EXPLORING DISPARITIES AND SEEKING HEALTH EQUITY

IN NEW YORK SCHOOL-BASED HEALTH CENTERS

January 2025

New York School-Based Health Foundation

apex
evaluation that works

The New York School-Based Health Foundation is a 501(c)(3) non-profit with a broad mission of education, research, and support for the growth and expansion of school-based health centers, as well as improving access for all children and youth statewide. The Foundation complements the member- and advocacy-focused New York School-Based Health Alliance, an affiliate of the National School-Based Health Alliance. For more information about the Foundation, please visit https://www.nysbhfoundation.org/about-us. For questions about this report, including those about evaluation methods, please email info@NYSBHfoundation.org.

Apex Evaluation is a third-party evaluation firm specializing in Systems Learning™. Apex has a long history of partnership with organizations and teams working to improve health and well-being, including school-based health centers. For more information about Apex, please see the "About this Evaluation" section at the end of this report or visit https://apexeval.org/.

EXPLORING DISPARITIES AND SEEKING HEALTH EQUITY IN NEW YORK SCHOOL-BASED HEALTH CENTERS

EXECUTIVE SUMMARY

This report is produced by the New York School-Based Health Foundation (the Foundation) and Apex Evaluation (Apex). Data regarding school-based health center (SBHC) users is drawn from the SBHC Data Hub, a data repository created by the Foundation and Apex in which 60% of NY's SBHCs now participate.

* * *

School-based health centers are positioned at the intersection of health care and education, offer a broad range of health services, and serve all students regardless of insurance status. They are powerful tools for addressing the health disparities faced by vulnerable young people and families in New York.

SBHCs are located in public schools serving the State's underserved communities. Unsurprisingly then, when compared to New York total public and charter school student population (all New York students), the students attending schools with SBHCs (SBHC host schools) are more likely to be:

- Economically disadvantaged,
- Have disabilities,
- Be English-language learners, and
- Face homelessness.

Furthermore, compared to all New York students, SBHC users are more likely to identify as nonwhite, including Hispanic or Latino(a) and Black or African American, and to either have public health insurance or be uninsured.

Additionally, when compared to all New York students, SBHCs appear to serve disproportionately fewer users who identify as Asian/Native Hawaiian or Other Pacific Islander (NHOPI). Compared to the student population of SBHC host schools, fewer SBHC users report themselves to be Black or African American or Asian/NHOPI. More work is needed to understand these differences.

This report also looks at disparities within the population of students who use SBHC services.

Among SBHC users, those who are uninsured appear to receive fewer services than their peers who have insurance. Specifically, they receive fewer:

- Behavioral health visits,
- Depression screenings, and
- Comprehensive physical exams.

SBHC users of different racial and ethnic groups show differences in the diagnoses and services they receive. These differences are particularly pronounced for students identifying as American Indian or Alaskan Native, Asian/NHOPI, and those reporting "Another Race".

Across all race and ethnicity groups, the differences in diagnoses and services were most apparent for:

- Behavioral health diagnoses,
- Depression screenings, and
- Comprehensive physical exams.

Significant differences are noted in the users of rural versus urban SBHCs. Rural SBHC users constitute only 14% of SBHC users in this data, compared to the 86% who are urban SBHC users.

Rural SBHC users differ demographically from their urban counterparts. They are:

- Predominantly White
- Less likely to be economically disadvantaged, have a disability, be English-language learners, and face homelessness compared to all New York students.

Rural SBHC users also utilize SBHC services differently than their urban counterparts. Our data shows that:

- Insured and uninsured rural SBHC users exhibit no disparity in the services they receive.
- Rural SBHC users of color are more frequently diagnosed with behavioral health problems, receive more depression screenings, and are more likely to utilize behavioral health compared to all rural SBHC users. Conversely, it is notable that, in urban areas, White SBHC users, while a smaller population, have the highest percent use of behavioral health services.

Important next steps are needed to deepen our understanding of disparities.

This report is the first exploration of disparities among New York's SBHC users. We hope it inspires SBHC sponsoring organizations (SOs) and community members to explore and address differences in the health conditions of and the services used by different groups of SBHC users as we seek health equity for all.

The Foundation provided each participating SBHC SO with a set of analyses specific to its own student and SBHC user population and has begun working together with SOs to develop SO-specific disparity action plans. In the future, we seek to deepen our own understanding of disparities, as resources allow, by:

- Continually improving data quality,
- Incorporating additional disparities measures,
- Examining additional patient-level social determinants of health such as distance to care and socioeconomic status, and
- Working toward the goal of capturing health outcomes.

The availability of such information on disparities is vital and the first step in our mutual quest to address disparities and assure health equity for all students. We are grateful to all who have supported and joined in this effort.

TABLE OF CONTENTS

DEFINITIONS

Disparity is a term used to describe a difference between two or more things or groups, particularly a difference that is usually significant and often not fair.

Health disparities are defined as preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.[1]

Equity means fairness and justice and is distinct from equality, although these two terms are often used interchangeably. When we prioritize equality, everyone will have access to the same resources and opportunities. When we instead prioritize equity, we recognize intentional and unintentional advantages and disadvantages and make adjustments for a more balanced outcome.[2]

Health equity exists when no one is kept from reaching their highest level of health because of social position or social identities.[3] To the authors of this report, health equity further means that everyone receives what is needed to achieve the highest level of health possible.

INTRODUCTION

In 2024, the New York School-Based Health Foundation (the Foundation) began work aimed at understanding and reducing disparities for students who use New York's school-based health centers (SBHCs). To support this work, the Foundation contracted with Apex Evaluation (Apex) to analyze disparities in SBHC care, utilizing data from the New York statewide SBHC Data Hub. Two learning questions guided this evaluation:

- How do students who use SBHCs differ from those who do not?
- For students who use SBHC services, what disparities are evident in the types of diagnoses and services they receive?

Data for this report comes primarily from two sources: the New York SBHC Data Hub[4] and the New York State Education Department.[5] The report examines differences in the SBHC user population, specifically in race, ethnicity, and insurance status (a rough proxy for socioeconomic status), and the diagnoses and services they receive. The report also examines the differences between rural and urban SBHC users. This is particularly important for New York State, where vast geographic, demographic, and cultural differences exist, particularly between New York City (NYC), its suburbs, and the rural communities outside of NYC.

Race and ethnicity are often correlated with socioeconomic status in the United States due to longstanding structural and systemic biases experienced by people of color.[6] We know these biases limit access to services, quality of care, health outcomes, and social determinants of health, but this analysis was not able to directly measure the consequences of these biases. We have used race and ethnicity to approximate the impact of these biases. We also recognize diversity within different racial, ethnic, and insurance groups.

For this analysis, the authors combined race and ethnicity into a single variable that includes six categories: American Indian or Alaskan Native, Asian/Native Hawaiian or Other Pacific Islander (NHOPI), Black or African American, Hispanic or Latino(a), White, and those identifying as "Another Race". This report includes many comparisons of SBHC service utilization by different SBHC user populations defined by race and ethnicity as well as insurance status. The Foundation and Apex selected the benchmark of 10% difference between specific population groups compared to all SBHC users as indicating a notable difference (not a measure of statistical significance). Nevertheless, differences of less than 10% between groups are mentioned throughout this report as well.

The data in this report is drawn from 14 SBHC Sponsoring Organizations (SOs) that participated in the New York SBHC Data Hub in 2022-2023. They operate 60% of the State's SBHCs, so our data set does not include all of New York's SOs or SBHCs. The reader should note that statewide totals are influenced by the predominance of urban over rural SBHC users (86% vs. 14%) and Hispanic/Latino(a) SBHC users (54%) in this data. Furthermore, data for rural SBHCs largely reflects one large rural SO and may not accurately characterize all rural SBHCs. Additionally, this large rural SO does not completely report two measures to the Data Hub (body mass assessment and nutrition and physical activity counseling). Because this skews statewide and rural data totals, we have not highlighted any findings related to this measure.

The reader should also note that several racial groups are small. In total, American Indian or Alaskan Native and Asian/NHOPI together make up 5% of all SBHC users (see the SBHC Users Demographic Tables on page 28 for totals). Findings for small groups should be interpreted cautiously, as characteristics within this group may vary across different samples and the results observed in this evaluation may not represent the broader population.

Finally, we are grateful to all of our partners and funders whose commitment to health equity for New York's students supports the Foundation in building a credible evidence base and allows for initiatives such as this one. We especially want to acknowledge the funders whose generous support make this 2024 Disparities Initiative possible, specifically:

- New York Health Foundation,
- Mother Cabrini Health Foundation, and
- The Ira W. DeCamp Foundation.

STATEWIDE ANALYSIS

WHO ARE THE USERS OF NEW YORK'S SBHCS?

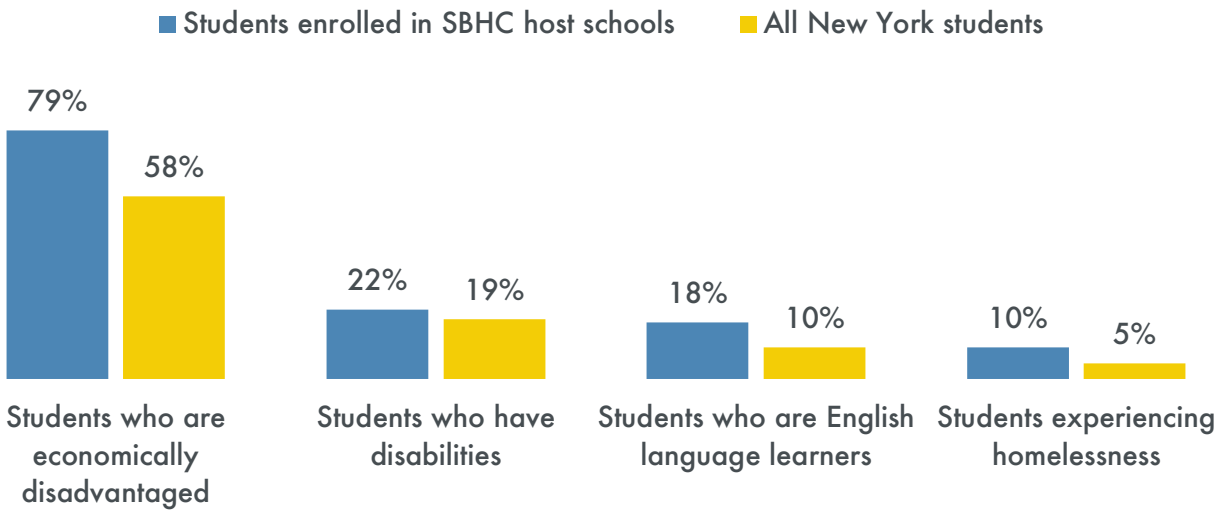
KEY TAKE-AWAYS

SBHCs are strategically located in New York's most vulnerable communities for the purpose of expanding access to healthcare, a fact reflected in our data. Therefore, unsurprisingly:

- **Students attending schools with SBHCs are more likely to be economically disadvantaged, have a disability, be an English-language learner, and experience homelessness, compared to all New York State public and charter school students**
- **SBHC users are more likely to have public insurance (i.e., Medicaid) or to be uninsured, compared to all children birth to 18 years old in New York State.**
- **Within SBHC host schools, SBHC users include more individuals who identify as Hispanic or Latino(a) and White compared to all students at the school.**
- **Notably, however, SBHC users also include fewer individuals who identify as Black or African American or Asian/NHOPI when compared to all students at the host schools. More work is needed to understand these differences.**

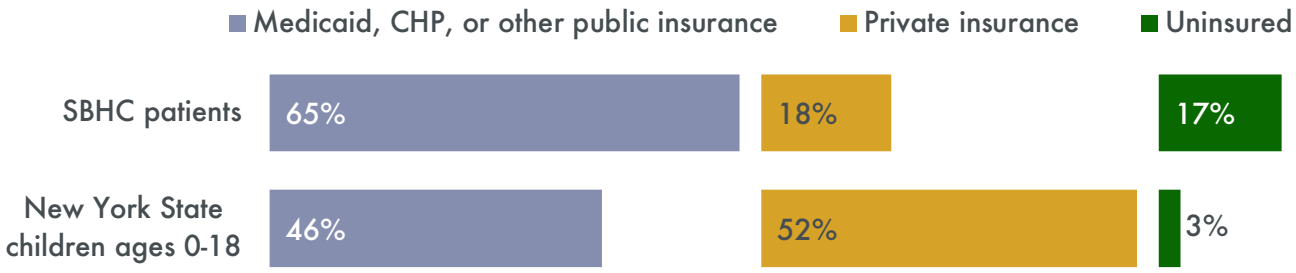
Graph 1: New York's SBHCs' host schools serve students with the greatest needs.

Students enrolled in SBHCs' host schools are more likely to be economically disadvantaged, have a disability, be an English language learner, and experience homelessness compared to all New York students, according to data from the New York State Education Department.[7] This finding reflects the mission of SBHCs to bring access to healthcare and other resources to the most vulnerable communities.



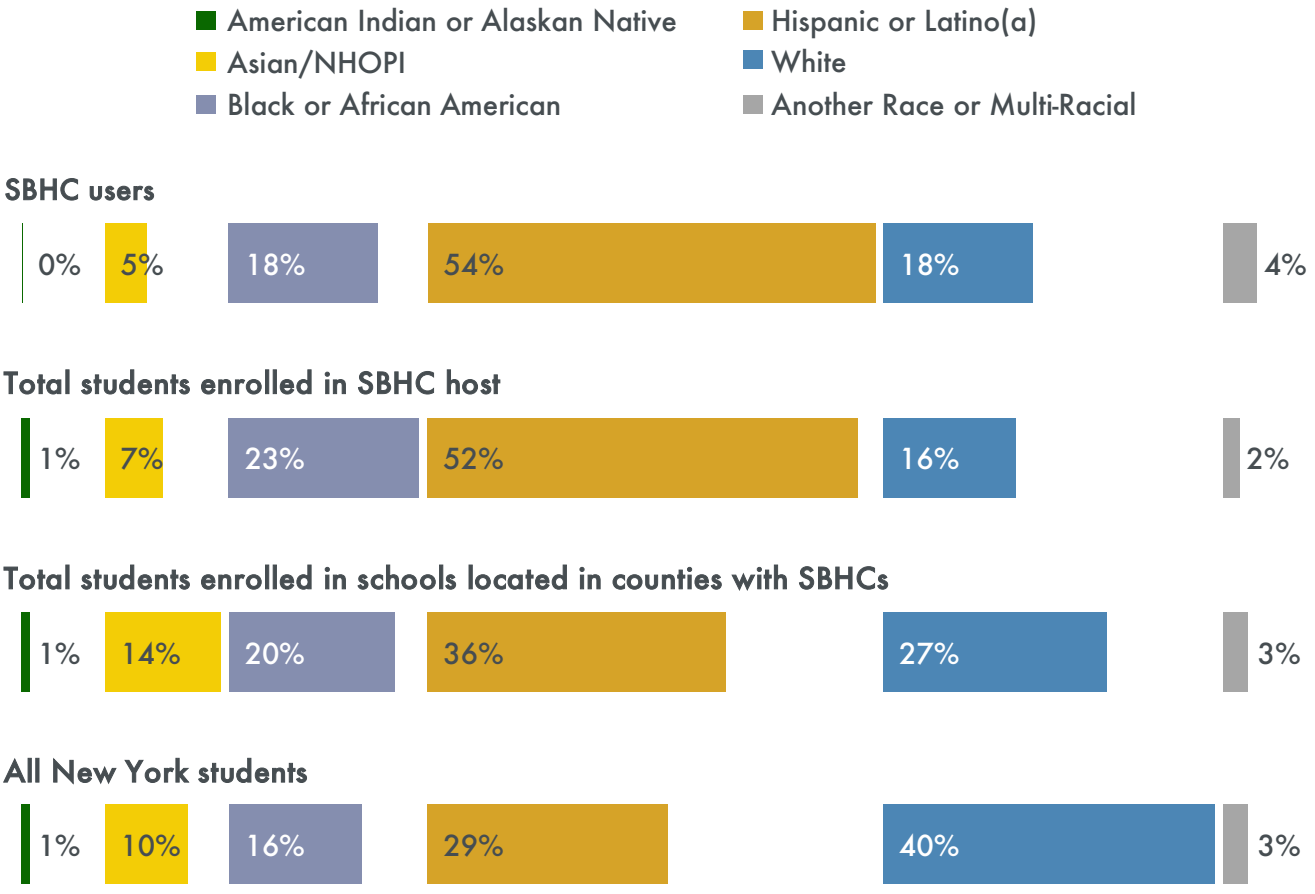
Graph 2: New York's SBHC users are more likely to have public insurance or be uninsured.

SBHC users are more likely to have public insurance (i.e., Medicaid or Child Health Plus) or to be uninsured, compared to all children in New York State based on estimates from KFF and using data from the American Community Survey.[8] Conversely, fewer SBHC users have private insurance compared to all children in New York State.



Graph 3: New York's SBHC users are more likely to be Hispanic or Latino(a).

SBHC users are more likely to be Hispanic or Latino(a), while fewer identify as Black or African American, Asian/NHOPI, and American Indian or Alaskan Native compared to their peers enrolled at the SBHC host schools. More work is needed to understand these differences and to support all students in getting the care and support they need.



HOW DOES SBHC USE DIFFER BY INSURANCE STATUS?

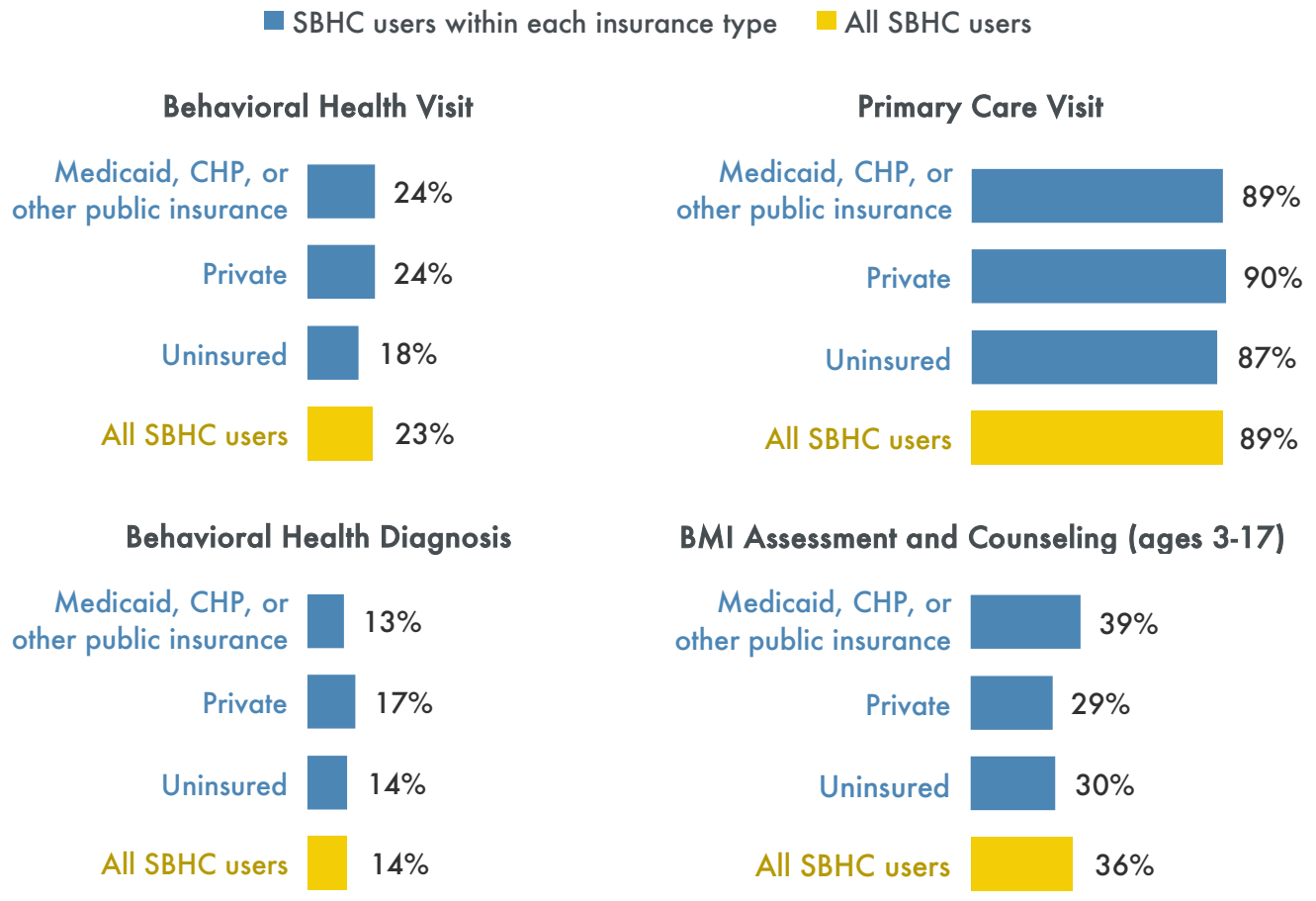
KEY TAKE-AWAY

Uninsured SBHC users appear to receive fewer services than their insured peers.

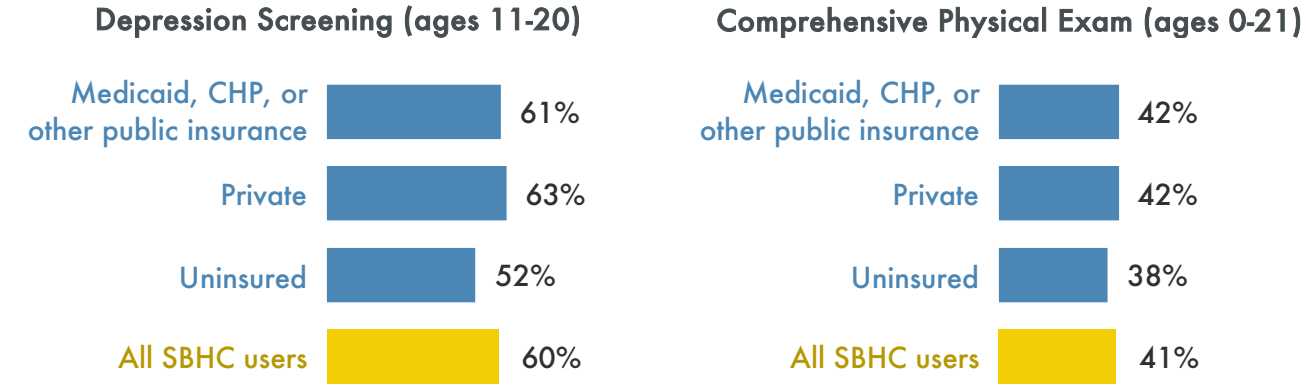
Note on the data: We measured the percent of SBHC users with each insurance type who received behavioral health visits, primary care visits, behavioral health diagnoses, body mass index (BMI) assessments and nutrition and physical activity counseling, depression screening, and comprehensive physical exams. The last three services are performance measures defined by the National School-Based Health Alliance[9] and are identified as priorities for healthcare for children and adolescents. As stated in the Introduction, differences observed for BMI assessment and nutrition and physical activity counseling are not described here, given concerns about missing data for rural SBHCs.

Graph 4: Uninsured SBHC users appear to receive fewer services.

Uninsured SBHC users appear to receive fewer services than their insured peers, specifically: behavioral health visits; primary care visits; depression screenings; and comprehensive physical exams. While often small, differences may signal important gaps in care and warrant further evaluation. This graph shows the types of services received by SBHC users within each insurance type compared to services received by all SBHC users.



Graph 4 (continued)



HOW DOES SBHC USE DIFFER BY RACE AND ETHNICITY?

KEY TAKE-AWAYS

- **SBHC users utilize services differently by race and ethnicity as well, particularly for two important preventive services – depression screening and comprehensive physical exams.**
- **Hispanic or Latino(a) SBHC users constitute more than half of all SBHC users and thus influence data on total statewide SBHC utilization.**
- **The percentage of SBHC users receiving primary care visits was high across all racial and ethnic groups, averaging 88% for all SBHC users.**

Note on the data: We measured the percent of SBHC users in each race and ethnicity group who received behavioral health visits, primary care visits, behavioral health diagnoses, BMI assessments and nutrition and physical activity counseling, depression screening, and comprehensive physical exams. Again, differences observed for BMI assessment and nutrition and physical activity counseling are not described here, given concerns about missing data for rural SBHCs.

Different racial and ethnic groups utilize SBHC services differently. Below we summarize by listing differences of 10% or more for each racial/ethnic group when compared to all users.

American Indian or Alaskan Native SBHC users, who make up less than 1% of all SBHC users, were
↑ More likely to receive a behavioral health diagnosis,
↓ Less likely to receive a depression screening, and
↓ Less likely to receive a comprehensive physical exam.

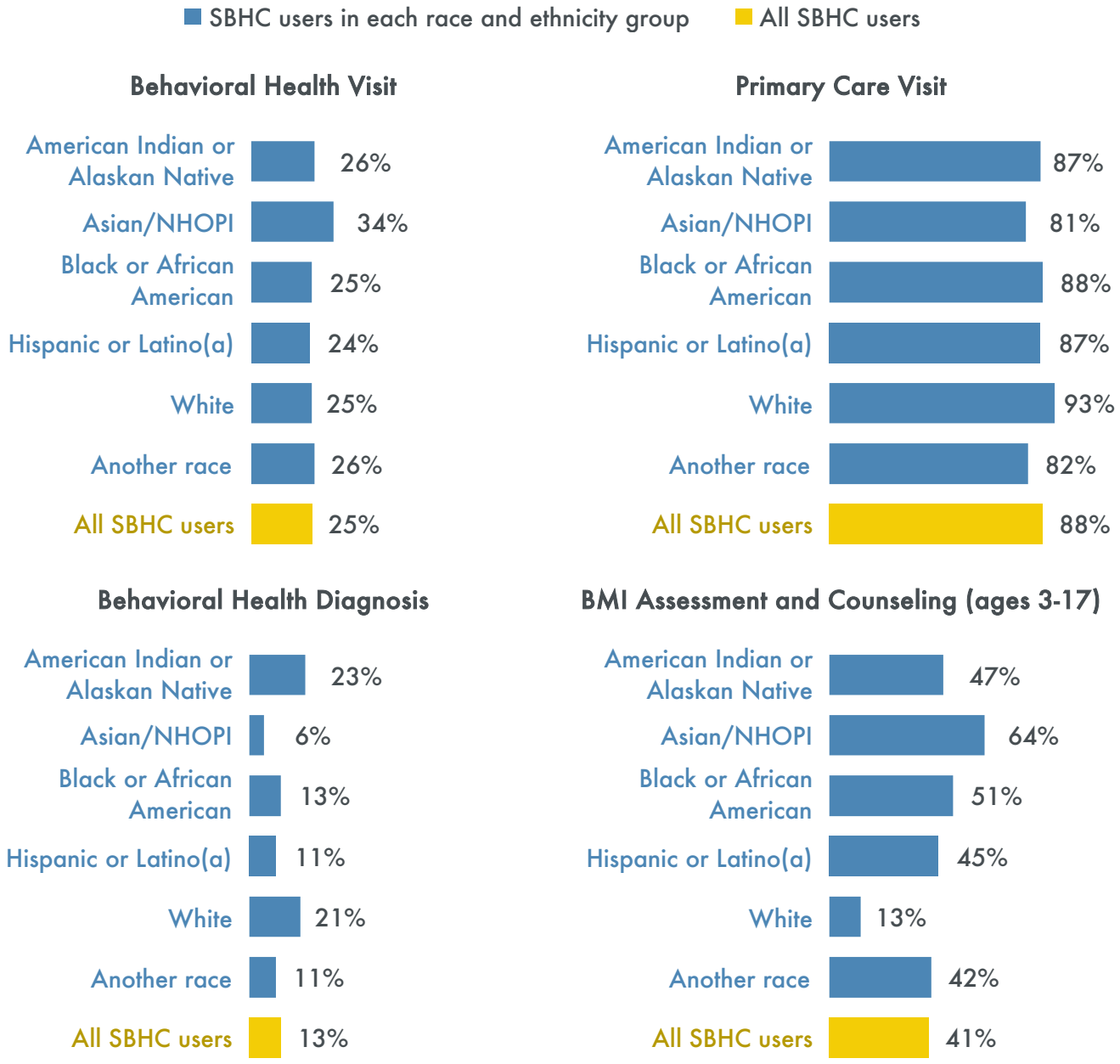
Asian/NHOPI SBHC users, constituting 5% of all SBHC users, were
↑ More likely to receive a depression screening, and
↓ Less likely to receive a comprehensive physical exam.

White SBHC users, who are 18% of all SBHC users, were
↑ More likely to receive a comprehensive physical exam.

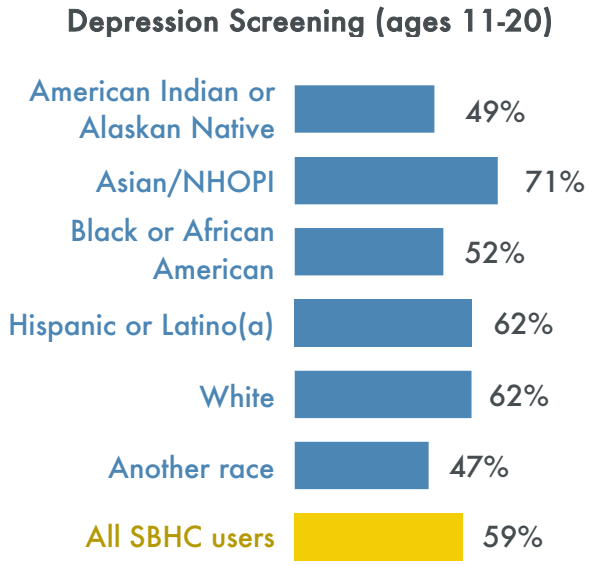
SBHC users indicating "Another Race," who comprise 4% of all SBHC users, were
↓ Less likely to receive a depression screening and
↓ Less likely to receive a comprehensive physical exam.

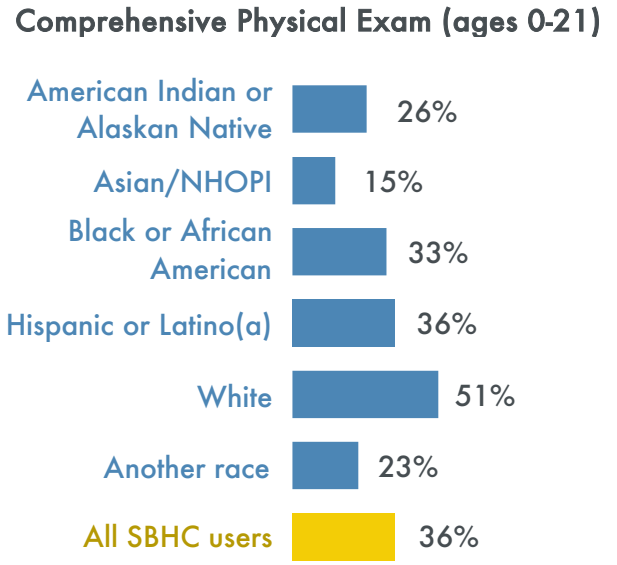
Graph 5: Types of SBHC visits appear to differ by race and ethnicity.

Graph 5 includes data for all groups, and differences of less than 10% are observed as well. Again, note that total statewide utilization is influenced by the majority of Hispanic or Latino(a) SBHC users who make up more than half of all SBHC users in our data. Thus Graph 5 below shows no differences greater than 10% between total SBHC users and their Hispanic/Latino(a) counterparts.



Graph 5 (continued)

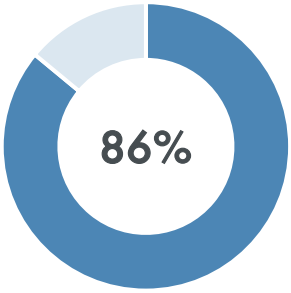




URBAN VS. RURAL ANALYSIS

KEY TAKE-AWAYS

- Urban and rural SBHC users represent notably different demographic groups and SBHCs tailor their services to meet patients' needs in their diverse communities.
- 86% of SBHC users in this data set receive care at urban SBHCs, which reflects the percentage of all New Yorkers who live in urban areas as well.[10] The predominance of urban SBHC users influences statewide totals in this data. Data for rural SBHCs tells a different story, and therefore most of the findings in this section focus on rural SBHCs.
- However, urban SBHC data exhibits a few clear differences from the statewide totals presented earlier in this report. Specifically, while White SBHC users represent only 5% of urban users, they constitute 90% of rural SBHC users. Further, White urban SBHC users receive care from SBHCs differently than their White rural counterparts. For example, White urban SBHC users are more likely to use SBHC behavioral health services than White rural SBHC users.
- In rural SBHCs, uninsured users are as likely to receive care as insured users. Small gaps in care may exist for uninsured users in urban SBHCs where they are less likely to receive some services than their insured counterparts.
- In urban SBHCs, White and Asian/NHOPI users are the highest users of behavioral health care; while in rural areas, they are among the lowest. Further, Black or African American and American Indian or Alaskan Native users are the highest users of behavioral health care in rural areas.
- In rural areas, depression screening is lowest for White and Black or African American SBHC users, with only users who indicate "Another Race" receiving fewer screenings. However, in urban areas, depression screening is lowest for Black or African American users, American Indian or Alaskan Native users, and users who indicate "Another Race".
- Utilization of primary care is high for all users, in both rural and urban settings. There is lower utilization of comprehensive physical exams overall as well as more variation across race and ethnicity user groups and rural and urban locations for this service.

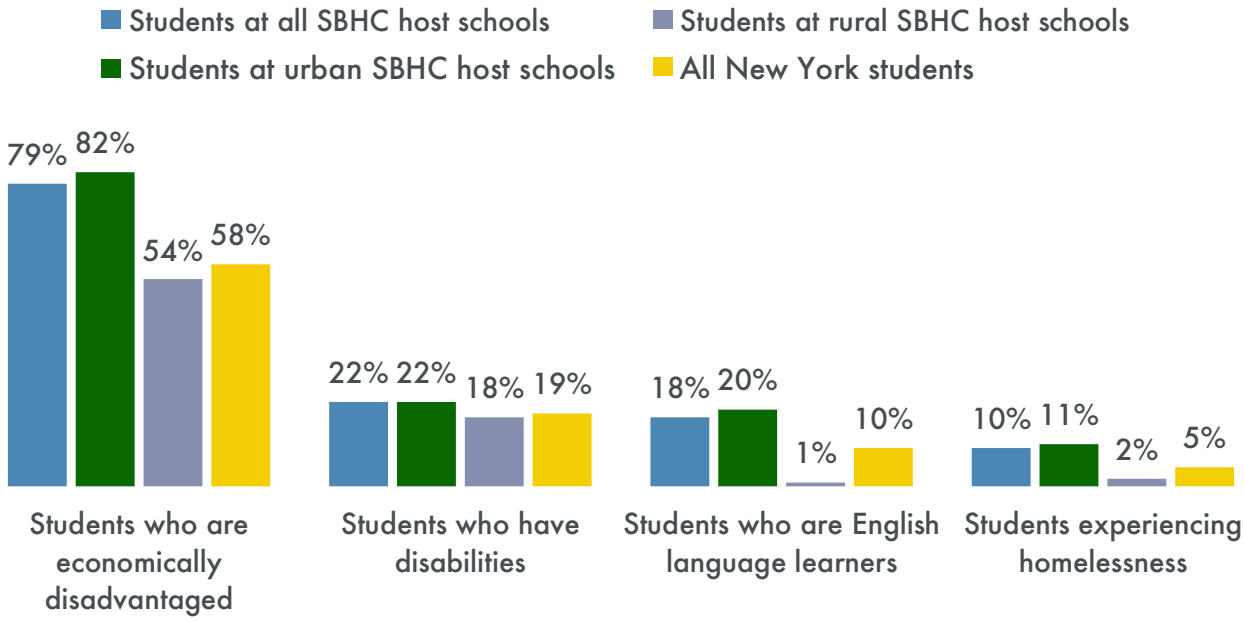


86% of SBHC users in this data set receive care at urban SBHCs. 80% of all New Yorkers live in urban areas.[10]

HOW DO RURAL AND URBAN SBHC USERS DIFFER?

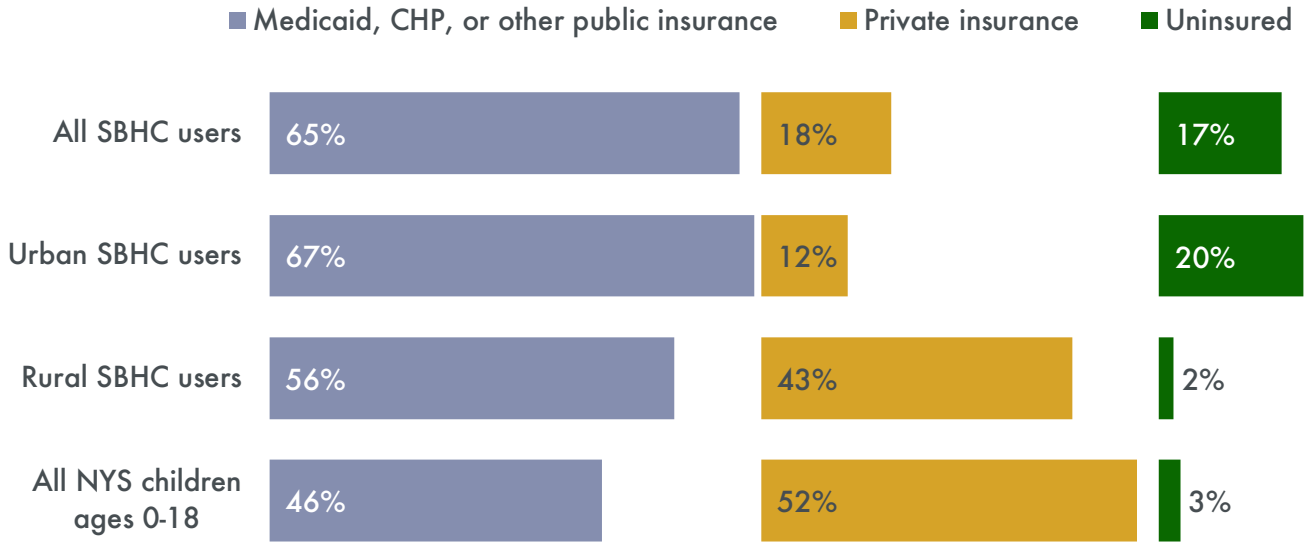
Graph 6: Fewer students at rural SBHC host schools are economically disadvantaged.

Fewer students at rural SBHC host schools are economically disadvantaged, have a disability, are an English language learner, or experience homelessness when compared to students at all SBHC host schools, students at urban SBHC host schools, and all New York students.



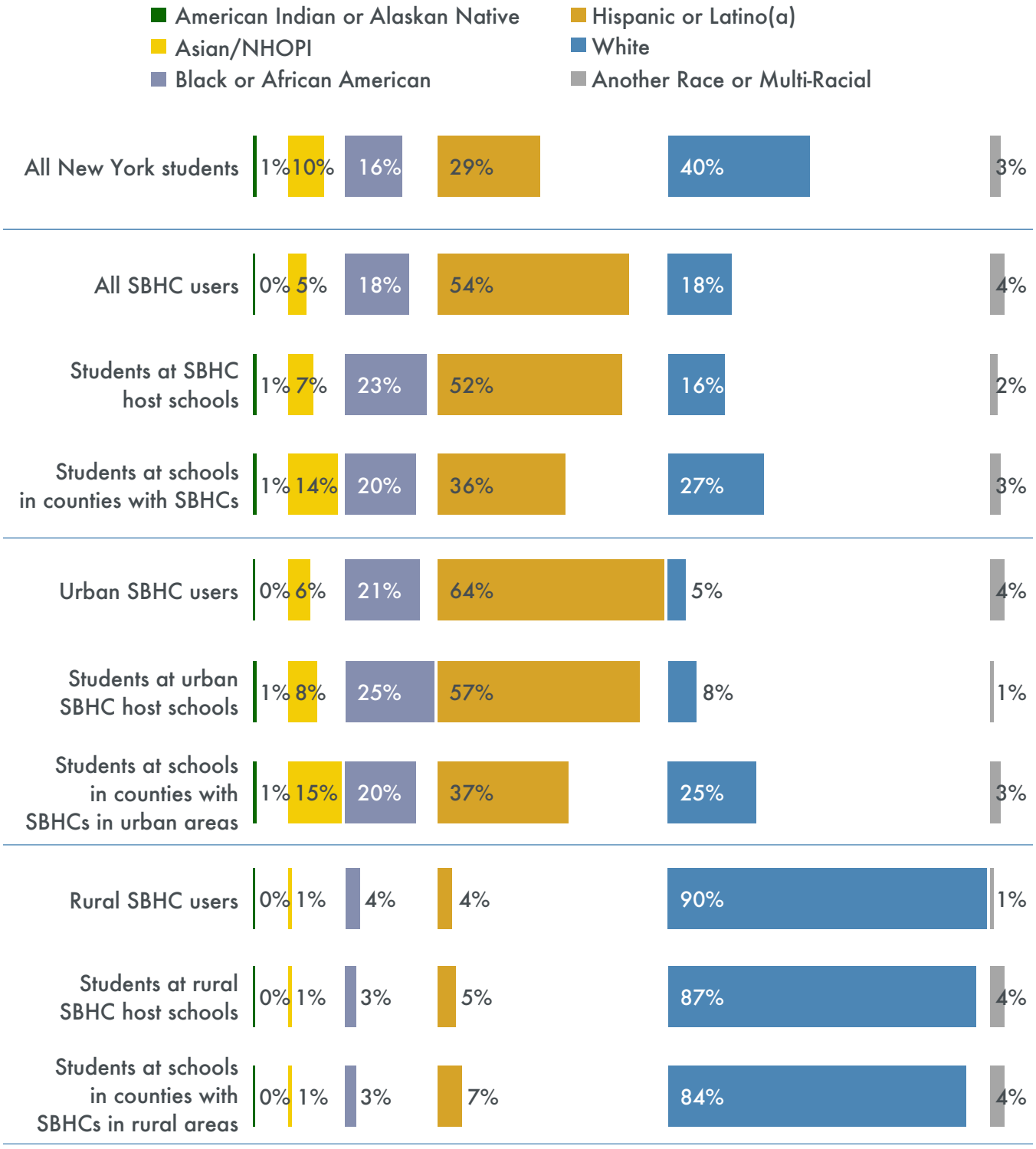
Graph 7: Urban and rural SBHC users differ in their insurance status.

Rural SBHC users have less public insurance and more private insurance than their urban counterparts. Far fewer are uninsured. This graph shows percent of SBHC users with each insurance type – Medicaid, CHP, or other public insurance; private insurance; and uninsured- including for all SBHC users, urban SBHC users, and rural SBHCs users when compared to all children in New York State (NYS) aged 0 – 18 years old.



Graph 8: Rural SBHC users are overwhelmingly White.

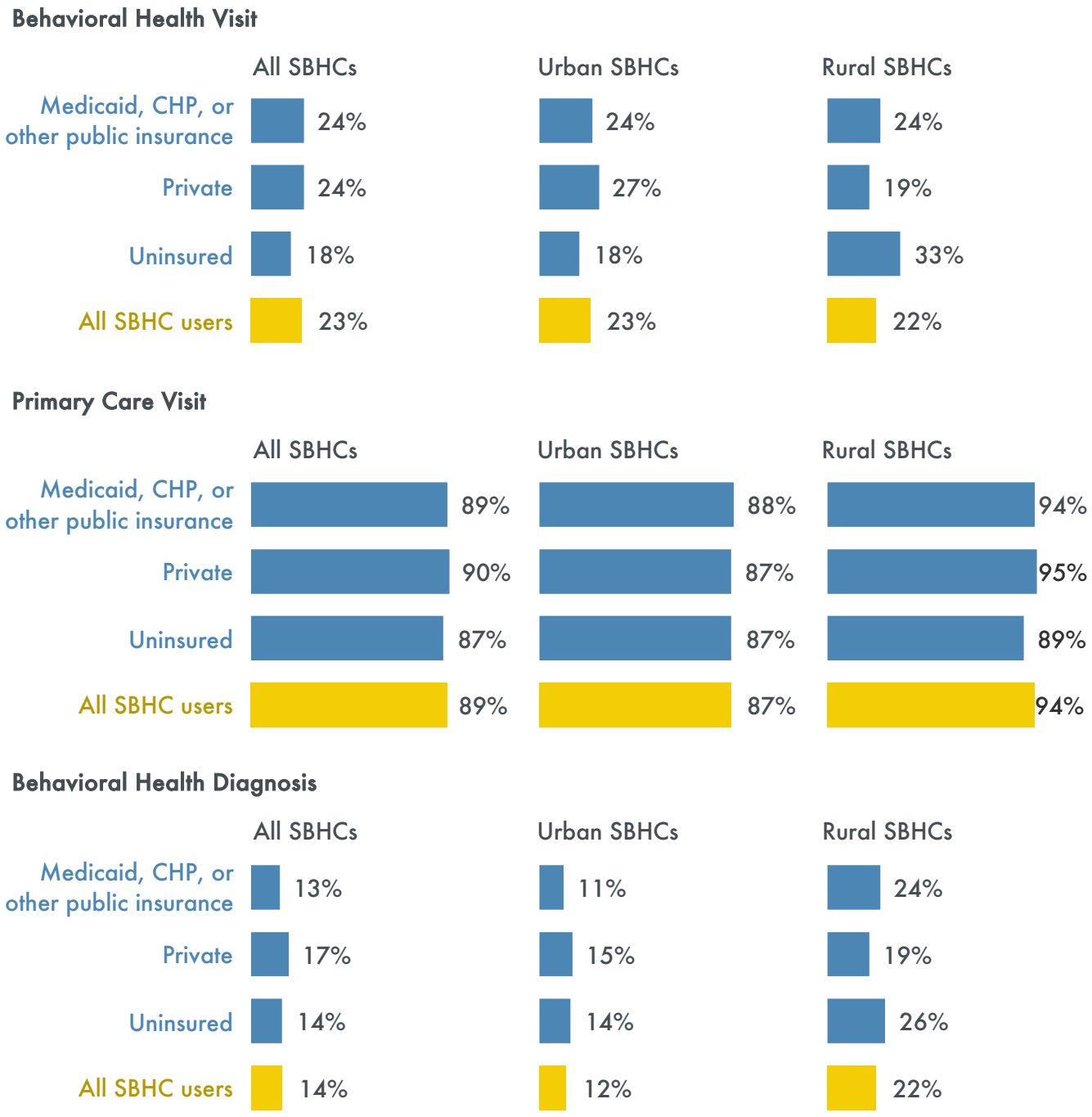
Rural SBHC users are overwhelmingly White, reflecting the rural population, while urban SBHC users are heavily Hispanic or Latino(a) or people of color. Graph 8 shows race and ethnicity of SBHC users (including urban, rural, and all SBHC users), compared to students at SBHC host schools, students at schools in counties with SBHCs, and all New York students.



HOW DOES SBHC USE VARY BY INSURANCE STATUS AND SITE TYPE?

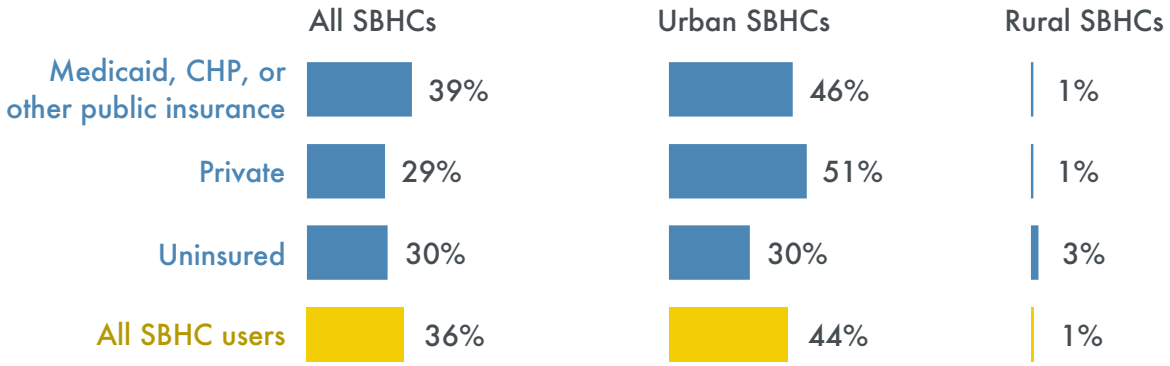
Graph 9: Rural and urban SBHC users with the same insurance use SBHC services differently.

Unlike their insured and uninsured urban counterparts, few disparities appear to exist between insured and uninsured rural SBHC users.

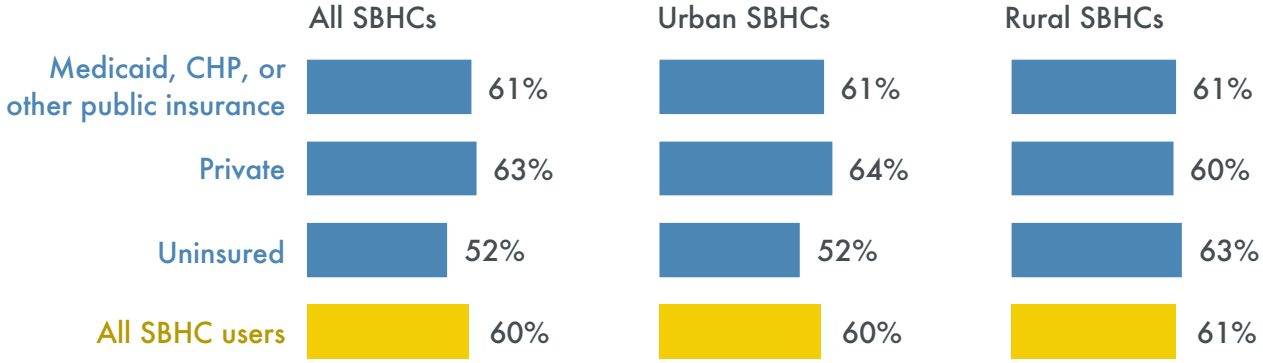


Graph 9 (continued)

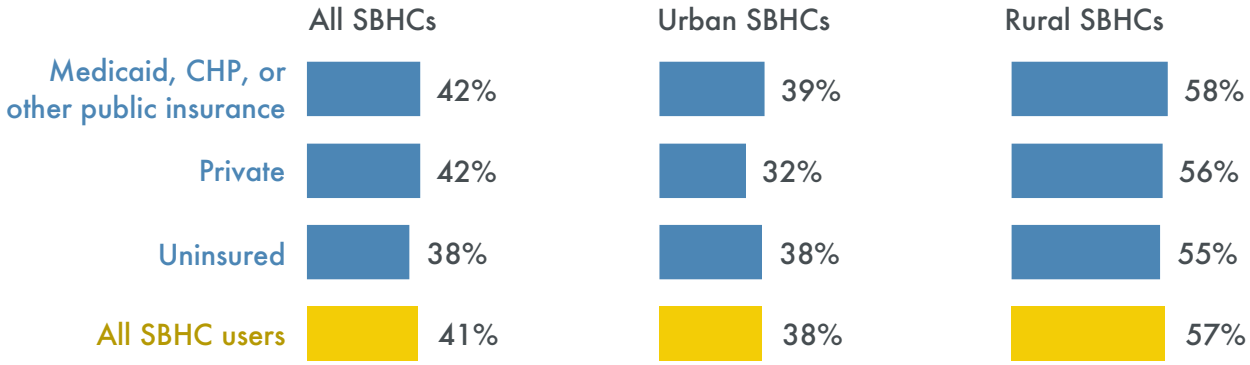
BMI Assessment and Counseling (ages 3-17)*



Depression Screening (ages 11-20)



Comprehensive Physical Exam (ages 0-21)

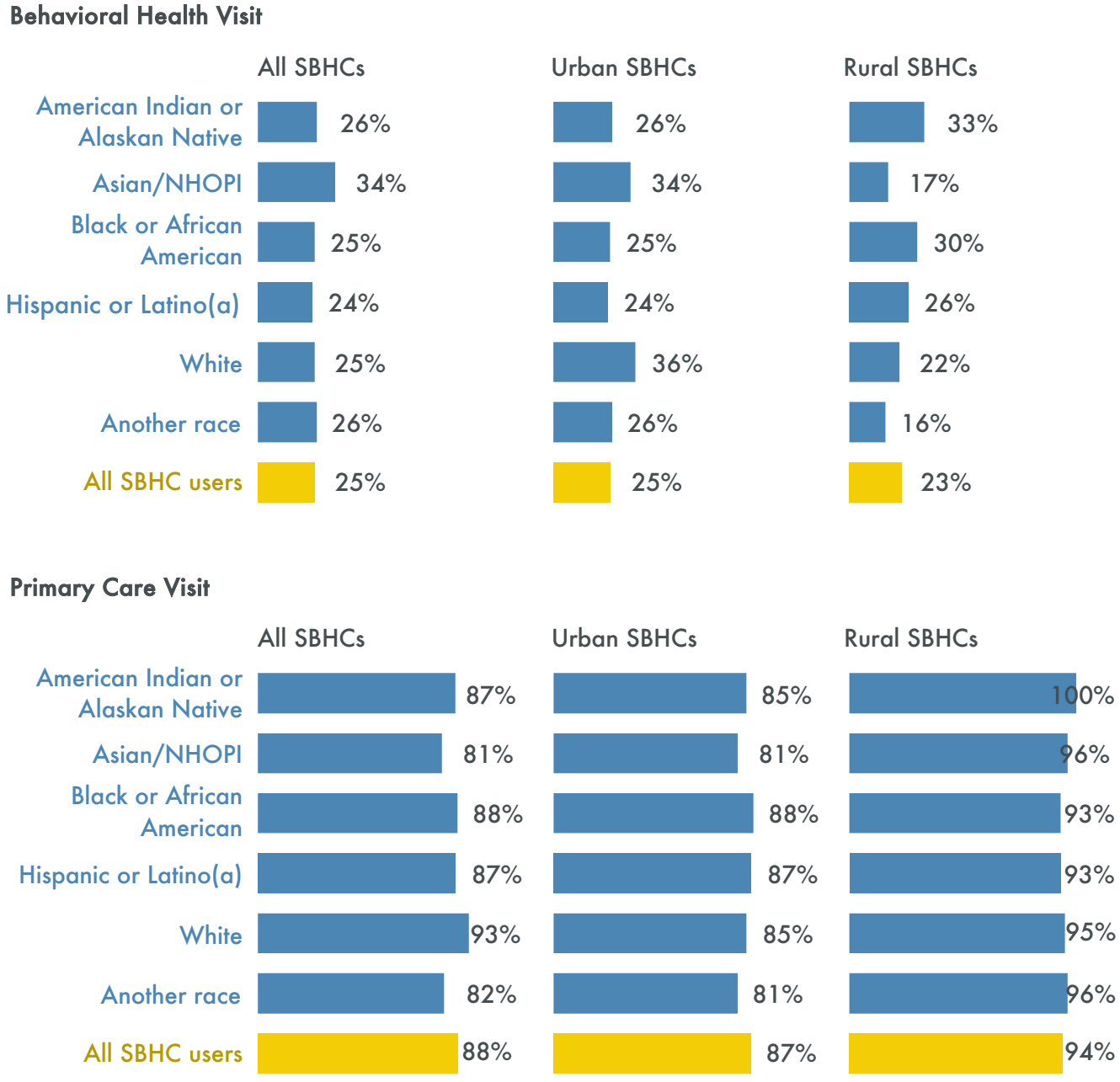


*One large rural SO does not completely report BMI assessment and nutrition and physical activity counseling. We have not highlighted any findings related to this measure in this report because the statewide and rural data totals are skewed by the missing data. The data for this measure for urban SBHCs included on this page is correct and reflects differences in how this service is provided by SBHC user insurance status.

HOW DOES SBHC USE VARY BY RACE, ETHNICITY, AND SITE TYPE?

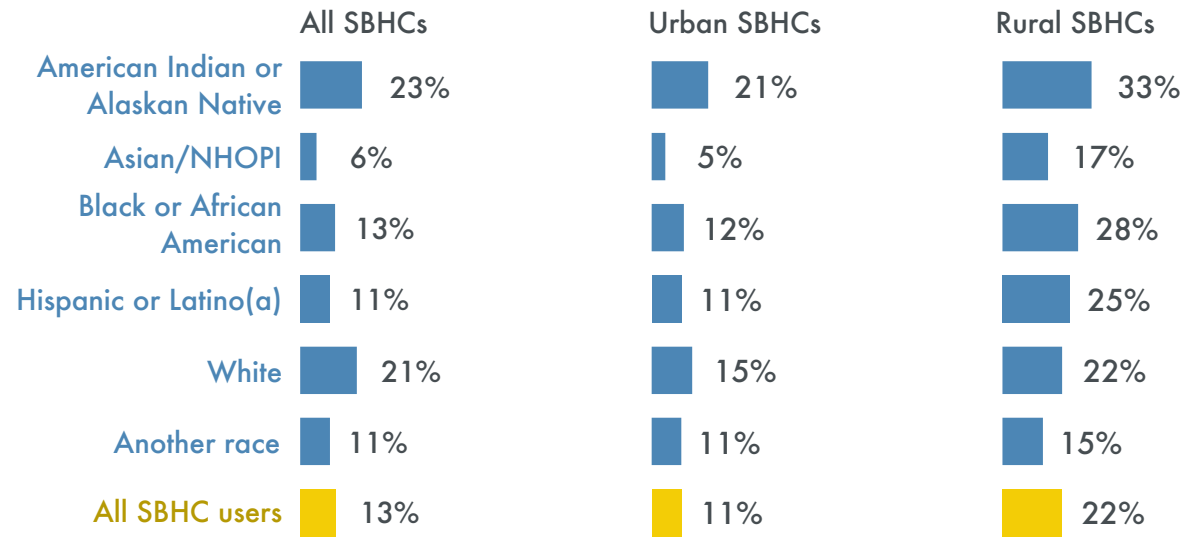
Graph 10: Urban and rural SBHC users from different races and ethnicities use SBHC services differently.

This graph shows the percentage of SBHC users in each race and ethnicity group who received a service compared to the percentage of all SBHC users who received the service for urban, rural, and all SBHCs.

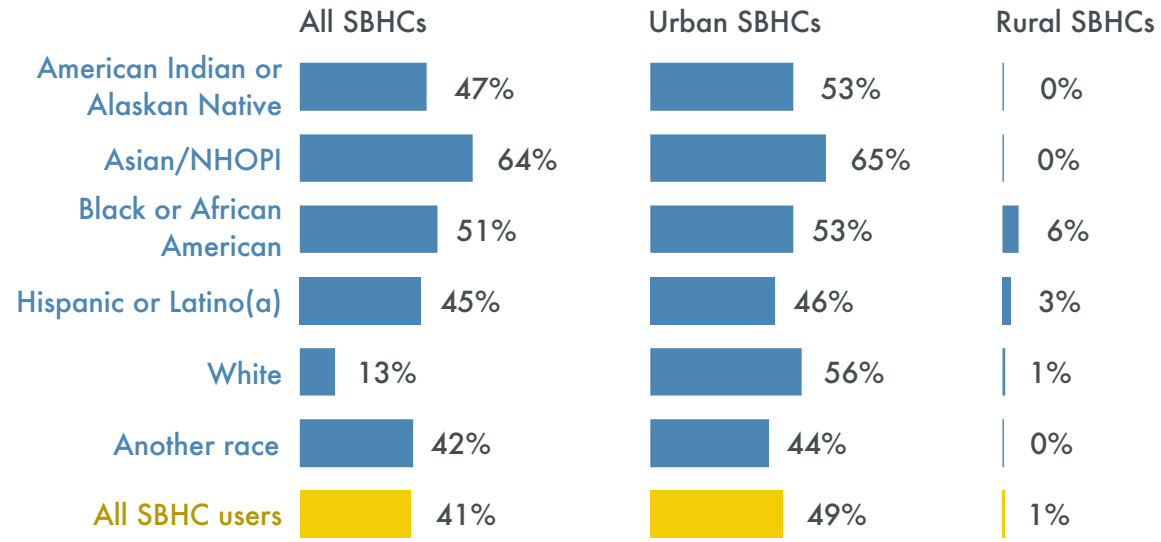


Graph 10 (continued)

Behavioral Health Diagnosis



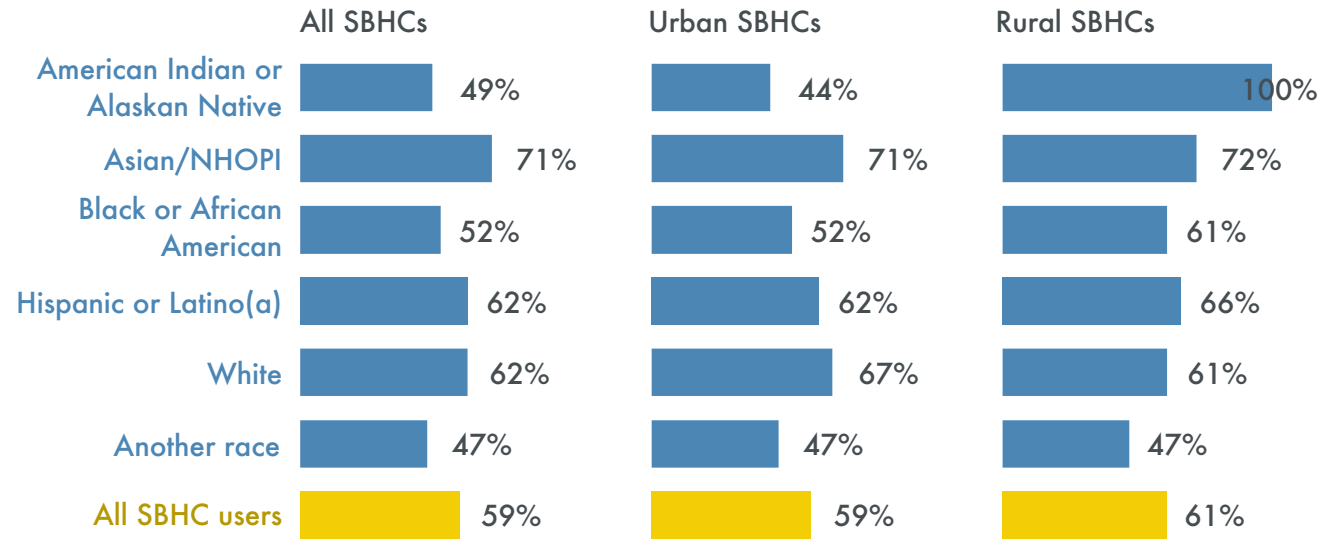
BMI Assessment and Counseling (ages 3-17)*



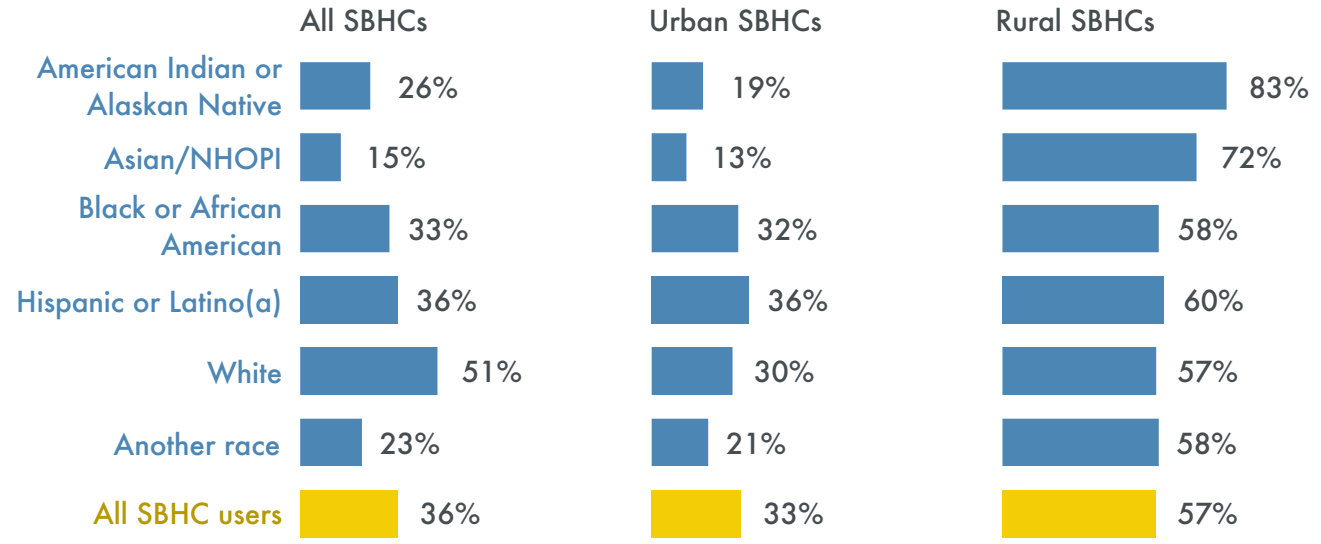
*One large rural SO does not completely report BMI assessment and nutrition and physical activity counseling. We have not highlighted any findings related to this measure in this report because the statewide and rural data totals are skewed by the missing data. The data for this measure for urban SBHCs included on this page is correct and reflects differences in how this service is provided by SBHC user insurance status.

Graph 10 (continued)

Depression Screening (ages 11-20)



Comprehensive Physical Exam (ages 0-21)



DISCUSSION AND ACTIONS

KEY TAKE-AWAY

SBHC sponsoring organizations have an opportunity to learn from their users, families, and other individuals in their communities about student and family experiences, beliefs, and external resources that may influence how individuals use the health care resources.

Data can point out differences, and this report provides an excellent starting point for reducing disparities. The next step, however, is better understanding the world this data represents, the lived experiences of the individuals included, and the possible levers for change.

Data cannot reflect the more nuanced realities of disparities as they are experienced by SBHC users and their communities, much less their causes and remedies. Data is only the beginning of the journey – student and family experiences, beliefs, and external resources (i.e., availability of health care services and supportive services such as transportation) also influence how individuals decide to use health care. Data provides SOs the opportunity to learn from their users, families, and communities.

All New York SOs participating in the SBHC Data Hub Program in 2022-2023 received a report with disparities specific to their own SBHC populations. The Foundation is supporting them in developing and implementing disparity action plans based on that data. By the end of 2024, this work was still in progress and common themes were emerging. For example, where the participating SOs found…

- Lower utilization of the SBHC for a particular race or ethnicity group compared to host school population, their action plans point to outreach and further information-gathering.
- Lower completion rates of depression screening for some racial/ethnic groups, their action plans are focusing on changes in workflow and/or data collection.
- Inaccuracies in insurance data, their action plans call for testing to identify source of errors, review and correction of data mapping algorithms and/or inclusion of additional data sources.
- Missing data on race, their action plans call for revisions to the forms used to gather this data from students and parents (including additional choices for race/ethnicity).

The Foundation and Apex are also considering next steps in our evaluation of disparities which will depend on resources available. This may include calculating additional quantitative measures of disparities and collecting data to more directly measure the impact of social determinants of health, as well as biases on access to services, quality of care, and health outcomes. More information about possible next steps for the evaluation is included below in the Technical Manual.

Finally, data from the SBHC Data Hub focuses largely on access and quality but is insufficient to assess outcomes. Notably, it lacks data on the comparable experiences of non-SBHC users. Neither does it identify services SBHC students may be receiving in the community. With support from our funders, the Foundation is deep in a pilot to access such data. If successful, this pilot will not only delve into SBHC outcomes, but identify gaps in students' care, regardless of where they receive it.

TECHNICAL MANUAL

ABOUT THIS EVALUATION

This report was prepared by Apex Evaluation. Apex is an evaluation consulting firm specializing in systems evaluation. Apex has worked in the education, health, and social service sectors for nearly two decades. Apex provides program planning, evaluation, facilitation, and technical assistance for a wide range of initiatives that address social conditions that pose barriers to individual, organizational, and community success.

Apex's approach to this work is guided by the Apex Blend[11], a combination of theories and methods to inform and guide practice. Three aspects of the Apex Blend were particularly important in this evaluation: Systems Learning™, utilization-focused evaluation, and equitable evaluation. The evaluation deliverables and learning that resulted from this work is born of our positionality, rooted in systems thinking, and optimized for equity; is designed for the target audience and includes actionable data to support change; and is the product of our work to build a body of credible evidence that links data with a diversity of perspectives, prioritizing those closest to the work and those most affected by the work.

This evaluation resulted in two types of evaluation deliverables. Apex has prepared this narrative report that describes disparities observed in statewide aggregate data including all fourteen participating SBHC operators as well as any differences between data for SBHC operators in urban areas and those in rural areas. Then, Apex prepared visualized data reports from a template for each of fourteen participating SBHC SOs.

The SBHC Data Hub imports or collects granular data at frequent intervals, allowing us to do more with data. Participating SBHCs in New York have submitted electronic health record encounter data to the Data Hub since 2020. This data includes SBHC user demographics and encounter information such as provider type and diagnoses and procedure codes for all visits that occurred at the SBHCs. The New York State Education Department provides enrollment data on student demographics and socio-economic factors for students at all public and charter schools in New York State. Data from the Apex Data Hub and the New York State Education Department represents services and students in the 2022-2023 state fiscal year.

The authors used the chi-square test to identify if race and ethnicity as well as insurance status are related to the six measures of utilization included in this report at the statewide level. The results revealed that race and ethnicity as well as insurance are related to all six measures – these variables are not independent – at a statically significant level ($p < 0.05$). We should proceed with caution in interpreting the results of these statistical analyses. Statistical significance tells us whether a result is unlikely to have occurred by chance and this is separate from the work to identify how meaningful or important the result is in practice. Because our dataset is very large (at least 40,000 users are included in each one of the statewide analyses), even very small differences or relationships can appear statistically significant. This means that while the numbers tell us there's a relationship, it might not be a meaningful one in practice. In addition to looking at whether the results are statistically significant, we should ask ourselves whether these results suggest an important connection that we can act on.

It is challenging to collect data on health and other well-being outcomes for SBHC users and students, so this evaluation was not able to address a third evaluation question about disparities in how users experience the outcomes that result from school-based health care. This is a priority area for this and other SBHC evaluations in the future.

FUTURE EVALUATION WORK

A next step for the evaluation of disparities in school-based health care, as funding allows, may include measuring disparities using a rate of disproportionality and a relative rate index[12]. The rate of disproportionality is a ratio of a specific demographic group's representation at two points in their engagement with a program or process. The relative rate index normalizes the rate of disproportionality for each demographic group relative to the most resourced group in the population and is calculated by dividing the rate of disproportionality for each demographic group by the rate of disproportionality for the most resourced group. The measures are calculated using these formulas:

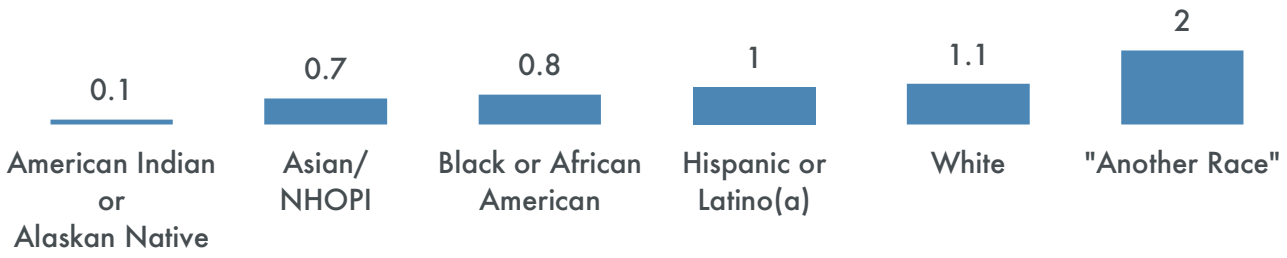
$$\text{Rate of Disproportionality} = \frac{\text{Demographic group's representation at a point in a program/process}}{\text{Same demographic group's representation at an earlier point}}$$

$$\text{Relative Rate Index} = \frac{\text{Rate of disproportionality for a demographic group}}{\text{Rate of disproportionality for the most resourced group}}$$

Here is an example using data from this report.

Graph 11: There were 0.1 times fewer American Indian or Alaskan Native SBHC users, 0.7 times fewer Asian/NHOPI SBHC users, and 0.8 times fewer Black or African American SBHC users compared to the students of SBHC host schools. There were 2 times more SBHC users who indicate "Another Race" compared to the students of SBHC host schools.

This graph includes the rate of disproportionality for SBHC users by comparing the representation of each race and ethnicity group at two "points". The first "point" represents students at the host school for whom SBHC services were available and the second "point" is users – students who actually do use the SBHC. A value of 1 means the representation is proportional for this group across the two points – individuals in this group are represented proportionally as students at the host school and users of the SBHC. Values greater than or less than 1 are disproportional – individuals in these groups are more (greater than 1) or less (less than 1) likely to be represented as a user of the SBHC than they are as a student at the host school.



The data used to calculate this rate of disproportionality is the same as the data in Graph 3, which compares the representation of SBHC users by race and ethnicity to that of students of the SBHC host school. The rate of disproportionality may be easier to understand than comparing percentages across multiple population groups (as is done in Graph 3). The rate of disproportionality can also be calculated to identify disparities in utilization of specific services.

Table 1: Showing Rate of Disproportionality Calculations (this is the same data that is in Graph 3)

Race or Ethnicity Group	Percent of SBHC users in this group	Percent of host school students in this group	Rate of Disproportionality
American Indian or Alaskan Native	0.1%	0.7%	0.1
Asian/NHOPI	5%	7%	0.7
Black or African American	18%	23%	0.8
Hispanic or Latino(a)	54%	52%	1.0
White	18%	16%	1.1
"Another Race"	4%	2%	2.0

Graph 12: Compared to White students, American Indian or Alaskan Native students were 0.1 times less likely to use the SBHC, Asian/NHOPI students were 0.6 times less likely to use the SBHC, Black or African American students were 0.7 times less likely to use the SBHC, and Hispanic or Latino(a) students were 0.9 times less likely to use the SBHC. Additionally, compared to White students, students who identify as "Another Race" are 1.8 times more likely to use the SBHC.

This graph includes the relative rate indices for students by comparing the rate of disproportionality from Graph 11 for students of color to White students. The relative rate index normalizes the rate of disproportionality for each group relative to the group that is most resourced (which we are defining as White students for the purpose of this example).

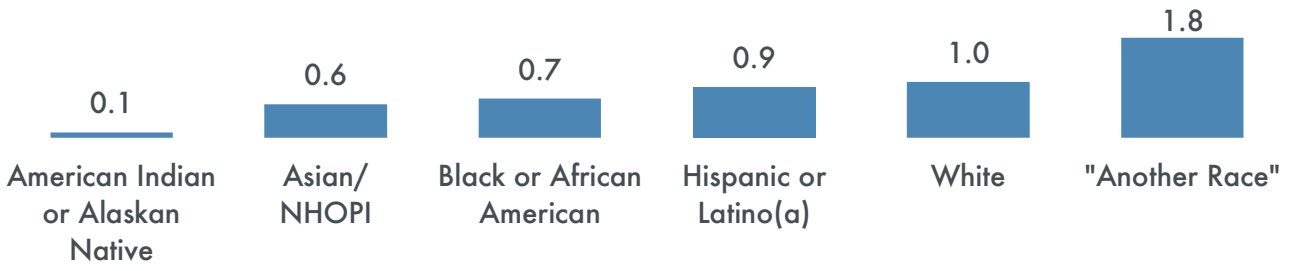


Table 2: Showing Relative Rate Index Calculations

Race or Ethnicity Group	Rate of disproportionality for this group	Rate of disproportionality for the most privileged group	Relative Rate Index
American Indian or Alaskan Native	0.1	1.1	0.1
Asian/NHOPI	0.7	1.1	0.6
Black or African American	0.8	1.1	0.7
Hispanic or Latino(a)	1.0	1.1	0.9
White	1.1	1.1	1
"Another Race"	2.0	1.1	1.8

Another next step for the evaluation is to collect additional data points to measure the impact of biases. One example of an additional data point may be the zip code of the SBHC user's primary residence, which we may use to understand distance to the SBHC and other places to receive healthcare. Data on SBHC users' families' socioeconomic status would be helpful to understand the resources available to families' for accessing health care services or barriers in place that prevent accessing services.

SBHC USERS: DEMOGRAPHIC TABLES

SBHC users who had missing insurance information or race and ethnicity information were excluded from the respective analyses, which is reflected in the total number of SBHC users in each table in this section. For more information about how users were excluded, see the "Excluded Data" section on page 32 in the Technical Manual.

All SBHCs User Insurance		
Insurance Status	N	% of Population
Medicaid, CHP, or other public insurance	31,148	65%
Private	8,529	18%
Uninsured	8,089	17%
Total	47,766	100%

Urban SBHCs User Insurance		
Insurance Status	N	% of Population
Medicaid, CHP, or other public insurance	26,401	67%
Private	4,883	12%
Uninsured	7,948	20%
Total	39,232	99%*

Rural SBHCs User Insurance		
Insurance Status	N	% of Population
Medicaid, CHP, or other public insurance	4,747	56%
Private	3,646	43%
Uninsured	141	2%
Total	8,534	101%*

*Does not sum to 100% due to rounding.

All SBHCs User Race and Ethnicity		
Race and Ethnicity	N	% of Population
American Indian or Alaskan Native	53	0%
Asian/NHOPI	2,780	5%
Black or African American	10,010	18%
Hispanic or Latino(a)	29,680	54%
White	9,856	18%
Another Race	2,170	4%
Total	54,549	99%*

Urban SBHCs Patient Race and Ethnicity		
Race and Ethnicity	N	% of Population
American Indian or Alaskan Native	47	0%
Asian/NHOPI	2,698	6%
Black or African American	9,699	21%
Hispanic or Latino(a)	29,358	64%
White	2,197	5%
Another Race	2,070	4%
Total	46,069	100%

*Does not sum to 100% due to rounding.

Rural SBHCs User Race and Ethnicity		
Race and Ethnicity	N	% of Population
American Indian or Alaskan Native	6	0%
Asian/NHOPI	82	1%
Black or African American	311	4%
Hispanic or Latino(a)	322	4%
White	7,659	90%
Another Race	100	1%
Total	8,480	100%

REFERENCES

1. Centers for Disease Control and Prevention. (2023, May 26). *Health disparities*. https://www.cdc.gov/healthyyouth/disparities/index.htm#1
2. National Association of Colleges and Employers. (n.d.). *Equity*. https://www.naceweb.org/about-us/equity-definition
3. New York City Health Department. (n.d.). (rep.). *Race to Justice Glossary*. Retrieved August 6, 2024, from https://www.nyc.gov/assets/doh/downloads/pdf/dpho/race-to-justice-action-kit-glossary.pdf.
4. Apex Evaluation. (n.d.) *Apex Data Hub*. https://apexeval.org/our-services/school-based-health-center-data-hub/
5. New York State Education Department. (n.d.) *NY State Data*. https://data.nysed.gov/
6. Braveman, P. A., Arkin, E., Proctor, D., Kauh, T., & Holm, N. (2022). Systemic and structural racism: Definitions, examples, health damages, and approaches to dismantling. *Health Affairs*, *41*(2), 171–178. https://doi.org/10.1377/hlthaff.2021.01394
7. New York State 2022-23 Enrollment Database. Accessed April 29, 2024 from https://data.nysed.gov/downloads.php.
8. KFF estimates based on the 2008-2022 American Community Survey: Health Insurance Coverage of Children 0 – 18. Accessed May 3, 2024 from https://www.kff.org/other/state-indicator/children-0-18.
9. School-Based Health Alliance. (2023, April). *STANDARDIZED PERFORMANCE MEASURES FOR SBHCs*. Retrieved September 18, 2024 from https://sbh4all.org/wp-content/uploads/2023/09/Quality-Counts-Standardized-Performance-Measures-Definitions_2023.pdf.
10. Ratcliffe, M. (2022, October 6). *Census Bureau's Urban and Rural Classification and Overview of 2020 Urban Area Criteria*. New York State Data Center Affiliates Meeting. Accessed January 15, 2025 from https://dol.ny.gov/system/files/documents/2022/11/urban-rural-classification-and-2020-urban-area-criteria-slides.pdf.
11. Apex Evaluation. (n.d.) *The Apex Blend*. https://apexeval.org/core-values/the-apex-blend/
12. Commonwealth of Massachusetts. (2024). *Racial and ethnic disparities (red) in the Juvenile Justice System*. Mass.gov. Accessed September 26, 2024 from https://www.mass.gov/info-details/racial-and-ethnic-disparities-red-in-the-juvenile-justice-system

DATA GLOSSARY

- Students who are economically disadvantaged, have a disability, are English-language learners, or experience homelessness are defined in the New York State Education Department Data Site Glossary: https://data.nysed.gov/glossary.php?report=reportcards
- Behavioral Health and Primary Care Visits are defined by the type of provider for the visit.
- Behavioral health diagnoses are defined by at least one visit with a diagnostic code in any position beginning with: Adjustment Disorder - F43; Anxiety Related Disorders - F40, F41, F42, F44, F45, F48, or F49; Depression -F32 or F33; ADD/ADHD - F90.
- BMI assessment is defined as a visit with a diagnostic code in any position beginning with Z68, E66, or R63.6. Nutrition counseling is defined as a visit with procedure codes Z71.3, 97802, 97803, or G8780. Physical activity counseling is defined as a visit with procedure codes Z71.82 or G8780.
- Visits where a depression screening was completed are defined by procedure codes 96160, 96127, G0444, G8431, 3725F, 1220F, 3351F, 3352F, 3353F, 3354F, G8510 or diagnostic code Z13.31 in any position.
- Visits where a comprehensive physical exam was completed are defined by diagnostic or procedure codes in any position including: Z00.110, Z00.111, Z00.121, Z00.129, Z00.00, Z00.01, Z01.110, Z01.111, Z00.8, 99381-99385, or 99391-99395.
- NHOPI: Native Hawaiian or Other Pacific Islander.

EXCLUDED DATA

To ensure consistency with KFF estimates of the health insurance status of children 0 to 18 years old in New York State based on 2008-2022 American Community Survey data, we excluded SBHC users with unknown, missing, or other insurance type from analyses including the SBHC user insurance type.

To ensure consistency with the New York State Education Department enrollment demographic data, SBHC user race and ethnicity is combined for this analysis. We prioritized ethnicity, so users who identify as Hispanic or Latino(a) regardless of their race are reported as Hispanic or Latino(a) and not included in any of the race categories. We excluded users with unknown race and non-Hispanic ethnicity, or with both unknown race and ethnicity.