United States General Accounting Office

GAO

Report to the Chairman, Committee on Government Operations, House of Representatives

May 1994

HEALTH CARE REFORM

School-Based Health Centers Can Promote Access to Care

GAO/HEHS-94-166

GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-252731

May 13, 1994

The Honorable John Conyers, Jr.
Chairman, Committee on Government Operations
House of Representatives

Dear Mr. Chairman:

Access to regular health care during childhood helps promote health; prevent disease, disability, and unnecessary hospitalization; and treat acute and chronic conditions. Many American children, however, lack access to the health services they need. The barriers that may stand in their way—inadequate or no health insurance, few available caregivers, lack of convenient transportation—particularly affect poor children.

In response to this problem, you asked us to study one of the current methods for delivering care to underserved children: school-based health centers. These centers, which are located on a school's grounds, can provide preventive, medical, and mental health services to the children of that school. We are currently examining (1) whether school-based health centers increase access to health services for adolescents and younger children, (2) how centers launch and maintain their services in the face of financial and other obstacles, and (3) the potential impact of aspects of health reform legislation on the centers. In the interim, you asked us to provide you with preliminary information from our ongoing review. We plan to issue a report with additional information and analysis later this year.

Results in Brief

Our work suggests that school-based health centers (SBHCs) do improve children's access to health care. SBHCs can help to overcome financial and nonfinancial barriers that currently limit access, including the lack of health insurance, transportation difficulties, and insufficient attention to the particular needs of adolescents.

School-based health centers around the nation face a common set of problems. For example, centers lack a stable source of funding, do not always have sufficient resources for meeting their patients' health needs, and have difficulty obtaining reimbursement from public and private insurers. They also face problems recruiting and retaining appropriately trained staff. Furthermore, local debates over the appropriateness of

providing reproductive health services in SBHCs have constrained centers' ability to meet some adolescents' health needs.

Federal health care reform that increases access to insurance coverage could alleviate some of the problems faced by SBHCs. However, reform that includes expansion of the role of managed care networks may exacerbate financing problems because of the reluctance of these networks to reimburse SBHCs.

Background

The development of SBHCs has been a grassroots effort and continues to gain momentum. By the early 1980s, around 30 SBHCs had been started in communities throughout the United States. The idea of placing health services in schools has gained increased acceptance in the last decade, with SBHCs now numbering in the hundreds.[1] According to a survey by the Center for Population Options (CPO), about 79 percent of school-based and school-linked health centers serve high school students, while 9 percent serve primary school children (that is, pre-kindergarten through eighth grade), and 12 percent serve a combination of high school and primary school students.[2]

SBHCs are innovative programs designed to deliver health services where the children are—in the nation's schools. Most provide primary care, physical examinations, and injury treatment, but specific services vary by location. Centers may also offer immunization, counseling, laboratory tests, chronic illness management, health education, substance abuse treatment, reproductive health care, and other services. SBHCs refer students to local health providers for services that they are not able to provide on site. Most SBHCs require a parental consent form, which typically provides parents with the option of denying specific services to their children.

The organizations that manage SBHCs vary. They include state and local public health departments, community health centers, hospitals, and school systems. Staff are usually an interdisciplinary team that often

[1]The exact number of SBHCs is difficult to estimate because there is no reliable national database. Available data generally combine information on SBHCs with information on school-linked health centers (SLHCs), which are either located on a school campus and serve more than one school or are located off campus and may serve one or more schools.

[2]CPO, "School-Based and School-Linked Health Centers: Update 1993," 1994 (forthcoming). These data are for the 1991-92 school year and are based on the 202 responses received from 510 school-based and school-linked health centers surveyed. Of these 202 health centers, 123 were school-based and 75 were school-linked. (The other 4 centers could not be classified.) Unless otherwise noted, all CPO data we present are for school-based health centers.

includes a midlevel provider (that is, a nurse practitioner or physician assistant), while the number and types of other personnel, such as physicians, mental health counselors, or health educators, may vary. Many SBHCs depend on links with existing health facilities and donated services to provide support for their operations and to increase the range of services available at the sites.

State, local, and private funds supply the majority of SBHC funding and are supplemented by funds from several federal programs. Only a small amount of money comes from payments by SBHC enrollees and private insurers. Nationwide, the median SBHC budget for the 1991-92 school year was $132,500, and centers received an average of $20,000 in donated services from other providers.[3]

Federal Funding Sources

Several federal programs in the Departments of Health and Human Services (HHS) and Education support SBHCs. Federal funding sources include the Maternal and Child Health block grant (Title V of the Public Health Service Act), Medicaid (including Medicaid's Early and Periodic, Screening, Diagnostic, and Treatment program), and the Family Planning program (Title X). HHS officials could not identify the amount of federal dollars currently going to SBHCs because none of these program funds is specifically earmarked for SBHCs.

The first federal programs targeted specifically to SBHCs were announced in May 1994. HHS is implementing two coordinated grant programs to support SBHCs. Public Law 103-112[4] provides $3.25 million to fund school-based primary care services for homeless and at-risk youth at 15 to 20 new sites. Complementing this program, HHS' Maternal and Child Health Bureau (MCHB) is providing an additional $1 million to these same sites for health education. MCHB is also funding a separate $1.5 million grant program to states and universities for SBHC staff development.

Scope and Methodology

Our approach consisted of case studies, interviews with public and private officials, and a review of the literature. We conducted case studies at eight SBHCs in California, New Mexico, and New York. We chose locations to

[3]CPO; data on median budgets are for SBHCs only, while data for donated services are for both school-based and school-linked health centers.

[4]The Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1994.

ensure that we visited urban and rural SBHCs in elementary, middle, and high schools. For our case studies, we visited the schools listed below.

California: Luther Burbank Elementary School, San Jose; William C. Overfelt High School, San Jose; and Thomas Edison High School, Stockton.

New Mexico: Espanola Valley High School, Espanola; and Escalante High School/Middle School, Tierra Amarilla.

New York: William Howard Taft High School, Bronx; Intermediate School 136, New York; and Primary School 155, New York.

During the 1992-93 school year, over 11,000 students attended these schools, of which over 3,700 used SBHC services, accounting for almost 20,000 individual visits. At the centers we visited, budgets ranged from $21,481 for a part-time SBHC at a rural school with 289 students, to $285,000 for a full-time SBHC at a school with 3,300 students. At the centers, we toured the facilities and talked with health care providers, administrators, students, and parents. We interviewed health providers at back-up facilities, other providers in the community, and state and local health and education officials. We also visited SBHCs in Colorado and Georgia.

We discussed health and financing issues for SBHCs with HHS, Department of Education, and local and national foundation and association officials, as well as other experts on SBHCs. Among the people we spoke with were representatives of the Robert Wood Johnson Foundation, American Academy of Pediatrics, National Association of State Boards of Education, Council of Chief State School Officers, CPO, and New York State Catholic Health Care Council. We conducted telephone interviews with administrators of SBHCs and managed care systems to obtain information on managed care systems' methods of reimbursing school centers in Baltimore, Maryland; Minneapolis and St. Paul, Minnesota; and Portland, Oregon. Additionally, we reviewed studies on the general status of children's health and on the experience of SBHCs.

We performed our work from April 1993 to May 1994 in accordance with generally accepted government auditing standards.

School-Based Health Centers Can Improve Children's Access to Health Care

SBHCs can improve children's access to health care by removing both financial and nonfinancial barriers in the existing health care delivery system. These centers represent a unique health care delivery option that gives children, especially those who are poor or uninsured, easy access to services.

Low-Cost Access to Providers

SBHCs provide services free of charge or at minimal cost to students. This is important because many children lack health insurance, making it difficult for parents to pay for needed health services. Poor children in particular typically receive only episodic and crisis-related care, leaving preventive, chronic, dental, and mental health needs unmet. Even when a child is insured, the parents may be unable to pay the deductible or the insurance may not cover needed services.

SBHCs bring providers to students, which is especially important in rural and inner city communities with few health practitioners. This also helps children who are among the 21.4 percent of American children covered by Medicaid, because they cannot always find physicians willing to treat them.

Increased Convenience for Students, Parents, and Providers

SBHCs improve access to health care by being more convenient for both students and parents. By being on the school site, SBHCs eliminate the need for parents to leave work or provide transportation, which may be unavailable or inconvenient. Health care facilities often have long waiting times, especially at public facilities such as county hospitals, further increasing the time parents and students must take off from work and school. Both SBHC providers and students told us that if there were no SBHCs, ill students often would not seek treatment elsewhere, potentially having their conditions worsen. We were told that sometimes students receive care at an SBHC and return to class instead of staying home and missing a full day of school.

SBHCs enable providers to contact and treat students easily. By being "where the students are," SBHCs are better able to follow up with students to ensure that they make and keep appointments with other providers, and if necessary can call students out of their classes. Adolescents in particular are poor at making and keeping appointments and may be deterred by long waits.

Adolescent and Cultural Needs

SBHCs are particularly suited to meet the special needs of adolescents. Adolescents present unique problems that tend to involve a complex web of physical, emotional, and social issues requiring more than simple medical care. To discuss these issues, teens need an atmosphere of trust and confidentiality. SBHC providers told us that students often will not discuss their problems until they spend time in the facility and feel comfortable with the staff. When students come in for apparently simple medical needs, they will often discuss more serious concerns such as depression, thoughts of suicide, or pregnancy if the staff ask probing questions. At one center that we visited, a nurse practitioner talked to a girl who seemed overly withdrawn; the girl then revealed that she had been raped.

Students we talked with emphasized the importance of feeling comfortable with SBHC staff and especially appreciated the confidentiality of services. They noted that other types of facilities in the community are impersonal and inconsiderate of adolescents' concerns. Providers at these other facilities tend to have less time to spend with patients, limiting providers' ability to identify the underlying causes of adolescents' problems. These other facilities also cannot readily serve patients without appointments and may not ensure continuity of care by the same provider.

By providing bilingual, culturally sensitive staff, SBHCs become a vehicle for meeting the health needs of minority students. Some students experience language and cultural barriers that discourage them from going to traditional health care facilities. For example, many families who are recent immigrants are not familiar with the health care system and do not know how to obtain services. Also, some of these families fear authority figures and, thus, will not seek services from the health care system. Providing services to students who have recently immigrated is especially important because they may not have received needed health care, such as physical examinations or immunizations, before coming to the United States.

Health Centers Face Problems

SBHCs face a common set of problems. Their principal challenge is obtaining access to stable sources of financing. Another hurdle that SBHCs face is the difficulty of finding an adequate supply of appropriately trained personnel. In addition, the decision to establish SBHCs has sometimes been controversial because some members of the community are concerned that the SBHCs would provide reproductive health services that they consider inappropriate.

Centers Are Concerned About Financing

SBHC staff report several difficulties in financing their operations. School centers often rely on fragmented and sometimes short-term sources of funding to operate. Funding is further constrained because SBHCs have difficulties billing both private and public insurers. Some SBHC providers report that they do not have enough resources to meet children's needs, especially for mental health and dental services.

SBHCs rely on fragmented sources of state, local, private, and federal funding to cover their start-up and operating costs. Private funds from foundations have played a large role in establishing new clinics, but this is frequently short-term funding, leaving the clinics with an uncertain flow of funds. A California organization we visited provides an example. It operates eight SBHCs. For school year 1992-93, its budget consisted of about $515,000 from 10 private and 4 state and local grants and about $100,000 in state and federal Medicaid funds. A 6-year annual private foundation grant for $100,000 ended that year; the other grants were awarded for 1-year time frames. Thus, Medicaid, which was only about 16 percent of the budget, was the only continuing source of funds.

Problems in billing insurers further limit SBHCs' ability to finance services. Difficulties at the sites that we visited include a lack of administrative capability to implement a billing process, low-income families' inability to pay insurance deductibles, and a reluctance to bill insurers because adolescents lose confidentiality when parents receive insurance statements. In addition, private insurers may not cover some services that SBHCs provide, such as preventive services and health education. As a result, some SBHCs do not bill third parties. Private insurance billing composes only 1 percent of school health center funding.[5]

SBHCs have had varied success in billing Medicaid despite serving large Medicaid-eligible populations. Problems that SBHC officials reported include eligibility determination, a burdensome billing process, and state

[5]CPO; data are for both school-based and school-linked health centers.

restrictions on services eligible for reimbursement. For instance, services provided by nurse practitioners in Colorado are not eligible for Medicaid reimbursement. Clinics linked to established providers, such as community health centers, reported easier access to Medicaid funding.

Administrators and health providers at some sites that we visited reported that budget limitations prevent them from meeting all of their patients' needs. The level of funding at some SBHCs requires them to operate on a part-time basis or with part-time provider staff even though full-time services are needed. Private and public health insurance coverage of mental health services, including Medicaid funding, tends to emphasize acute or emergency conditions rather than ongoing care. Yet SBHC providers consistently emphasized the large demand for mental health services at their facilities. Providers also cited difficulties addressing dental needs. CPO reported that about 13 percent of SBHCs provide dental services on-site. Obtaining these services in the community is difficult because of prohibitive costs, long waiting times for referrals, or a lack of dentists.

Appropriately Trained Staff Difficult to Recruit and Retain

The key providers at SBHCs are midlevel practitioners (that is, physician assistants and nurse practitioners), who are generally in short supply. The effect is exacerbated because SBHCs lack competitive salaries and working conditions when compared to other health care settings, such as hospitals or health maintenance organizations. Also, SBHC providers are expected to work more autonomously than providers in private settings or to work in potentially dangerous urban neighborhoods or remote rural areas.

We saw the effect of this in New Mexico where seven rural sites with interest in setting up SBHCs have been unable to find providers. One of these—only 20 miles from Albuquerque—was unable to utilize a state grant because of its inability to recruit a midlevel provider during a 2-year period. The need for providers with special qualifications, such as training in work with adolescents or bilingual ability, further diminishes the pool of qualified staff for SBHCs. In California, we were told that midlevel practitioners come to SBHCs to gain experience, then leave to work for a private provider.

Controversy Over Reproductive Health Services Constrains SBHCs' Ability to Meet Some Adolescents' Health Needs

Controversy over the appropriateness of providing reproductive health services in SBHCs has caused some centers to limit or eliminate family planning services, move their operations off the school campus, or not open. Others have had their funding withheld. Several sites that we visited had encountered opposition at some point in their development.

The increasing level of sexual activity among adolescents suggests that many teens need access to reproductive health services. Many adolescents are sexually active and at risk for problems associated with unprotected sexual intercourse. Every year in the United States, more than 1 million adolescents become pregnant, representing nearly 1 teenage girl out of every 10, a rate that is at least twice as high as in other industrialized countries. In addition, the prevalence of gonorrhea increased 325 percent among 10- to 14-year-olds and increased 170 percent among 15- to 19-year-olds between 1960 and 1988. Furthermore, the Centers for Disease Control and Prevention (CDC) reported a total of 1,412 cases of acquired immunodeficiency syndrome (AIDS) among adolescents through September 1993.[6]

The reproductive services that adolescents need include counseling, gynecological exams, pregnancy testing, sexually transmitted disease diagnosis and treatment (including human immunodeficiency virus [HIV] testing), prescription and distribution of contraceptives, and prenatal care. Many SBHCs provide all or some of these services; the majority do not provide contraceptives on-site.

SBHCs have taken a number of steps to address concerns over reproductive health services. For example, in response to community pressures, a school board in New Mexico prohibited one SBHC that we visited from dispensing contraceptives. The decision was reversed when the school experienced an apparent increase in the number of teen pregnancies, and students and parents showed strong support for the services. Effective strategies that SBHC supporters have used to address community concerns include (1) presenting data to document the need for reproductive services; (2) involving key individuals, such as medical providers, school personnel, and community leaders; and (3) educating the public. Parental consent forms often give parents the opportunity to select specific services that their children can receive.

[6]CDC noted that while the number of adolescents with AIDS was relatively small, many additional young people are infected with human immunodeficiency virus. Since 1 in 5 reported AIDS cases is diagnosed in the 20-29-year-old age group, and the median incubation period between HIV infection and AIDS diagnosis is about 10 years, many people who were diagnosed with AIDS in their 20s became infected as teenagers.

Federal Health Reform Promises Assistance and Challenges

Proposed federal reforms of the health care system could have a significant impact on the financial future of SBHCs. Expansions of health insurance coverage and new programs could give SBHCs greater financial stability. At the same time, if reform results in expansion of the role of managed care, financing problems may arise.

The Health Security Act (S. 1757; H.R. 3600) currently under consideration by the Congress would create a Public Health Service (PHS) program to award grants to develop school health service sites.[7] The authorization for this initiative would be $100 million in fiscal year 1996 and rise annually until it reached $400 million in fiscal years 1999 and 2000. Grant recipients would be state health departments or local community partnerships, which would include at a minimum a local health care provider, one or more public schools, and at least one community-based organization with a history of providing services to at-risk youth in the community to be served.

HHS officials expect that this program would provide funding to create 3,000 to 4,000 new school health service sites.[8] Under the health care system proposed in the Health Security Act, the sites that receive these grants would automatically become essential community providers. The health plans proposed by the act would be required for 5 years to pay school health centers for health care provided to plan members if the center is designated as an essential community provider and is in the plan's service area.[9] This would give many SBHCs an important source of funding during this period.

SBHC staff as well as state and local officials emphasized the importance of clearly addressing the relationship between managed care and SBHCs in any health reform effort. Officials cited the current difficulty that SBHCs confront in obtaining reimbursement for services to students who are insured by Medicaid and private managed care plans. When SBHCs do not receive reimbursement, they are in effect subsidizing the plans. Managed care providers are often reluctant to incorporate SBHCs into their networks because of concern that they lack control over the care provided.

[7]These sites could be similar to the SBHCs we have described or be located in settings not on school premises.

[8]HHS officials told us that funds might also be awarded to existing SBHCs for major expansion of services.

[9]Individuals would purchase insurance coverage from these health plans for a comprehensive package of health benefits. The plans would arrange with health care providers to provide health services to their members, often creating a managed care network.

Additionally, it is not in their financial interest to reimburse centers. The proposed Health Security Act would begin to address this problem.

SBHCs may still face reimbursement problems under the proposed act, however. For example, under the Health Security Act as introduced, managed care networks would not be required to pay existing SBHCs or new ones developed outside the PHS grant program. Additionally, because health plans would not always have to pay SBHCs located outside their service area, SBHCs would not necessarily receive payment for services provided to all students. Finally, SBHCs often perform public health functions that might not be included in a managed care contract. Public health activities that SBHCs sometimes undertake for the entire school population include tuberculosis testing, health education, state-mandated vision and hearing screening, and immunization.

Recently, a few SBHCs have been successful in arranging reimbursement from managed care providers. Although managed care systems often reimburse providers on a capitated basis,[10] reimbursement of these SBHCs is usually on a fee-for-service basis. We discussed the advantages and disadvantages of a capitated system with representatives of SBHCs and managed care providers who are experimenting with reimbursement arrangements. They told us that capitation may create too great a financial risk for SBHCs if the demand for services far exceeds estimates. If an SBHC serves a small number of students from a particular plan, it is especially hard to estimate utilization. Additionally, because SBHCs are not open 24 hours a day and do not provide all medical services, they must have arrangements with back-up facilities and would have to share capitation fees with those other providers, further complicating the determination of fees. Capitation may, however, have the advantage of greater administrative simplicity for SBHCs.

SBHC and managed care administrators stated that their efforts began too recently to provide a definitive answer to the question of which approach—fee-for-service or capitation—is preferable. They generally agreed that while state and federal agencies may wish to encourage managed care plans to reimburse SBHCs for the services they provide to their enrollees, it would be best for now to allow individual SBHCs and managed care providers to design the system that works best for them and not mandate any particular arrangement.

[10]Under this arrangement, the provider receives a per-capita lump-sum payment to provide or arrange for all covered health services for insured individuals. This contrasts with fee-for-service systems, which reimburse providers on a per-service basis.

We are sending copies of this report to other interested committees, the Secretary of Health and Human Services, and the Secretary of Education. We also will make copies available to others upon request.

If you or your staff have any questions concerning this report, please call me at (202) 512-7119 or Bruce D. Layton, Assistant Director, at (202) 512-6837. Other analysts who contributed to this report include Mary A. Needham, Joe Sikich, Helene F. Toiv, and Frederick K. Caison.

Sincerely yours,

Mark V. Nadel

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