational mobility patterns, and wages for nurse aides. A major challenge SBHC administrators face is sustaining funding for professional staff. School-based health centers facing cuts were usually determined by reducing staff, requiring administrators to

work in dual roles – both Nurse Practitioner and Budget Administration. In agreement with Bobo et al. (2013), the findings reflect the need for school nurses to determine the somatic and mental health business needs of children, serve as the front line administering SBHC budgets, and develop cultural sensitivities enabling children to receive the access to care.

Healthcare worker and nurse shortages. As SBHC administrators mentioned, MSDE policy does not determine staffing levels. In the state of Maryland, cuts in grant services provided by the Department of Social Services has reduced Social Worker positions in SBHCs. Due to the lack of continuous funding, Social Worker positions in SBHCs were eliminated at a time when mental health illnesses in children are increasing, as well as the need for family support services.

SBHC administrators acknowledged the challenges described by Turale (2011) for the need for advanced nurse practitioners who can utilize their skill, knowledge, and competencies to address the workforce shortages in the coming decade. If shortages persist, specific training in mental health services may initiate the development of mental health nurses and overcome gaps in specialized areas of the public health workforce (Jones, Brener, & Bergen, 2013; Manion & Odiaga, 2014; Turale, 2011). School-based health center administrators noted organizational structures had shortages of Social Workers to address the increased caseloads for their business operations.

Federally qualified health centers. School-based health center administrators have found funding successes in the operation of FQHCs, which cover all-inclusive rates to supplement the costs of all business services provided. Regardless of the cost, FQHCs

employees provide: (a) mental health, (b) dental, (c) urgent care, (d) pharmacy service, (e) referrals, and (f) substance abuse services (Alvarez et al., 2013; Grogan, 2011). A significant benefit of FQHC status was the enhanced opportunity to create a business model to serve the public regardless of the number or types of patient visits to the center (Sefton et al., 2011). Having the status of FQHC, address full reimbursement through Medicaid and funding offsets the cost of uncompensated care for uninsured children (Keeton et al., 2012). School-based health center administrators concluded this model of care provided the best rate of payment for all SBHC business services because the FQHC business model was a flat rate reimbursement structure regardless of who provides the services.

Business processes. School-based health center administrators indicated managing SBHC business operations required knowledge of fee-for-services and technical assistance for billing, coding, and reimbursements. The findings from this study support that business processes as defined by Singh (2012) are a collection of related, structured activities or tasks that produced or delivered a specific product to a particular customer or client. Managers use business processes to define inputs and outputs, structure for action, acquire critical process efficiency, execute management, and operational processes (Singh, 2012). Overall, managers' responsibilities ensured linkages among business projects so that projects aligned with the organization's overall strategy and business concept (Singh, 2012).

The findings also indicated one center was a full-service clinic, whose employee's bill for all services, and the participants who identified as FQHCs do not receive fees-for-

services. All other participants indicated they did not bill for services. A chief justification indicated administrators do not have time or the infrastructure to develop fee-for-service deliveries. In the literature, the fee-for-service organization worked well for routine and standardized processes such as payroll and loan application processes (Holweg & Pil, 2012). However, the enterprise structure does not work well if the corporation is complex, customized, or infrequently operational (Singh, 2012). The findings do not suggest that SBHC business operations are complex or infrequently operational and do not require services such as recruitment, benefits advisers, or management of developmental activities.

SBHC administrators supported the need for technical assistance to help in the areas of billing, coding, and reimbursement for SBHC business services. As mentioned, the W. K. Kellogg Foundation's leadership subsidized nine state SBHCs with years of financial and technical assistance to advance local, state, and federal health and education (Richardson & Wright, 2010). According to Hilliard and Boulton (2012) and Keeton et al. (2012), the findings SBHC administrators continue to face are challenges to secure funding for professional staffing and consistent billing systems for reimbursement.

Applications to Professional Practice

The findings from this study may apply to professional practice in two ways. First, SBHC administrators may consider the development of formal marketing plans to illustrate the significance of SBHC business operations, and demonstrate administrators' efficient use of existing funding to garner new revenue. Incorporating the development of an annual marketing plan may (a) publicize accomplishments to external funding sources,

(b) provides immediate data on ROI, (c) fulfill requirements established by FQHC status, and (d) provide the community with information on business services. This finding is relevant to improve business practices by developing an annual marketing plan that expands the collaborative efforts between the school, community partnerships, and MSDE's professional networks in support of evidence-based programs. Harvard's Office of Sustainability reported key areas of sustainability include staffing and marketing for short and long-term success (Cohen, 2012; DuPuis & Ball, 2013).

Second, SBHC administrators may have an opportunity to articulate to MSDE and MASBHC the need for increasing professional staff positions. The hiring of professional staff with technical assistance in completing Medicaid reimbursement payments, billing, and coding is significant for improving the business practices at SBHC locations. This finding is relevant to improve business practices for sustaining the funding of professional staff so that no gap will exist in the business services provided by SBHC. Kataria et al. (2013) emphasize tailoring messages based on job relevance and cost-saving measures throughout organizations. Finally, these findings are relevant for improving business practices for stakeholders to build collaborative initiatives addressing the need for SBHC formal marketing plans and the expansion of professional staffing positions in areas to meet critical business services.

Implications for Social Change

The findings in this study may contribute to positive social change by improving the SBHC administrators' ability to coordinate business services. These recommendations might provide information for SBHC administrators by developing a

multifaceted team approach within school environments that coordinate financial resources (Manning, 2009). Also, the findings in this study may contribute to positive social change by identifying and communicating business practices that demonstrate the significance of SBHCs and the need to increase mental health services for students in the communities in which they live.

Tangible improvements to individuals, communities, and organizations may occur through the implementation of positive social change initiatives since:

- SBHC administrators may apply these findings to the development of a formal marketing plan to articulate the business services and significance of SBHC business services to a wider audience.
- SBHC administrators' application of these findings may create and expand jobs for Social Workers to meet the needs of children and families experiencing the impacts of invisible mental health signs.
- MSDE and MASBHC leaders may collaborate to apply findings from this study to build better relationships with SBHC administrators, leveraging institutional knowledge, and maintaining personal face-to-face contact to increase the opportunities for additional revenue to sustain business services.

Recommendations for Action

Recommendations for further action include distributing the findings of this study to the MSDE School-based Health Center Department, MASBHC Executive Board, and the participating SBHC administrators. These recommendations may assist in

strengthening the local and state relationships among MSDE, MASBHC, and the SBHC administrators to create formal marketing plans targeting specific areas of potential funding opportunities, as well as promote the SBHC business operations throughout the state of Maryland. The findings might inform the National Association of School-Based Health Centers about SBHC administrators best practice strategies in the state of Maryland; and *jump start* opportunities to assist SBHC administrators with conceptual ideas for marketing plans; support areas of technical assistance, and identify national revenue sources for expanding professional staff in mental health business initiatives. As recommended by Madrid et al. (2008) and Weist et al. (2014), legislators should expand the organizational structure outlined in the 2008 MSDE application to include social workers to meet the mental health needs of students. Recommendations for SBHC administrators are:

- SBHC administrators create marketing plans and demonstrate readiness through the current service delivery model to obtain additional funding to increase areas for professional staff,
- SBHC administrators that operate centers that are not certified pursue the opportunity to obtain FQHC status to supplement the costs of all business services required, and
- SBHC administrators collaborate with MSDE and MASBHC to obtain technical assistance support in the areas of proper billing, coding, and reimbursement.

Recommendations for Further Study

A key recommendation for further research is to study the development of formal marketing plans created by SBHC administrators to increase networking capabilities, and become acquainted with philanthropic funding sources. As recommended by Dupuis and Bell (2013) and Hutchins et al. (2013), increased networking may guarantee long-term success for funding resources, demonstrating the incorporation of guidelines for success in achieving annual goals. Another recommendation based on the application of sustainability planning is to conduct qualitative studies that explore long-range staffing scenarios to employ SBHC professionals with targeted funding from state and federal government subsidies. Moseley (2011) suggested sustainability requires the realization of a long-term planning perspective to assess the benefits of new modeling and lasting change for at least ten years. Hutchins-Goodwin (2013) supported this recommendation, which suggested ACA funding finance all SBHC services, and the ability to become self-sufficient was due to the benefits of (a) new funding, (b) technological acumen, or (b) innovation.

A limitation identified in Section 1 was restricting the research to the perspective of SBHC administrators in the state of Maryland narrowing the research breadth. This study excluded individuals outside of the SBHC business structure. Future studies can include social service specialists, state of Maryland program managers, executive directors, or state association members with the responsibility of identifying and allocating funding for SBHC business services.

Reflections

SBHCs implementing best practices demonstrate how to improve the well-being of children who require health services and mental health assessments (Morgan et al., 2014). In longstanding evidence-based programs, SBHCs administrators who served on the forefront exhibited sustained commitment with annual, but limited resources. Conducting this study provided the opportunity for line staff to provide their input to the business services deemed essential to the success of public education, a good social impact, and more importantly, reducing absenteeism in school age children. School-based health center administrators participated enthusiastically because no one in the state of Maryland had ever sought out their opinion, experiences, or knowledge of how they develop budgets for operationalizing SBHCs. They welcomed the opportunity to lend their voices and appreciated the anonymity in my research design.

Summary and Study Conclusions

The purpose of this qualitative, descriptive study was to identify and understand the best practice strategies SBHC administrators face in developing and sustaining SBHC business operations. I explored this perspective from the administrators' day-to-day experiences as nurse practitioners and budget administrators. Twenty full time SBHC administrators working in multiple, separate locations throughout the state of Maryland provided descriptive data and narratives that related to the research and open-ended interview questions. Administrators had work histories of more than 1 year and up to 20 years of service with a school year funding cycle. Although SBHC administrators admitted receiving annual funding, there was no accountability, evaluation, or feedback

provided to SBHC entities in the state of Maryland regarding adequate funding levels for business services. The findings identified possible pathways stakeholders might use to create marketing plans, increase FQHCs status, and develop better collaboration with MSDE and MASBHC to provide technical assistance to support proper billing, coding, and reimbursement for sustaining SBHCs business services in the state of Maryland.

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Appendix A: Permission to Reprint Figures

From: Linda Juszczak <ljuszczak@sbh4all.org>
Sent: Thursday, October 31, 2013 5:19 PM Hayes, Ingrid
To: Hayes. Ingrid
Subject: RE: Permission to reprint (again)
Sensitivity: Private

Dear Ingrid,

You have permission to use the figures you requested from the Census Report, with proper attribution.

Sincerely,
Linda J Juszczak

Linda Juszczak DNSc, MPH, CPNP
President
School-Based Health Alliance
(f/kla National Assembly on School-Based Health Care)
1010 Vermont Avenue, NW Suite 600
Washington, DC 20005
202-638-5872 x212 (p)
202-638-5879 (f) linda j@sbh4all.org www.sbh4all.org

From:Hayes,Ingrid [majlto:::::Ingrid.Hayes@finra.org]
Sent: Thursday,October 31, 2013 4:03 PM
To: Linda Juszczak;Ingrid Hayes Burrell
Subject: RE: Permission to reprint (again) Importance: High
Sensitivity: Private

Hi Linda, I have been advised by the Methodologist to update the figures used in my study. I have attached the 2010-2011 Census Report and would like to cite this data in my study. Via email will you (again) provide me with permission to reprint the figures within my dissertation? Thank you.

FINRA
Office of General Counsel
1735 K Street, NW Washington, DC 20006
Phone/Fax: 202-728-6995/202-728-8894
Ingrid.hayes@finra.org
Protect the environment- please do not print this email unless necessary.

Appendix B: Permission to Use Figures

February 2, 2013

Dr. Linda Juszczak
President
National Assembly on School-Based Health Centers
1010 Vermont Avenue, NW, Suite 600
Washington, DC 20005

Re: Permission to Use Figures in Doctor of Business Administration Doctoral Study, Walden University

Dear Dr. Juszczak,

Thank you for your consideration to allow me to use the attached figures in my dissertation entitled, "Financing School-Based Health Centers: Sustaining Primary and Mental Health Services." Under these conditions, I intend to reproduce the documents as follows:

- It will be used in my research study, not for sale or use with any compensated management development activities,
- The source statement will be included on all figures, confidentially secure, and retained for 5 years, and
- A completed research study will be forwarded to your attention.

If these are acceptable terms and conditions, please indicate so by electronic signature and return your authorization to my Walden University email address. Thank you very much for your attention to this request.

Sincerely,
Ingrid M. Hayes Burrell
Doctoral Candidate 2013
Doctor of Business Administration, Specializing in Leadership
Walden University, College of Management and Technology

/bmh
Enclosure(s)

Appendix C: Informed Consent of Participants Over the Age of 18 and Email Communication

You are invited to take part in a research study regarding sustaining and developing funding for business operations of Maryland School-based Health Centers (SBHCs). Ingrid Hayes Burrell, Doctor of Business Administration Candidate, College of Management and Technology, at Walden University extends the invitation to program administrators who work in SBHC facilities in Maryland, and must have a minimum of 1 year of service in an SBHC environment. In order to participate, you must be 18 years old. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part. This study conducted by the sole researcher, Ingrid Hayes Burrell, who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to explore and learn of the best practice strategies of SBHC administrators regarding strategies on how to sustain and fund the operations of primary and mental health services for SBHC business operations. In this study, the business impact might identify funding sources to sustain primary and mental health services in SBHC business operations. This study might contribute to social change by building on the business practices by campaigning for the sponsorship of SBHCs on a private, state, and national level, and the statewide reimbursement business practice of Medicaid payments for all primary and mental health care services.

Procedures:

Procedures:

If you agree to be in this study:

- Schedule and attend the audio-recorded one hour telephonic interview;
- Within a two-week timeframe, I will send via email the transcribed interview notes, which allows me to conduct member checking with you for validating the data and provides a consistent and objective representation of your responses.

Here are some sample questions:

1. What strategies can SBHC administrators use to develop and sustain funding for business operations?
2. How do you identify and build relationships with funders or potential funders?
3. What significant challenges affect administrators in SBHC business services?

Voluntary Nature of the Study:

This study is voluntary. Your decision of whether or not you choose to be in the study will be respected. If you decide to join the study now, you can still change your mind later. You may
stop at any time.

Risk and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, like stress or becoming upset. Being in this study will not pose risk to your safety or wellbeing. The study's potential benefit seeks to add new knowledge to the research conducted on School-based Health Centers and its impact on the learning environment; uninsured families; and universal health care reform.

Payment:

No monetary transaction or payments for participation are connected to this study.

Privacy:

All information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. In addition, the researcher will not include notes, memos, your name, or anything that could identify you in the study reports. Data will be kept secure by electronic encryption and filed on a separate hard drive. Data will be kept for a period of 5 years, as required by the university.

Contacts and Questions:

You may ask any questions now, or if you have questions later, you may contact the researcher via 202-285-5481 or Ingrid Hayes Burrell, Doctor of Business Administration Student at Walden University. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 1-800-925-3368, extension 3121210. Walden University's approval number for this study is **10-10-14-0322013** and it expires on **October 9, 2015**. For your records, you may save or print a copy of the consent form Hayes-Burrell Consent Form IRB Certified.

Statement of Consent:

I have read the above information, and I understand the study well enough to make a decision about my involvement. By replying to the email with the words 'I Consent', you are agreeing to participant in the study.

Via Email Communication
October 29, 2014

Attention SBHC Administrator:

I am completing my Doctor of Business Administration study on the business operations of School-based Health Centers in the state of Maryland. I am contacting you to request your participation in a one-hour telephone interview to understand your experiences in sustaining and developing funding for the business operations of Maryland's (SBHCs). The results of this study could contribute to understanding the financial strategies administrators utilize to develop budgets, oversee administrative, financial responsibilities, and sustain business operations, respectively.

Participation would involve a private, audio recorded one-hour interview. Within a two-week timeframe, the transcribed interview notes, sent via email, allows me to conduct member checking for validating the data and provides a consistent and objective representation of your responses. All responses will remain confidential and determined by a participant identifier. I look forward to sharing this information with you, answering any questions about my study and the data collection process. If you are interested in participating, please contact me at Ingrid.hayes-burrell@waldenu.edu. Thank you very much for your assistance in this matter.

Ingrid M. Hayes-Burrell
Doctoral Candidate, Doctor of Business Administration
Walden University, College of Management and Technology

Appendix D: Research and Interview Questions

The research question for this study was as follows: What strategies can SBHC administrators use to develop and sustain funding for business operations?

The following interview questions will guide the study.

1. What significant challenges affect administrators in SBHC business services?
2. How do you build relationships with funders or potential funders?
3. What skills do SBHC administrators use to enhance the development of existing funding?
4. What SBHC program receives the least revenue, and which program receives greater funding support? Why?
5. How do you demonstrate to funders the return or practical outcome of the funds?
6. What was your perception of the funder's investment in your center?
7. How do SBHC administrators and Medicaid providers identify what services provide revenue from fee-for-services?
8. How do you evaluate the marketing plan for continued SBHC implementation?
9. What other information would you like to add that I did not ask?

Appendix E: NIH Certificate of Completion

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Ingrid Hayes** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 09/12/2014

Certification Number: 1549365