

School-Based Health Centers: Adapting to Health Care Reform and the Utilization of Health Information Technology

November 17, 2010

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Background

Students perform better when they show up for class, healthy and ready to learn. School-based health centers (SBHCs) bring the doctor's office to the school so students avoid health-related absences and get support to succeed in the classroom. SBHCs may vary based on community need and resources. An SBHC provides comprehensive preventive and primary health care services to students on or near a school campus. While school-based health centers vary to meet the community's needs, there are general characteristics of all school-based health centers.

- They are designed to serve all students with a focus on the uninsured and underserved.
- An advisory board of community representatives, parents, youth, and family organizations participate in planning and oversight of the health center.
- They are staffed by a multi-disciplinary team of health care professionals. The staff may include a physician/medical director, nurse practitioner or physician's assistant, registered nurse, school nurse, social worker, psychologist, licensed professional counselor and receptionist. Some school-based health centers also employ dental providers including dentists, dental hygienists and dental assistants.
- The SBHC may have linkages with a hospital and/or other providers to accept referrals for complex health problems and to provide services to students during hours when the SBHC is not open.
- The SBHC works cooperatively with school nurses, coaches, counselors, classroom teachers, and school principals and their staff to assure that it is an integral part of the life of the school.
- Written consents signed by parents are required for children before services can be provided.
- Clinical services are the responsibility of a qualified health provider (hospital, community health center, health department, group medical practice, etc.)

The school-based health center provides a comprehensive range of services that specifically meet the serious health problems of young people as well as provides general medical care.

There are many benefits provided by the SBHC:

- Attends to unmet health care needs by placing health care where the kids are and when they need it.
- Supports students by providing a safe place to talk about sensitive issues such as depression, family problems, relationships, and substance abuse
- Supports the school environment by helping children stay in school and by identifying and addressing health problems that may intervene in the learning process
- Supports families by allowing parents to stay at work while attending to their child's routine health care needs
- Saves money by keeping children out of hospitals and emergency rooms
- Teaches students to be better health care consumers
- Strengthens the connection between the community and the school¹

The services range from preventive services to chronic illnesses to primary care.

- Routine Checkups/Physical Exams
- Health Education
- Immunizations
- Referral & Follow-up for Specialty Care

¹ <http://www.dshs.state.tx.us/schoolhealth/healctr.shtm>

- Laboratory Testing
- Reproductive Health Care
- Diagnosis & Treatment of Sexually Transmitted Diseases
- Mental Health Services
- Crisis Intervention
- Individual, Family & Group Counseling
- Prescription & Dispensing of Medications
- Treatment of Acute Injuries and Illnesses
- Nutrition Counseling & Weight Management
- Dental Care (selected sites only)

The most commonly reported staffing models are:

- Primary Care (PC) - The primary care model is typically staffed by a nurse practitioner or physician assistant with medical supervision by a physician. While 25% of SBHCs with a PC model have physicians on staff, their role is largely administrative: 61% of those physicians report providing four or less hours of clinical services per week. Clinical support to primary care providers is offered by a registered or licensed practical nurse with assistance from a medical assistant or health aide. In a small percentage of these SBHCs, primary care staff may be augmented by social service, health education, or dental professionals. Mental health services are not offered in this model.
- Primary Care Mental Health (PCMH) - The largest group of SBHCs is staffed by primary care providers in partnership with a mental health professional – whether a licensed clinical social worker, psychologist, or substance abuse counselor. Clinical and administrative support is similar to the PC model.
- Primary Care Mental Health Plus (PCMH+) - This model is the most comprehensive; primary care and mental health staff are joined by other disciplines to complement the health care team. The most common addition is a health educator, followed by social services case manager, and nutritionist.²

Today, there are approximately 1,700 centers across the country located in 45 states plus the District of Columbia. A majority (96%) of the SBHCs are located in the school building, while 3% are in a separate facility on school property. Only 1% are mobile, or non-fixed. SBHCs are located in geographically diverse communities, with the majority (57%) in urban communities. More than one-quarter (27%) of SBHCs are in rural areas. The following is a chart showing the number of SBHCs in each state.³

Alabama 5	Indiana 87	Nebraska 1	Rhode Island 2
Alaska 3	Iowa 16	Nevada 6	South Carolina 7
Arizona 81	Kansas 2	New Hampshire 1	South Dakota 6
Arkansas 4	Kentucky 20	New Jersey 40	Tennessee 21
California 160	Louisiana 64	New Mexico 79	Texas 70
Colorado 45	Maine 26	New York 206	Utah 5
Connecticut 79	Maryland 71	North Carolina 49	Vermont 5
Delaware 28	Massachusetts 59	Ohio 17	Virgin Islands 1
District of Columbia 4	Michigan 90	Oklahoma 11	Virginia 19
Florida 245	Minnesota 16	Oregon 51	Washington 20
Georgia 3	Mississippi 31	Pennsylvania 28	West Virginia 50
Illinois 62	Montana 3	Puerto Rico 2	Wisconsin 8

² NASBHC School-Based Centers: National census School year 2007-2008

³ NASBHC School-Based Centers: National census School year 2007-2008

Settings for SBHCs are as varied as the types of schools in the United States. A large majority (80%) of the programs report serving at least one grade of adolescents (sixth grade or higher). A national trend over the last few years has been to redesign schools to create non-traditional grade combinations as a way to improve students' academic success. The Census shows a similar change in the number of SBHCs located in "other" schools with non-traditional grade combinations such as grades seven through twelve (20%). Sponsors (organizations that serve as the primary administrative home) of SBHCs are most typically a local health care organization, such as a community health center (28%), a hospital (25%), or local health department (15%). Other community sponsors include nonprofit organizations, universities, and mental health agencies. Twelve percent of SBHCs are sponsored by a school system. SBHCs are often supported by schools and others through in-kind donations of space and services. The majority indicate that they do not have financial responsibility for construction and renovation (66%); maintenance and/or janitorial services (77%); utilities (82%); or rent (93%). School health services and SBHCs partner to provide care for students. Census data show that over three-quarters (78%) of schools in which SBHCs are located has a school nurse. Where both are present, 40% are located in separate facilities while 38% are co-located within the same health suite. Eighty-two percent of schools in which SBHCs are located have a school-employed mental health provider in the building – of these 67% are separate from the health center, and 15% are co-located with the health center. Thirty percent of SBHCs partner with the school to support students with special health care needs (students with health issues that affect their ability to learn and/or attend school). SBHCs support the academic success of these students in several ways: monitor medications (95%); review medical records (94%); assist in implementing the Individualized Health Plan (IHP) (75%); and serve on the Individualized Education Plan (IEP) development committee (70%).⁴

Students in schools with SBHCs are predominantly members of minority and ethnic populations who have historically experienced under-insurance, uninsured, or other health care access disparities. Thirty-six percent of SBHCs report serving only children who attend the school(s) they serve, a decrease from the 2004-2005 Census, where 45% reported serving only the student population. This trend indicates that SBHCs are expanding their ability to provide access to care to others in the community. Factors that may have influenced this trend are increased budgetary constraints and a weak economy, coupled with greater need for affordable health care in the community. Patient populations seen by SBHCs that open their doors beyond their school's students include: students from other schools in the community (58%); out-of-school youth (34%); faculty and school personnel (42%); family members of students (42%); and other community members (24%).⁵

The majority of SBHCs (95%) are open during normal school hours. Beyond the school day, the Census shows that 60% are open after school, 49% before school, and 36% during the summer. SBHCs are typically open for more than 30 hours per week. Sixty-seven percent report a pre-arranged source of after-hours care to assist students outside of normal SBHC operating hours through an on-call⁶

Funding

State funding has been a leading factor in the growth of school-based health centers over the past decade primarily through state general funds and the Maternal and Child Health Block Grant under Title V of the Social Security Act. In recent years, states have tapped into other resources

⁴ NASBHC School-Based Centers: National census School year 2007-2008

⁵ NASBHC School-Based Centers: National census School year 2007-2008

⁶ NASBHC School-Based Centers: National census School year 2007-2008

such as tobacco taxes and funds from tobacco settlement dollars to fund school-based health centers. In addition, many states have recognized the need and advantages to billing third-party resources, such as Medicaid, for their services.

The majority of SBHCs bill public insurance for health center visits, including Medicaid (81%), the Children's Health Insurance Program (68%), and Tri-Care (41%, the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, and survivors. Fifty-nine percent of SBHCs bill private insurance; 38% bill students or families directly. A majority of SBHCs (85%) also assist children and families with enrollment in public insurance programs. Improving the effectiveness of billing and collection practices and enrolling children and families in public insurance has been a major focus of sustainability efforts for SBHCs.

SBHCs also report receiving support from a variety of revenue sources not related to billing, including state government (76%), private foundations (50%), sponsor organizations (49%), and school or school district (46%). Thirty-nine percent of SBHCs receive funding from the federal government.

Managed care organizations (MCO) play a large role in SBHCs' ability to get reimbursed for services. Critical to being reimbursed for care is whether an MCO recognizes services delivered in a SBHC and whether the provider is considered to be a primary care provider or part of the recognized/approved primary care network. The census showed that 35% of MCOs recognize SBHC staff as primary care providers/preferred providers, while 30% of SBHCs indicate that MCOs do not recognize them as such.⁷

A closer look at federal and state funding sources indicates support from a diverse base of federal programs. Almost a quarter (23%) of SBHCs receives Section 330 monies through the Public Health Service Act for community, migrant, and rural health centers; these SBHCs are mainly sponsored by Community Health Centers. State Departments of Public Health are the most common source of state funds – almost half of SBHCs report receiving funds from these state entities – while the departments of human or social services and education fund about 11% of programs. In 21 states, the state funds or sponsors a grant program specifically dedicated to SBHCs.⁸

National Developments

Recent federal legislation has changed the face of health care and health care delivery. The Patient Protection and Affordable Care Act (a.k.a. the “health care reform act”) mandates health insurance coverage to all eligible individuals. The “Health Information Technology for Economic and Clinical Health (HITECH)” Act, (part of ARRA, or the “stimulus package”) promotes the adoption of health information technology (HIT) to improve efficiency, quality, and safety. HITECH contains funds for: financial incentives for eligible professionals and hospitals to adopt electronic health records and for their meaningful use; state Health Information Exchange (HIE) projects; support for “HIT extension services;” demonstration projects such as “Beacon Communities;” education and workforce training programs; standards for IT interoperability.

The Patient Protection and Affordable Care Act (PPACA)

SBHC-Specific Provisions

⁷ NASBHC School-Based Centers: National census School year 2007-2008

⁸ <http://www.seenmagazine.us/Sections/ArticleDetail/tabid/79/ArticleID/864/smid/403/reftab/326/Default.aspx>

PPACA includes two specific provisions related to school-based health centers (SBHCs): language authorizing a federal SBHC grant program and an emergency appropriation that would provide \$200 million for SBHCs over four years.

Individual Health Coverage

The Patient Protection and Affordable Care Act require U.S. Citizens and legal residents to have qualifying health coverage or face a tax penalty. The penalty will be phased in beginning in 2014 and will reach the greater of \$695 (\$2,085 maximum for a family) or 2.5% of household income in 2016. After 2016, the penalty will be increased by the cost of living.

The federal mandate for individuals to have qualifying health coverage is important to school-based health clinics because some parents do not seek out coverage for their children even if it is available at little or no cost and studies have shown that children of uninsured parents are less likely to use health services even when the children have health coverage

Employer-Based Health Coverage

The PPACA does not mandate that employers must offer insurance to their employees. However, the PPACA does provide for the following:

- Employers of 50 or more fulltime employees (30 hours per week) who do not offer insurance must pay a fee (equal to the tax credit received by employees or \$400 per employee receiving a tax credit whichever is less) Pay or Pay.
- Employers of 200 or more employees must automatically enroll employees into plans offered by the employer (employees may opt out if they have insurance from another source.)
- Small Business Tax Credits of up to 35% of the employer's contribution would be available in 2011 and 2012 (less than 25 employees with average wage \$40K or less and employers of 10 or fewer employees with average wage \$20K or less would receive full credit) in 2013 and beyond the percentage would increase to 50% for employers of fewer than 25 employees. The credit will be available for two years.

General Mandates

Effective September 2010, the PPACA changes many long-held policies for all insurers. Coverage is extended to dependent children to age 26; insurers cannot exclude children from coverage due to pre-existing conditions; there are no lifetime limits on coverage; insurers are prohibited from rescissions of coverage except for cases of fraud; and there is no cost sharing for preventive services and immunizations. Annual limits on coverage must meet standards set by DHHS and will be eliminated altogether in 2014

Health Insurance Exchanges

A Health Insurance Exchange will be a state agency or non-profit corporation that offers health coverage through qualified health plans. Exchanges will pre-qualify health plans that offer standard benefit packages, and provide educational materials to consumers. Exchanges will offer numerous health insurers/plans to consumers (the Connecticut Exchange currently offers 48 different health insurers/plans). Exchanges must coordinate enrollment with Medicaid and the State Children's Health Insurance Plan (SCHIP).

By January 1, 2014, states must establish Exchanges for individuals (American Health Benefit Exchanges) and for small businesses (Small Business Health Options Program Exchange)

Health Insurance Exchanges will offer four benefit levels:

- Bronze, covers 60% of the cost of benefits with out-of-pockets limits based on Health Savings Account limits and income
- Silver, covers 70% of the cost of benefits with out-of-pockets limits based on Health Savings Account limits and income
- Gold, covers 80% of the costs of benefits with out-of-pockets limits based on Health Savings Account limits and income
- Platinum, covers 90% of the cost of benefits with out-of-pockets limits based on Health Savings Account limits and income

Medicaid Expansion

Effective January 1, 2014, states must cover all individuals (except undocumented aliens) under age 65 with adjusted gross incomes below 133% of poverty (currently \$29,327 for a family of 4). In addition, state must cover foster care children to age 26. This will result in a very large increase in the number of individuals who will be covered by Medicaid. Each State must fund the state match for these individuals.

Accountable Care Organizations (ACOs)

Health care reform legislation allows demonstration of pediatric ACOs to share in savings they achieve for the Medicaid program. ACOs must be accountable for the overall care of their covered beneficiaries, have adequate primary care physicians, define a process to promote evidence-based medicine, report on quality and costs, and coordinate care. The ability to capture, share and analyze data will be an important aspect of ACOs. The legislation also allows Medicare ACO demonstrations. ACOs may be the model for other payers and future reorganizations of the health care delivery system

Impact of Health Care Reform on SBHC

A larger portion of children will be covered by some form of health coverage. This will mean less reliance on grants and other funding sources and greater reliance on billing insurers and health plans. If Connecticut's experience holds true, SBHCs will have to be able to deal with a number of insurers/health plans and be recognized by them as a source of care. Medicaid eligibility will be simplified so it will be easier for SBHCs to assist families in gaining eligibility. For managed care provider and ACOs, SBHCs will have to become a part of an ACO or potentially lose the right to treat portions of the school population.

One important section of the PPACA mandates the creation of a patient-centered medical home. This is defined as a mode of care that includes personal physicians; whole person orientation; coordinated and integrated care; safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements; expanded access to care; and payment that recognizes added value from additional components of patient-centered care. This may pose problems for SBHCs if they cannot link to the child's primary care provider.

- Medicaid payments to primary care physicians for primary care services will be increased to 100% of Medicare rates January, 2013. The difference between current rates and the new primary care rates will be covered with 100% federal financing in 2013 and 2014.

Health Information Technology (HIT)

The health care industry lags most others in the use of information technology for its core business (clinical care), although HIT is extensively used in some aspects (such as billing and

claims submission). Even though health information may be created and stored electronically, it is often not shared electronically across or even within organizations.

Medicaid Incentive Payment

As an incentive for providers to adopt HIT, the Health Information Technology for Economic and Clinical Health Act (HITECH, enacted as part of the American Recovery & Reinvestment Act of 2009) authorized financial incentive payments through Medicare and Medicaid to eligible medical professionals and hospitals for efforts to adopt, implement, upgrade, and meaningfully use certified electronic health record (HER) technology. The purpose of EHRs and meaningful use is to improve quality, safety, efficiency, and reduction of health disparities; engage patients and families in their health care; improve care coordination; improve population and public health; and ensure adequate privacy and security protections for personal health information.

The ARRA amended the SSA to authorize a 100% federal match for a portion of payments to encourage the adoption of EHRs (including support services and maintenance) to certain Medicaid providers who meet certain requirements. Allowable costs are paid directly to the healthcare provider without any deduction or rebate, the provider is responsible for payment of the EHR technology costs, the user certifies “meaningful use,” and the technology is compatible with federal administrative management systems.

Eligible providers would include: physicians, nurse mid-wives, pediatricians, and nurse practitioners who are not hospital-based and who have patient volume of at least 30% attributable to Medicaid patients. In order to be eligible, the provider would be required to waive any right to Medicare EHR incentive payments.

This provider group would be eligible for payments of up to 85% of their net allowable technology costs. However, the allowable costs of the purchase and initial implementation of EHR technology cannot exceed \$25,000 or include costs over a period of five years. Annual allowable costs not associated with the initial implementation or purchase of the EHR technology may not exceed \$10,000 per year or be made over a period of five years. Aggregate allowable costs, after application of the 85% adjustment, may not exceed \$63,750.

Rural healthcare clinics, physician assistant-led rural clinics, and federally-qualified health centers with at least 30% patient volume attributable to Medicaid patients would also be eligible for Medicaid incentive payments at amounts to be determined by the Secretary.

Detailed information regarding provider criteria and determination of Medicaid patient volume may be found at: <http://www.cms.gov/EHRIncentivePrograms/Eligibility>

Additional information on meaningful use may be found at: http://healthit.hhs.gov/meaningful_use

Certified technology information may be found at: <http://www.cms.gov/EHRIncentivePrograms/Certification>

Regional Extension Centers (RECs)

RECs are federally-designated entities dedicated to helping providers navigate the complex Electronic Health Record (EHR) marketplace by providing neutral, unbiased information and support. Their role is to assist providers throughout the entire adoption process from selecting and adopting an EHR to meaningfully using it to improve the quality of care delivered to their patients.

RECs will help the provider in vendor selection and group purchasing, implementation and project management, practice and workflow redesign, functional interoperability and health information exchange, and privacy and security best practices. Supporting meaningful use includes education on Stage 1 meaningful use objectives, oversight on vendor compliance on meeting meaningful use criteria, assisting practices in data capture for quality reporting, conducting post-implementation review, evaluating practices meeting meaningful use criteria, and monitoring meaningful use reporting.

Health Information Exchange (HIE)

The HITECH Act provides requirements for the State Health Information Exchange Cooperative Agreement Program. The State HIE Cooperative Agreement Program is a federal program that funds states' efforts to rapidly build capacity for exchanging health information across the health care system both within and across states. The State HIE Cooperative Agreement Program awards funding to states to develop and advance mechanisms for information sharing across the health care system, including establishing health information exchange (HIE) capacity among health care providers and hospitals in their jurisdiction, ultimately enabling exchange across states.

Participating states will also be expected to use their authority and resources to:

- Develop and implement up-to-date privacy and security requirements for HIE with and across state borders
- Develop state-level directories and technical services to enable interoperability within and across States
- Coordinate with Medicaid and state public health programs to enable information exchange and support monitoring of provider participation in HIE
- Remove barriers that may hinder effective HIE, particularly those related to interoperability across laboratories, hospitals, clinician offices, health plans and other health information exchange partners
- Ensure an effective model for HIE governance and accountability is in place
- Convene health care stakeholders to build trust in and support for a statewide approach to HIE.⁹

Additional information is available at <http://healthit.hhs.gov/programs/stateHIE>.

Impact of HIT on SBHCs

The SBHC's role in preventive and primary care becomes very complicated when other collaborating providers are involved. The sharing of information is either very slow or nonexistent. Once the SBHC becomes enrolled in the HIE, the ability to coordinate an individual's care will be greatly enhanced. Safety and efficiency are the obvious end results of this coordination. SBHCs are strongly encouraged to work with their sponsors on health information technology. Given the size of most SBHCs, the financial and personnel status of the SBHC does not readily lend itself to implementing its own certified HIT program that meets meaningful use criteria. Most sponsors (e.g., hospitals, FQHCs) may already be in the process of adopting, implementing, or upgrading their existing technology.

The accumulated data base from the SBHC will enable the providers (both SBHC and other care providers) provide a long-term positive impact on students ranging from better health to greater

⁹ <http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=1834>

academic performance. SBHCs will be able to re-affirm their contributions to the students' health and educational efforts through analysis of this data. Many decried the critical shortage of data that has meaning to policy makers and purse holders and show the value of important medical and non-medical functions of school-based health care. How do school-based health centers demonstrate that they are keeping kids out of emergency rooms and other inappropriate health care settings? That compared to traditional pediatric and adolescent health care practices, school-based health centers do a better job of achieving primary care goals? How can school-based health care data incorporate national medical and public health quality assurance yardsticks and goals such as HEDIS and Healthy People 2010? How can these yardsticks be augmented to include preventive services, such as AMA's Guidelines for Adolescent Preventive Services (GAPS)? Advocates suggested that data from the New York school-based health center Medicaid carve out will be very valuable. How will the extensive billing of more than 100 school-based health centers inform a national audience about normative access and utilization for school-age Medicaid enrollees?¹⁰

Many SBHCs lack staffing, software, and administrative structures to support billing third-party payers, such as Medicaid, for their services. SBHCs are adopting HIT to enhance their work with more than half (56%) using electronic billing systems, and 53% with a management information system. A smaller number use an electronic medical record (32%) and electronic prescribing (22%) and 7% of SBHCs have a telemedicine system.¹¹

¹⁰ NASBHC Issue Brief: critical issues in School-Based Health Care Financing

¹¹ NASBHC School-Based Centers: National census School year 2007-2008

Recommendations

The SBHC's in the school and community can be a vital access point for health services for the student population. The following recommendations will allow the SBHCs to continue to provide these needed services effectively and efficiently.

- The SBHCs must strengthen their ability and capacity to bill Medicaid and commercial insurances for the eligible services. The SBHCs must not solely rely on the schools and community to fund these clinics. With the expansion of Medicaid eligibility, more students will likely be seen by these clinics, resulting in more demand on the financial status of the clinics. Billing Medicaid and commercial insurances will be a necessity.
- Medicaid eligibility requirements will become easier. Staff at the SBHC should become familiar with Medicaid eligibility requirements so they may assist families to enroll in Medicaid. SBHCs should develop a relationship with the local Department of Human Services to facilitate these enrollments.
- The eligible providers within the SBHCs must become meaningful users of HIT. This will strengthen the quality of the services they render and greatly enhance the communications between the primary providers and other ancillary providers for this population. Stronger communications between primary providers will help create the patient-centered family home.
- Analyze the service history to identify new coverage rules. There may be new opportunities for billing previously uncovered services, such as immunizations and other preventive care. Mental health services are provided by many of the SBHCs. These services may now be billable to Medicaid and/or commercial insurers.
- Connect to resources that can support the development of meaningful use for HIT, including RECs and HIEs. These connections will assist the SBHC to obtain certified health information technology and attain meaningful use. The RECs and HIEs are there to help eligible providers.
- Participate in the larger service delivery organizations, such as ACOs or managed care organizations (MCO), as part of their provider panel. The SBHCs may be rendering services that may be duplicative of the ACO or MCO. Being part of the ACO or MCO will also assist in the continuous flow of information and patient-centered family home.
- Take advantage of the SBHC organizational capacity to build expertise across the network. Let the associations work for the SBHCs. The associations can collectively analyze the importance, capabilities, and abilities of the SBHCs to enhance the physical and mental health of the student population thereby enhancing their academic health. The strength of the associations can assist with the legislative opportunities to recognize and fund SBHCs nationally and statewide.