School-Based Health Centers and Health Care Reform

California School Health Centers Association
March, 2013

Background

Since they were first established in the 1980s, California's school-based health centers (SBHCs) have been growing in number. The state currently has 200 SBHCs providing health care to more than 250,000 children in grades K-12. Children served by SBHCs live in many of the state's most distressed neighborhoods where children and families are uninsured, experience barriers to accessing preventive health care, and have high rates of emergency room visits, obesity, asthma, and exposure to violence and trauma.

California's SBHCs have come to be an important part of the safety net, providing a range of primary care services, managing students' chronic illnesses, such as asthma and diabetes, and integrating reproductive health services, mental health, youth development, and dental services.

Definition

The California School Health Centers Association defines SBHCs broadly, as a *facility that delivers clinical medical, behavioral health, or oral health services on a school campus or in an easily accessible alternate location including a mobile health van*.

SBHCs are distinct from school nurses in that they employ practitioners licensed to diagnose and treat illness (nurse practitioners, physicians, physician assistants) in addition to registered nurses (the majority of school nurses) who are restricted to implementing practitioners' orders.

➔ The defining characteristics of an SBHC is that the *health care providers work in partnership with the school* to reach as many students as possible, ensure follow-up, and address health and learning problems comprehensively.

Funding

Third Party Reimbursement

Until recently, school health centers relied heavily on local, state and federal grants and private funding from foundations and hospitals. However, the uncertainty of these sources combined with a move toward market-driven health care financing has increasingly led SBHCs to partner with community health providers that are able to bill insurance carriers. Although there are a handful of California school health centers that are able to

Snapshot of SBHCs in California

How many:
- 108 in 2000
- 200 in 2013
- 40 scheduled to open in the next few years.

Who runs them:
- 49% run by community health centers
- 34% run by school districts
- The remainder run by local health departments, hospitals and community-based organizations.

What grade levels:
- 42% in high schools
- 32% in elementary schools
- 12% in middle schools
- 14% "school linked" or mobile medical vans

What services are offered:
- Primary Medical Care 85%
- Health Education 61%
- Mental Health 59%
- Reproductive Health Screening & Education 59%
- Reproductive Clinical Care 47%
- Nutrition and Fitness Programs 36%
- Dental Prevention 30%
- Dental Treatment 14%
- Youth Engagement 14%

fund themselves almost entirely through third-party billing, there is a wide range in the amount of revenue centers generate from billing. Current sources of third party reimbursement include:

- The Child Health and Disability Prevention Program (CHDP)
- Family PACT
- Medi-Cal
- Healthy Families
- EPSDT (County mental health)
- Private Insurance

Education Funding

Most SBHCs receive support from their host school or district. Most commonly this support includes facilities, utilities and custodial services. Some school districts use a portion of their Title I-A, LEA Medi-Cal or Medicaid Administrative Activities reimbursements to support . school health services, and others contribute personnel (e.g., school nurse or clerk).

Government and Private Grants

SBHCs have always relied on local, state and federal grants and private funding from foundations and hospitals. These funds often support prevention and education programs such as teen pregnancy prevention, nutrition and fitness, violence prevention or youth leadership. Because SBHCs depend on grants to fund these programs, they are often unstable.

State Programs

California is one of the only states with large numbers of SBHCs and no state program. In 2006, Governor Schwarzenegger signed AB 2560 (Ridley-Thomas), which created the *Public School Health Center Support Program*. The program was designed to collect data on SBHCs and facilitate their development. In 2008, Governor Schwarzenegger signed SB 564 (Ridley-Thomas), which added a grant program to the *Public School Health Centers Support Program*. This grant program was designed to provide technical assistance and funding for the expansion, renovation and retrofitting of existing SBHCs and the development of new SBHCs. Both AB 2560 and SB 564 were to be implemented only to the extent that funds were appropriated. As of 2013, these funds have not been appropriated, and thus the functions of the *Public School Health Center Support Program* have not been implemented.

Federal Programs

The Affordable Care Act (ACA) included a one-time appropriation of $200 million for SBHC capital and equipment. These funds have been fully allocated, and California received $30 million, which has contributed to rapid expansion in recent years. The ACA also authorized a grant program to fund SBHC operational costs. That program has yet to be funded and the authorization will expire after FY 2014. The National Assembly on School-Based Health Care and hundreds of school health stakeholders are working on an appropriation of $50 million for SBHC operational grants in the FY 2014 budget and will then be working on reauthorization of the program.

SBHCs and the Triple Aim

Primary care redesign has gained enormous traction as the nation sets its sights on reforming an ailing health care system and achieving the "triple aim" of better health, better health care, and lower costs. SBHCs offer an opportunity to expand the delivery of prevention programs and reshape children's primary care to achieve the triple aim.

Better Health Care: Improved Patient Experience

SBHCs represent the height of consumer-centeredness as no complex planning or resources are required for children to access care in school. The growth in the number of SBHCs in California despite the absence of state or federal funding is a testament to their popularity with students, parents, and community members.

Many research studies have documented the success of SBHCs in offering a patient experience that encourages utilization.

- A study in Denver compared health care utilization among 1299 children, aged 4-13, who attended schools with and without SBHCs.[1] Students attending schools with SBHCs were significantly more likely to have had a physician's visit since the start of the school year and to have had an annual dental exam, and were significantly less likely to have used the emergency room.
- A second study focused on more than 1700 adolescents who were either uninsured or enrolled in Medicaid or S-CHIP.[2] Compared to adolescents who had used a community-based clinic, SBHC users were more likely to have had at least three primary care visits, to have received key immunizations, and not to have used the emergency room.
- A study conducted in 12 urban California high schools, 6 with SBHCs and 6 without, found that adolescent girls with SBHC access were more likely to get reproductive preventive care, use hormonal contraception, and have been screened for an STI, than similar girls without access to an SBHC.[3]

School-Based Diabetes Management

A 13-year-old living with a single, disabled parent has diabetes. Because her parent has limited mobility, visits to a medical provider were few and far between. During elementary school the student had trouble keeping her blood sugar under control. When she started middle school, she fainted in class and was taken to the ER and seen by an endocrinologist. This incident brought the student's condition to the attention of the school which had an SBHC. The nurse at the SBHC worked with the endocrinologist and monitored the student's blood sugar, insulin administration, and diet every day for two weeks. She reported back the results and, with guidance from the endocrinologist, worked with the student to modify her diet and self-administer her insulin.

→ Better Care: Student has daily contact with a provider.

→ Better Health: Blood sugar at healthy levels.

→ Lower Cost: Reduced likelihood of future ER visits.

Improved Population Health

SBHCs have a documented impact on health outcomes. They can greatly enhance the effectiveness of patient education by using multiple channels for health education, such as student groups, schoolwide events, classroom session, and parent education. Moreover, SBHCs are uniquely positioned to transform patient awareness into actual behavioral change. For example, nutritional counseling in traditional office-based settings is taken to another level altogether in SBHCs where routine monitoring of eating and physical behavior is possible, and where it is combined with advocacy for increased access to healthy foods on campus.

- In Michigan, researchers evaluated the impact of SBHCs on the health and health behaviors of 744 middle and high school students.[4] Sixteen schools, including sites with and without SBHCs, participated in the study. At the end of two years, SBHC users reported greater satisfaction with their health, more physical activity, and greater consumption of healthy foods than non-SBHC users.
- A Cincinnati program was designed to improve the quality of asthma care through enhanced collaboration between SBHCs, schools, and community partners.[5] Researchers found that SBHC users were less like to have asthma-related restricted activity days and were less likely to visit the emergency room for asthma.
- Researchers in Denver found significantly greater reductions in the unplanned teen pregnancy rate in areas with SBHCs.[6] They concluded that the decline was likely the result of SBHCs' work to identify, intervene, and follow up with students at risk for unplanned pregnancy.

Lower Costs

SBHCs are a cost-effective model that can lower Medicaid costs. Researchers from across the country have studied the positive impact of SBHCs on ER use and hospitalizations.

- A study in Cincinnati showed that SBHCs lowered users' Medicaid costs by improving students' "health-related quality of life," resulting in lower costs to the public health care system.[7]
- In Baltimore, researchers found that SBHC access was associated with a reduced likelihood of ER use and fewer hospitalizations.[8]
- In Denver, researchers found that SBHC users had fewer emergency room visits and were less likely to be hospitalized.[9]
- In Greater Cincinnati, the opening of an SBHC reduced the relative risk of ER trips and hospitalizations, and reduced hospitalization costs, for students with asthma.[10]

School-Based Obesity Prevention

An elementary school student is severely overweight and, while his family recognizes the problem, has made no progress in changing his diet or exercise habits. The nurse at the SBHC works with the mother to identify dietary changes and engages the health educator to support new behaviors. The health educator coaches the classroom teacher to encourage the student to be more active in P.E. and recess, and invites the family to a cooking class with other families as part of a PTA activity. At the same time, a school wellness initiative is making presentations on healthy foods in science classes, demonstrating the preparation of healthy foods at PTA meetings, working with the district's school lunch program to replace 2% milk with non-fat.

→ Better Care: Comprehensive approach to prevention in the student's own environment
→ Better Health: Reduced weight
→ Lower Cost: Reduced likelihood of type 2 diabetes and associated health care costs.

Special Issues for SBHCs in Health Care Reform

Can SBHCs be patient-centered medical homes?

As the ACA pushes more providers to seek recognition as patient-centered medical homes (PCMH), questions have emerged about whether SBHCs can meet these standards. In fact, many SBHCs do function as a medical home for the patients they serve. CSHC recently assessed the status of 36 SBHCs run by 12 federally-qualified health centers. Two have already received recognition from the Joint Commission; 11 expect to receive recognition from the National Commission on Quality Assurance (NCQA) within a year. Only 7 SBHCs have such a limited scope of services that their FQHC sponsor believes that, as currently operated, these SBHCs would not be appropriate for PCMH recognition.

This assessment also revealed SBHCs' unique advantages and challenges with respect to the standards used by NCQA. SBHCs have advantages in providing enhanced access due to their location, walk-in availability, and trusted relationships with students and school staff. However, they often lack extended hours and can be challenged to meet continuity standards if providers at the SBHC rotate to other sites. SBHCs are often well-positioned to identify and manage patient populations because their patients are defined by their connection to the school and easily accessible. In terms of managing care, SBHCs' on-site location enables them to provide more regular and intensive care management, but they may lag behind in adopting a standardized approach to utilizing evidence-based guidelines. SBHCs have a clear strength in the area of self-care and community resources. They conduct extensive health education including classroom, schoolwide, peer and parent programs. They also have strong relationships with other community providers, some of which may be co-located in the SBHC. Tracking and coordinating care is also a strength at many SBHCs where many services, including dental and behavioral health, are offered in a single location. Performance measurement and quality improvement is an area where SBHCs are not as advanced as other providers.

What is the role of SBHCs vis-à-vis primary care providers in a health plan?

SBHCs run by school districts or that are open only a few hours a week do not have contracts with health plans to serve as a PCP. On the other hand, an increasing number of SBHCs are comprehensive primary care sites and do have contracts with health plans to serve as a PCP.

In some schools, many students and families have selected the SBHC as their PCP. This is an optimal situation in terms of continuity of care and sustainability because the SBHC is paid by the health plan to serve as the PCP.

In other schools, there may be only a few students for whom the SBHC is compensated as a PCP because many students may be uninsured, be Kaiser members, or have selected a private doctor or another clinic as their PCP, possibly due to closer proximity to their home. Students in these situations still seek care at the SBHC since it is convenient and confidential. Often students come for sensitive services (reproductive or behavioral health) or because they were assigned to a PCP but have never actually accessed care there. In other cases, the student can get into the SBHC more quickly for time sensitive services such as an immunization needed to start school or a physical to play sports.

When the SBHC is not the PCP, it is serving as an alternative access point for primary care, which raises the question of how the services will be coordinated with the services provided by the PCP. Many PCPs have no information about the services their patients are receiving at school. This is a problem, both for coordination of care and for the long-term financing of school-based services.

Because even SBHCs that are the PCP for some students are also in the position of serving students for whom they are not the PCP, there are two avenues that must be pursued by the field as whole: 1) expand services and obtain contracts with health plans to serve as a PCP, and 2) improve communication with other providers which, increasingly, will be taking place through electronic health records and health information exchange.

How can SBHCs be financed in a managed care system?

When SBHCs serve as a PCP under a health plan contract, they receive a monthly capitated payment for each patient. The increasing number of SBHCs that are able to function in this capacity is a positive step toward greater integration and sustainability of SBHCs. However as new delivery and payment systems emerge, one of the important questions for SBHCs is whether there will be funding mechanisms to allow consumers to access care in locations of their own choosing. These might include clinics not only in schools but also in workplaces and pharmacies. When the SBHC serves as an alternative access point for patients for whom it is not the PCP, an alternative payment method is needed. The state has shown support for alternative access in the area of family planning through the creation of Family PACT which allows people who need to keep family planning services confidential to see any Medi-Cal provider. This program is critical to enable SBHCs to deliver care to all students.

Beyond family planning, additional mechanisms are needed to compensate SBHCs for the care they provide as an alternative access point. If the SBHC is not the assigned PCP, most health plans will not reimburse the SBHC when it serves the plan's members. There is a partial solution to this situation in the Medi-Cal program. All health plans contracting with the California Department of Health Care Services are required to execute agreements or MOUs with local school districts or school sites to support the provision of CHDP services. These agreements may include subcontracts for reimbursement, direct contribution of staff or resources to provide CHDP services, or indirect support to assure member access to CHDP services at school sites. Although there has been little enforcement of this provision, two plans have developed robust programs to work with SBHCs as alternative access points.

In 2001, Health Net and the California School Health Centers Association developed a joint template agreement to provide reimbursement to SBHCs. Health Net currently has 36 school-based health agreements in place. Once an agreement is in place, school based providers are reimbursed on a fee-for-service basis for services provided to a Health Net member. SBHCs may bill for preventive care and acute care for all Health Net Medi-Cal or Healthy Families members, unless the patient is assigned to the SBHC provider in which case care is covered under the capitation payment. Health Net's health assessment coordinators work with the SBHCs to coordinate necessary follow-up services with the student's PCP.

L.A. Care Health Plan began to reimburse SBHCs in 2006. SBHCs may bill LA Care directly for all CHDP and "CHDP Like" services provided to L.A. Care's direct line of business members

and to Medi-Cal members served by its plan-partners. SBHCs can also bill for acute care services provided to L.A. Care direct line of business members. Care coordination is promoted by requiring the SBHC to mail a PM160 form to the health plan and a copy to the member's PCP.

How will expanded prevention programs be funded?

A major gap in funding for SBHCs is coverage for the expanded preventive services that they are uniquely positioned to offer. Services provided in SBHCs are not the same as the clinical "office visit" reimbursed by health insurance. School health services encompass functions such as education, case management, coordination with parents, consultation with teachers, and troubleshooting referrals, all of which fall outside the scope of a billable clinical encounter. The funds currently available to cover these services are a patchwork of categorical programs or grant opportunities that are generally temporary.

The ACA strengthens prevention through grant programs from the Prevention and Public Health Fund (e.g., Communities Putting Prevention to Work) and the Innovation Center in the Centers for Medicare and Medicaid Services. Thus far, these programs have provided very limited opportunities for the type of preventive services provided by SBHCs. There is also potential that new delivery models, such as patient-centered medical home, and new payment models, such as accountable care organizations, will provide greater incentives for payers and providers to develop more expanded approaches to prevention. One of the challenges to including SBHCs in these models is that payers are most interested in innovations with a high pay off in terms of reducing costs associated with older patients with multiple conditions. While no one questions the value of early prevention, children account for a small share of the health care dollar, and preventive care does not pay off quickly.

SBHCs deliver outcomes that cut across multiple service systems. Financing possibilities created by the ACA (e.g., health plan reimbursement, enhanced payments for PCMH, or participation in accountable care organizations) should be leveraged with resources from other systems such as:

- Public health funds for disease prevention and surveillance.
- County mental health funds for EPSDT or the Mental Health Services Act.
- Education funding for special education and student support services, including school nurses, counselors and psychologists.

To the extent that a standardized model for coordinating these funds can be developed across counties, or even within a single county, SBHCs will be better able to develop permanent, sustainable prevention programs.

Changes in SBHC Practices Needed to Maximize Their Value

Strive to meet patient-centered health home criteria being advanced by national credentialing bodies.

- Identify PCMH standards that are particularly difficult for the SBHC, like after-hours access, and develop strategies to help support the SBHC in achieving them. For example, SBHCs can arrange for another organizational site to provide after hours appointments for the SBHC population. This will promote continuity of care and reduce ER utilization for ambulatory-sensitive clinical events.

- Strengthen the ties of the SBHC to the sponsoring clinic's quality improvement committee. SBHC staff should participate in the quality improvement committee, understand the clinical process and outcome metrics that are relevant to children and adolescents, and ensure that these metrics are included in the clinic's improvement work and compared across all sites.
- Develop a continuity of care plan for the SBHC. Assigning clinicians to permanent positions in the SBHC, rather than having the clinician rotate between sites within the organization, would allow SBHCs to better meet continuity of care standards.
- Review the benefits of the SBHC and the PCMH model with the school administrators so that they implement policies that facilitate the broadest possible access to care.
- Report on quality performance measures and outcomes of SBHC patients – especially those that challenge health plans and providers, such as adolescent immunizations, well-child/adolescent visits, chlamydia screening, and nutrition counseling.

Build on SBHC strengths in prevention, outreach, and community resources.

- Identify best practices from the SBHC that can be spread to other sites, like the utilization of community resources and coordination with behavioral health resources.
- Strengthen the SBHCs role in outreach and enrollment by setting up systems to determine patient insurance enrollment and health home assignment.
- Develop innovative approaches to prevention that build on connections between clinical care in the SBHC and activities or environmental changes in the school and community.

Strengthen communication with other providers.

- Prioritize communication with the PCP to ensure continuity of care (if the SBHC is not serving as the PCP) while ensuring appropriate protection of confidentiality.
- Adopt electronic health records and seek opportunities to participate in health information exchange.

Policy Changes to Realize the Promise of SBHCs in Achieving the Triple Aim

Leverage Medi-Cal managed care contracts

- The state's Medi-Cal managed care contracts include requirements for reimbursement and coordination of CHDP services with schools. The Department of Health Care Services must enforce greater accountability for this contract requirement as currently no information is available about plan compliance.
- Medi-Cal contracts with health plans require them to provide health education to their members. Greater accountability for health education is needed at the state level; currently, information about health plan compliance is unavailable.
- Moving beyond existing contract requirements, health plans with Medi-Cal contracts should be required to follow the model of Health Net and L.A. Care and reimburse SBHCs as alternative access points for their members to receive primary care.

Strengthen accountability for outcomes

- Performance measures focused on access for children and adolescents must be preserved and adopted (e.g., the HEDIS measure for adolescent well-visits). Because preventive care may

not pay for itself within the time frame relevant to a single health plan, the state must assure society's long-term interest in children's access to care by holding plans accountable for delivering preventive care.
- Accountability and payment incentives unique to the care of difficult-to-reach populations should be developed to encourage health plans and delivery systems to focus on the needs of these patients and to adopt strategies such as SBHCs for meeting these needs.

Build a role for school-based services in new delivery and payment models

- In adopting a definition of medical home, California must allow for care to be delivered and coordinated in multiple locations, including schools.
- Payment reform should create financial incentives for the delivery of health education and prevention.
- Schools must be engage in the enrollment portal for public programs and Covered California.
- Policies should be explored that enable "co-management" privileges with insurance plans so that SBHCs to be reimbursed for care provided to patients who are insured and assigned to off-site PCPs.

Preserve existing policies that enable SBHCs to function

- It is essential that Family PACT and Medi-Cal Minor Consent be protected. These programs remove barriers to adolescents receiving critical services and enable providers to be reimbursed.
- The CHDP Gateway program must be preserved as an entry point to coverage and safety net for uninsured children to receive periodic medical and dental check-ups, and treatment services. A key feature of this program is that children can be enrolled on site by any certified CHDP provider, including school health services providers.
- FQHCs' cost-based reimbursement rates must be preserved to support the financial sustainability of the SBHCs they operate.

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