Health-Care Reform and School-Based Health Care

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SYNOPSIS

There is growing recognition that health and health care at school can significantly impact children's health. From childhood obesity interventions to new immunization mandates, schools are at the forefront of child health discussions. The 2008 presidential campaign and the renewed focus on health-care reform raise the possibility that in 2009 school health will play a larger role in health policy conversations than previously.

This article explores the proposition that both school health and national health policy will benefit from closer attention to the role of school health within the U.S. health system. It offers a Maryland case study to suggest both the opportunities and operational challenges of linking school health to the larger community health system.

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Fifteen years ago, the U.S. entered into a vigorous debate about a new direction for the American health-care system. Issues of access, cost, and effectiveness were on the table for debate and change. While school health was included in the Clinton Administration's proposed *Health Security Act,* the provisions involving school health were marginal to the discussion.[1]

The 2008 presidential contest has reopened the debate about health-care reform. But in contrast to 1993, schools are increasingly mentioned as an important venue for addressing children's health needs. This article explores the interdependence of school health and health-care reform. The authors suggest that not only can school health make an essential contribution to health-care reform by linking its prevention and service activities to community care, but that health-care reform will strengthen school health programs because partnering with community health services will compel school health programs to clarify their purposes and operating standards, thereby increasing support for these programs. Experiences from the state of Maryland during its first decade of Medicaid managed care, especially as its school-based health centers (SBHCs) sought to position themselves within the reform initiatives, indicate some of the benefits and challenges that school health will confront as it seeks to participate in health system changes.

WHY SCHOOL HEALTH IS ESSENTIAL TO HEALTH-CARE REFORM

Every year, about 50 million children spend six to seven hours a day, nine months of the year attending public school.[2] Ten percent of them are medically underserved due to inadequate health insurance[3] and/or limited access to health care.[4] At least 15% come to school with one or more known preexisting medical conditions.[5] All students come needing support for their physical and emotional development, care for acute illnesses and chronic conditions, and assurance of a safe and healthy physical environment. As a result, schools are on the front line for providing child and adolescent primary, secondary, and tertiary preventive services and programs.

Primary prevention

Childhood health status and health behaviors are strongly linked with physically and financially debilitating adult medical problems, such as adult obesity.[6] To achieve better health outcomes for all Americans, health reform initiatives need to reach into the child population and support efforts that promote healthy behaviors and, consequently, healthier adults.

While states differ on the mandated age for school attendance, by age 8 almost all children across the country are required to attend school six to seven hours a day, nine months a year until age 16–18,[7] making schools second only to home as the place where a child develops health habits. Routine school activities—classroom learning, eating, socializing, attending to hygiene, and being physically active—create multiple opportunities for intervention. And from classrooms to playgrounds to cafeterias, schools have the space, programs, and staff to capitalize on these opportunities. Nutritionists, health educators, physical education teachers, school nurses, school mental health professionals, and classroom teachers can all contribute their expertise to promote health and prevent disease.

Secondary prevention

Schools already host both informal and formal screenings for health problems and conduct surveillance for disease and child development issues. Some school-based secondary prevention measures make sense because of their direct ties to academic performance. These include screenings for vision, hearing, and learning disabilities. School-based secondary prevention services also identify conditions that may lead to future morbidity (e.g., childhood obesity) or recognize the arrival of an infectious disease and create the opportunity to interrupt its spread.

The importance of school health records for outbreak investigations was highlighted by a Rhode Island study brought up at a roundtable discussion that opened the American Public Health Association's National Public Health Week 2007.[8] Investigation into students' absentee records was critical in determining the outbreak to be mycoplasma, an infectious respiratory infection, but public health and school officials also recognized that better records could have identified the outbreak sooner. By meeting health-care needs before they escalate, school-based secondary prevention contributes to lower health-care costs.

Tertiary prevention

Not all health problems are successfully avoided. Asthma, a chronic condition affecting 9.6% of young Americans aged 5–17,[9] is responsible for excess emergency room use and absences from school and work that create a significant societal burden.[10,11] The burden increases when asthma is inadequately controlled,[12,13] and is mitigated when an SBHC enables asthma to be better managed.[14,15] Acute conditions, such as orthopedic injuries, cause a similar burden when health care is unavailable to address a child's needs.[16,17] For both chronic and acute conditions, medication management

by trained medical professionals is a daily need in schools.[18–20]

School policies and child (and adult) health

School policies can have a major impact on child and adult health. A class schedule with few opportunities for vigorous physical activity or lunch menus with poor nutritional content contribute not only to unhealthy children but also unhealthy adults by encouraging poor health habits and facilitating bad health results. In the language of public health, these school policies and decisions create exposures and behaviors that either promote or deter healthy outcomes. In the end, health-care reform needs school-based programs to help build a healthy population and restrain health system costs.

WHY HEALTH-CARE REFORM IS ESSENTIAL TO SCHOOL HEALTH

School health programs vary from district to district and state to state. Their complexity and diversity frustrate health policy makers and discourage linkages between school and community health. Currently, school health staff total an estimated 56,000 nurses, 1,725 SBHCs, 99,000 counselors, 30,000 psychologists, and 14,000 social workers. A smaller but unknown number of dentists and dental hygienists, physicians, substance abuse counselors, and other counselors and educators also contribute to the workforce. The total cost for these personnel is estimated at $10.4 billion.[21]

The size and cost of this workforce alone argues for including school health programs in health-care reform discussions. While some health programs offer limited care provided by unlicensed personnel, other programs—especially those in large cities—make available comprehensive prevention programs as well as health services. These programs frequently involve schools partnering with community organizations.[22–25]

Recently, national and state leaders have identified schools as appropriate sites for child health measures. In 2003, the President's New Freedom Commission on Mental Health endorsed school-based mental health.[26] That same year, the Arkansas legislature mandated public schools to measure students' body mass index and report that information to parents.[27] Other states have followed suit.[28] The federal government has promoted school-community collaborations by urging school health professionals and community providers to join forces not only to fight the obesity epidemic, but also to co-manage chronic conditions such as asthma and diabetes.[29,30]

Health-care reform offers school health the opportunity not only to explain its services to the larger health-care world, but also to align itself more closely with the service standards and prevention approaches familiar to the health-care system. With a shared understanding of the content and quality of school health programs, collaboration between school and community health is more likely to follow.

Over the past few years, school-nursing leaders have laid a solid foundation for discussing the relationship between school health programs and health-care reform. The nurses have taken the lead in developing credentialing and operating standards for school health that are similar to practice guidelines that apply to mainstream health organizations. While not all state agencies have adopted these standards, the notion that standards are an essential component of school health practice and in some states are associated with patient care reimbursement has been established.

The state of Maryland provides a useful example of the opportunities and challenges associated with school health and health-care reform. Historically, the state has adopted both laissez-faire and interventionist approaches to school health programming. While Maryland mandates the provision of school health to all public school students, it does not fund these services. Rather, funding comes from local health and/or educational agencies. The state recommends, but does not mandate, that local agencies use national school health standards. The state's 24 local jurisdictions vary in how they approach school health. But despite their diverse staffing and funding models, all Maryland school health programs are engaged in some level of school-community collaboration that facilitates co-management of chronic childhood diseases, disease prevention, and health promotion. Additionally, both local and state government in Maryland invest in SBHCs. Currently, 64 centers in 11 of the 24 jurisdictions are receiving state general funds, with a smaller number receiving patient care revenues through Medicaid. The operation of these centers and their relationship to Maryland health reform initiatives offer possible insights into how school-based health care and health reform might interact.

HEALTH-CARE REFORM AND SCHOOL HEALTH SERVICES IN MARYLAND

In the mid-1990s after the collapse of federal health reform, Maryland, like many other states, moved its Medicaid fee-for-service programs into privately run managed care networks.[31] In 1995, Maryland submitted a federal waiver requesting permission to implement a Medicaid managed care plan. The goal was to contain

costs through competitive managed care contracting. In 1997, with its waiver approved, Maryland launched its Medicaid managed care program, HealthChoice, and moved the majority of Medicaid children into the plan. As a result, old rules of Medicaid reimbursement were undone and both new and established health providers sought to secure or improve their position within the Maryland health-care system.[32]

Perhaps because SBHCs looked most like the mainstream health-care organizations, they were first among school health services to seek a place for themselves in the new Medicaid health-care system. Despite vigorous lobbying in the legislature and with state government representatives, the centers were unable to persuade the state leaders to carve out the centers from plan participation and retain their fee-for-service reimbursement for prevention, early intervention, and comprehensive health services. What they were able to obtain, however, were state regulations permitting reimbursement for a set of eight acute-care limited follow-up services, without requiring prior authorization from a student's health plan.

Having lost the more generous Medicaid fee-for-service reimbursement, however, the SBHC leaders determined that their services needed to have the look and feel of other health system providers. [32] This required that the centers adopt operating standards, data collection processes, a public presence, and a stronger and more diverse group of partners. The leaders also recognized the importance of stronger internal procedures and an infrastructure sufficient to handle billing, medical records management, and practice administration requirements.[33]

The health centers' agenda has focused on these practice goals ever since. In the late 1990s, state officials and center leaders collaborated to develop operating standards. And while these standards remain voluntary, their influence drives health center practice. Data collection and research activities became a joint effort between the centers and the school health office in the State Department of Education. Since 1996, policy and advocacy efforts on behalf of the SBHCs have been spearheaded by their membership organization, the Maryland Assembly on School-Based Health Care.

Efforts to integrate SBHCs with the community health-care safety net system continue. In 2005, a state commission charged with strengthening community health-care resources in Maryland included SBHCs as part of the community health-care system and recommended a new grant program dedicated to school-based health care. A commission-funded study has also recommended the state consider expanding its center-focused reimbursement policies to include prevention and early intervention services. The commission's future work will focus on community mental health services and will serve to advance both public understanding of and support for school-based mental health services.[34]

Maryland's experience over the past decade suggests that school health programs will need to think clearly about where they fit within health reform efforts. This will involve not only continued technical challenges but political ones as well. The SBHCs' experience indicates that successful resolution of these issues will require that political champions be secured in both the state legislature and state bureaucracies as development of broad grassroots support for school health programs and services.

CONCLUSION

As the nation begins a new debate about health-care reform and considers the role of children's health in a restructured system, the opportunities for improved child health outcomes offered by school health programs require consideration. The potential benefits of effective prevention and treatment services are too substantial to be ignored. Reform strategies that acknowledge school health and link its considerable services and opportunities to the community-based system of care will have the potential to provide children with consistent and cost-effective primary, secondary, and tertiary preventive health services. However, as the Maryland experience suggests, for school health programs to integrate successfully with a reorganized child health system, school health leaders need to anticipate the operational requirements and standards associated with community-based care and consider how school health programs can align their work with them. School health programs, in concert with community care, offer an opportunity to improve child health in a way that is unparalleled in public health history.

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