

Here you go Jen
Ch

To: Maggie Williams
From: Bill Curry
Re: School Based Health Clinics

The Problem

At least 11 million American children are without health insurance of any kind. Millions more have only catastrophic or second rate primary coverage. Frequently, even children who have coverage are underserved because parents can not/will not attend to non emergency needs or because there is insufficient primary care available in their communities.

There exists a network of school based and community based health clinics struggling to meet the needs of these children. There is strong evidence that these clinics- in particular the school based clinics- are far and away the best means at our disposal of reaching underserved children. They are certainly the most cost effective way of delivering care.

But school based clinics are just getting off the ground while community health clinics are taking a financial pounding from Medicaid's transition to managed care and from cuts in federal, state and local human service budgets. Typically, these clinics are not organized to discriminate between their insured and uninsured patients. Nor are they equipped to secure third party reimbursements for those who are insured. Thus, ironically, the clinics, while straining to provide health care to the uninsured, must subsidize private insurance plans by providing uncompensated care to millions of their insured dependents.

The Opportunity

At present there are about 700 school and community based clinics in the United States. Most provide a wide range of primary care services at a cost that is likely as much as 40% lower than Medicaid or even capitated HMO costs. One New York plan provides primary health, dental and mental health coverage for \$318 per student per year. The average Medicaid primary health care cost per child, without dental coverage, is around \$560 per year. Private sector HMOs are even higher.

The immediate and achievable solution to the problem of providing health care to our children lies in the dramatic expansion of school and community based clinics. Of the two, school based clinics are better at accessing kids into the system and are almost certainly cheaper. The President and the First Lady have that rare opportunity to provide the right leadership at just the right moment-- and to nurture and grow a nascent idea into a vibrant healthy system capable of meeting our sacred obligation to protect the health of our children.

This can be done without massive spending, cumbersome bureaucracy or coercive regulation. We need only respond to the grassroots call of parents and communities who know what their children need and fix the system so that it supports what works. Here's how to begin:

1. We must challenge all insurance and managed care companies to devise a system to reimburse school and community based clinics for services rendered to their covered dependents. Some might wish to make an annual contribution in lieu of payments. Some might require in network provision of certain specified services. Some might prefer capitation

to other methods of reimbursement. But the industry must come together to meet the challenge. In so doing, they will help midwife a transition that in the long run will bring down costs and expand service, thus serving their own needs as well as the needs of others.

2. We must get our own house in order by making Medicaid reimbursement much easier than it is now.
3. We must provide or identify funds for the clinics to develop billing systems that enable them to participate in the marketplace.
4. We should condition school construction funds on at least the submission of a clinic plan.
5. We should consider freeing up other more narrowly programmatic money to this broader purpose.

This is obviously a very brief and incomplete presentation of the issues that need to be addressed. I am of course available at any time to talk with anyone concerned underlying issues, language, politics, etc. good luck.



STATE AND LOCAL PARTNERSHIPS TO ESTABLISH
SCHOOL-BASED HEALTH CENTERS

Issues in Financing School-Based Health Centers: A Guide for State Officials

September 1995

Prepared by:

***Making the Grade* National Program Office
The George Washington University
Washington, DC**

**Rosenberg & Associates
Point Richmond, California**

THE GEORGE WASHINGTON
UNIVERSITY
SUITE 505
1350 CONNECTICUT AVE., NW
WASHINGTON, DC 20036
(202) 466-3396
FAX (202) 466-3467

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UNIVERSITY

- **Issues in Financing School-Based Health Centers:
A Guide for State Officials**

Despite the recent, unprecedented growth of school-based health centers and the related increased support from state governments, the future of school-based health centers is uncertain. Proposed cut-backs in government spending may limit previously available public health dollars and state governments that intend to include school-based health centers in their health care networks for school-age children must now determine how to ensure financing for those centers.

Given the fiscally conservative climate in Washington, DC., states cannot rely on federal grant initiatives, federal protection for cost-based reimbursement, or federal mandates for inclusion of school-based health center programs in Medicaid managed care arrangements. Nor can the states rely on private insurance or other commercial sources to support the centers. The expansion of privately financed managed care and the continuation of ERISA exclusions has eroded opportunities to enlist private dollars in support of school-based health centers. Each state must develop its own approach to supporting the centers. A critical precondition for creating a financial strategy is for each state to address the following basic questions:

- *What is a school-based health center?*
- *Whom should the school-based health center serve if the center is to secure public funding ?*
- *What specific services must be provided?*
- *How will these services be paid for and who (or what) will receive payment for the services?*

This paper discusses approaches to answering these questions.

Issues in Financing School-Based Health Centers: A Guide for State Officials

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Background

Since the first comprehensive school-based health centers were established in the early 1970s, states and localities have increasingly looked to schools as reasonable and innovative sites for assuring access to health care for children and adolescents. Between 1985 and 1992, the number of such programs around the nation grew from 40 to more than 400. According to a national survey conducted by the *Making the Grade* National Program Office, by 1994 there were 607 school-based health centers in 41 states and the District of Columbia (see figure 1, page 6). Nearly half of these programs are located in high schools and over one quarter are located in elementary schools (Schlitt, et. al., 1995). Fueling the recent exponential growth of the centers has been the development of a number of state government initiatives to support school-based health center programs.

At present, most states fund school-based health centers through grant programs that draw from either Maternal and Child Health (MCH) block grant dollars or state general funds. The *Making the Grade* survey found that in school year 1993-1994, 32 states allocated an estimated \$38.8 million to local governments or health care institutions to support the centers. Twenty-five states allocated \$12 million in MCH dollars to school-based health centers, while another group of 25 states appropriated \$22.3 million in general fund support for the centers (see figure 2, page 6). Three states designated funds from the US Department of Education's "Drug Free Schools and Communities" program. Illinois is the only state that commits a portion of its federal Social Services block grant, Title XX, to its school-based health center program. Several states, including California, Florida, Louisiana, Massachusetts, and Missouri, fund their school-based initiatives through special taxes, such as supplemental sales taxes and tobacco excise taxes.

Other major funding for school-based health centers comes from federal grants, private foundations, and local dollars. Since the *Making the Grade* survey, 27 centers have received grants from the federal Bureau of Primary Care. Private foundation initiatives in Connecticut and Michigan are investing an additional \$6 million in centers in those states.¹ The Robert Wood Johnson Foundation will provide nearly \$18 million for school-based health centers through its national program, *Making the Grade: State and Local Partnerships to Establish School-Based Health Centers*.²

¹ School-based health centers are rarely supported by a single source of funds. In addition to state grants, most centers or their sponsoring institutions pay their expenses through a combination of resources: local health department grants, in-kind contributions from the host schools, support from their sponsoring agencies, and corporate contributions. A number of school-based health centers receive no state grant support. Among the 41 states with school-based health centers, eight states report that fewer than half their school-based health centers receive state support, and eleven states provide no funding to the centers.

² Under the *Making the Grade* initiative, 12 states received planning grants to create long-term funding strategies for school-based health centers as well as develop or expand local school-based health center programs. To date, three states, Colorado, Connecticut, and New York, have received implementation grants.

- Local support remains vital. All school-based health centers receive help from their host schools; other local agencies contribute varying levels of support. Twenty-three school-based health centers supported by the Robert Wood Johnson Foundation, through its previous grant program the *School-Based Adolescent Health Care Program*, reported that one-third of their budgets were provided in-kind by local sources. In Oregon's Multnomah County, in Fiscal Year 1995, local tax dollars provided \$1.4 million or 64 percent of the total operating budget for the ten school-based health centers in Portland.

States that have initiated funding for school-based health center initiatives, in most cases, have asked their health departments to take the lead in program and policy development. In response, the health departments have organized the state grant-making process -- writing the grant application guidelines, developing service standards and quality assurance measures, and determining staffing requirements. Within the health departments an individual or office generally has responsibility for providing technical assistance to local programs as well as facilitating the development of state policies to support the centers.

During the early phase of state support for school-based health centers, the states have considered these initiatives small-scale pilot programs whose characteristics were hand-tailored to fit the small number of communities in which the centers were located. However, as demand for the centers increases and they become part of the state's larger strategy of assuring health care for all children, the policy questions become more complex and require more detailed responses. How should states determine the need for such centers? How can start-up funds for the centers be secured? How will on-going support be obtained? Fundamental premises underlying such questions must be tested: Are the centers to serve all children or only some children? Are there spending priorities for public dollars?

If a state is to assure the availability of school-based health centers as a component of its health care system for school-aged children, the state will need to establish funding priorities by defining where they wish to locate school-based health centers (**targeting criteria**) and by establishing the services the school-based health centers will provide (**service criteria**). This paper reviews possibilities for targeting and service criteria and articulates the financing issues that states must confront as they move to fit school-based health center programs into an on-going, soundly-financed system of health care for children.

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Schlitt, JJ, Garfinkel, S. Where the kids are. State government news 1995; 38(6):20-24.

Schlitt, JJ, Rickett K, Montgomery L, Lear JG. State initiatives to support school-based health centers: A national survey. J of Adolesc Health 1995; 17:68-76.

See updated
to 1996
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Fig. 1. School-Based Health Centers, 1985-1994

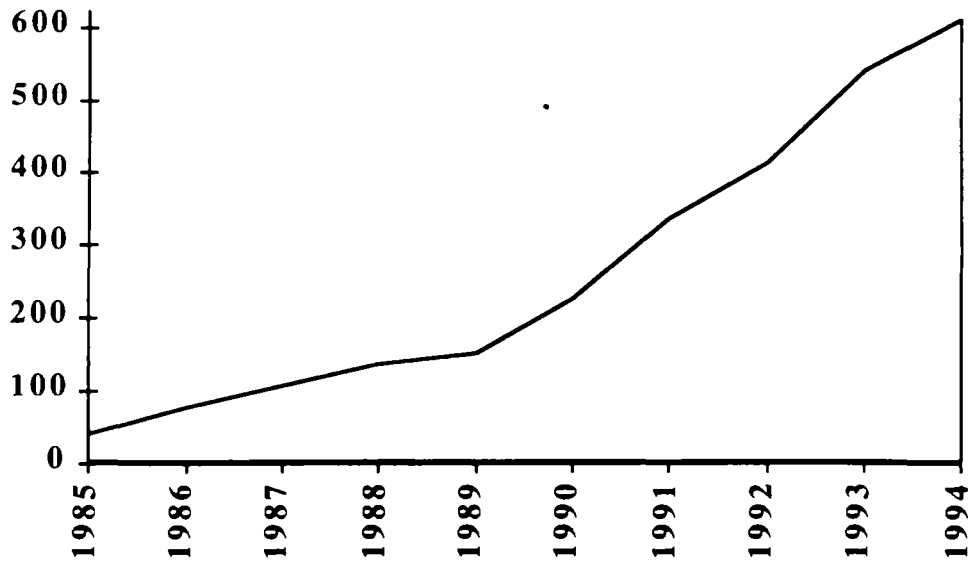
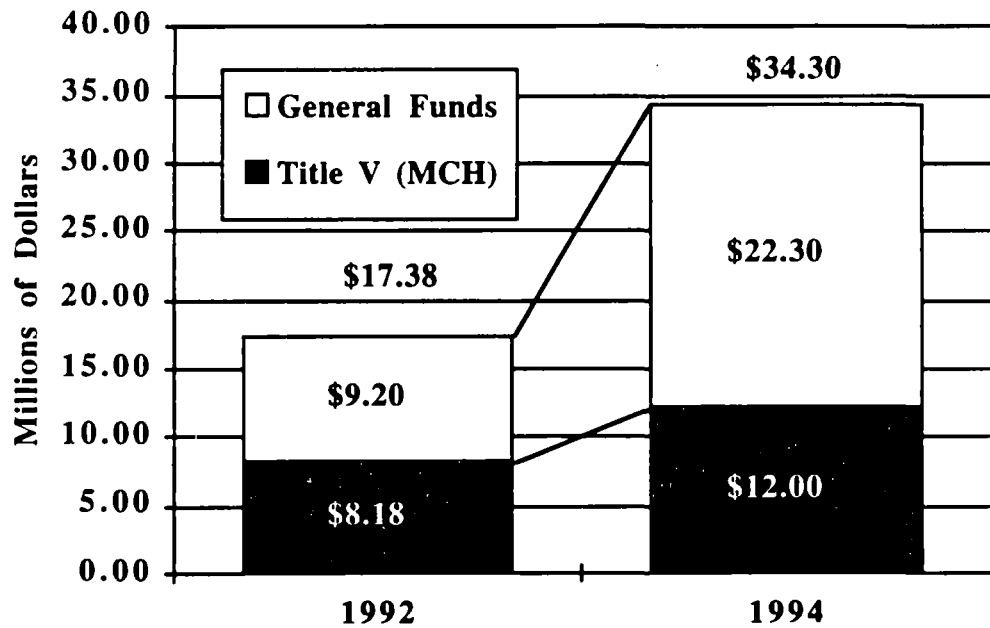


Fig. 2. State Financing of SBHCs, 1992, 1994



Sources:

Figs 1. and 2. Schlitt et. al. State initiatives to support school-based health centers. J of Adolescent Health, 17(2), 1995.

- **Difficulties in financing school-based health centers through third-party payments**

Most school-based health centers have been started and sustained with private and public grant dollars. Funds from patient care reimbursement, whether through private insurance or Medicaid, have only recently contributed measurably to the center budgets (see Table 1, page 8). This limited support from patient care revenues has been due to several factors:

- Initially, school-based health centers were considered experimental projects that were more appropriately funded by grant dollars.
- If privately insured students use the health centers, they are likely to have policies with large deductibles and limited coverage for primary health care and mental health services. While nine states and the District of Columbia have passed the Child Health Insurance Reform Plan (CHIP), which requires insurers to provide coverage for complete preventive health services for children 0 - 19, to date few health centers are reporting significant revenues from private insurance. The potential gains from CHIP may be offset by the movement of privately-insured families to ERISA-protected, self-insured plans, which need not comply with CHIP requirements.
- Adolescents from low-income families are less likely than their younger counterparts to be Medicaid insured. As a result, school-based health centers located in high schools have high rates of uninsured patients (see figure 3, page 9).
- Not all services provided to Medicaid-insured students are reimbursable due to state-specific Medicaid plan limitations or exclusions.
- Because patient care revenue potential is perceived as minimal, many school-based health centers have elected not to bill either patients or their insurers for services provided. These school-based health centers and their sponsoring organizations conclude that the cost of billing would exceed the revenues generated.

Despite barriers to billing, those who organize school-based health centers increasingly believe that patient care revenues are essential to funding the centers. Health care reform discussions have contributed to a perception that in the very near future all personal health services -- even those targeted to low-income students -- will be paid for through a patient care funding mechanism, whether by fee-for-service or pre-paid arrangements. Thus, the critical question: Can these centers fit into the emerging system of health care financing?

The shift from a grants-based strategy towards a greater reliance on patient care revenues is complicated by a concern that a billing or service-focused financing strategy may threaten the unique set of services currently offered by the centers. The centers were established to provide a comprehensive mix of medical and mental health care, health education and preventive services. Health center professionals provide clinical care, sponsor counseling groups, provide classroom education and work with parents, athletic staff and students to encourage a healthier school

- environment. Many of these activities are not billable, but most health centers believe these activities are among the most important things they do. To tie the work of the center to a traditional reimbursement system is to risk forcing the health center to alter its package of care from a multi-faceted social model to a medical model of care that de-emphasizes mental health and other less billable services.

Sources:

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Newacheck PW, McManus MA, Gephart J. Health insurance coverage of adolescents: A current profile and assessment of trends. *Pediatrics* 1992; 90(4):589-596.

Perino J, Brindis C. Payment for services rendered: Expanding the revenue base of school-based clinics. Center for Reproductive Health Policy Research, University of California, San Francisco, Report to the Stuart Foundations, 1994.

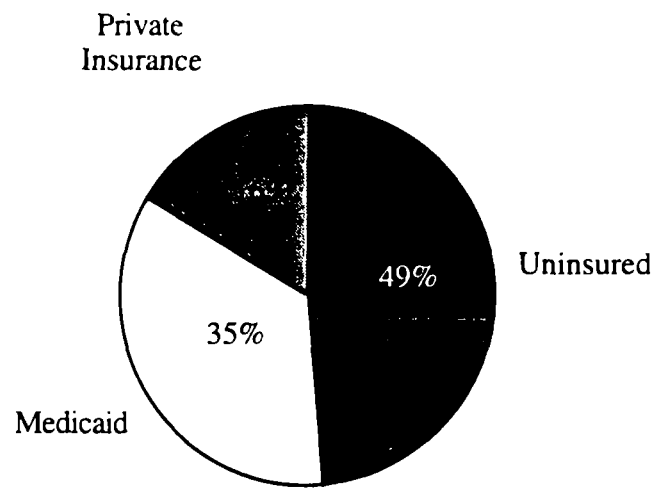
**Table 1. Current Funding Sources
for SBHCS**

State Health Departments	24%
Private Foundations	18%
MCH Block Grants	17%
Local government	12%
School Districts	8%
Community Health Centers	7%
State human services	3%
Title XX (AFL)	3%
Medicaid	2%
Other	7%

Source:

Table 1. Center for Population Options. School-based and school-linked clinics: Update 1991.

Fig. 3. Health Insurance Status of SBHC Users



Source:

Fig. 3. The School-Based Adolescent Health Care Program, The George Washington University, Washington, DC.

- **Recent events with major impact on funding strategies for school-based health centers**

State and federal governments have utilized a variety of strategies to support health programs targeted on specific populations. These include funding multi-site demonstration programs, establishing preferential payment-for-service formulae, and promulgating rules and regulations that create a favorable environment for the desired services. A number of recent events affect the ability of federal or state governments to use these approaches for the benefit of school-based health centers.

The federal government role in long-term funding strategies is constrained by the collapse of health care reform at the federal level and election of a fiscally-conservative Congress. One component of the proposed Health Security Act that received bipartisan support in both the House and Senate was a section providing for a large-scale federal grant initiative for school-based health centers.³ Funding for this initiative was to come from cost-saving changes in the plan. Failure of the overall plan eliminated projected savings *and* the likelihood of a large federal grant initiative. The post-election anti-Washington sentiment and the impact of presidential campaign politics on the Congressional legislative process only increases the difficulties confronting federal efforts. As a result, there is increased pressure on the states to solve their own health care funding crises.

States are facing continued fiscal pressures due to explosive Medicaid growth. In the post-Clinton reform environment, states are facing continued Medicaid budget pressures. In five years state Medicaid expenditures more than doubled, growing from \$22.5 billion in 1988 to \$53.6 billion in 1993 (see figure 4, page 12). Now many state Medicaid offices no longer have the flexibility to initiate or expand innovative access programs, including school-based health care. Congressional proposals to reduce federal public health dollars and curb Medicaid spending either through block grants or federal spending caps will exacerbate the states' financial difficulties.

States are responding to fiscal pressures by developing Medicaid managed care programs. As Medicaid spending has accelerated, politically-sensitive state governments are targeting their Medicaid cost-savings on AFDC clients. These beneficiaries are being enrolled in Medicaid managed care plans, primarily through the creation of Section 1115 and 1915(b) waiver programs that, with HCFA approval, permit mandatory assignment of Medicaid beneficiaries to managed care (see figure 5, page 13). Thus, those school-based health centers that have learned

³ Title III (Subtitle G, Part 5) of the Health Security Act called for investment of \$100 million in FY 1996 in school-related health services, growing to \$400 million in FY 1999 and 2000, with support totaling \$1.525 billion over five years. The Education and Labor Committee of the House of Representatives reported out its version of health care reform with a similar level of support for school health services. In its version of Title III, the Senate Labor and Human Resources Committee increased support for school-related health services to \$2.35 billion over six years. The Senate committee unanimously approved this section of health care reform legislation.

- how to implement fee-for-service billing systems may find themselves unable to collect payment for services because their Medicaid patients are now enrolled in managed care.

Federal eligibility standards for cost-based reimbursement are increasingly restricted and reduce revenue potential for school-based health centers. One method some school-based health centers have used to increase reimbursement from Medicaid has been to enter into contractual relationships with federally-qualified health care (FQHC) clinics. These clinics receive cost-based reimbursement under both Medicare and Medicaid because they serve communities federally-designated as "medically underserved." As FQHC satellite facilities, school-based health centers may receive cost-based reimbursement for care provided to Medicaid beneficiaries. With the federal government facing budget limitations, the identification of communities eligible for "medically underserved" status has become more restrictive. Expansion, and indeed, retention of the FQHC programs is increasingly uncertain as managed care programs have spread. Currently, litigation (NACHC v. Shalala) is challenging the right of the US Department of Health and Human Services to waive FQHC entitlements under Medicaid managed care programs.

School-based health centers have not been defined as "Essential Community Providers" and are therefore not automatically entitled to any special treatment that may be accorded "safety net" services. In an effort to retain cost-based reimbursement for programs targeted on the underserved, a number of health care providers have been identified at the federal or state level as "Essential Community Providers" (ECPs). School-based health centers have not been included in any federal or state definition of "essential community provider," nor are designated essential community providers such as community health centers required to contract with the school-based health centers. Given the legislative and regulatory environment, expansion of ECP designations at the federal and state levels may be difficult.

HCFA appears to be narrowing FQHC and ECP protections. Pending a decision in the NACHC v. Shalala case, the agency maintains that while cost-based reimbursement for FQHC providers is protected under 1915(b) waivers, 1115 waivers give states broader authority to waive all protections for FQHC providers. Moreover, even under a 1915(b) waiver, the state need not protect all FQHCs or ECPs but need only assure that Medicaid beneficiaries retain access to one such provider. Thus, contracts between a school-based health center and a FQHC might *not* assure participation in a managed care plan or cost-based reimbursement.

The Employee Retirement Income Security Act (ERISA) exempts large numbers of employers from complying with state laws regulating health insurance. ERISA, the federal law governing self-insured employers, precludes states from placing any requirements on self-funded health insurance programs, including managed care. Increasing numbers of employers are self-insuring their employees so that nationally almost half of all privately insured workers come under self-insured plans. As a result, there is a shrinking private insurance market from which states might seek support for school-based health centers via sales or other taxes. While school-based health centers may well be viewed positively by the private

- sector, ERISA legislation may limit a state's ability to require its participation in school-based health center initiatives or to control how that participation takes place. Cooperation among private insurers, major employers and government agencies may bring about a partnership to support school-based health centers, but the state's role in such efforts at this point appears likely to be advisory rather than directive. Note, however, that the April 1995 decision in the New York Conference of Blue Cross and Blue Shield Plans et al. v. Travelers Insurance Co. et al. may increase the ability of states to finance and regulate health care.

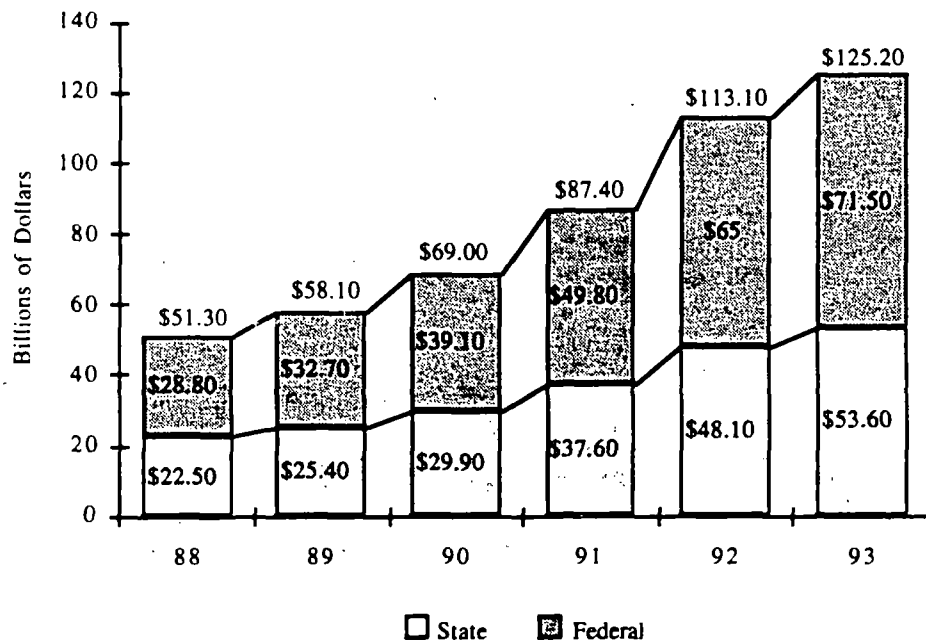
Sources:

Iglehart, JK. Health policy report: Medicaid and managed care. NEJM 1995; 332(25):1727-1731.

National Health Policy Forum, Issue Brief No. 656. ERISA and state flexibility: Exploring options from a state perspective, Fall 1994.

Rosenberg & Associates. Financing adolescent school-related health centers under the proposed National Health Security Act. Author, Point Richmond, CA, January 1994.

**Fig. 4. Federal and State
Medicaid Expenditures, 1988-93**



Source:

Fig. 4. J. Iglehart. Health policy report: Medicaid and managed care. NEJM, 332(25), 1995, 1727-3

Fig. 5. Medicaid Managed Care Enrollment, 1984-1994

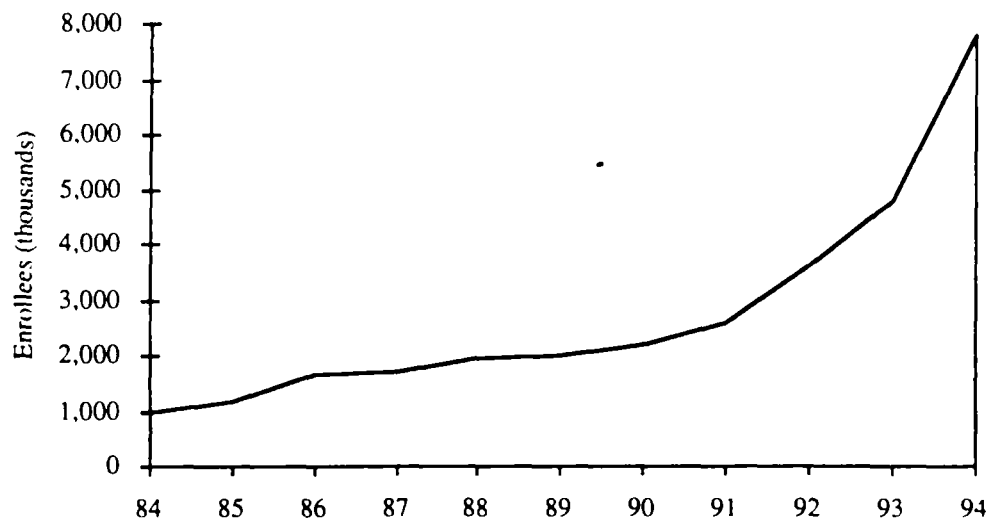
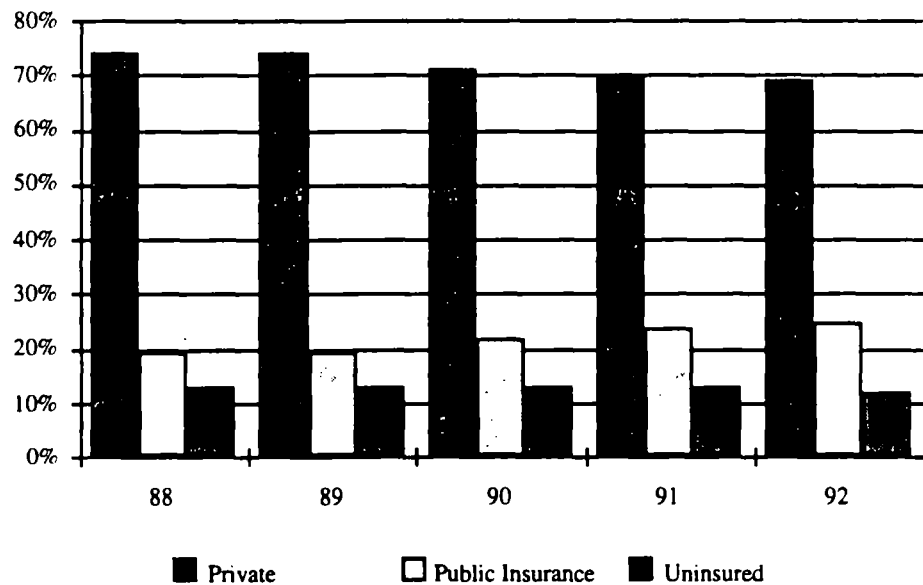


**Fig. 6. Health Insurance Status of Children Under Age
Eighteen
1988-92**



Sources:

Fig. 5. DHHS Health Care Financing Administration, Medicaid Managed Care Office.

Fig. 6. Newacheck et al. Children and health insurance: an overview of recent trends. Health Affairs, Spring 1995, 244-54.

- **Defining a school-based health center: An essential step towards a financing policy**

Because federal Medicaid regulations do not define school-based health centers as participating entities within the program, if a state is to develop special Medicaid-related funding strategies for the centers, the state Medicaid program needs to define the centers as a reimbursable ambulatory care provider-type, that is, a particular health care delivery system unit that can be shown to meet specific standards. Examples of ambulatory care provider types include hospital or health department-sponsored out-patient clinics, federally qualified health centers (FQHC), rural health centers, physicians and physician practice groups, and certified nurse practitioners.

There are advantages, particularly related to reimbursement, to designating school-based health centers as a specific provider type. For example, federal law stipulates that FQHCs and rural health centers (RHC) are entitled to reimbursement for the full cost of providing services to both Medicare and Medicaid beneficiaries. This arrangement allows the centers to include in their payment rate the costs of providing non-medical health services (social work and mental health services, case management, outreach, transportation, community health education, etc.) that are not typically reimbursed in a private medical practice. School-based health centers affiliated with FQHCs and RHCs have the potential for realizing cost-based reimbursement through their sponsor.

States as regulators of Medicaid rate payments can also establish a special reimbursement rate for school-based health centers that, similar to the FQHCs, compensates school-based providers for a broad scope of services to Medicaid beneficiaries. To pursue such a strategy, however, the State Medicaid program must define a school-based health center -- both by identifying the population to be served and by delineating the specific services to be provided.

(1) Options for targeting criteria: defining the communities to be served by state-supported school-based health centers.

Limited resources preclude the expansion of centers into every community that might desire one. Decisions must be made. Priority-setting among communities (i.e. targeting) might utilize one or a combination of the following factors: income, age, insurance status, and health care access.

(a) Low-income

While all school-age children need a broader set of services than is covered under most health insurance, upper-income communities appear more able to finance their own needs. Parents may be more likely to have full-family employer-based health insurance coverage, as well as the time and money to coordinate the different needs of their children. However, working families with low to moderate incomes may have more limited resources, in terms of both time and money. A state may wish to locate centers in those communities with a significant proportion of poor and near-poor households.

- A rationale for using low-income as a targeting criterion is that health services research has documented that low income children experience greater health problems than children as a whole.
- Children with emotional or developmental problems are likely to be poor, to have multiple persistent problems, to live in identifiable underserved neighborhoods, and to face particular barriers to needed services (Starfield B, 1992).
- The high child poverty rate in the United States substantially increases the health problems of children. The frequency rates for many medical problems are double to triple the norm among low-income children. Child deaths due to diseases are triple to quadruple those of other children, and low-income children have much greater percentages of conditions limiting school activity, lost school days, and severely impaired vision (Starfield B, 1992).

(b) Age

Age may be used as a targeting criterion to improve health care access for a specifically-defined age group that experiences greater access barriers than other age groups, or may have greater needs. Historically, adolescents ages 10-19 have been a primary target group for school-based health care because national data suggest that, as a whole, adolescents are less healthy and utilize health services less frequently than their pre-adolescent peers.

As more communities place school-based health centers in elementary schools, states must carefully assess the political ramifications of targeting populations generally thought to be less in need and better served by traditional health care systems.

Some of the data confirming the health needs of adolescents are as follows:

- At least 20 percent of adolescents have one serious health problem. These include visual, auditory and dental problems that can seriously impede the ability to perform well in school. Many adolescents also suffer from a diagnosable mental disorder (Office of Technology Assessment, 1991). Mental health problems increase with age: while 12.7 percent of 6-11 year olds are reported as having emotional or behavioral problems, 18.5 percent of 12-17 year olds have these same problems. The highest frequency of problems is reported among males ages 12-17. The most common problems include attention deficit disorders, phobias and anxiety disorders, depression, and learning disabilities (Zill and Schoenborn, 1990).
- In addition to chronic physical and mental health problems, adolescents have experienced some striking increases in behavior-related problems. Suicide and homicide rates have tripled among young people aged 15-19. One in five adolescents acquires a sexually-transmitted disease by age 21, and teen pregnancies continue at a rate of one million teenage girls becoming pregnant each year (Lear, 1995).
- Mainstream delivery systems are not geared to adolescents. Adolescents present special problems to caregivers given that their care needs to be confidential, convenient, comprehensive and age-appropriate (Office of the Inspector General, 1993).

- Adolescents see office-based physicians less frequently than other age groups (Klein et al, 1992).
- Many primary care physicians do not feel comfortable with adolescents, who are seen as not fitting into a pediatric or an adult care model (Klein et al., 1992).
- Young people are often "of the moment." They are likely to seek care at the time it is needed. If medical attention must be scheduled at a later time, a broken appointment is likely to result (Office of the Inspector General, 1993).
- In many states, Medicaid and other public assistance programs cover few adolescents.
- Uninsured adolescents are reluctant to burden financially-struggling families with health care costs (Feiden, 1993).

(c) Insurance Status

As employer-based health insurance declines and children of working parents become increasingly less likely to be insured, states may choose to target communities with significant numbers of uninsured school-age children. Recent publications have documented the increased numbers of uninsured children and the implications for health care access:

- An article in the New England Journal of Medicine showed that uninsured children aged 6-17 were significantly less likely to see a physician for four common conditions for which medical care is considered necessary (pharyngitis, acute earache, recurrent ear infections, and asthma), even when socioeconomic conditions were taken into consideration (Stoddard et al., 1994).
- Children's employment-related insurance coverage declined from 64.1 percent in 1987 to 59.6 percent in 1992 (Teitelbaum, 1994).
- Lack of health insurance crosses boundaries of race, family status and family income. In 1992, almost 8.3 million children were uninsured for the entire year, of whom 6.4 million were white (12 percent of all white children), 1.4 million were black (13.5 percent of all black children), and about 2 million were Latino (25.7 percent of all Latino children, noting that persons of Latino origin may be of any race) [Teitelbaum, 1994].
- In 1987, most uninsured children lived in poor or near-poor families. Almost half of children from families with incomes below the federal poverty level (FPL) was uninsured for all or part of the year; almost 35 percent of children in families between 100 percent and 200 percent of the FPL was uninsured for all or part of the year (Monheit, 1992). In 1991, the highest percentage of uninsured children was from families with incomes between \$10,000 and \$19,000 (Kogan, 1991, cited by Teitelbaum).

d) Inadequate primary care access

Barriers to ambulatory care due to inaccessible or limited numbers of primary care providers may constitute another criterion for community selection. Evidence of access problems for school-age children have been reported in leading medical journals.

- • Investigations by the United Hospital Fund in New York City, which reports on City programs providing innovative AIDS and health care services to high-risk adolescents, indicate that adolescents have problems in accessing care in underserved areas (Feiden, 1993).
- Hospital admissions in New York City for ambulatory care-sensitive conditions, which suggest inappropriate emergency room utilization and inadequate primary care availability, are significantly associated with area and income for children aged 6-17 (Billings et al. 1993).
- A recent article in the New England Journal of Medicine by the Medicaid Access Study Group points out that for Medicaid beneficiaries, obtaining ambulatory care outside of emergency rooms is difficult (Medicaid Access Study Group, 1994).

In summary, it might be argued that the children for whom school-based health centers are most useful are adolescents, ages 10 - 19, from low-income families. Many of these young people are without health insurance, and even for those who have Medicaid or some other form of coverage, access to care may be limited by social conditions including the absence of appropriate providers in their community. In addition, the range of care for chronic physical, mental health and behavioral conditions, and the social support to help them manage ongoing problems, is not routinely available through existing health care provider organizations.

States will likely have many more needy communities than can be served by a state-sponsored program. Therefore, it may be important for a state to add additional criteria, such as community support or evidence of parental leadership. States may also choose to rank-order communities in terms of variables such as the availability of local matching dollars, or the perceived likelihood of success. The viability of a state-sponsored school-based health center program will be significantly enhanced by the development of explicit criteria for the kinds of needy communities where the program is most likely to be effective.

(2) Defining school-based health center services

To determine the costs of operating a school-based health center as well as to lay the groundwork for discussions with managed care plans, states must define the required components of school-based health care and identify standards for how services are to be rendered. The School Health Policy Initiative at Montefiore Medical Center, in collaboration with groups of national experts, has developed both a set of operating principles for school-based health centers and an outline of recommended services to be provided by the centers (Brellocks, 1995).

Service criteria typically include a statement of program objectives. An example for a school-based health center might be: "to assist students to function appropriately in their social and educational environment by meeting their physical, social and behavioral needs in a comprehensive primary care center with-in a school-based health program." Services to achieve this objective can include:

- preventive and primary care, including health education.
- diagnosis and treatment of illness and injuries, including referral to linked partners, follow-up care, and longitudinal management of chronic problems,
- limited on-site laboratory capability;

- radiology service through linked providers.
- access to appropriate mental health resources.
- behavioral health care and social support.
- coordination of health and educational concerns.

State standards for school-based health centers are spelled out in documents supporting a number of state grant initiatives. While state Medicaid programs have not yet become involved in the definition of school-based health centers, state health departments have become increasingly so. In the process of initiating grant programs for school-based health centers, the health departments have established program goals, described service and staffing standards, and defined prototypes for replication. Of the 50 states surveyed by the Making the Grade National Program Office, 22 have established state school-based health program guidelines, ranging from suggested to mandated program standards (see Table 2 below). Twelve of these standards, judged by the Program Office to be well-defined and comprehensive, are summarized in the appendix. Nine states reported that program guidelines were under development. With few exceptions, states define school-based health centers as vehicles for coordinating and delivering accessible primary physical and mental health services to students. The states' definition of required or desired services are fairly uniform. The services to be provided include: preventive health care, acute care, routine examinations, immunizations, social services, health education and mental health counseling. Reproductive health services are more frequently suggested than required for centers serving older students. What becomes clear from conversations with state officials is that the process of defining the school-based health center service package is difficult given the value attached to a strong programmatic role for local officials and community groups. Extensive discussions involving a mix of state and local representatives are essential to establish consensus on the service package (Schlitt JJ, et al).

Table 2. State Guidelines For School-Based Health Centers¹

Required/Suggested Guidelines²		In Development³	No Guidelines⁴	
Colorado	Michigan	Arkansas	Alabama	Nevada
Connecticut	Nebraska	Iowa	Alaska	New Hampshire
Delaware	New Jersey	Maryland	Arizona	North Dakota
Florida	New Mexico	Missouri	California	Oklahoma
Georgia	New York	Rhode Island	Idaho	South Carolina
Hawaii	North Carolina	Tennessee	Kansas	South Dakota
Illinois	Ohio	Utah	Kentucky	Washington
Indiana	Oregon	Vermont	Minnesota	Wisconsin
Louisiana	Pennsylvania	West Virginia	Mississippi	Wyoming
Maine	Texas		Montana	
Massachusetts	Virginia			

¹ With many states developing new school-based health center initiatives and other states assessing and re-assessing their preferred models, all state guidelines might be considered "works in progress."

² States in this category have either issued guidelines which must be complied with as a condition of state funding or have developed guidelines that are recommended to communities but are not a requirement for funding.

³ Some states that have funded school-based health centers using general guidelines are now clarifying their service standards and staffing requirements. These states are moving towards an explicit comprehensive model. A number of states are elaborating several models for health services in school, ranging from limited services to comprehensive health centers. States that have recently funded school-based health centers are developing their initial standards by drawing upon the experience of older programs.

⁴ States that have not developed guidelines for school-based health centers either do not support centers or have a total commitment to local control.

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Strategies to fund school-based health centers: Alternative reimbursement models.

Once the state has defined a school-based health center provider-type by identifying the community to be served and the services to be provided, the state must then address how the school-based health centers will be paid for their services. In so doing, the distinction between local and state perspectives must be considered. The individual school-based health center or its sponsor is responsible for covering its operating costs; the full range of alternatives from contracts with managed care plans to fee-for-service billing to categorical grant initiatives and in-kind contributions must be explored. Regardless of its creativity and energetic pursuit of financing, however, the health center's access to financial support will be determined, in great part, by decisions at the state level.

The level of state support for school-based health centers is a function of the combined decisions of all the state agencies that agree to participate in supporting care provided by the centers. It is therefore important that the broadest range of decision-makers sit at the table when determining what resources can be applied to school-based health centers. In general, the key participants will include the Medicaid director, the Commissioner of Public Health, the Superintendent of Schools, the Commissioner of Mental Health and, perhaps, the Insurance Commissioner. If special health care reform offices have been established, their involvement is essential as well.

To assure stable long-term financing for school-based health center programs, resolution of the following issues is critical: Should payment to the centers be on a fee-for-service basis? How are uninsured students to be covered? How can this program fit with managed care? Should state-supported programs be paid only through Medicaid, and if so, should they serve only the Medicaid-eligible population? Experience has shown that whichever model the state chooses to adopt must be accepted and supported at every level of state government.

There are a limited number of approaches for paying school-based health centers for the care they provide to designated populations. These include a regulatory approach, a market approach, and a "pooled fund" approach.

A regulatory approach

Under this approach, the state through its regulatory process defines the school-based health center provider-type, including the establishment of targeting criteria and services to be provided, and mandates that Medicaid managed care plans (and/or potentially all licensed insurers in the state) pay the provider-type for services provided to their enrollees at a stipulated rate determined to cover the costs of providing that care.

This approach is not dissimilar to some existing provisions under managed care. For example, family planning services are often "carved out" from the primary care contracts of Medicaid managed care providers. That is, although family planning is a covered benefit for which the managed care plan is responsible, enrollees may obtain family planning services outside the plan without going through their

- primary care "gatekeeper." The managed care organization excludes family planning services from the per capita payment to the primary care provider, and pays the family planning organization on a fee-for-service basis. This is done because all parties want enrollees to have free access to family planning services, which would be less likely to occur if pre-approval were needed from the primary care gatekeeper.⁴

The regulatory approach has several benefits: it provides stable funding; it defines and codifies the school-based health care model; and it allows the state to determine the scope and breadth of the program. It also fits well within the traditional role of government in serving the low-income population. The necessary technology exists to implement the approach, since the centers will be serving in an established role, that is, they will operate as vendors to managed care plans.

There are also drawbacks: The percentage of school-age children for whom a school-based health center would receive payment under such an approach must be carefully assessed. Because states may lack adequate regulatory authority over self-insured plans (approximately half of all insured employees and dependents are insured through self-insured plans), the financing of school-based health centers will be largely dependent on Medicaid and other insurance plans regulated by the state. If only a small number of students are covered under Medicaid and other state-regulated plans, funding for the centers from this source will necessarily be limited.

From the perspective of the school-based health center, the regulatory approach calls for considerable administrative effort. The center will need to identify the managed care plan in which the student is enrolled (in general it is the parent, rather than the child, who is the direct enrollee, making identification sometimes very difficult). The center must then obtain all necessary billing numbers and generate a bill that meets the needs of the managed care plan. The problems faced by Medicaid managed care programs in managing the Medicaid population will be passed on to the center, and are likely to become magnified in the process. Notification of plan enrollment change by the parent may not be accomplished smoothly, and the problem of eligibility may become even more difficult. Representatives of Medicaid managed care plans complain that their greatest problem arises from involuntary disenrollment through loss of eligibility, which often affects 50 percent of their covered population annually.

Other complex problems may arise in a Medicaid managed care plan, including possible limitations on mental health services providers, and an unwillingness to reimburse for services of clinical social workers, who often play a major role in school-based health care. Moreover, the managed care plan may limit the number of outpatient mental health visits, or may require (as in New York State) that after 10 such visits the patient's care is shifted to a mental health managed care provider.

⁴ By a 1986 amendment to Title XIX of the Social Security Act, Congress "carved out" family planning from the Medicaid managed care programs under the 1915(b) waiver process to assure that Medicaid beneficiaries had broad access to family planning services. However, the carve out is not applicable to Medicaid managed care programs operating under Section 1115 waivers. See P.L. 99-509, Section 9508. Sara Rosenbaum et al., *Beyond Freedom to Choose: Medicaid Managed Care and Family Planning*, Center for Health Policy Research, The George Washington University, Washington, DC.

- Lastly, to participate efficiently within a managed care system, school-based health centers will need medical billing capability and full understanding of the complexities of health care accounting practices.

A market approach

Under the market approach, rather than identifying and certifying the school-based health center as an essential provider-type, the state would define the function of the school-based health center as an essential *service*. That is, the state would specify that if a managed care organization is authorized to serve an area with more than a certain percent of Medicaid enrollment, it must provide school-based health care services as part of its Medicaid contract.

Using this approach, it would be possible for managed care organizations to work collaboratively with community schools to ensure a sound, well-organized program. Collaboration, however, is by no means guaranteed. Several centers might be organized by competing plans in schools that are in close proximity to one another. Will the centers serve students who are not enrolled in the sponsoring plan? Indeed, there are a number of potential problems, including neglecting the sensitivities of the school itself. Some schools may not want a center either for political reasons or due to space scarcity. The issue of governance is also likely to be problematic: who would own the center and could it be owned by one plan, or by several together?

The question of accountability also arises. To whom would the managed care organization be accountable, and for what? Could students vote with their feet and obtain services elsewhere? Hypothetically, unless the managed care organization is held accountable for the services it provides via school-based health center standards, the plans may find it in their best interest to limit resources and make the program extremely unattractive. Without accountability, there will be limited acceptance of responsibility for the needs of the student, and an idiosyncratic program may well develop.

A "pooled fund" approach

Under the pooled funding approach, the state assumes direct responsibility for the program, and funds it via a global budget paid directly to each center. The state determines the centers' operating cost and creates a fund to pay for a specific number of centers by pooling money from a variety of sources. These include Medicaid funds obtained under 1115 waivers, federal maternal and child health funds, state general revenue support, foundation grants, and other related funds available through education and human services. By the state pooling these funds together, matching federal Medicaid funds under the terms of the 1115 waiver could be obtained. The project could then be administered by an appropriate state agency in accordance with defined targeting criteria and service levels as previously discussed.

In 1991, the New York legislature considered a variation of this approach. As reported by Christel Brellochs, proposed legislation sought "to take advantage of disproportionate share allowance provisions of the federal Medicaid program by designating the \$3 million in State funds allocated to school-based health centers as the state contributions to Medicaid. If this amount were matched by local (25%) and federal (50%) shares, approximately \$10 million would be generated for the school-based health centers. Combined with the Title V allocation of \$3.5 million,

- a total of \$13.5 million would be available to fund school-based or school-linked services." The proposal was rejected by the New York Senate as a result of end-of-session politicking, but the New York experience suggests the possibility of this approach (Brellocks, 1992).

The model, however, has not been implemented in any state. As a result, there are a number of issues that will need to be resolved. The state must be able to monitor the management of global budgets by the centers to assure efficient operation. Incentives for optimum utility must be incorporated so that if a center's utilization rate is lower, it receives a smaller budget. At present, there are limited data available to inform the establishment of an appropriate budget based on utilization (that is, we don't currently know, in a high school of, for example, 1,000 students, what the normative budget for a school-based health center should be, or what might impact on that budget in terms of making it larger or smaller).

A major attraction of this approach is that currently-available funds, such as the Maternal and Child Health block grant program and private foundation grant awards such as those from the Robert Wood Johnson Foundation, the Kellogg Foundation, and the William Caspar Graustein Memorial Fund could be used to learn more about how to organize this kind of program and manage global budgets efficiently. It would then be possible to "carve out" the services and finances from state-sponsored Medicaid managed care programs, and continue the program as a direct state-supported operation with an appropriate global budget. The learning period could also be used to continue to build solid community support for the program. This includes working with the schools to assure their perception of ownership and working with community providers to develop sound referral relationships, an essential requirement for collaborating with managed care programs.

It seems as if we can see the future for school-based health center programs, as for all other health care endeavors, only in a glass darkly. Nonetheless, it seems possible that this kind of globally-budgeted program, funded by the state through pooling a variety of resources, may provide a sound interim step in learning not only how to fund the program for the longer term, but also how to implement it effectively through well-developed targeting and service criteria.

A comparative analysis of the three long-term financing approaches is summarized in Table 3 on the next page.

Table 3. Alternative Reimbursement Models For State-Sponsored School-Based Health Center Programs

	Regulatory Model	Market Model	Pooled Fund
Accountability	Must meet state-defined criteria	Unclear	Managed by state dept. of health
Payment Mechanisms	State-stipulated per-unit rate (fee-for-service)	Determined by market	State-determined global budget
Administrative Burdens	High for all parties: state, centers and managed care plans	Low for states; market determines for managed care plans	Mid-level for states; minimal for centers and managed care plans
Student Evaluation	Choice limited to enrollment opportunities under Medicaid managed care	Unclear	State accountability process must include student assessment

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SCHOOL-BASED HEALTH CENTERS

By Rebecca Craig and Tracey Hooker

Twenty percent of youth have serious health problems.

The number of clinics has climbed dramatically in the last 10 years.

Over the last 20 years, disease and death rates have steadily risen for youth in the United States. Twenty percent of the country's 31 million adolescents are thought to have at least one serious health problem, according to estimates by the U.S. Office of Technology Assessment.

There are a number of barriers to health care for young people: inadequate insurance, lack of money to pay for services, a limited number of adolescent health providers, inconvenient facilities, insufficient information about health care, and absent or working parents.

School-based health centers (SBHCs) show promise in providing accessible, appropriate and effective health care for adolescents. They offer medical and mental health screening and treatment at schools. The number of clinics has climbed dramatically—from 31 in 1984 to more than 600 in 41 states and the District of Columbia by the fall of 1994.

State Role

State governments play an important role in developing centers. States can pilot new efforts, determine standards of care and staffing guidelines, and develop long-term strategies. State legislatures affect clinics through appropriations and by passing laws on informed consent by minors, confidentiality and disclosure of medical information, and health professionals' ability to prescribe and dispense medication.

The array of services provided by each center depends upon the populations' needs, local politics, funding and availability of trained professionals. According to a recent study by

SERVICES OFFERED BY SCHOOL-BASED HEALTH CENTERS		
Physical examinations	Immunizations	Reproductive health
Mental health services	Substance abuse	Sexual health
Prescriptions	Pregnancy testing	Chronic illness management
Laboratory services	Medications	Screening and testing
Immunizations	Psychological exams	Source: Advocates for Youth, School-Based and School-Like Health Centers Update, 1994

Advocates for Youth, medical care and health information accounts for the nearly two-thirds of services used by young clients. Mental health care has grown to 20 percent and reproductive health care is 19 percent of services used by students enrolled in school clinics.

Securing stable funding to start and operate clinics is difficult. Nearly 40 percent of students using the clinics are uninsured, according to Advocates for Youth, and most centers do not receive full Medicaid reimbursement. Funding comes mostly from local and state government.

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Denver Office: 1560 Broadway,

Suite 700

Denver, Colorado 80202

303.830.2200

Washington Office: 444 N. Capitol St., N.W.,

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Washington, D.C. 20001

202.624.5400

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federal Maternal and Child Health block grants, community health centers, Medicaid, private foundations, and to a lesser extent— private insurance, patients and donations. Center budgets are affected by the type of sponsoring agency, size of staff, services, location and the number of people served. The average annual operating budget for a school health center is \$170,710. The cost to operate a center is \$179 a year per enrolled student or \$66 per student visit.

School-based health clinics can be controversial. Criticisms center on the role of the school, the content of information and services, and parents' rights. Some medical and educational groups are concerned about schools straying from their primary objective to educate students, even though most centers are run by community, not school, organizations. Opponents argue that sex education, family planning services and contraceptives, provided without parents' knowledge or involvement, encourage sexual activity and should be the responsibility of parents. Schools acknowledge many of these concerns by requiring a signed parental consent form before a student can receive services. Schools are also inviting community participation on advisory committees to develop, review and recommend appropriate services.

Critics of school clinics want more parental control.

A 1994 U.S. General Accounting Office study found that clinics can help overcome financial and other barriers that currently limit access. The conclusions on the benefits of school health centers include:

Centers reach students who have no other medical care.

- Centers are located in communities with the greatest needs and are used most by students who have no other source of routine medical care and no health insurance.
- Students, parents and school personnel are very satisfied with the clinics and value their accessibility, convenience and care.
- Some studies show centers have a positive impact on substance abuse, school attendance and dropout rates.
- There is scattered evidence that clinics with comprehensive family planning services may delay the initiation of intercourse, improve effective contraceptive use and lower pregnancy rates.

A recent study of school health center revenue noted that stable and continuous funding must be secured if these programs are to remain viable. Other important challenges for the centers include:

- Educating communities about the primary objectives of school-based health centers.
- Employing adequately trained providers, especially bilingual and bicultural professionals.
- Continuing services when schools are closed and reaching adolescents who drop out.
- Establishing reliable ties to community hospitals and local health care providers.
- Securing payment for nonmedical services such as counseling, health promotion and education that traditionally are not funded under third-party reimbursement systems.
- Participating in the national shift in health care delivery from a fee-for-service system to a fixed payment (managed care) system that requires contracting with health maintenance organizations.

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Contacts for More Information

Tracey Hooker
NCSL—Denver
(303) 830-2200

Charcly Seagle
Advocates for Youth
(202) 347-5700

John Schlitt
Making the Grade: State and Local Partnerships to Establish School-Based Health Centers
(202) 466-3396



SCHOOL-BASED/LINKED HEALTH CENTERS

Overview

Many children lack access to the routine health care needed to prevent disease, disability and unnecessary hospitalization. Children need access to regular health care services because many of the major health problems that face our country are preventable, acquired in youth and attributable to a few types of behavior, including those that lead to injury and poor nutrition. Adolescents experience unique problems and are confronted with a complex web of physical, emotional and social issues requiring more than simple medical care. To address these concerns, a small but growing number of communities are using an innovative approach to reach children with limited access to health services: School-Based/Linked Health Centers (SBHC).

SBHCs provide preventive, medical and mental health services to elementary, middle and high school students around the country. In 1994, 79% of SBHCs serviced high school students, 9% serviced primary school children (pre-K through 8) and 12% serviced a combination of high school and primary school students. Since the early 1980s, states and communities have established SBHCs in about 650 of the nation's 80,000 schools. SBHCs are financed primarily through state, local and private foundation funds. Federal programs, particularly Medicaid, CHCs and the MCH Block Grant, supplement these funds.

Where are SBHCs?

SBHCs operate in schools in many states. The majority of SBHCs developed in rural and inner city communities where there are many uninsured children and high rates of adolescent health conditions caused by high risk behaviors. For example, New York has 140 of the 650 SBHCs, 112 of which are in New York City. New Mexico and California also have many SBHCs with 29 and 26, respectively.

Who is Served by SBHCs?

SBHCs serve a wide range of students. The children and adolescents vary in age, from pre-K to 12th grade, and have diverse ethnic, geographic and economic backgrounds. While many different populations use these health centers, the majority of SBHCs target low-income or below poverty level children and adolescents. For example, according to the Office of Technology Assessment, many of the adolescents who use school-linked health centers (SLHCs) have no other health care source. Among the other populations which many SBHCs target are ethnic minorities and high risk groups, such as teen parents. Some clinics extend services to siblings and parents of students.

SBHCs in Elementary Schools

While SBHCs provide particular benefits to adolescents, they are also beneficial for elementary school children. A 1994 GAO report concluded that the monitoring and early treatment of chronic conditions (e.g., asthma) can prevent unnecessary hospitalization and deaths. In addition, the report concludes that mental health services are particularly effective at

this level when problems first appear because younger children are more malleable, feel less peer pressure and are more open to discussing their problems than adolescents. The GAO report also noted that elementary school students are more likely to use a SBHC than other health care facilities because parents and students are already familiar with the school and the SBHC is a part of the school. Parents feel a SBHC is a much friendlier place to receive care. Also, SBHCs in elementary schools involve parents more directly because providers need the younger children's medical records or must instruct parents on a child's medication regimen.

Average Costs for SBHCs

A recent study of SBHCs by the Health Resources and Services Administration (HRSA), reporting data through 1993, estimated annual clinic costs for 6 SBHCs in 5 different states. Several estimates were generated, including total annual costs, costs per registered student, cost per user and cost per visit. Costs per user ranged from \$122 to \$500, while cost per visit ranged from \$29 to \$90. These costs varied significantly for the schools for a variety of reasons and therefore should not be used for comparison. For example, the cost estimates were not always based on data from the same school year; the clinics offer a wide variety of differing services; some of the clinics did not account for the costs of all in-kind services they received; and not all of the clinics included administrative costs in their estimates.

Major Problems Facing SBHCs

- Many SBHCs lack stable sources of financing. Because SBHCs receive financial support from a patchwork of sources, SBHC funding is fragmented and often short-term. Contributions from Medicaid are not a certainty given the increasing number of low-income children enrolled in Medicaid managed care organizations. Reimbursement from other sources is also difficult because SBHCs often have limited administrative capacity to implement effective billing mechanisms to bill Medicaid and third party payers. Private foundations, which have played a prominent role in establishing SBHCs, generally cease contributing funds once their grants expire.
- Budget limitations have adverse effects on the provision of services by limiting their availability. For example, there is a large demand for mental health services from elementary and high school facilities. Both public and private health insurance coverage of mental health services tends to emphasize acute or emergency conditions, rather than ongoing care, which limits SBHC's ability to receive reimbursement for services their clients need. Dental care is also a problem. Few SBHCs give onsite dental care (13%) and such care is hard to obtain out in the community due to high costs, long waits and a lack of dentists.

Other Problems Confronting SBHCs

- The comprehensiveness of referral networks vary among SBHCs.
- Some students drop out of school or, for those under age 5, are not in the school system.
- SBHCs may not always be open, especially in the summer and during school vacations,

- and often have limited hours when students are in school.
- SBHCs find it difficult to recruit, train and retain nurse practitioners and physician assistants, the key primary care providers at SBHCs.
- Outcomes research on the effectiveness of SBHCs is sparse.
- There is controversy in most communities over SBHCs providing reproductive health care services, e.g., counseling, gynecological exams, pregnancy testing, sexually transmitted disease diagnosis and treatment, prescription and distribution of contraceptives and prenatal care.

Types of Services Offered (See Attached List)

- The most commonly provided services at SBHCs are:
 - primary care
 - physical examinations
 - injury treatment
- But, specific services vary by location and include:
 - immunizations
 - counseling
 - laboratory tests
 - chronic illness management
 - health education
 - substance abuse treatment
 - reproductive health services

Support for SBHCs

SBHCs generally enjoy parental support because they offer easy access to health care by bringing providers to the children. This eliminates the need for parents to leave work or to provide transportation. SBHCs also facilitate follow-up, offer free or low cost services and provide services in an atmosphere of trust and confidentiality in a culturally sensitive manner. Many programs, especially in elementary schools, require parental consent forms indicating which services can be provided to a child.

Assessing SBHCs

Although there are no national, comprehensive evaluations of either school-linked or school-based health centers, informal assessments of particular programs have been done at the state and local levels. Most of the findings show positive behavior and health outcomes for clinic users. The following are examples from either school-linked health centers (SLHC) or school-based clinics (SBHC):

- An evaluation of 6 SBHCs noted that there was considerably lower alcohol consumption

in most of the schools evaluated in comparison to other schools. However, there were no significant differences in use of illegal drugs.

- That evaluation also found that only a SLHC with a full-time physician which required all new students to have physical examinations positively impacted the likelihood of students having seen a doctor recently. Among those impacts were:
 - An 11% increase in the number of students seeing a doctor within the past 12 months.
 - An increase in the number of students receiving a physical exam, blood test or urine test in the past two years or having seen a dentist recently.
- School-linked community health centers, serving pre K-12th grade in three New York cities, report that parents, when electing the level of care on enrollment forms, chose levels that provide more than usual school health services. Principals and teachers declare that the health centers' programs have had positive impacts on learning and school attendance.
- An evaluation of seven SBHCs collectively serving elementary, junior and high schools reveals that clinic users are less likely to drop out of school than regular students and that the dropout rate for the schools as a whole has declined.
- A demonstration SLHC which served junior and senior high school students reported that knowledge and use of contraceptives significantly increased for students using the center's services. Also, previously increasing pregnancy rates eventually stabilized and declined; within 28 months it declined by 30 percent.

Existing Government Efforts to Improve the Health of Children through SBHCs

The Health Resources and Services Administration's (HRSA) Healthy Schools, Healthy Communities initiative is one example of a government program to improve the health of the nation's children in a school setting. Through this program, school-based primary health care sites have been developed in 27 communities to provide services for 24,000 students who are at risk for poor health, school failure, homelessness and other consequences of poverty. The 27 centers provide comprehensive primary care services on site, including diagnosis and treatment of acute and chronic conditions, preventive health services, mental health services and preventive dental care. The programs are from 8 rural areas and 19 urban areas representing 20 states and the District of Columbia. Children of all ages from kindergarten through grade 12 are being served.

Chapter 1
Communities Use School-Based Health
Centers to Provide Health Services to
Children

Figure 1.1: Types of Services SBHCs May Provide

Medical Services	Health Education/Promotion
- Comprehensive medical and psychosocial histories - Immunizations - Comprehensive physical examinations per EPSDT guidelines - Developmental assessment - Assessment of educational, achievement, and attendance problems - Vision and hearing screening - Dental assessment - Referral for dental care - Dental care - Diagnosis and treatment of minor and acute problems - Management of chronic problems - Prescription of medicines for minor, acute, and chronic problems - Dispensing of medicines for minor, acute, and chronic problems - Laboratory testing - Referral to medical specialty services - Twenty-four hour coverage - Gynecological/urological care - Family planning services or referrals - Contraceptive prescriptions or referrals - Condom availability - Pregnancy testing - Options counseling - Prenatal care services or referrals - Well child care of students' children - Referrals to well child care - On-site STD and HIV/AIDS treatment - Referral for STD and HIV/AIDS treatment - HIV testing and counseling - Referral to HIV pre/post test counseling - Case management	- One-on-one patient education - Group/targeted education at SBHC - Sample topics: smoking cessation - teen parenting classes - weight reduction seminars - Family and community health education - Supplemental classroom presentations and resource support for comprehensive health education - Sample topics as appropriate: - STD/HIV/AIDS education - pregnancy prevention - drug use prevention - intentional and unintentional injury prevention - chronic conditions (e.g., asthma) - general parenting skills
	Mental Health Services
	- Individual mental health assessment, treatment, and followup, including: physical/sexual abuse identification and referral - physical/sexual abuse counseling - substance abuse assessment - substance abuse counseling and referrals - Group and family counseling - Crisis intervention - Mental health referrals
	Social Services
	- Social service assessment - Referrals to and followup with social service and other agencies for: - basic needs (e.g., food, shelter, clothing) - employment services - legal services - public assistance (e.g., AFDC, Medicaid) - Case management - On-site provision of services (e.g., food pantry) - Transportation

Encouraging Preventive Services for Low-Income Children

The Effect of Expanding Medicaid

PAMELA FARLEY SHORT, PHD, AND DORIS C. LEFKOWITZ, PHD

Every year since 1984, Congress has expanded Medicaid to cover an increasing proportion of low-income children. In this study, a multivariate analysis of data from the 1987 National Medical Expenditure Survey was used to determine whether expanded Medicaid eligibility is likely to be effective in encouraging recommended preventive visits for low-income, preschool children. For low-income children who would otherwise be uninsured, a full year of Medicaid increased the probability of any well-child visits by 17 percentage points, and compliance with the guidelines of the American Academy of Pediatrics for well-child visits increased by 13 percentage points. The generosity of Medicaid fees did not alter the magnitude of these effects. However, even if all uninsured children under 200% of the poverty line were eligible for Medicaid, low-income children would continue to lag behind other children in their use of preventive services. Factors other than insurance and income, such as the lower educational attainment of low-income mothers, explain approximately 80% of the gap between children above and below 200% of poverty. The rate of compliance with the American Academy of Pediatrics guidelines was less than 50% for all preschool children. Departures from the recommended schedule of visits were particularly pronounced in the second year of life and may interfere with children receiving the recommended immunizations in a timely manner. Key words: children; Medicaid; preventive services. (Med Care 1992; 30:766-780)

In their efforts to extend coverage to persons who are presently uninsured, federal and state policymakers have been particularly concerned about uninsured children.

From the Center for Intramural Research, Agency for Health Care Policy and Research, Rockville, Maryland.

Presented at the annual meetings of the Association for Health Services Research in San Diego, California, July 1991.

The opinions expressed herein are those of the authors. No official endorsement by the Department of Health and Human Services or the Agency for Health Care Policy and Research is intended or should be inferred.

Address correspondence to: Pamela Short, PhD, Suite 500, 2100 East Jefferson Street, Rockville, MD 20852.

As a result of continuing federal legislation since 1984, states eventually will be required to cover all poor children up to 18 years of age under their Medicaid programs (Omnibus Budget Reconciliation Act of 1990), and children up to 6 years of age in families with income less than 133% of the poverty line (Omnibus Reconciliation Act of 1989). States have the option of implementing demonstration projects to extend Medicaid coverage to all children with family incomes up to 185% of poverty (Omnibus Reconciliation Act of 1989) and the option of covering all children in families with incomes below Aid to Family and Dependent Children (AFDC) thresholds (so-called "Ribicoff children"). In

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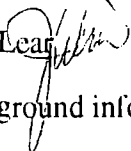
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STATE AND LOCAL PARTNERSHIPS TO ESTABLISH
SCHOOL-BASED HEALTH CENTERS

August 9, 1996

Memorandum by messenger

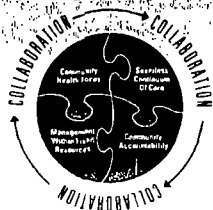
To: Jennifer Klein
From: Julia Lear 
Subj: Background information on school-based health centers

Enclosed are some of the materials we discussed. I also put in the overheads I am using next week in St. Paul. There may be some data of interest.

I will be out of town on Monday and Tuesday but my colleague John Schlitt will be in the office. Please let us know if there are particular questions we could help you address.

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UNIVERSITY
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1350 CONNECTICUT AVE., NW
WASHINGTON, DC 20036
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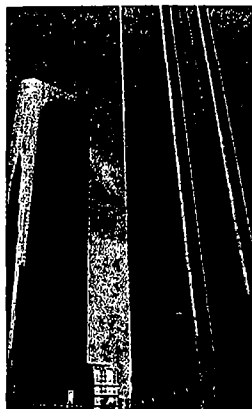
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Joe Geringer, editor

On Structuring Public Health

With health care focusing more than ever on community outcomes, the significance of the role of public health agencies and the contributions they make to community coalitions is increasingly being noticed. CCN Vision has approached several experts to offer their views on where and how public health fits into the changing health care scene, American communities, and the improvements being garnered by a gamut of public and private community participants.

Carol Brown – Director of Data & Community Assessments National Association of County & City Health Officials (NACCHO)

Although the language differs from state to state, state and local governments have a governmental responsibility to preserve and protect the public health. Local public health departments may derive their powers to maintain a healthier community under either a city, county, state, district or other governance structure.

At a local level, government has a responsibility to make sure a health problem is identified and monitored and that the needed services to correct the problem are available. Its mandate, in general, assumes that needed services *are* provided by agencies and institutions, public or private. Community care networks will benefit most from linkages to local public health departments because each unit is located where services are provided, where the people actually live, and where the hospital or health system partners operate.

continued on page 2

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Key Issues Affecting School-Based Health Centers and Medicaid

Julia Graham Lear, Lisa L. Montgomery, John J. Schlitt, Kamala D. Rickett

ABSTRACT: *Public support for establishing school-based health centers has outstripped understanding of how to pay for them in the long term. As a result, a large number of school-based health centers have been started without a clear notion of how they will be sustained. Since 1990, the number of school-based health centers has grown from an estimated 200 to almost 700. A substantial portion of these centers face staffing and service cuts if stable funding mechanisms to support school-based health centers are not put into place. This article addresses issues raised as state governments and the centers consider the possibility of patient care revenue as a component of a long-term funding strategy. (J Sch Health. 1996;66(3):83-88)*

The first school-based health centers were established about 25 years ago. The twin themes of increasing access to care for adolescents and reducing teen pregnancy appear early in discussions of school-based health centers. Their expansion, however, has been fueled primarily by concern that adolescents *in general* have not been well served by the traditional health care delivery system and a desire *in particular* to increase access to health care for low-income students.¹

As described in an Office of Technology Assessment (OTA) report,² barriers to adolescents' access include a high rate of uninsurance and other financial problems; difficulties private physicians may have in identifying and treating behavioral, emotional, and substance abuse problems; and concerns some adolescents have about confidentiality from traditional office practices. While the first school-based health centers were established primarily in high schools, increasingly state initiatives and community programs have developed centers in elementary and middle schools. The 1994 Making the Grade Survey found that 46% of school-based health centers were located in high schools, 28% in elementary schools, 16% in middle or junior high schools, and 10% in alternative or K-12 schools. While state and local government support for school-based health centers increased sharply, the number of centers grew from about 50 in the mid-1980s to almost 700 by the end of 1995.

In late 1995, the U.S. Congress considered legislation creating a new federal grant program (Medigrant) to help states pay for health care to the poor. This legislation termi-

nates open-ended Medicaid support for health care for the poor and replaces it with a fixed-sum grant program. State funding levels are tied to previous federal payments, with some minor adjustments related to demographic changes. This legislation reduces federal program requirements and permits state flexibility in determining who will be eligible for services, what services will be covered, and what standards for service delivery will be enforced. Ultimately, the impact of these changes may be great, but current arrangements will influence the shape of state programs for several years. Thus, the relationships that school-based health centers have developed with their Medicaid agencies will serve as the foundation for future developments.

FUNDING HISTORY OF SCHOOL-BASED HEALTH CENTERS

In 1994, 25 states allocated \$12 million of their Title V (Maternal and Child Health) block grant funds to school-based health centers, a 45% increase over the 1992 allocation of \$8.1 million. In 1994, 25 states also appropriated \$22.3 million in state general funds for school-based health centers, a 140% increase over the \$9.2 million appropriated in 1992. Less easily documented, but nonetheless important, has been support from local governments. Community support has played a critical role in financing school-based health centers. As indicated in Table 1, 11 urban areas that organized multi-site health center programs during the past decade are supporting 46% of the total budget from local resources.

Historically, school-based health centers were started and sustained with public and private grants. A 1990 survey³ reported that: state health departments provided 24% of funding for centers, private foundations 18%, Maternal and Child Health block grants 17%, local governments 12%, schools 8%, community health centers 7%, Medicaid 2%, and private payers less than 1%.

Funds from patient care reimbursement, whether from private insurance or Medicaid, only recently have contributed significantly to the operating costs of school-based health centers. For the 1992-1993 school year, 24

Julia Graham Lear, PhD, Director; and John J. Schlitt, MSW, Making the Grade: State and Local Partnerships to Establish School-Based Health Centers, #505, 1350 Connecticut Ave., NW, Washington, DC 20036; Lisa L. Montgomery, MPA, Health Insurance Specialist, Medicaid Managed Care Team, Health Care Financing Administration, 8946A Town and Country Blvd., Ellicott City, MD 21643; and Kamala D. Rickett, MHA, Associate Director for Program Analysis and Communications, Center for Health Care Strategies, 353 Nassau St., Princeton, NJ 08540. Funding for this article was provided, in part, by the Robert Wood Johnson Foundation. Views expressed in this article are those of the authors and not those of the Foundation. This article was submitted November 21, 1995, and accepted for publication December 15, 1995.

school-based health centers funded under a Robert Wood Johnson Foundation initiative reported that 13% of their operating budgets were supported by patient care revenue, most of which was for services to Medicaid-insured students.⁴ The 11 urban centers reported that third party payments accounted for 8% of their operating budgets. Based on comments by representatives from 24 school-based health centers and by representatives from 12 state governments, the limited support from patient care

revenues and Medicaid is ascribed to several factors:

- State officials perceived the school-based health centers as experimental projects that more appropriately were funded by private and public grant dollars.

- In the past, relatively few privately insured students have attended schools with health centers. Even if students have private insurance, that insurance might not cover preventive health services and might require large out-of-pocket payments.⁵

Table 1
Funding 11 Multi-Site School-Based Health Center Programs in Urban Settings, Fiscal Year 1995

City	# Sites	Total Operating Budget	County/City	%	State Grants	%	Federal Grants ¹	%	Third Party	%	Other	%
Baltimore City	10	\$ 2,069,837	\$ 1,288,510	62	\$ 346,050	18	\$ 251,726	12	\$ 183,551 ²	9		
Baltimore County ²	15	963,179	400,000	42	123,179	13			440,000	46		
Boston ⁴	8	1,243,964 ⁵	126,200	10	190,600	15			146,355 ⁶	12	\$ 780,809 ⁷	63
Bridgeport, Conn.	8	1,541,691	583,070	38	807,621	52			1,000		150,000	10
Dallas ⁸	9	3,178,646	1,999,662	62			24,984	(1)			1,154,000	36
Denver	5	1,043,930	287,176	28	116,000	11	163,000	16			477,754	46
Multnomah County, Ore.	10	1,952,000	1,432,000	73	110,000	6	270,000	14	140,000	7		
New Haven, Conn.	10	1,291,238	288,875	22	683,900	53	50,000	4			268,463	21
St. Paul, Minn.	7	997,478	10,000	1	545,431	55	237,170	24	194,877 ⁹	20	10,000	1
San Jose, Calif. ¹⁰	8	962,801	8,070	1	22,295	2			154,231	5	778,205 ¹¹	47
Seattle/King County, Wash.	8	1,165,571 ¹²	1,163,571	100					2,000	(1)		
Total	98	\$ 16,410,335	\$ 7,587,134	46	\$ 2,945,076	18	\$ 996,880	6	\$ 1,262,014	8	\$ 3,619,231	22

¹ Federal grant supports appears in three categories: Federal grants, Maternal and Child Health (MCH) block grant funds allocated by state government, and MCH block grant funds allocated by local government. Federal Medicaid support appears in the Third Party column.

² Includes \$123,324 in patient care revenues from health-related special education services and \$60,227 in attributed Medicaid payments

³ Baltimore County opened four new sites in January. All sites are part-time. The health department, school system, and university support and maintain these center programs. Billing takes place at all sites. The program also has begun to negotiate contracts with managed care plans.

⁴ Eight of Boston's 13 school-based health centers are sponsored by the Boston Dept. of Health and Hospitals. In fiscal year 1995, there were five full-time and three part-time sites. In fiscal year 1996, there will be six full-time and two part-time sites.

⁵ Reflects a phased-in budget. The fiscal year 1995 budget is closer to \$1.5 million, an amount not including in-kind support from other agencies.

⁶ Rough estimate. Because the Boston Dept. of Health and Hospitals is a city agency, reimbursement flows directly to the general fund and not to the program.

⁷ A one-time external (state) source of funds. In fiscal year 1996, program will be shifted partially to city dollars.

⁸ Dallas figures reflect the 1995-1996 budget which will support nine comprehensive Youth and Family Centers located in high schools but serving clusters of schools including elementary and middle schools.

⁹ Includes \$115,000 in Medicaid payments and \$79,877 in commercial insurance; most payments are made through contracts with HMOs.

¹⁰ In 1993-1994, two full-time and six part-time sites which were open two-four days a week.

¹¹ Support includes \$593,382 from medical sponsor, Good Samaritan Healthy System, \$159,106 from the Good Samaritan Charitable Foundation, and \$25,717 from grants/donations.

¹² In-kind contributions as well as dollar support from non-health department sponsoring health care institutions are not included. Seattle tax levy specifically to fund programs for school-age children contributed \$540,000 for program budgets in 1994-1995. Tax levy legislation will expire in 1997.

Information provided by school-based health center program directors in Baltimore, Baltimore County, Boston, Bridgeport, Dallas, Denver, Multnomah County, New Haven, St. Paul, San Jose, and Seattle/King County.

- Poor adolescents are less likely than their younger counterparts to have Medicaid coverage and, as a result, school-based health centers located in high schools frequently have high rates of uninsured patients.

- Not all services provided to Medicaid-insured students are reimbursable due to state-specific Medicaid plan limitations or exclusions. Some states refuse reimbursement to nurse practitioners unless a physician is on-site when care is rendered, and nearly half of the states prohibit reimbursement for mental health services delivered by a clinical social worker.

- Due to the projected limited revenue potential and the administrative burden associated with billing, some school-based health centers have chosen not to bill either patients or their insurers for services provided. These school-based health centers and their sponsoring organizations have concluded that the cost of billing would exceed the revenues generated.

Despite barriers to billing, organizations that sponsor school-based health centers increasingly find that patient care-related revenues are an essential component to funding these services. The Clinton Health Security Act, in attempting to finance school-based health centers by integrating them into the proposed regional and corporate health plans, contributed to a perception that all personal health services — even those targeted to low-income students — ultimately will be financed through a patient care funding mechanism. Moreover, since school-based health centers commonly report more than 30% of their patients as uninsured, there is a growing sense that available grant dollars should be used to cover the cost of serving those patients.⁴³ Interest in third party payment also accelerated as the numbers of school-based health centers increased and uncertainties about federal funding through block grants and Medicaid grew.

Greater reliance on patient care revenues is not endorsed by all school-based health centers or their supporters. Critics emphasize the large number of uninsured students using the centers and the importance of public health dollars in funding care for the uninsured. Others suggest that a financing strategy that requires school-based centers to fit within a traditional medical services model may undercut the unique blend of social, mental health, and medical services that have been the hallmark of many comprehensive school-based health centers. Health center staff undertake a number of activities, such as classroom health education and work with school faculty and parents, that are not billable. To tie the work of the center to a reimbursement structure that does not recognize these services appears to some to threaten what is most valuable about school-based health centers.⁴⁴

MEDICAID PARTICIPATION IN SCHOOL-BASED HEALTH SERVICES

Until recently, most health services delivered at the school site were not reimbursed by Medicaid. In general, state Medicaid officials maintained that health services provided at schools either were not included in the defined list of services eligible for Medicaid reimbursement, were not provided by eligible providers, or already were paid for by local and state dollars used to employ or pay for the school health providers. Changes in the Medicaid program under the Omnibus Budget Reconciliation Act of 1989

(OBRA 89), as well as federal support for health-related services for disabled children have created opportunities for state Medicaid plans to pay school systems or providers based in schools for specifically defined health services delivered at the school site.

Early Periodic Screening, Diagnosis, and Treatment

OBRA 89 expanded the number of women and children eligible for Medicaid and its related component, the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The EPSDT program is intended to make preventive and comprehensive health services available to Medicaid beneficiaries younger than age 21. Because beneficiary participation in EPSDT had been less than many child health advocates had hoped, OBRA 89 encouraged states to implement the EPSDT expansions by directing the U.S. Dept. of Health and Human Services to set state-specific annual EPSDT participation goals. The Health Care Financing Administration (HCFA), acting on behalf of the Secretary of the U.S. Dept. of Health and Human Services, set goals designed to attain EPSDT participations of 80% or more by 1995. In 1990, after consultation with the states, HCFA added an instruction to the *State Medicaid Manual* regarding the goals. With that prodding, a number of states have looked to schools, with their proximity to children and adolescents, for help in attaining these goals.⁴⁵

Health Services for Disabled Children

Simultaneously with development of Medicaid funding for in-school EPSDT services has been increasing support for in-school health care for children with disabilities. Special education services were mandated for handicapped children through the Education for the Handicapped Act in 1975. Medicaid reimbursement for the health-related services required to educate disabled children was not available until the late 1980s. However, a court decision in 1987 and Congressional action in 1988 opened the door to federal support for medically necessary services for Medicaid beneficiaries.⁴⁶ Congress declared, as part of the Medicare Catastrophic Coverage Act of 1988, that Medicaid funds were available to pay for health-related services. Specifically, Congress stated that nothing under the Medicaid statute should be interpreted to prohibit HCFA from paying for services provided under a state Medicaid plan simply because the services were provided as part of an Individualized Education Plan (IEP).

The extent to which the provisions of health-related services have transformed the health service mix in the schools is demonstrated by data from New York City. In fiscal year 1992, the New York City Health Dept., the official provider of school health services, budgeted \$8.18 million for school health services. In the same year, the city Dept. of Mental Health, Mental Retardation, and Alcoholism Services spent \$5.6 million on school-based mental health services. Two years earlier (the most recent data available at the time), the New York City Public Schools spent \$41.7 million on health education and related services, and \$65.9 million for therapeutic services for special education services.⁴⁷ In terms of resource utilization, health-related services provided to special education students has come to represent the greatest part of health care in schools and growth in this area has led states to press for Medicaid reimbursement for services to its

beneficiaries.

Varied State Experiences

By 1992, it was reported that 28 states had authorized schools to bill Medicaid for at least some services rendered to its beneficiaries. Of the 28 states that had chosen to use school-based providers, 11 indicated they were considering reimbursing for care provided by schools.⁷ While state interest in Medicaid participation in school-based services has grown, states differ greatly in levels of financial support, administrative structures, billing procedures, provider credentials, and how federal revenues received as a result of billing are used, according to a December 13, 1994 memorandum from Sally Bachman, The MEDSTAT Group, to Julia Paradise, Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Services.

One challenge school-based health centers confront in securing Medicaid support for care provided to its beneficiaries has been Medicaid officials' unfamiliarity with the content of health care offered by the centers. As noted, Medicaid involvement with schools is a recent phenomenon. It mostly has involved reimbursement for EPSDT examinations, outreach activities to support the EPSDT program, and provision of health-related services for the Medicaid-insured special education students. Most state Medicaid officials are unfamiliar with school-based health centers and do not know how they differ from traditional school health services. In early 1994, the Health Care Financing Administration began an inquiry into the role of Medicaid plans in the delivery of school-based health services. A workgroup was convened, the so-called Camden Yards Work Group on School-Based Health Care, chaired by Donna Checkett, Missouri Medicaid Director. A report from the workgroup, which was expected in late 1994, has been delayed. Moreover, HCFA and state Medicaid officials express concern that schools may misunderstand basic Medicaid requirements. In a December 22, 1993 memorandum to all regional Medicaid officers, the Medicaid Director commented:

"...for any service to be covered under the Medicaid State plan, it must be included among those listed in section 1905(a) of the Social Security Act (the Act). There is no benefit category in the Act titled 'school-based services.' Consequently, the State must describe its school-based services in terms of the specific 1905(a) services which will be provided..."

The variety of state-supported school health services complicates the policy making on reimbursement for Medicaid officials. For example, the Connecticut Public Health Dept. defines several different types of health services in schools including basic school health services, enhanced clinical services, part-time school-based health centers (for schools with less than 500 students), and full-time comprehensive centers. The latter two models provide on-site primary care, function as a medical home, and are organized by a mainstream health care organization which provides 24-hour back-up as well as weekend and vacation coverage. However, when the Dept. of Public Health and Addiction Services sought reimbursement under Medicaid for its school-based health center services, the state Medicaid officials neither understood that the centers truly were providing primary care, nor that state grants to

support the centers were paying only a portion of the cost. Thus, health department officials spent more than three years discussing the issue of reimbursement with the state Medicaid officials before approval for Medicaid reimbursement was granted.

The Connecticut Medicaid program is not the only one to question payment for health services delivered to beneficiaries at a school-based health center. Delaware has chosen not to reimburse for services provided at its school-based health centers. In this case, the school-based health center services primarily are grant-funded by the state and the Medicaid office has argued successfully that to reimburse for services through Medicaid would constitute duplication of payment. The health care organizations that sponsor the school-based health centers have countered, unsuccessfully, that the state grants provide only partial support to the centers.

Other states have taken a different position. New Jersey and North Carolina treat school-based health centers sponsored by health care organizations as satellite facilities and reimburse as if the services were delivered at the main site of the sponsoring agency. As a result, in New Jersey, health centers at Jersey City's Snyder High School and Dickinson High School sponsored by the Jersey City Family Health Center, a federally funded community health center, generated \$150,000 in revenues during the 1992-1993 school year for care provided by a Federally Qualified Health Center (FQHC). Patient visits by Medicaid enrollees, like visits to the Family Health Center itself, were reimbursed on a cost basis. In North Carolina, a county health department-sponsored school-based health center in Greensboro, generated \$20,000 in the 1993-1994 school year, with North Carolina Medicaid using a fee schedule to reimburse the health center. In New York, the state offers school-based health centers two reimbursement options. Sponsoring hospitals or diagnosis and treatment centers can bring their school-based health centers under their state-issued operating certificates, which allow the centers to bill at the sponsoring facility's all inclusive Medicaid rate, or the centers can bill under a state-established fee schedule for school-based health centers.

The dramatic growth of managed care in the past several years complicates the entry of school-based health centers into the health care financing mainstream. In 1993, private managed care plans were found in 46 states and the District of Columbia.¹⁰ For Medicaid beneficiaries, some form of managed care was available in 45 states and the District of Columbia.¹¹ In 1991, 2.6 million of the 28.3 million Medicaid beneficiaries were enrolled in managed care plans; three years later, 8.1 million of 33.6 million Medicaid beneficiaries were enrolled. This change represented a 189% increase compared to a 18.9% increase in the total number of Medicaid beneficiaries during the same period, according to personal communication with the U.S. Dept. of Health and Human Services, Health Care Financing Administration, Medicaid Managed Care Office, June 30, 1994.

While coordination of school-based health centers and Medicaid managed care initiatives is in its infancy, states such as Massachusetts, Rhode Island, Oregon, and Connecticut are taking steps to link school-based health centers and managed care organizations. Other states such as California and Maryland are facilitating local agree-

ments between managed care plans and school-based health centers. However, a far greater number of states have done little to develop relationships between these two entities.¹ To encourage coordination between managed care organizations and school-based health centers, in June 1995 the Director of the Health Care Financing Administration Medicaid Managed Care Team sent a memorandum to the state Medicaid directors providing a list of state contacts knowledgeable about school-based health centers and noting explicitly that "...We at the Health Care Financing Administration believe such linkages are important..."

ISSUES IN LINKING SCHOOL-BASED HEALTH CENTERS AND MEDICAID

The need for school-based health centers to develop relationships with Medicaid and managed care plans presents an imposing challenge. Many individual school-based health centers have not worked with either private or public health insurers and are unfamiliar with the language and requirements of organizations that purchase health care. State offices that administer school-based health center programs generally have focused exclusively on grants strategies for funding the centers and equally are unfamiliar with health care financing issues. However, state Medicaid programs, which have little experience with school-based health centers, increasingly have become involved with other kinds of health services in school and have some knowledge to contribute to the discussion. As described below, specific issues must be addressed for Medicaid policymakers and school-based health centers to negotiate a better fit between these different approaches to organizing better health care for low-income children.

Duplication of Payment

One of the most pressing issues from a Medicaid perspective is assuring that its reimbursement for school-based health care does not result in duplication of payment. Such concerns have deterred several states from reimbursing care for Medicaid-enrolled students. In these states, Medicaid officials have taken the position that state or other grants to support the centers already were paying for the care of Medicaid enrollees. The task for school-based health centers and public health officials has been to document that grant support is not paying the entire cost of care and Medicaid is not being asked to pay for care funded under other arrangements.

Medicaid managed care programs present other concerns. Fees are paid to managed care plans based on an estimate of what the state would pay for an actuarially equivalent group of people under a fee-for-service arrangement for a given time period, usually a year. At the same time, some school-based health centers seek permission to bill Medicaid separately for services rendered to its beneficiaries. As a result, there exists the potential for states to pay twice for services provided to Medicaid children and adolescents. A solution to this problem may involve "carving out" funds for services provided by the school-based health centers from the state centers (similar to arrangements made in Maryland and New York for family planning services) or using either the state contracts with the managed care plans or the local plan contracts with health care providers to assure that school-based health centers are included in managed care networks.

A related issue is the development of an adequate capitation rate for adolescent health care. If the capitation rate is based on the historic patterns of under-utilization of health services by adolescents, the capitation rate has the potential for locking in the pattern of underservice. An inadequate capitation rate guarantees insufficient funds to expand the service system sufficiently to offer adolescents an appropriate level of care.

Free Care

An obstacle to arranging for Medicaid reimbursement of services provided in schools has been a statutory prohibition against Medicaid reimbursement for services provided free of charge to non-Medicaid patients. This provision, however, does not apply to services provided under the Individuals with Disabilities Act (IDEA) or to Title V grantees and providers. With Title V providing funds to a substantial number of sponsors of school-based health centers, the Title V exclusion may eliminate the free care barrier for many school-based health centers, according to a March 10, 1994 memorandum from Linda Sizelove, Health Care Financing Administration Medicaid Bureau, to Camden Yards Work Group on School Health.

Quality Assurance

State Medicaid plans have addressed quality assurance, in part, by specifying the provider qualifications required for participation in the medical assistance program. Under Medicaid managed care programs, the state Medicaid plans are giving more intense attention to quality of care measures and plans administering Medicaid managed care initiatives will be required to document the degree to which they meet certain quality goals. In this area, there is a good fit between managed care and school-based health centers. Nearly half the states have outlined quality assurance activities for the school-based health centers. These activities take one of three forms: the state requires a school-based health center to participate in the quality assurance programs of an external organization such as the medical facility with which the center is affiliated; the state provides guidelines to school-based health centers outlining ways in which quality assurance activities should be conducted; or the state administers a quality assurance program which may include site visits, chart reviews, grievance process reviews, and quarterly reports. Most comprehensive school-based health centers are using computer-based registration and encounter systems that permit reporting the kinds of data likely to be required by the managed care plans.

Some managed care plans have been reluctant to establish formal relationships with school-based health centers due to the plans' uncertainty about quality of the services being provided. A precondition to negotiating a contract between a school-based health center and a managed care organization is assuring that the medical director of the managed care organization is comfortable with the care provided by the school-based health centers. Reaching this goal has required health centers to host site visits, share clinical data, permit review of medical records, and respond to questions concerning operating procedures, productivity, and provider training. Health Start, a nonprofit corporation in St. Paul, Minn., which operates seven school-based health centers as well as several community clinics, successfully undertook all these steps to reach a contract

with RamseyCare, the largest Medicaid managed care provider in Ramsey County. With 75% of Health Start's patients expected to be enrolled in managed care by the end of 1994, successful negotiations were essential to survival of school-based health centers.¹²

School-Based Health Center Services and Provider Teams

One approach to addressing concerns about the content of care is to define clearly the service package and describe the providers who offer that package. An increasing number of states either mandate or recommend a specific model for school-based health centers.¹ At present, 22 states have developed guidelines, with some 12 described as comprehensive.

While product standardization is an essential component of quality control and linkage of school-based health centers to managed care systems, the drive toward standards creates tension with one of the strengths of school-based health centers — community control. A long-standing tenet of school-based health centers is that they are overseen by a community advisory committee and that key policies and program direction are defined at the local level. Accommodating the need for flexibility at the local level while recognizing the importance of defining a set of care services is one of the key challenges of the next several years.

A Single Unified Medical Record

Development of a single, unified record for each patient is the embodiment of the medical home concept and the foundation on which managing patient care rests. Information exchanges between school-based health centers and managed care plans have been limited, making the establishment of a unified medical record difficult at best. Yet the managed care provider may have accepted contractual responsibility for complete case management of its enrolled patients. In many cases, lack of patient information sharing is the result of the two providers not having established a formal relationship. The provider's desire to honor patient confidentiality and to devote limited time to patient care rather than to administrative tasks also may contribute to the difficulty of finding a quick solution. In Massachusetts, the state Medical Assistance Division (Medicaid) has facilitated a solution to this problem by convening a work group of managed care plans that has developed a universal communication form to be used for exchanging data between the school-based health centers and a child's medical home. In St. Paul, Health Start and RamseyCare included requirements on medical record information exchange in their contractual agreement.¹⁰

TOWARD THE FUTURE

The last half-decade of the 20th century offers both opportunity and peril for school-based health centers. In recent years, states expanded the number of children covered by Medicaid and are implementing Medicaid managed care with the purpose, in many states, of continuing to increase state capacity to guarantee care for low-income children. These developments may create an opportunity for school-based health centers to become part of a comprehensive service network for children. In this approach, school-based services could be supported

partially through part of the capitation rate or through separate state funds.

The growth of managed care, especially the growth of Medicaid managed care, however, also could limit the replication and sustainability of school-based health centers. There may be financial incentives for managed care plans to exclude school-based health centers from the provider networks. There may be administrative complexities that deter contractual relationships between insurers and school-based health centers. Although managed care and the school-based health centers share the goal of improving access to primary preventive care, competition for scarce primary care dollars to fund those services, may impede school-based health center participation in the new health care system.

For school-based health centers to secure their role as part of a network of accessible services for school-aged children, state and local sponsors must pay particular attention to documenting service delivery gaps for children, identifying the services the school-based centers provide to fill those gaps, and monitoring the political and policy discussions that attend the development of managed care initiatives. Inclusion of school-based centers in the publicly supported system of care for Medicaid beneficiaries will depend on the long-term presence of school-based health center representatives at the bargaining table as future arrangements for primary care are hammered out. ■

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ORIGINAL ARTICLE

Reorganizing Health Care for Adolescents: The Experience of the School-Based Adolescent Health Care Program

JULIA GRAHAM LEAR, Ph.D., HOPE BURNES GLEICHER, M.S.W.,
ANNE ST. GERMAINE, Ph.D., AND PHILIP J. PORTER, M.D.

During the past decade, two forces emerged on the health scene that may alter significantly the delivery of health services to adolescents in the future. These are 1.) a growing public recognition of health problems and health-compromising behaviors among adolescents that impede their ability to complete school and become productive members of the workforce, and 2.) the increasing acceptance of school-based health centers as appropriate mechanisms for addressing adolescent health care needs.

In the late 1980s, The Robert Wood Johnson Foundation launched a multi-site demonstration effort, The School-Based Adolescent Health Care Program, to test on a large scale the ability of school-based health centers to increase access to health care for low-income young people, to provide comprehensive services at the school, and to secure the commitment of community institutions to participate in and sustain the school-based health centers. This paper reports on the progress of 23 health centers established under this program toward achieving these goals.

History

The School-Based Adolescent Health Care Program built on accumulating concern about the health status of many adolescents and a nearly 100-year history of developments in school-related health care. Adolescent health issues emerged as a focus of national attention in the late 1960s and 1970s when the population in the 15-24 year age group increased by 77% from 24 million in 1960 to 42.5 million in 1980. Concurrently the Surgeon General reported that these young people were the only age group whose mortality rate was higher in 1979 than in 1960 (1).

Throughout the 1980s, while rates of death and disability decreased somewhat, the health community took increasing note of the immediate and long-term negative effects of risk-taking behaviors (2). The epidemic in previously recognized sexually transmitted diseases, the new risk of human immunodeficiency virus (HIV) infection, the continued blight of unplanned pregnancies, as well as persistent alcohol and other drug-related problems compelled increased attention to adolescent health problems. Awareness that five million adolescents have no health insurance, and many more are underinsured prompted concern that financial barriers may limit access to health services that could potentially address these problems (3).

That policy makers and health providers would turn to schools as a locus of care for responding to these needs represents a rethinking of an old idea. Providing medical services in schools to achieve both public health and child health objectives has a long

From the School-Based Adolescent Health Care Program, Children's National Medical Center (J.G.L., H.B.G.), Adolescent Health Program, Minneapolis Public Schools (A.S.G.), Minneapolis, Minnesota and School-Based Adolescent Health Care Program, Harvard University (P.J.P.), Cambridge, Massachusetts.

Address reprint requests to: Julia Graham Lear, Ph.D., School-Based Adolescent Health Care Program, Children's National Medical Center, 111 Michigan Avenue, NW, Washington, DC 20010.

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history. In 1892, New York City officials initiated the first school health program which assessed and, if necessary, excluded from the classroom children with contagious diseases. In 1902, they expanded the program to employ the first school nurse who cared for student patients and followed their illnesses and recovery (4).

As school health programs were adopted across the country, health screening and communicable disease control remained their principal focus. By 1980, schools employed 45,000 nurses to assure that immunizations were complete, screen for vision and hearing problems, and refer children for medical care. A few school districts contracted with physicians to conduct sports physical examinations and, in the more generously staffed school systems, health programs employed a variety of counselors, social workers, health educators, and substance abuse counselors at least on a part-time basis.

As the twentieth century draws to a close, school health services vary widely across the nation. By state law, about one-half of the states require vision and hearing testing; 16 require evidence of a physical examination, but none requires evidence of treatment for problems found (5). Some local school systems such as in New York City, employ no school nurses; others, such as in Denver, employ nurses or nurse practitioners in all schools.

Although most school systems have continued to limit their health role to screening and prevention services, in a few communities schools have explored the possibility of developing health programs that can not only identify but also treat the health problems of students.

The development of comprehensive, multidisciplinary staffed health centers in schools has occurred slowly, following varying paths in different communities, and involving primary as well as secondary schools. Events in Cambridge, Massachusetts; Dallas, Texas; and St. Paul, Minnesota suggest the two central themes that have emerged in the evolution of the school-based health center model.

School-based health care can provide accessible, affordable health care to poor children.

In 1967 the Cambridge health department began providing medical services to school children at a clinic in a Cambridge K-8 school (6). A nurse practitioner-staffed clinic opened 7 years later in a Cambridge high school. In 1970, the West Dallas Youth Center at Pinkston High School, founded as an outreach center for the federally funded Children and Youth Program based at the University of Texas Health Sciences Center Pediatrics Department, be-

came the nation's first high school to offer services provided by nurse practitioners, physicians, social workers, nutritionists, and health educators. The finding of these early pilot programs—that school-based health centers are a workable, effective means to increase young people's access to care—has been repeated in a variety of other communities nationwide (7-9). Two multi-grant national programs supported by the Robert Wood Johnson Foundation in the late 1970s and early 1980s, as well as single-site projects funded by the same foundation in Chicago, Illinois; Kansas City, Missouri; Flint, Michigan; and Houston, Texas also confirmed the earlier experience (10,11).

School-based health services may also be an effective means of reducing rates of teen pregnancies and improving birth outcomes for young women who do become pregnant.

The role of school-based health centers in preventing or delaying teen pregnancies and improving birth outcomes has been debated, but the potential of these health centers for addressing issues related to adolescent sexual behavior has fueled much of the interest in school-based health centers. In 1973, the Maternal and Infant Care Program at St. Paul-Ramsey Medical Center opened a comprehensive health center in Mechanic Arts High School primarily to provide pregnancy prevention, prenatal care, and postnatal care. Augmenting these services was a child care facility designed to retain parenting teens in school. The St. Paul project leaders reported that patients served at the school clinic had a lower incidence of obstetric problems than adolescent patients treated in the community (12). It was also reported that the health center reduced initial and repeat teen pregnancies as well as school drop-out after delivery (13). A recent reanalysis of the St. Paul data, using city-wide birth statistics and longer time frames, concluded that the health centers had not reduced teen births (14). Improvements in birth outcomes were not re-evaluated.

Reports of the positive impact of school-based health centers on adolescents' access to health care as well as teen birth rates fostered support for the school-based health center model. That many physicians were attracted to the concept was demonstrated in a 1986 American Medical Association survey of primary care physicians. Almost one-half of those responding said that general medical care clinics, including those that provide contraceptive information, should be available in all high schools regardless of the school's maternity rate (15).

Although there was growing enthusiasm for this

new, intensified approach to health services in schools, proposed implementation of the school-based health center model also generated heated controversy in some communities. Both local residents and national groups argued that schools are not an appropriate locale for the discussion or provision of contraception. Opponents also maintained that school-based health centers would lead to a loss of parental control over their children's health care. In several cities applications to The Robert Wood Johnson Foundation program were not made, or were later withdrawn, owing to opposition from some segments of the population. However, in schools that received Johnson Foundation funds, there has been little expressed opposition. No parents in these schools have organized against the health centers, and it appears that, where opposition developed, it came from outside the school community. This fact together with the willingness of the health centers to refer students off site for contraceptive services and the requirement that all students receive written parental consent to use the health centers appears to have satisfied parental and community concerns as borne out by generally high enrollment.

By the end of the 1980s, the American Academy of Pediatrics, the American Medical Association, the Society for Adolescent Medicine, the American School Health Association, the American Nurses Association, the National Association of Pediatric Nurse Practitioners, the National Association of School Nurses, and the National Association of State School Nurse Consultants had all adopted statements in support of the continued development of school-based health centers (16–18). In 1990, the United States Public Health Service, through its national goals statement, *Healthy People 2000*, identified school-based and school-linked health services as model programs that could help achieve the Year 2000 health objectives for young people (19). This recommendation was repeated 9 months later by the Congressional Office of Technology Assessment in its report, *Adolescent Health* (20).

Methodology

To describe the progress made by The Robert Wood Johnson Foundation grantees in developing 23 school-based health centers over the past 3 years, we have analyzed data provided by these projects in quarterly management information reports. These reports summarize characteristics of newly enrolled patients, patient visit volume, patient visits by pri-

mary diagnosis or service, and services by provider. Patient registration and encounter data are collected by health centers using either hand counts or a computerized data management system. There are no penalties or rewards from the granting agency linked to data. Within the limits of staff constraints, the data appear to reflect accurately the clinical services provided.

Additional information on parental consents, numbers of actual student users, and school enrollment is recorded and reported by staff of participating health centers. Information related to project startup as well as implementation is gathered through frequent telephone conversations and annual site visits by program office staff and expert consultants.

Program Implementation

The Grantees

A variety of institutions applied for grants to support school-based health centers. Ultimately, project sponsorship has been spread among three academic health centers, four teaching and community hospitals, four school systems, five county health departments, and two not-for-profit agencies. Community health centers participate in school-based health centers through affiliation with the funded teaching hospitals (two) or school systems (two).

The grantees are located in 11 states—Alabama, California, Colorado, Florida, Louisiana, Michigan, Minnesota, New Jersey, New York, North Carolina, and Tennessee—and 14 cities.

Early Program Experience

In the first year of the program, 1987–1988, a few projects began providing services immediately. Most projects required 4–8 months to renovate health center space, hire staff, organize clinical services, negotiate relationships with the school staff, and market the services to the school faculty, staff, students, and their parents. This relatively brief start-up period is probably related to the lengthy pre-funding activities generated by the program requirement that detailed letters of support from community leaders be included with the grant proposal.

During the first grant year, 34% of the students had parental consent to use the health centers (Figure 1). The number of students with consent ranged from a low of 3% to a high of 97%. Total patient

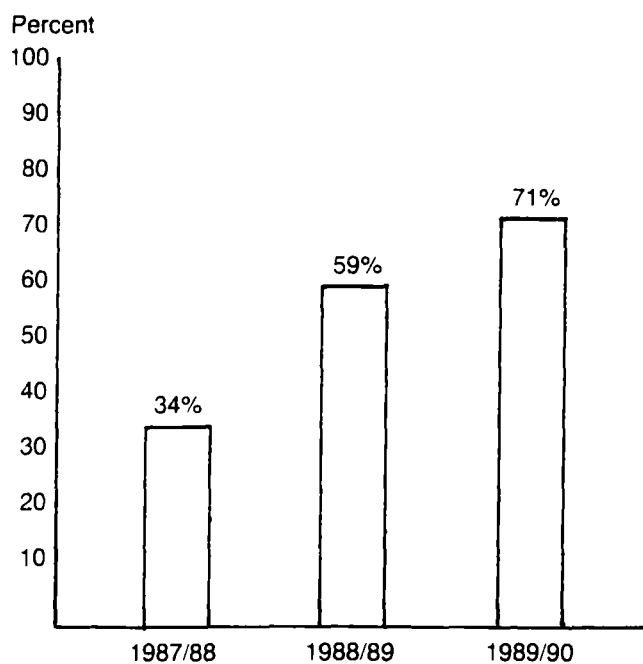


Figure 1. Percentages of students whose parents consented to care.

visits ranged from 31 at a clinic that struggled with temporary space to 2,200 at a health center that had been opened the year prior to Johnson Foundation funding.

Recent Program Experience

Data provided in Tables 1–3 describe the experiences of The School-Based Adolescent Health Care Program grantees as they became established providers.*

During the second grant year (the first full operating year), the percentage of students who had parental consent to use the health centers increased from 34 to 59% and in the third grant year, the average rose to 71%. These data are consistent with those reported from four schools in St. Paul in 1984–1985 (21).

Although total patient visits varied among the 23 sites, Table 2 indicates that 15 of the 23 reporting health centers provided more than 2,000 patient visits during the 1989–1990 year. Of these, six provided more than 3,000 patient visits. The 3.7 visits-per-patient ratio provides evidence of the potential of these health centers for providing continuity of care.

*The number of health centers has varied slightly from year to year. In 1987–1988, 22 health centers provided services, a 23rd center which was funded 6 months later did not open until 1988–1989. In 1989–1990, the health center number remained at 23, but that number reflected the loss of one clinic in New Jersey and the addition of a third clinic at the Denver project. A 24th clinic is scheduled to open in 1991.

Again, program experience is mirroring that reported by other full-time, comprehensive health centers (21–23).

Health center users. Student users are divided about equally between males and females. However, more young women than young men have made health center visits, with 63% of the visits in 1989–1990 being made by females (See Table 2). Although males make fewer visits to health centers than females, they use school-based services in greater numbers than they use other community-based services in greater numbers than they use other community-based adolescent services (11). In several program projects, visits by males approach 50% of the total.

Patient visits classified by race/ethnicity also vary somewhat from the general student population. Grant applications, which used 1986 school data, indicated that student enrollment by race/ethnicity was African-American, 52%; Hispanic, 28%; non-Hispanic white, 16%; Asian, 4%; and Native

Table 1. Student Enrollment and Visits, 1989–1990

State	High school	Enrollment	Parental consents (%)	Clinic users	Total visits	Visit rate ^a
AL	Ensley	1,200	96	714	2,555	3.6
CA	Los Angeles	2,706	82	910	1,518	1.7
CA	Jordan	1,790	86	951	1,736	1.8
CA	San Fernando	2,764	58	954	3,803	4.0
CA	Overfelt	1,950	67	549	1,653	3.0
CA	San Jose	625	74	405	1,560	3.9
CO	Lincoln	1,572	59	727	4,246	5.8
CO	East	1,511	53	555	2,326	4.2
CO	Manual	1,007	49	255	1,050	4.1
FL	Northwestern	1,890	41	484	2,840	5.9
LA	Istrouma	700	100	674	3,294	4.9
LA	Westdale	640	87	405	2,827	7.0
LA	Carver	1,447	66	766	2,439	3.2
MI	Northern	1,300	57	873	2,553	2.9
MI	Northwestern	1,650	58	815	1,827	2.2
MN	Southwest	1,219	N.A.	421	1,674	4.0
MN	Harding	1,644	77	487	2,834	5.8
NJ	Snyder	1,200	70	785	3,538	4.5
NY	Taft	2,400	63	800	3,129	3.9
NY	Morris	1,700	85	1,450	3,049	2.1
NY	Far Rockaway	1,500	75	897	4,010	4.5
NC	Gillespie	766	48	269	1,805	6.7
TN	Northside	925	100	602	2,803	4.7
Total		34,106	71	15,748	59,069	
Average		1,483	71	685	2,550	3.7

^aVisit rate shown as visits per patient.

^bThe larger number of parental consents than students enrolled reflects student drop-outs and transfers in during the school year.

Table 2. Patient Visit Data^a for 1988–1989 and 1989–1990^b

Data	1988–1989	1989–1990
Total visits (<i>n</i>)	49,337	59,069
Repeat visits	81	84
New visits	19	16
Patient visits by sex		
Female	65	63
Male	35	37
New registrants by most recent medical care		
Within one year	59	58
1–2 years	22	21
2+ years	19	21
New registrants by insurance status		
Medicaid	24	18
Private insurance	27	25
Self-pay	49	58
New registrants by routine source of medical care		
Physician/clinic	63	72
Emergency room	8	8
No regular source of care	29	21
Patient visits by race/ethnicity ^c		
Asian	2	1
African American	56	57
Hispanic	21	19
Non-Hispanic white	19	20
Other	3	3
Patient visits by primary diagnosis/service ^d		
Acute illness/accidents	25	26
Mental health related	20	21
Immunization, vision/hearing testing, other	13	12
Reproductive health	13	12
Physical exams	12	12
Chronic disease management	5	4
Acne/other dermatology	4	4
Nutrition/eating disorders	3	3
Dental services	1	2
Substance abuse	1	1

^aData cited as percentages unless otherwise indicated.^b23 school-based health centers reporting.^c8,000 patient visits (14% of total) not reported by race/ethnicity.^d13,000 patient visits (22% of total visits) not reported by primary diagnosis or service.

American/other, 1%. African-American students accounted for about 57% of patient visits in 1989–1990. Hispanic students, who had been under-represented in the first two years' patient visits, remained so and declined from 21% of patient visits to 19% of total patient visits in 1989–1990. White students constituted 20% of visits, a number that has changed little during the program. Since these data are *visit based* and not *unduplicated user based*, conclusive statements about the propensity of var-

Table 3. Patient Visits by Primary Provider

	1988–1989 (%)	1989–1990 (%)
Nurse practitioner/physician assistant	44	41
Social worker	11	14
Nutritionist	2	2
Health educator	6	4
Pediatrician/family physician	17	17
Psychologist	7	4
Nurse	6	9
Dentist	(1)	1
Ob/Gyn	(1)	(1)
Midwife	(1)	(1)

ious ethnic groups to use the health centers cannot be made. In general, health center staff report that clinic users reflect the population of the school. For the most part this is consistent with earlier descriptions of clinic users (8,24,25).

Data provided by new registrants suggest that the student users of the health centers are medically underserved. As indicated in Table 2, this past year 21% reported that they had not received medical care for more than two years; 58% described themselves as self-pay and were presumed to be uninsured, and 21% said they had no regular source of medical care. Although family insurance status information reported by adolescents should be used with caution, Newacheck and McManus have previously described a large uninsured adolescent population (3). One in seven adolescents was reported as uninsured in 1984.

Health center staffing and hours. All projects are open at least 7 hours a day, 5 days a week during the school year. Summer and vacation hours are generally limited, with the sponsoring medical institution providing back-up clinical hours and telephone service. In some centers, the students are given the on-call number for the clinicians; in others, the students are asked to report to the back-up facility outpatient department or emergency room if problems occur when the center is not open.

Core staff vary little from high school to high school. Part-time staffing, however, shows considerable diversity and reflects the local availability of in-kind contributions from affiliated agencies.

Of the 23 reporting health centers, 22 have similar full-time staff: a medical assistant/receptionist and a nurse practitioner or physician assistant. Mental health services are provided primarily by a master's level, clinically trained social worker. In 11 health centers the social worker is full-time, and in 4, half-

time. Other centers provide mental health services through part-time psychologists and psychology graduate students and, in one case, a psychiatrist.

All health centers have a pediatrician or family practitioner on site who can see students during at least one session (4 hours) a week. Three centers also have an obstetrician/gynecologist on site for limited hours. Obstetrical/gynecological (Ob/Gyn) staff members have proven difficult to maintain owing to rising costs. Two projects employ nearly the equivalent of a full-time physician; most use significantly less physician back-up. Eight centers engage a physician for two sessions a week and eight more schedule a physician for only one session a week. With one session a week of physician time, it is difficult to schedule students who need to see a physician and also review charts and also review charts and arrange adequate clinical conference time with other staff.

Five health clinics staffed by academic medical centers and teaching hospitals have developed training rotations for pediatric and, in one case, family practice residents. Although the rotations are described as very popular with 2nd and 3rd year residents, the training programs have been introduced only after issues of on-site supervision, advisory board support, and clinic staff support have been thoroughly explored.

A key feature of the health centers is that the staff members are multi-disciplinary and acknowledge the critical role that psycho-social issues play in adolescent health concerns. Case conferencing and consultation encourage cross-disciplinary thinking and the melding of skills to address adolescent health problems.

Patient visit by provider data reflect the staffing patterns at the health centers. Nurse practitioners and physician assistants provided the greatest amount of care—43% of total visits in 1989–1990. (Table 3) In the third grant year, physicians continued to provide 16% of total visits and social workers maintained their visits at 14% of the total. The nurses, however, increased their visits by 100%—from 6% to 12% of the total.

Patient visits by type of service. As Table 2 indicates, primary services requested by and provided to students are truly comprehensive. Data are not submitted on secondary or tertiary diagnoses or services. The importance of providing a full range of services was attested to by Edwards et al. (12) in describing the poor start experienced by the St. Paul program when its first clinic began by offering a full

range of reproductive health care. Only when services expanded to include physical examinations, immunizations, and weight control programs did the clinic enrollment begin to grow.

Treatment of acute illness and injury remains the leading service provided (26% of total services). Mental health-related care, including individual as well as group therapy, constitutes 21% of services. Physical examinations, reproductive health care, and a miscellaneous category that includes important school-related health services such as immunizations and vision/hearing screening each represented 12% of total visits. Chronic disease management and skin problems each involved 4% of services. Dental services, available at only a few sites, represented 2% of total visits. Despite public concern and program focus on substance abuse, alcohol and other drug abuse services were only 1% of total service. Although some schools have separately funded and operated substance abuse programs, school-supported services generally focus on prevention rather than assessment and treatment. Thus it seems that the school-based health centers need to examine carefully the extent to which their services meet the needs within the student population.

Perhaps as significant as the diversity of the services provided is the length of time students are spending with providers. In contrast with national data that showed that 20% of adolescent medical visits lasted 16 minutes or more (27), the health centers reported in 1989–1990 that 46% of visits lasted longer than 20 minutes; 36% lasted between 10 and 20 minutes, and 19% lasted under 10 minutes.

Nonclinical activities. In addition to direct clinical service, school-based health center staff are engaged in a variety of extramural activities to promote student health. From once-a-year school fairs to ongoing participation on crisis intervention teams, some health center staff are investing substantial time in outside-the-clinic programs. As indicated in Table 4, providing classroom education is the most common of these functions.

Most health centers have assumed a number of nonclinical responsibilities. Of the 18 grantees, 16 have undertaken at least three health center/school staff collaborative efforts.

Discussion

Program experience to date documents that it is politically and institutionally possible to establish

Table 4. School-Based Health Center Participation in Extramural Activities by Activity Type^a—1990

Activities	Participating projects (n)
Classroom health education	16
Schoolwide health fairs	9
Schoolwide immunization programs	8
PTA/other parent education	7
Nonclinic sports/other physicals	6
Schoolwide crisis intervention teams	5
Teacher education	5
Drop-out prevention	5

^aActivities reported by 18 program grantees.

comprehensive, school-based health services in geographically and ethnically diverse communities and that students will use these services with a frequency that makes continuity of health care possible.

An evaluation study supported by The Robert Wood Johnson Foundation is assessing the impact of school-based centers on access to care and health status.

The utilization data currently available suggest strongly that these programs have, at the least, laid a foundation for intervention in high-risk problem areas by 1.) serving a large percentage of students at each school, 2.) reaching an ethnically diverse population of male and female students, 3.) providing health education and services that relate to key adolescent problems, and 4.) having multiple contacts with students. With 46% of patient visits lasting 20 minutes or longer and the average student user having nearly four visits a year, the health centers have created the opportunity for impact. Future research should examine the degree to which improved access to care improves health status and evaluate the costs/benefits related to this new mode of health care delivery.

Community acceptance of these health centers is evident. Of 24 sites, 23 started up in less than a year and without community conflict. More than 90% of parents who consented for their children to use the health centers chose not to limit services that their children could receive. In addition, the diversity of geographic location and institutional sponsorship suggest that belief in the need for more adolescent health services and the appropriateness of school-based health services is not limited to a narrow sector of the public or health care community.

Equally important as community acceptance is adolescent approval of the health centers. The continued growth in student enrollment, the number of

repeat visits, and the use of health centers to address confidential mental health needs as well as to secure more routine care all suggest that students are receptive to school-based health centers. The fact that the health centers draw patients from all segments of ethnically diverse high schools also indicated broad appeal and acceptability.

As noted at the beginning of this article, the great impetus for exploring new approaches to organizing adolescent care is growing recognition that many young people are at risk for serious physical and mental health problems that impede their ability to complete school or become effective workers. Because schools offer the setting most accessible to young people, reorganizing the health services delivered in school has been the approach most attractive to those concerned about unmet adolescent health needs.

The transformation of school health care from a nurse's office to a comprehensive center staffed by a multi-disciplinary team involves fundamental organizational changes. First, the role of the school nurse is being reconsidered. School nurses have historically been constrained by school board directives and state law from performing important health services. Because of these limitations, expectations of school health have been reduced. Overcoming low expectations for school health programs challenges school districts and health officials who attempt to broaden the school health mission. Although some school nurses, as in Baltimore, have welcomed the opportunity to participate in a comprehensive program, others have resisted the structuring of new roles (28).

The health centers differ from nurses' offices not only in providing a new scope of service but also in bridging the traditional separation of school health from other health care institutions in the community. School-based health care is integrated with that provided by others in the community. The health centers are operated by qualified institutional medical providers. Even if a school system administers the grant, under The Robert Wood Johnson Foundation program, it may not hire health professionals directly but must contract with hospitals, health departments, or other suitable providers to manage the delivery of health services. Thus, health services provided at the school are a unit of a larger health care institution.

This strategy, rooted in the belief that the way to strengthen school health services is to make those services an integral part of the community's health care system, relies on traditional providers to assure

that students served by school-based health centers receive needed care. The sponsoring medical institutions arrange medical referrals, address infection control, arrange laboratory pick-ups, protect medical confidentiality, provide medical back-up when the health centers are closed, and respond to the myriad of issues that arise in the daily management of the health centers. Additionally, and perhaps most importantly, these institutions struggle with the difficulty of securing specialty care for young patients who are either uninsured or underinsured.

While the location of school-based health centers would appear self-evident, increasing references by policymakers and program analysts to school-linked health centers as including both school-based and off-site services may blur this characteristic of school-based health centers. This is not a matter of nomenclature. There is a fundamental difference between delivering services on-site at a school and using a case management system to organize the delivery of care at locations away from school. The research that supports positive outcomes related to increased access to health care for adolescents at school-based health centers has not been shown to apply to school-linked programs.

From the beginning of health service delivery in schools, there has been on-going debate over how much health care should be provided in schools, who should provide the care, and how it should be funded. However, a consensus is emerging that for some children these protracted debates are costly. Their unmet physical and mental health needs are so great that these children will be lost to the future unless the needs are addressed quickly; and reaching these children through the school has become an increasingly acceptable strategy.

It would appear that the favorable experiences to date from the school-based health centers together with a political need to respond to the urgent problems of poor children will drive continued development of school-based health centers. Nevertheless, as some projects found, overcoming barriers to better care is not a simple task. During the first 2 years of the program, one project found that it could not resolve space renovation issues or conflicts with established school health personnel. Other projects have found that staff turnover due to salary constraints or normal attrition have limited anticipated growth.

Physician staffing has been a particular challenge. To control costs, 8 of 23 health centers provide only one session a week for the health center physician.

With 4 hours a week, it is difficult to schedule students who need to see a physician, review charts, consult with referral physicians, and arrange clinical conference time with other staff.

Nearly all projects learned that simply "being there" does not inform students that services are available, confidential, and responsive to students. The low enrollment rates during the first year of operations reflected in part the projects' staffing and renovation priorities, but they also demonstrated that special marketing initiatives were required.

At least one-half of the projects needed to re-think their approach to making their services known to students. Re-energized marketing strategies included staff presentations to school faculty, developing referral relationships with the school nurse (if one is on site), frequent meetings with school administrative staff, working with sports team coaches to organize athletic physical examinations, and having staff available in the school office when parents enroll their children. Most projects found that there is no substitute for close working relationships with faculty and school staff to educate students and their families concerning the availability and utility of school-based health services.

Although this article has focused on clinical activities, as noted above the school-based health centers have also been engaged in health promotion and disease prevention efforts to a degree not possible in off-site adolescent health care settings. Most health center staff see themselves as part of a school-wide effort to create healthier learning environments for young people.

Joint health center/school activities nurture the very partnership that seems to make the health centers successful. Health centers that engage in health promotion and education activities in the classroom do not appear to offer less clinical service in the health center. Rather, those health centers that are fully engaged in their host schools also become the centers to which teachers, principals, coaches, and students refer young people who need assistance, with resulting patient volume pressing health center staff to the limit.

This work is supported by grants from the Robert Wood Johnson Foundation.

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NEWSCOUNT

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Publication	Page	Date	Circulation
All Tribune Newspapers			99,680
Chandler Tribune			9,225
Gilbert Tribune			5,010
Mesa Tribune			55,405
Scottsdale Progress Tribune	B-1	4/8/96	18,680

State to pay students' health costs

DHS: Tobacco tax to fund services

By Mark J. Scarp
Tribune writer

Adolescents from homes with lower incomes will receive medical services at three Scottsdale-area elementary schools thanks to money from a state tax on tobacco products.

Scottsdale Memorial Health Systems Inc. received \$201,356 to establish primary medical care, prenatal screening, cervical cancer screening and other services at Hohokam, Palomino and Yavapai elementary schools, the Arizona Department of Health Services said.

Local care funded by the 40-cent-per-pack tax will also be offered at SMH's Family Practice Center and at the Fort McDowell Mohave-Apache Indian

Community clinic northeast of Scottsdale.

SMH was one of 25 Arizona health-care organizations that received nearly \$5 million from the 40-cent-per-pack tax. The funds are dispensed through a one-year contract with each of the organizations, which may renew the pacts annually for up to four years, DHS spokesman Brad Christensen said.

The hospitals are able to serve about 4,000 students with the funds, said Wendy Lyons, SMH vice president for health systems integration.

"The money is very, very welcome,"

Lyons said. "It enables us to reach out into the community and help people who could not afford care otherwise. It opens the doors up for people to seek medical attention."

"We're real excited about this. People tend to think Scottsdale isn't affected by these issues, but they are."

The awards represent a second round of primary-care contracts funded by the "medically needy" account of the tobacco tax law, passed by state voters in 1994. That account holds 70 percent of the revenue raised by the tax.

The first round, announced in January, distributed funds to health-care organizations in several communities with full-service primary care programs for the poor already in place. Maricopa County recipients of the first round included programs in Avondale, Chandler, Guadalupe and south Phoenix.

DHS officials say programs funded by the tax will help serve the estimated 650,000 uninsured people in Arizona.

Through funds from the tobacco tax, Arizona is now among the leaders in the nation in addressing the basic health-care needs of its citizens, said Dr. Laurence Platt, associate director for DHS Public Health Services.

"(These funds) will bring health-care services to areas where there are shortages and will make these vital services financially available to our working poor," Platt said.

*A sample of
what some of the
states are up to.*

Times Magazine

Louisa

28 WEDNESDAY, JUNE 27, 1996

LOCAL/STATE

Foster won't veto school health centers

By LISA L. ROLAND
Times Baton Rouge Bureau

BATON ROUGE — Gov. Mike Foster said Monday that he hasn't found any reason to veto money allocated to school-based health centers.

The health centers stirred controversy during the recent legislative session when Christian Coalition leaders pushed to remove the funding because of the centers' alleged ties to Planned Parenthood.

Sally Campbell, director of the Louisiana chapter of the Christian Coalition, said the group sent Foster a tape of a Planned Parent-

hood leader "in which she discussed how they get around the law through the clinics."

The laws Campbell referred to are those prohibiting school health centers from giving abortion advice or referrals and from dispensing contraception.

Campbell claims the centers refer students to public health centers, which freely dispense contraception and give abortion advice.

But proponents of the centers argue that they help children who often would never see a doctor.

"Most of (the centers) are economically disadvantaged areas where there are no abortion providers or providers that may be the only place where services without parental

consent, he would be more inclined to veto the funding.

"The truth is we're a poor state, and we need these clinics to help provide medical care to these children," Foster said.

He had insisted, however, that if he agrees to keep the funding in the bill, he would have law enforcement officials ensure that the centers obey the law.

Campbell said she will meet with Foster this morning, where she will make another push for a veto.

Foster said he plans to sign the \$12 billion budget bill by Friday, and that he will try to veto as few items as possible.

Maine
Newcastle, ME.

Lincoln County
Weekly 9/28/95

NO GO, PLAY & DINE INSIDE

Lincoln County Weekly

96

36 PAGES

3 SECTIONS

25 CENTS

LA Health Center to tackle teens' issues

Student survey cites domestic abuse
and widespread smoking

BY ALAN CROWELL

NEWCASTLE — Results of a survey of Lincoln Academy sophomore, junior and senior classes underscores the need for focusing health services on teen smoking, and abuse at home.

The June survey was conducted as an effort to better focus the school's new health center on the issues which students perceive as critical.

Among the findings: 75 percent of students who replied said the school needs a health center. About 57 percent said they would use it.

Of the 285 students who replied, 89, or 31

percent, said they smoked and less than half said they regularly wear a seat belt when driving in a car.

Perhaps the most shocking result was that 117 students, 40 percent, said the health center should provide help for students who suffer abuse or violence at home.

School nurse Sharon Morrill said wording in the survey makes it unclear if responding students were referring to personal abuse, or abuse which they believe is occurring elsewhere.

Morrill, who previously was school nurse at Cony High School in Augusta, has also worked

SEE HEALTH ON PAGE A2

bin of freshly
re photos and

Romer Salutes Lincoln H.S. Health Center



Gov. Roy Romer speaks to Lincoln High School students and teachers about the importance of school-based health centers. Many students are not covered by private insurance. The centers offer them professional care.

- Photo by Hank Fellerman

By Hank Fellerman

Governor Roy Romer, and his wife, Bea, toured the School-Based Health Center (SBHC) at Abraham Lincoln High School last Wednesday. They made the visit to recognize success of the eight year old clinic in making medical care available to the school's students.

Romer was accompanied by Patti Shwayder, acting director of the Colorado Department of Public Health and Environment and Dr. Paul Melinkovich, Director of Denver's SBHC program.

The clinic at Lincoln is staffed by six professionals. Two are employed by Denver Public Schools, while the remainder are funded by government and private grants.

the clinic for an average of three visits a year, according to Melinkovich. Melinkovich said providing treatment at the school lowers the dropout rate.

The most prevalent reason for clinic usage is for chronic illnesses, which account for about 45 percent of visits. Mental health related problems account for 25 percent of visits, exams and reproductive health comprise 10 percent, while treatment for substance abuse uses less than 10 percent of clinic resources, according to Melinkovich.

Romer said he came to Abraham Lincoln to see how the SBHC delivers health care. Finding ways to provide the best quality health care at the best price is an is-

is qualified to deliver medical care. Citing the increased use of physician's assistants, he called for a non-elected board composed of doctors and lay people to determine who is qualified to provide medical care.

Romer acknowledged his wife for her support of programs to provide health services for youth.

Senior Cathy Cordova explained how the center had helped her. As a freshman she had run away from the home of her drug addicted mother, who had a warrant issued for her return.

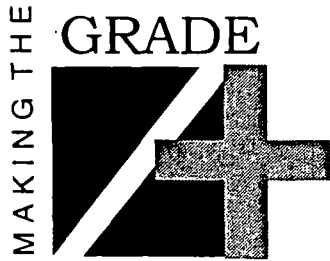
A sympathetic counselor at SBHC interceded with the court to allow her to live with her father. A SBHC therapist helped her come to terms

After she graduates, Cordova plans to attend the Community College of Denver at Auraria and go into a line of work where she can help others.

Cordova believes the staff of SBHC were a key to turning her life around. "They let me know someone cared. Someone was there for me."

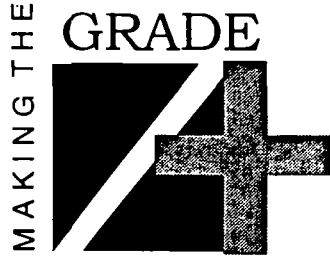
The clinics in schools are a cost effective way to deliver health care services, according to Barbara Ford, SBHC Program Administrator. Each student visit costs about \$93, which is average for a "health care encounter," according to Ford.

If the SBHC program were eliminated, many youth would not have access to health care, even at Denver General Hospital, according to Dr.



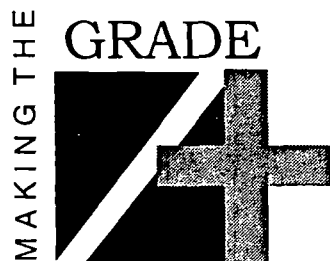
**MANAGED CARE AND SCHOOL-BASED
HEALTH CENTERS: OPPORTUNITIES TO
STRENGTHEN HEALTH SERVICES FOR
ADOLESCENTS**

ADOLESCENTS IN THE WORLD OF MANAGED CARE, Tuesday, August 13, 1996, 9:15 - 10:45, Annual Conference of the National Academy for State Health Policy. Julia Graham Lear, George Washington University.



Adolescents: Their health needs and the world of managed care

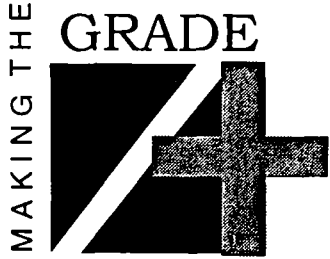
1. What are adolescents health needs? Why should adolescents be singled out for special attention?
2. What have some states and some communities done to improve the health systems' response to adolescent needs?
3. What are some of the major challenges in addressing those health needs in a managed care environment?



As measured by key indicators of emotional, physical and mental well-being, American children are worse off today than they were 30 years ago.

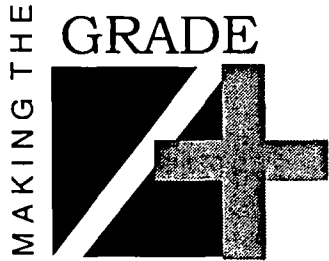
1. The suicide rate, homicide rate, births to unwed mothers, reported child abuse and obesity rates have steadily increased. The percent of children without health insurance has risen in the past several years. In 1993, 11 million children had no health insurance.
2. Other measures of child well-being have moved in the wrong direction: The number of children living in households with only one parent tripled; SAT scores and other measures of academic performance declined, and the percent of children living in poverty has continued to increase since the 1970s.

The causes of this deteriorating situation appear to be decreases in time and financial investments in children.



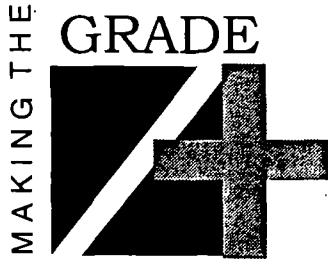
Adolescents have specific health status problems:

1. One in five adolescents has at least one serious health problem, including visual, auditory and dental problems that can impede school performance.
2. Many adolescents suffer from a diagnosable mental disorder.
3. Adolescents have experienced sharp increases in behavior-related problems:
 - suicide and homicide rates have tripled for adolescents ages 15 - 19 over the past 20 years.
 - one in five adolescents acquires a sexually transmitted disease by age 21
 - teen pregnancies continue at the rate of one million a year



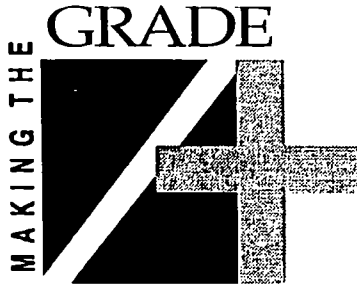
Adolescents face greater barriers to securing health services than other age groups

1. They visit office-based physicians less frequently than other age groups
2. Many primary care providers are not comfortable with adolescents
3. There are shortages of primary care and mental health professionals trained in adolescent health issues.
4. Confidential care for that is accessible and acceptable to adolescents is frequently difficult to find.
5. Relatively few low-income adolescents are insured by State Medicaid programs
6. Uninsured adolescents are reluctant to burden their families with health care costs



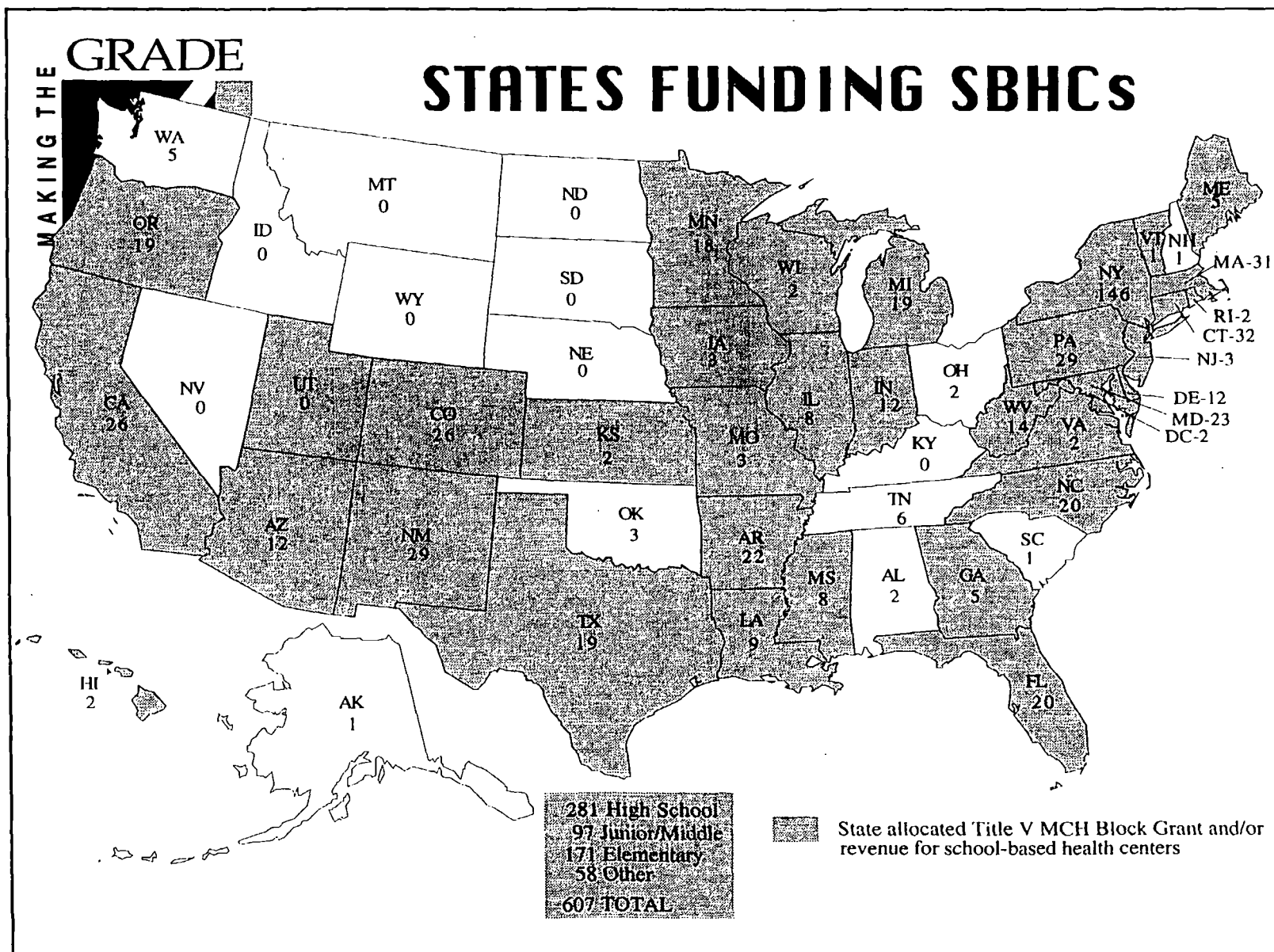
Addressing adolescent problems

In response to adolescent health problems and a desire to improve adolescent well-being through increased investments in health care, a large number of states and communities are investing in the development of school-based health centers.

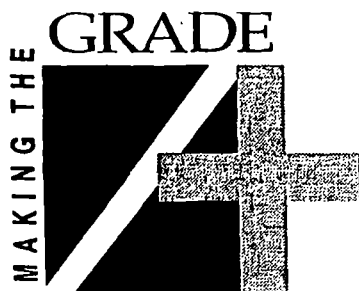


DEFINING CHARACTERISTICS OF A SBHC

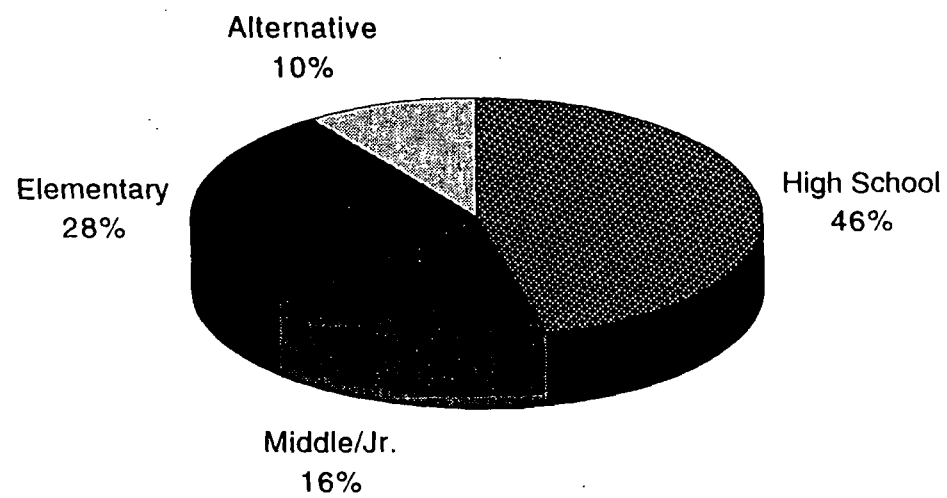
- On school site
- Comprehensive primary care including diagnosis and treatment
- Staffed by a multi-disciplinary team
- Parental consent policy
- School-community partnership
- Community advisory council

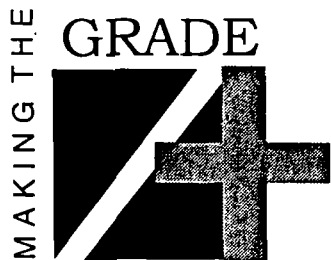


Managed Care, Medicaid and School-Based Health Centers: Opportunities to Strengthen Health Services for School-Age Children and Youth. Julia Graham Lear, February 23, 1996.



SBHC SETTINGS

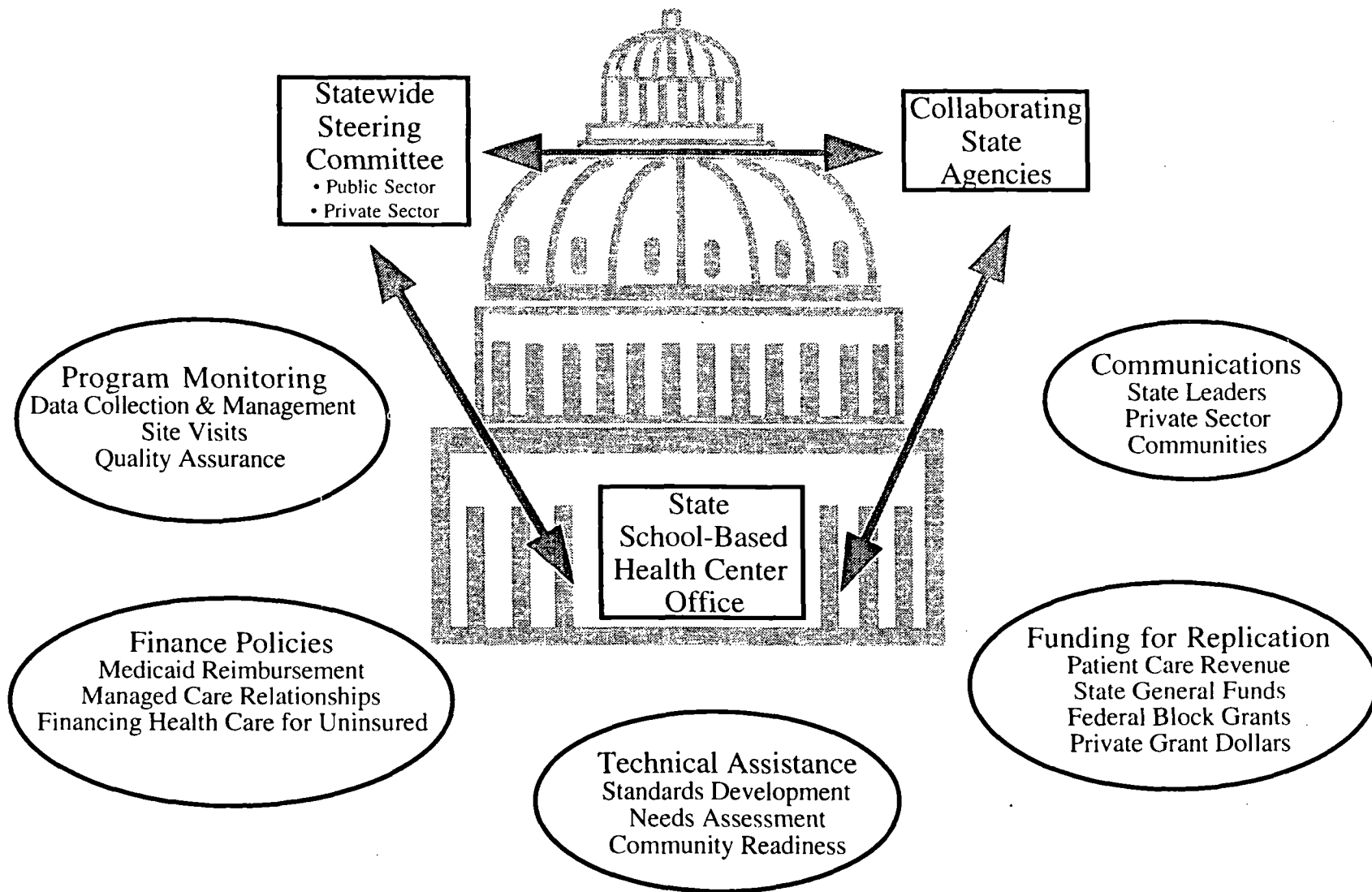




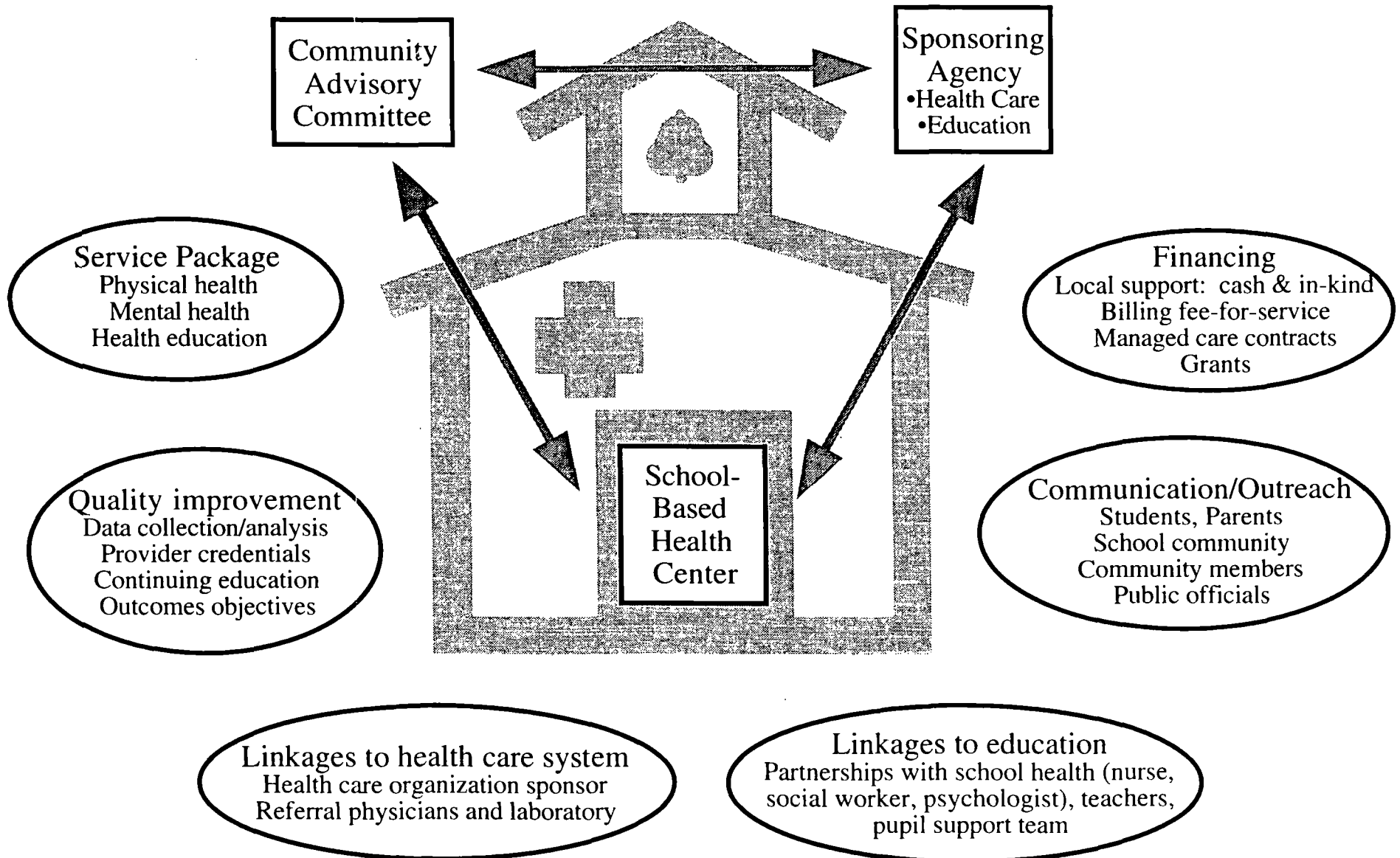
Communities and States with Substantial SBHC Initiatives

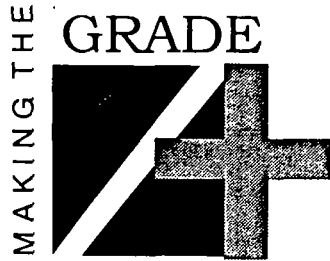
No. of SBHCs		Millions	
• Baltimore City	(16)	• Connecticut	\$ 4.0
• Baltimore County	(13)	• Delaware	\$ 3.0
• Boston	(13)	• Illinois	\$ 1.4
• Bridgeport	(8)	• Louisiana	\$ 2.5
• Dallas	(9)	• Massachusetts	\$ 1.4
• Detroit	(6)	• Michigan	\$ 2.6
• New Haven	(10)	• New York	\$10.0
• Portland	(10)	• North Carolina	\$ 1.7
• St. Paul	(7)	• Texas	\$ 2.0
• San Jose	(8)		
• Seattle	(8)		

STATE PARTNER



LOCAL PARTNER

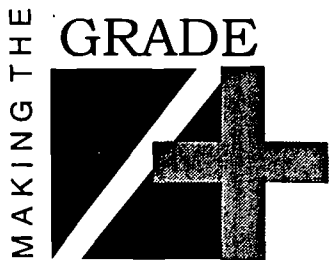




States facilitating linkages between school-based health centers and managed care plans

Colorado
Connecticut
Delaware
Maryland
Massachusetts
New York

Oregon
Rhode Island
Vermont
West Virginia



Strategies for linking SBHCs with managed care plans

- State Medicaid Request for Proposals to managed care plans require plans to contract with SBHCs in service area: CT, DE, MA, NY, RI
- State development of model contracts: CT, NY
- School-age plan members may seek care from SBHC without pre-authorization. Plan must reimburse the SBHC: MD
- Financial incentive program: Up to 2 percent additional capitation for plans to contract with public health care providers, including SBHCs: WV
- State code requires managed care plans to develop action plans to address health needs of adolescent enrollees: MN
- State facilitative activities: state sponsored meetings of SBHC representatives and managed care plans -- MA, OR; state development of common data exchange form -- MA; state development of accountability measures for SBHCs, draft benefits package for SBHCs -- CO