Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SCHOOL-BASED HEALTH CENTERS AND MANAGED CARE

DECEMBER 1993 OEI-05-92-00680

EXECUTIVE SUMMARY

PURPOSE

This inspection describes school-based health centers and their degree of coordination with managed care providers.

BACKGROUND

According to surveys and estimates, there are between 200 and 500 school-based health centers across the country, and the number of school-based health centers is increasing rapidly. These school-based health centers vary depending on the community, but the vast majority are located in middle or secondary schools. Visits for physicals and mental health needs are the most common services provided in school-based health centers.

This inspection focuses on adolescents due to their unique health needs and the fact that most school-based health centers serve this age group. However, school-based health centers are also proliferating at the elementary school level. Many of the ideas discussed here are germane to elementary school-based health centers as well.

School-based health centers often receive funding from a combination of public and private sources. The most common sources of private funding are foundation grants and private health insurance. The largest Department of Health and Human Services (HHS) financial contributions come from Title V Maternal and Child Health Block Grants (providing an estimated 16 percent of school-based health centers' funding), community health center funding (6 percent), and Medicaid (2 percent).

At the same time that HHS supports school-based health centers to promote access to health care and better public health, it also supports the growth of Medicaid managed care delivery systems to promote better access to quality health care. Thirty-two States and the District of Columbia have some type of managed health care option for Medicaid recipients. A common feature of managed health care plans requires recipients to be "locked in" to one medical plan or provider. "Locked in" recipients cannot normally receive non-emergency treatment from providers outside of the plan. As both managed care and school-based health services expand, adolescents enrolled in managed care plans will be more likely to have access to school-based health centers and the need for coordination will grow.

FINDINGS

School-based health centers increase access to health care for adolescents.

On-site school-based health centers increase access to health care and specialize in providing services aimed at adolescents. Staff at school-based health centers are trained in dealing with adolescents and problems unique to their age group. By going "where the kids are," school-based health centers surmount a major barrier to health care access even managed care providers cannot address.

Early assessments of school-based health centers are promising, and anecdotal evidence supports the idea that school-based health centers are an appropriate way to deliver services to adolescents. But the literature on school-based health centers rarely gives a national perspective and provides little information about health outcomes for adolescents.

However, little coordination exists between managed care providers and school-based health centers.

Few agreements, formal or informal, exist between managed care providers and school-based providers. Little exchange of medical information takes place between managed care providers and school-based health centers. As a result, neither managed care providers nor school-based health centers can coordinate or manage all the care given to their patients.

Respondents describe multiple barriers to coordination between managed care providers and school-based health centers. These barriers include communication, finances, legal issues, and confidentiality of medical records. Most respondents believe there will be negative consequences if school-based health centers and managed care providers do not coordinate.

Some initial efforts to coordinate demonstrate potential benefits for adolescents, managed care providers, and school-based health centers.

In communities where school-based health centers have agreements with local managed care providers, all parties can benefit from increased capabilities to deliver managed and coordinated care.

Even though school-based health centers and managed care are expanding rapidly, HHS has no focal point coordinating departmental programs and activities in these areas.

The HHS has a hand in both managed care and school-based health centers in a variety of agencies. There is no focal point in either the Public Health Service or the Health Care Financing Administration for outside entities to contact or to provide a locus for decisionmaking.

RECOMMENDATIONS

The Assistant Secretary for Health and the Administrator for Health Care Financing should each designate a contact to coordinate school-based health center issues in their agencies. In addition, these contacts should provide a point-of-entry for those outside HHS who need information about school-based health centers.

The Public Health Service, the Health Care Financing Administration, and the States should encourage cooperation between school-based health centers and managed care providers.

The Public Health Service and the Health Care Financing Administration should work with HHS agencies to fund appropriate studies and grants that will add to our knowledge on school-based health centers and managed care providers.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration and the Public Health Service. Both agencies supported the recommendations, suggested pertinent clarifications and identified additional issues regarding school-related and youth health programs. The complete text of the Health Care Financing Administration comments are included in Appendix G. The Public Health Service comments are included in Appendix H. We made appropriate revisions to the report based on their comments.

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INTRODUCTION

PURPOSE

This inspection describes school-based health centers and their degree of coordination with managed care providers.[1]

BACKGROUND

School-based health centers

Delivery of health care to children and adolescents poses a difficult challenge to communities, particularly in low-income areas where access to care may be minimal. However, since the mid-1980s, some communities have addressed the problem by setting up primary health care for children and adolescents in school-based health centers. According to surveys and estimates, there are between 200 and 500 school-based health centers across the country, and the number of school-based health centers is increasing rapidly. These school-based health centers vary depending on the community, but the vast majority are located in middle or secondary schools.

Nearly all school-based health centers provide general, primary health care ranging from general physicals to chronic illness management.[2] Many school-based health centers also provide a health curriculum that is age and developmentally-appropriate.[3] Visits for physicals, acute illness, psychosocial and mental health needs are the most common services provided in school-based health centers.

School-linked health services

In addition to communities establishing school-based health centers, many community health centers and hospitals have also entered into agreements with local schools to provide children and adolescents access to comprehensive health care. By November 1992, 240, more than one-third of the community and migrant health centers and

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1 *Some people refer to this as coordinated care, but we will refer to it as managed care for purposes of the report.*

2 *Over half the school-based health centers offer the following medical services: assessment and referral to community health systems and physicians, chronic illness management, diagnosis and treatment of minor injuries, Early and Periodic, Screening, Diagnostic, and Treatment services, general physicals, gynecologic exams, immunizations, initial and follow-up examinations for birth control methods, laboratory tests, pregnancy and prenatal care referral, prescription and dispensing of medication, sexually transmitted disease diagnosis and treatment. The majority of school-based health centers offer the following counseling and educational services: counseling on birth control methods, drug and substance abuse programs, family counseling, health education, mental health and psychosocial counseling, nutrition education, parenting education, pregnancy counseling, sex education in a classroom setting, sexuality counseling, and weight reduction programs.*

3 *In addition to efforts by school-based health centers, many schools offer health programs and activities to enhance the health of school-aged populations, such as nutritious meals, physical fitness and sports programs, an environment free of drugs, violence, pollutants, etc. There are also adolescent health efforts aimed at achieving, maintaining, and improving the health of adolescents, not limited to adolescents attending school.*

health care for the homeless programs funded by the Department of Health and Human Services (HHS) had arrangements with local schools and school districts to care for poor and underserved populations of school-aged children.

For purposes of this report, unless otherwise noted, any further discussion of school-based health centers applies to school-linked health services as well. In addition, we will focus on adolescents because most school-based health centers serve this age group. However, school-based health centers are also proliferating at the elementary school level, and many of the ideas discussed are germane to these school-based health centers as well.

Managed care

At the same time that HHS supports school-based health centers to promote access to health care and better public health, it also supports the growth of Medicaid managed care delivery systems to promote better access to quality health care. Thirty-two States and the District of Columbia have some type of managed health care option for Medicaid recipients. Private managed care plans exist in 46 States and the District of Columbia.

A common feature of managed health care plans requires recipients to be "locked in" to one medical plan or provider. "Locked in" recipients cannot normally receive non-emergency treatment from providers outside of the plan. This "lock in" means that managed care providers can coordinate the care given and be certain of its quality and its cost effectiveness.

Managed care plans offer a wide range of medical specialties and services for its members. By assigning each patient a primary care case manager, patients should have increased access to primary care. Managed care providers inform enrolled patients that the plan is responsible for all their medical care.

Although managed care can take different forms, generally managed care describes a health care delivery system where:

- care is arranged with selected providers to provide comprehensive health care services to members,
- health care providers are chosen based on selection standards,
- plans have formal programs for ongoing quality assurance and utilization review,
- members have significant incentives to use providers associated with the plan.[4]

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[4] *The Health Insurance Association of America defines a managed care plan as one integrating both financing and health care delivery. These four elements are integral to that integration.*

Mainstream medical delivery systems are not geared to adolescents.

All mainstream health care delivery systems, whether family physicians, pediatricians, or managed care providers, must deal with the dilemma of adolescent health. Adolescents present special health needs to medical caregivers. Chief among these needs is care that is confidential, convenient, comprehensive, and age appropriate.

Adolescents are generally perceived as healthy, but this perception may be deceptive. In its 1991 study on adolescent health, the U.S. Office of Technology Assessment (OTA) estimated that 20 percent of adolescents have at least one serious health problem. The OTA states that many adolescents suffer from a diagnosable mental disorder. Prior studies have also described other teenage morbidities including youth drug and alcohol abuse and sexually transmitted diseases.

For myriad reasons, most adolescents do not seek routine medical care, and often will wait for problems to become severe before soliciting treatment. One consequence is that adolescents see office-based physicians less than any age group.[5] In some ways, the nature of adolescence may present a barrier to health care. Adolescents often do not keep medical appointments.[6]

The OTA describes many difficulties adolescents have accessing and receiving the health care they need. Among these difficulties:

- "...access problems that affect adolescents particularly - for example, lack of money to pay for services or transportation, lack of convenient hours, concerns about confidentiality, and perceived lack of approachability of mainstream services."

- "...there is some evidence that many adolescents are unwilling to visit their private physician for concerns about sexuality, substance abuse, or emotional upset and also would be unwilling to seek care for these problems with their parents' knowledge."

- "Primary care physicians appear to have difficulty in identifying adolescents who have behavioral, emotional, and substance abuse problems."

- "...those adolescents who seek health care are likely to see providers who have not been specially trained to work with them."

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5 *Klein, Jonathan D., Slap, Gail B., Elster, Arthur B., Schonberg, S. Kenneth, "Access to Health Care for Adolescents", Journal of Adolescent Health, Vol 13, #2, March 1992, p.164.*

6 *The prevailing view of respondents for this study was that teens are "of the moment" and that adolescents "do not walk around with appointment books."*

In addition, health care coverage for teens is problematic. One in seven teens has no health insurance. Where private health insurance covers adolescents, restrictions often limit services for teens. For example, maternity related expenses are not included for one-third of teens covered by their parents' employment-based health plan.

These represent serious obstacles that impede access to basic health care for adolescents. Reducing the occurrence of many serious adolescent health problems depends on overcoming these barriers.

Even managed care delivery systems, designed to increase access and coordinate health care, have difficulty meeting adolescent health care needs.

While managed care plans offer comprehensive health care, most, like their fee-for-service counterparts, offer few counseling services geared to adolescents. According to OTA, "...Medicaid and many private ... insurers place limitations on reimbursement for mental services that they may not place on services for physical problems." So drug and substance abuse, nutrition, reproductive, and sexuality counseling is not provided routinely through managed care providers.

Because adolescents' problems may be complex, and not strictly of a physical nature, diagnosis is difficult. Because treatment of these problems may require dealing with more than one health or related system, case management services and referrals for social services may be necessary. But managed care plans do not provide these "special needs" services, and instead must refer adolescents for these services.

Recognizing the difficulties promoting health care and wellness among adolescents, some managed care plans have developed special adolescent clinics. Some have also designed programs addressing a specific health problem (e.g., AIDS). These approaches have had varying degrees of success.

Funding sources for school-based health centers

The school-based health centers often receive funding from a combination of public and private sources. The most common sources of private funding are foundation grants and private health insurance. Public funding sources include: State health departments, city and county health departments, school districts, and HHS. The largest HHS financial contributions come from Title V Maternal and Child Health Block Grants (providing an estimated 16 percent of school-based health centers' funding), community health center funding (6 percent), and Medicaid (2 percent). School-based health centers have also been very creative in attracting in-kind contributions, such as mental health and substance and alcohol abuse services.[7]

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7 *Sources of funding information: Office of Technology Assessment report, Adolescent Health, 1991, Volume III, p. 48. The School-Based Adolescent Health Care Program, Access to Comprehensive School-based Health Services for Adolescents, Fall, 1992, p. 1.*

The expanding HHS role in school-based health centers

In the past, HHS funds have comprised a relatively small portion of funding for school-based health centers. Recently, however, there have been efforts to increase HHS involvement with school-based health centers. In 1987, the Centers for Disease Control and Prevention (CDC) created the Division of Adolescent and School Health to identify and monitor major health risks among youth and to implement national programs to diminish these risks. In conjunction with the Carnegie Foundation, CDC is funding an initiative at the Columbia University School of Health Policy which has brought together a national workgroup to identify barriers to establishing school-based health centers and to develop recommendations for a core set of services for school-based health centers.

In 1991, the Advisory Council on Social Security recommended that the Federal Government help States establish health clinics in or near elementary schools, and share with States the costs of providing health and dental services for poor children. The HHS and the Department of Education recently published the "Practical Guide to School-linked Service Integration." In addition, the Interagency Committee on School Health was created under the leadership of the HHS Office of Disease Prevention and Health Promotion as a joint activity of HHS and the Department of Education. Staff support for this effort is provided by the Office of Disease Prevention and Health Promotion and the Department of Education's Office of Elementary and Secondary Education. Representation from HHS, Department of Education, the Department of Agriculture, and a number of other Cabinet-level departments and Federal agencies is included on the Interagency Committee on School Health.

Another effort demonstrating HHS support for school-based health centers comes from the Health Care Financing Administration (HCFA). The HCFA encourages schools to become providers for Medicaid's Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) program.

EPSDT

The EPSDT program was created in 1967 to provide initial and periodic examinations and medically necessary follow-up care for Medicaid-eligible children. The Omnibus Budget Reconciliation Act of 1989 expanded EPSDT coverage for most Medicaid-eligible children under age 21. In July 1990, HCFA established participation goals for EPSDT requiring that States screen 80 percent of eligible children by 1995.

To help States meet these goals, HCFA is encouraging States to enroll schools as EPSDT providers and recently published *EPSDT: A Guide for Educational Programs*. This guide provides school officials with information about State Medicaid agencies, the EPSDT program, and the benefits of EPSDT participation.

METHODOLOGY

We conducted an extensive literature review on school-based health centers and relevant legislation. Within HHS, we held discussions with officials in HCFA and the Public Health Service (PHS). We attended a Child Health Conference that addressed managed care and child health issues. Representatives from HCFA, PHS, managed care consulting firms, State Medicaid agencies, State offices of Maternal and Child Health, State and local health departments, and foundations concerned with child health attended the conference. In addition, we attended the annual conference of the Society for Adolescent Medicine and a meeting of the Ad Hoc Committee on Health Promotion Through the Schools.

Using HCFA data on managed care providers and from existing literature and experts in the field of school-based or school-linked health, we identified 10 communities where both school-based health centers and managed care providers exist. Our criteria for selection gave priority to communities where school-based health centers and managed care providers were working toward agreement. We also favored communities that would give us a geographically diverse sample. To obtain detailed descriptions of how school-based health centers coordinate with managed care providers, we used in-depth, structured personal interviews with representatives of both school-based health centers and managed care providers in these communities.

To gain a State level perspective, we contacted officials in all States with both Medicaid managed care and school-based health centers. We spoke with Medicaid and Maternal and Child Health officials in 32 States and the District of Columbia[8] to discuss managed care coordination with school-based health centers. We used in-depth, structured telephone interviews for this purpose. From all respondents, we requested information on the barriers to coordination between school-based health centers and managed care providers and the methods for overcoming these barriers.

In total, we used structured interviews with 88 respondents. Twenty-two were school-based health center and managed care respondents, while 66 respondents were from the States. We also gathered information during open-ended discussions with 27 others in the fields of adolescent health, school-based health centers, and managed care. No standards for measuring school-based health center processes and outcomes exist; available data varies by community. Our evaluation is based, perforce, on qualitative data. Such data does not provide conclusive proof regarding program effectiveness, but does highlight promising leads and identify areas needing further study.

Although we focused on specific groups of respondents, our findings have much wider implications. Most of our discussions with managed care respondents related to Medicaid managed care, but our findings are relevant to all managed care plans whose

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8 *The District of Columbia respondents will be counted with State respondents in this report.*

enrollees can receive services at school-based health centers. Because the preponderance of school-based health centers are located in high schools and middle schools, and the serious health problems relating to adolescents, our discussions with respondents focused on adolescent health and school-based health centers for adolescents. As more communities create school-based health centers to meet the health needs of younger children, the many of the issues discussed in this report will apply at the elementary school level.

Appendix A lists the managed care and school-based health center sites visited. Appendix B lists other contacts in the fields of school-based and adolescent health, and managed care. Appendix C is a selective bibliography which includes references we found particularly valuable in this study.

We conducted our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Mainstream health care delivery in the United States is undergoing profound change. Managed care and school-based health services represent some of this change.

National health care reform may include both managed care and school-based health centers. Either managed competition guaranteeing health insurance, or a universal health care system increases the demand for access to primary health care provided by these current delivery systems. Managed care with its aggregate of physicians and related services, and school-based health centers with their unique abilities to treat adolescents, offer mechanisms to provide this primary medical care.

With the health care landscape changing rapidly, the timing for creating new, productive linkages may never be better. Although this report focuses on school-based health centers and coordination with managed care providers, it is logical that other medical delivery systems need to develop similar connections that ensure patient access to services and exchange of medical information.

SCHOOL-BASED HEALTH CENTERS INCREASE ACCESS TO HEALTH CARE FOR ADOLESCENTS.

On-site school-based health centers increase access to health care.

Overwhelmingly, State agency respondents (91 percent) feel that school-based health centers improve access to health care. Many respondents cite the clinic's location as being critical in treating adolescents. By going "where the kids are," school-based health centers surmount a major barrier to health care access even managed care providers cannot address.

Being physically located in the school where adolescents spend much of their day serves to encourage clinic usage. This access to health care is illustrated by the repeat visits made by adolescents. The Robert Wood Johnson (RWJ) Foundation's School-Based Adolescent Health Care Program estimates that in the 1990-91 school year, 87 percent of the visits made to their grantee school-based health centers were repeat visits.

Parents of adolescents in schools with school-based health centers appreciate the health care access provided their children. The RWJ reports 71 percent of parents consented to having their child treated in school-based health centers in 1990-91, an increase from 34 percent only 2 years prior.

Parental or guardian consent is the only requirement for students to enroll in school-based health centers. All school-based health centers we visited, and all mentioned by State agency respondents, treat all students in need of care if a parent or guardian has signed a consent form authorizing treatment. Without school-based health centers, many adolescents would not receive health services since they are not covered by private insurance or Medicaid. For example, New York State estimates that in 1992, 58 percent of the students treated in their 122 school-based health centers were uninsured.

Services provided at school-based health centers are geared toward adolescents.

In addition to primary health care, the school-based health centers provide specialized services aimed at adolescents. These services include educational, preventive, and confidential services. The school-based health centers can provide health and wellness training in a classroom setting to educate many students, or use individual counseling sessions, whichever is appropriate. The school-based health centers use outreach approaches to attract students to their clinics. These outreach efforts vary from newsletters to posters to word-of-mouth.

One form of outreach school-based health centers use effectively is follow-up and case management for students. The school-based health centers, by virtue of their location and ties to the school, can call in the student for follow-up treatment or to provide reminders to keep their medical appointments. According to school-based health center respondents, adolescents referred to outside health providers by school-based health centers have a high rate of completion for referrals.

Staff at school-based health centers are trained in dealing with adolescents and problems unique to their age group. The staffs are often multidisciplinary to deal with more complex cases. These multidisciplinary teams draw providers from the fields of medicine, nursing, social work, psychology, health education, and nutrition.

One of the school-based health center staff becomes the case manager, directing the patient to all necessary services, ensuring appointments are kept, and following up on any outside referrals. In depicting how this school-based health center case manager functions, a Journal of the American Medical Association article describes a Louisiana nurse practitioner's actions: "If they're positive (pregnant) ... she immediately refers them to the Teen Advocacy Program, and then they immediately hook up with the nurse midwife program at the local hospital, and they immediately begin good prenatal care with close, ongoing follow-up at school, at home through the social worker, and at the hospital."[9]

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9 *Goldsmith, Marsha F., "School-Based Health Clinics Provide Essential Care", JAMA, Vol 265, #19, May 15 1991, p.2460.*

Respondents agree that school-based health centers can provide some services more easily than a managed care provider.

All managed care, school-based health center, and State agency respondents feel that certain services can be delivered more easily by school-based health centers. Some respondents attribute this ease to the school-based health centers' physical proximity to the students, rather than special expertise of school-based health centers.

Respondents disagree on which services are more easily provided in school-based health centers versus a managed care setting. Some of the differences are due to local variations in school-based health centers and the services they offer. Routine health screenings, mental health, reproductive counseling, and treatment of psychosocial problems were most often cited by respondents as areas where school-based health centers were able to provide services more easily to adolescents.

The HCFA encourages States to use school-based health centers to perform EPSDT screenings. Even though many Medicaid children are covered by managed care plans, HCFA recognizes that school-based health centers offer an opportunity to perform health screening for many school-aged children who might not otherwise be tested.

Despite respondents' perspectives and anecdotal evidence indicating school-based health centers are responsive to adolescent needs and increase access to health and psychosocial services, no national data exist that demonstrate school-based health center quality and effectiveness. Early school-based health center evaluations focus on utilization of services rather than health outcomes. The few attempts at measuring school-based health center outcomes focus on a few clinics in a limited geographic area, and their findings cannot be projected to all school-based health centers. To date, much effort has been expended to start and operate school-based health centers rather than to define how school-based health centers should operate and what they should accomplish. As a result, standards and outcome measures that recognize common school-based health center functions and goals, beyond local interests, have not yet evolved.

Some efforts are underway to define broadly accepted standards for school-based health centers. One organization, The Coalition For School-Based Primary Care, has proposed school-based health center Standards and Operations for New York State school-based health centers. (Appendix D shows the proposed standards developed by The Coalition For School-Based Primary Care.) Also, as part of a CDC-funded initiative, Columbia University has convened three meetings of the national workgroup to recommend national standards for school-based health centers.

HOWEVER, LITTLE COORDINATION EXISTS BETWEEN MANAGED CARE PROVIDERS AND SCHOOL-BASED HEALTH CENTERS.

Few agreements, formal or informal, exist between managed care providers and school-based providers.

Few respondents told us of any agreements, formal or informal, between school-based health centers and managed care providers. Four of the twelve school-based health center programs we visited have formal agreements with managed care providers. State officials in 7 of the 33 States we talked to think school-based health centers and managed care providers are coordinating either formally or informally. In the other 26 States, officials knew of no agreements between school-based health centers and managed care providers. In many communities, issues between managed care providers and school-based health centers are too new to have been addressed.

Little exchange of medical information takes place between managed care providers and school-based health centers.

Most respondents said sharing patient information is not routine. Neither the school-based health centers nor the managed care providers are aware of all the treatments the students have received. Consequently, managed care providers cannot coordinate or manage all the care given their patients.

Respondents give different reasons for the limited exchange of information. Some believe information sharing is only necessary on complex illnesses. Providers may only share information with patient consent, and some say this has been a barrier to the exchange of patient information. Some school-based health centers believe time constraints prevent them from sharing information with other providers. Some providers also believe that systems for sharing information have not been set up. For example, in Baltimore and Philadelphia, school-based health centers share information with providers where they have established relationships or formal agreements. But there are many providers with whom these clinics have not established relationships.

Many State respondents believe that information sharing does not occur because there has been no interaction between managed care providers and school-based health centers. The most common barrier to exchange of patient information mentioned by respondents is that there is no system or history of relationships that foster the sharing of information.

Differences between school-based health centers and managed care providers underlie many of the barriers to coordination.

When respondents told us why they feel managed care providers and school-based health centers have difficulty coordinating medically and financially, many described inherent differences between the two providers. Managed care providers and school-based health centers have some fundamental differences in their approaches to treating adolescents. These opposing perspectives are illustrated by comparing some defining features of managed care providers and school-based health centers in the following table.

Defining Features of Managed Care Providers and School-based Health Centers

Descriptive Feature	Managed Care Providers	School-based Health Centers
Patient characteristics	All ages Diverse in race and economic status All are insured	School-aged, mostly adolescents Diverse in race and economic status Medically underserved, large number of uninsured
Services provided	Full range of primary, secondary, and tertiary services	Primary care geared to children with emphasis on education, prevention, psychosocial, and mental health services
Hours of service	Required to provide 24 hour access to care	Usually open school hours with backup from sponsoring institutions
Goals regarding service utilization	Designed to increase primary care and reduce unnecessary inpatient hospital and emergency room utilization	Designed to increase appropriate service utilization
Profit or not-for-profit status	Can be for-profit, or not-for-profit	Not-for-profit
Funding sources	Billing of private policy holders, Medicaid, and Medicare agencies	Multiple funding sources including: grants from foundations, local, State, or Federal agencies; third-party billing; and, in-kind contributions

The table explains some differences between school-based health centers and managed care providers in their approaches to service utilization. While many States told us they are expanding managed care Medicaid as a way to increase access to a primary care physician and to provide medical homes for their Medicaid clients, States also expect managed care providers to control utilization of services. By requiring patients to go through their primary care physicians for authorization of services, managed care providers reduce the likelihood that patients will use inappropriate or unnecessary services. Managed care providers typically serve a more diverse patient population where concerns about overutilizing services are more relevant than with adolescents. In contrast, because school-based health centers focus on an age group that traditionally underutilizes services, they approach health care with the purpose of increasing appropriate service usage.

Although both managed care and school-based health centers offer primary care to adolescents, school-based health centers are able to attract adolescents to use medical services. The school-based health centers have the advantage of high visibility to adolescents due to their site location.

Respondents cite numerous barriers to coordination between school-based health centers and managed care providers.

Most respondents described multiple barriers to coordination between managed care providers and school-based health centers. The two most commonly mentioned barriers are communication and financial barriers. Respondents also encountered obstacles related to issues of legality and confidentiality.

- Communication Barriers

Forty percent of our respondents said communication impedes coordination. Many State officials told us that school-based health centers and managed care providers have never communicated, and in some cases, managed care providers may not know school-based health centers exist.

Before the two providers can effectively communicate, they must be able to appreciate each other's role and perspective. State and school-based health center respondents indicate that each provider "doesn't understand the other," there are "different motivations" from the two types of providers, and the providers face the obstacle of overcoming a perceived philosophic difference of a "public health versus a lower utilization" outlook when communicating.

Managed care respondents see communication as a logistical obstacle. They believe there are many parties involved in coordinating with school-based health centers. In addition to coordinating with the school-based health center, a provider may have to coordinate with health departments, school boards, and a variety of agencies involved with the school-based health centers. Another problem cited was that school-based health centers communicating with some primary care case manager plans may be difficult since there are often hundreds of primary care case managers within one plan.

- Financial Barriers

Thirty-eight percent of all respondents believe financial barriers impede coordination. Financial barriers impede negotiations between school-based health centers and managed care providers because the two providers must in some ways compete for a limited amount of funds. As school-based health center respondents explain, managed care providers are often "profit motivated, so there is no incentive to coordinate with us," and "providers do not want to give up care of their patients if it affects their income."

So while managed care providers support the concept of school-based health centers, they may have a disincentive to forge formal agreements with them because it may mean giving up some funds. Although managed care providers were much less likely to mention financial barriers, some did admit that "we might see it as a cost increaser" if patients got care at the school-based health centers. The State officials' comments echo these sentiments. Many State respondents pointed out that the providers must work out who will provide what services, and who will be paid for these services.

- Legal Barriers

Legal considerations represent a barrier to coordination in several ways. Managed care providers are liable for their patients' care. If school-based health centers provide care, the managed care plan must oversee the school-based health centers to ensure quality of care.

Also, school-based health centers may not meet some of the qualifications primary care physicians must meet to participate in managed care plans. Respondents from two States mentioned State laws that prevent school-based health centers from delivering Medicaid services because of the fact that non-physician professionals deliver most services rather than physicians.

Confidentiality of patient records present a legal barrier to coordination. Patient medical records must be confidential, and coordination between managed care providers and school-based health centers could breach that confidentiality. Many providers told us they had overcome this problem however, with consent forms allowing release of pertinent medical information to their providers.

- Confidentiality Barriers

Aside from the legal issue of confidentiality, respondents mention that coordination may jeopardize adolescents' need to keep certain services confidential. Adolescents may want to keep certain medical treatment confidential from friends, teachers, or even parents. Without assurance that their records are confidential, adolescents may not seek these services.

Where school-based health centers coordinate with managed care providers, adolescents may have fears that their medical records will be less confidential if school-based health centers bill or notify managed care providers about these services. Adolescents may fear that parents will have access to the managed care provider's copy of their records. Also, medical plans routinely send an Explanation of Benefits to the patient's home. For these reasons, school-based health centers may be reluctant to coordinate with managed care providers, or to bill Medicaid or managed care providers for these services.

Most respondents believe there will be negative consequences if school-based health centers and managed care providers do not coordinate.

The vast majority of our respondents believe there would be undesirable consequences if school-based health centers and managed care providers do not coordinate with each other. Responses are similar for all types of respondents. Those we interviewed worry most about how a lack of coordination may affect the continuity of health care for patients. They worry one provider "might not know about services provided by the other." Some believe that "clients will be confused about where to get care" because no one is telling them when it is appropriate to go to a school-based health center and when a managed care provider may be more appropriate. Respondents feel lack of coordination between the two types of providers can be "disastrous for individual healthcare," because adolescents may "get lost in a maze of a health care system," or "fall through the cracks."

State and school-based health center respondents are particularly concerned about duplication of payment, saying school-based health centers in effect subsidize managed care providers when they serve managed care patients. The school-based health centers often treat students enrolled in managed care plans, but usually are not reimbursed by managed care providers since school-based health centers are out-of-plan providers. In a sense, school-based health center services to Medicaid managed care students are paid twice. The State Medicaid agency pays first when it pays managed care providers a fixed rate for each patient enrolled in its plan. If managed care providers are unwilling to reimburse the school-based health center for services to its enrolled patients, then the school-based health center pays for the service a second time from its own funds.

Respondents believe this duplication of payment is serious because it drains school-based health center resources and may force some borderline school-based health centers out of business. In this way, duplication of payment may indirectly limit access to health care for all school-based health center patients, not just those in managed care plans.

Medicaid managed care providers face reduction in their Medicaid capitation rate if they are not providing all services reflected in the capitation rate. These providers could perceive the school-based health centers as removing patients from their medical home and draining funds from the managed care system.

SOME INITIAL EFFORTS TO COORDINATE DEMONSTRATE POTENTIAL BENEFITS FOR ADOLESCENTS, MANAGED CARE PROVIDERS, AND SCHOOL-BASED HEALTH CENTERS.

In communities where school-based health centers have agreements with local managed care providers, all parties can benefit from increased capabilities to deliver managed and coordinated care. To understand these benefits, a description of the

different models is helpful. A companion report, School-based Health Centers and Managed Care: Examples of Coordination (OEI-05-92-00681) describes each of these examples in greater detail.

1. State law requiring Medicaid managed care providers to coordinate with school-based health centers

Oregon is the only State with a law requiring coordination between managed care providers and school-based health centers. The law requires State agencies to mandate that managed care providers and publicly funded health care providers develop agreements authorizing payment for the following services: immunizations, sexually transmitted diseases, and other communicable diseases. Because all Oregon school-based health centers are operated by county governments or State agencies, they fall under the rubrics for publicly funded health care providers. The law also requires State entities to encourage and approve agreements between managed care providers and publicly funded healthcare providers for additional services and to develop agreements to coordinate in other ways. (Appendix F contains a copy of the Oregon law and the Medicaid agency implementing procedures.)

2. Legal contract between managed care provider and school-based health center

Only one community we contacted has a formal contract between a managed care provider and area school-based health centers. St. Paul, Minnesota's Health Start school-based health centers have negotiated a contract with Ramsey Hospital, a managed care provider for the St. Paul area. The six Health Start school-based health centers are reimbursed on a fee-for-service basis by Ramsey Hospital for all Ramsey's Medicaid patients the school-based health centers treat. The contract treats the school-based health centers much like any other plan provider, subject to the same review as other primary care physicians for Ramsey. Therefore, the school-based health centers must adhere to the quality standards other Ramsey providers must meet.

3. Formal protocol for referral and treatment between managed care provider and school-based health center

Although no contract exists, Total Health Care, a managed care provider in Baltimore, and Baltimore City school-based health centers have worked out a detailed agreement to coordinate services for students enrolled in Total Health Care. The school-based health centers and Total Health Care have agreed on protocols that define when a child should be referred to Total Health Care and when it is appropriate for the school-based health center to provide service. When school-based health centers provide services to Total Health Care students, they are reimbursed by Total Health Care at Medicaid rates. The protocols require reporting any care given at the school-based health center to Total Health Care so that the primary care physician stays informed. The school-based health centers often schedule and follow-up on

appointments with Total Health Care primary care physicians for the students. (Appendix E includes a chart depicting the protocols established.)

4. Including managed care providers in coalitions which fund and develop school-based health centers

The Minneapolis, Minnesota Board of Education is negotiating with several managed care providers in the area. As a result of these meetings, Medica, a managed care plan, is underwriting the full cost of one of the Minneapolis school-based health centers for a year. The other managed care plans in Hennepin County are collaborating with the school-based health center program and are considering pledging $1 million to fund the other Minneapolis school-based health centers. In return, students enrolled in their plans will receive primary care and preventive services through the school-based health centers. The managed care plans will work together with the school-based health centers to determine which health services should be delivered in schools and which should be delivered elsewhere in the community.

5. Entities that administer school-based health centers also administer managed care plans

In three communities we visited, public entities who run managed care plans also operate school-based health centers. Although this structure was not developed to address the conflict between managed care providers and school-based health centers, this type of administration has several benefits. For example, in Brooklyn, New York, students enrolled in Healthcare Plus, the managed care plan run by Sunset Park Family Health Center, can choose one of ten school-based health centers also run by Sunset Park as a primary care provider. Sunset Park has just developed a data system for all of its clients so that when a child receives care at the school-based health center, the record of that visit is available throughout the Sunset Park network.

6. Managed care providers authorize school-based health centers to provide care and bill Medicaid directly for service

Another example of informal coordination takes place in several communities where school-based health centers get an authorization number from a managed care provider to treat students and bill Medicaid directly for services. For example, in Hillsborough County, Florida, primary care case managers sometimes authorize school-based health centers to conduct EPSDT screening. Also in Hillsborough County, the major managed care provider, Century/PCA Health Plans, has authorized a school-based health center located in an alternative school for pregnant teens to deliver all prenatal and postpartum care to several of the plan's Medicaid eligible members.

7. Managed care gives expedited patient care on school-based health center referrals

In San Francisco, the Balboa High School Teen clinic has an informal arrangement with Kaiser Permanente so students receive expedited appointments when the school-based health center makes referrals to Kaiser Permanente. When a patient enrolled in Kaiser Permanente goes to the school-based health center and needs further care, the clinic telephones a representative from the managed care plan and arranges an appointment for the child. In this case, the school-based health center performs a triage function when making referrals by assessing the urgency of the child's problem.

EVEN THOUGH SCHOOL-BASED HEALTH CENTERS AND MANAGED CARE ARE EXPANDING RAPIDLY, HHS HAS NO FOCAL POINT COORDINATING DEPARTMENTAL PROGRAMS AND ACTIVITIES IN THESE AREAS.

The HHS has a hand in both managed care and school-based health centers in a variety of agencies. Within HHS, there is no locus for decisionmaking on issues affecting both school-based health centers and managed care. The Interagency Committee on School Health offers a first step toward bringing the fragmented players in school-based health together. But no committee participant nor PHS or HCFA is a focal point for outside entities to contact. Therefore, those States new to school-based health centers or managed care may not know where to request information or technical assistance. As States expand both managed care and school-based health centers, the need for a focal point to bring together perspectives in HHS will grow.

Numerous State and local governments are establishing school-based health centers in response to the documented need of primary medical care for adolescents. Twenty-six of thirty-three State Maternal and Child Health agency respondents say their States anticipate school-based health center expansion in the next several years. Also, some States that currently do not have Medicaid managed care, like West Virginia, are making school-based health centers integral to their States' health care reform.

Managed care plans may play an increased role in health care delivery when national health care reform occurs. If so, the number of managed care plans, providers and patients covered by managed care will also rise. In addition, States see managed care as a way to increase access to care for Medicaid patients as well as contain health care costs. Thirty of thirty-three State Medicaid agency respondents say their States will expand managed care in the near future. Some of this expansion will be massive. For example, California Medicaid covers 600,000 recipients under managed care plans and is seeking to expand coverage to 3 million in the next few years. In addition, some States that currently do not have managed care will institute managed care programs.

As both managed care and school-based health services expand, adolescents enrolled in managed care plans will be more likely to have access to school-based health centers and the need for coordination will grow. The immediate need is to find ways for managed care and school-based health centers to complement each other in delivering health care to adolescents.

Conclusion

At present, there is a dearth of needed information on school-based health centers, and in particular, regarding coordination with managed care. Current literature on adolescent health explains their health needs in great detail and the consequences of not addressing these needs. However, there is no adequate assessment of how different providers deliver care to adolescents. We do not know how adolescents are being served by managed care organizations. Early assessments of school-based health centers are promising, as shown by RWJ, and anecdotal evidence supports the idea that school-based health centers are an appropriate way to deliver services to adolescents. But the literature on school-based health centers rarely gives a national perspective and provides little information about health outcomes for adolescents, and there are no national school-based health center performance standards for process or outcome measures.

Both managed care providers and school-based health centers argue that they deliver services cheaply. But, the data showing the extent of services provided to adolescents by managed care providers and school-based health centers vary by community. In addition, no one has systematically tried to assess and compare the cost-effectiveness of each in delivering primary and preventive care to adolescents.

Only a few communities have begun to address coordination between school-based health centers and managed care providers. Because their efforts are new, we cannot draw conclusions about their effectiveness. With these gaps in our understanding of managed care and school-based health centers, HHS has little information available to make policy decisions regarding school-based health centers and managed care.

RECOMMENDATIONS

The Assistant Secretary for Health and the Administrator for Health Care Financing should each designate a contact to coordinate school-based health center issues in their agencies. In addition, these contacts should provide a point-of-entry for those outside HHS who need information about school-based health centers.

Both the PHS and HCFA designated contacts should lead efforts to bring parties in the Department together to resolve issues between managed care providers and school-based health centers. Both PHS and HCFA administer a variety of programs relating to school-based health centers and managed care. The designated contacts should work to coordinate these efforts.

The designated contacts should present a cohesive view of HHS activities on school-based health centers and direct people to appropriate sources of information. The designated contacts would also be HHS' link to other agencies, like the Department of Education, who have also taken an active role in school-based health centers.

The designated contacts should work with national organizations and experts to develop a strategy for providing needed information to interested local, State and Federal parties. Many communities are new to managed care or school-based health centers. As they seek information regarding school-based health centers, they should be able to access information from someone with an overview of school-based health centers, as well as an understanding of issues relating to managed care and school-based health centers.

The designated contact for school-based health centers appointed by the Assistant Secretary for Health should work with PHS to maintain current information about the development of school-based health centers on a national basis. Since it is likely that HHS funds to school-based health centers will increase as the number of school-based health centers grows, HHS needs to be aware of school-based health center activity.

The PHS, HCFA and the States should encourage cooperation between school-based health centers and managed care providers.

Those HHS agencies working with States and communities on school-based health centers and managed care should encourage States and communities to forge working relationships between managed care providers and school-based health centers. As health care reform takes shape, this coordination will be more important than ever. Many treated at school-based health centers who currently have no health insurance coverage may soon be guaranteed access to health care, and many of these students may enroll in managed care plans. Coordination between managed care providers and school-based health centers is essential to address adolescents' special needs, like

expanded mental health services and counselling, and to overcome treatment barriers unique to adolescents, like patient confidentiality.

Examples of actions that could be undertaken include the following.

- The PHS and HCFA can work together to include both managed care and school-based health centers on issues affecting child health, where appropriate. These issues offer opportunities to bring both managed care and school-based health centers together to resolve problems or meet national priorities. The PHS and HCFA should work closely with their designated contacts on issues relating to managed care providers and school-based health centers.

- The PHS' Health Resources and Services Administration, CDC, and HCFA's Medicaid managed care division can coordinate internal sessions so those working with managed care issues can have exposure to those working with school-based health centers and vice versa. These sessions can be a part of routine conferences, or arranged separately from conferences already scheduled. These agencies should make attempts to include other agencies represented on the Interagency Committee on School Health when planning training that focuses on school-based health centers and managed care. The training should inform agencies working on school-based health centers and managed care of the State and national issues involving coordination and the obstacles to coordination between school-based health centers and managed care providers.

- To encourage States to forge working relationships between managed care providers and school-based health centers, HHS agencies can host several regional meetings or a national training conference on managed care and school-based health clinic coordination. Participants should include, but not be limited to, representatives from managed care systems and school-based health centers. Conference organizers should also bring together State Medicaid and Maternal and Child Health officials, and representatives from foundations, interest groups, and other agencies to discuss issues and efforts related to coordination between managed care and school-based health centers, obstacles to coordination, and strategies for overcoming barriers to coordination. For example, one meeting could address the barrier created by the patient's desire for personal privacy when confidential services are provided (e.g., mental health services). The need for privacy conflicts with the need to exchange medical information between the school-based health center and the physician managing the care of that patient.

- The PHS and HCFA can complement their conferences and training with other mechanisms to share information on managed care and school-based health centers. The PHS and HCFA can include information on managed care and school-based health centers in literature they routinely send to State agencies to keep them informed of new developments in this area.

The PHS and HCFA should work with HHS agencies to fund appropriate studies and grants that will add to HHS' knowledge on school-based health centers and managed care providers.

Options that would add to HHS' information[10] include:

- Within PHS, the Agency for Health Care Policy and Research (AHCPR) could fund a study of utilization of adolescent primary and preventive health care services, including mental health and substance abuse prevention and treatment services. The study should focus on utilization in private and public managed care organizations as well as in school-based health centers. The study should compare the cost-effectiveness of school-based health clinic services to managed care services for this age group. In designing the study, AHCPR should set guidelines for the minimum criteria that should be included in comprehensive adolescent primary and preventive care.

- The PHS could work with HCFA's managed care division to provide small grants to communities to encourage innovations that address coordination between managed care providers and school-based health centers. These grants should include evaluation of these innovations to look at what types of solutions may be appropriate for certain models of managed care providers.

- The PHS and HCFA could contract for a study on model performance standards for school-based health centers. If HHS intends to recognize the value of school-based health centers in the health care system, it must identify features and practices integral to any school-based health clinic.

- Within PHS, the Center for Mental Health Services could expand their current child studies that examine effective ways to deliver mental health services to adolescents in school settings.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration and the Public Health Service. Both agencies supported the recommendations, suggested important clarifications and identified additional issues regarding school-related and youth health programs. The complete text of the Health Care Financing Administration comments are included in Appendix G. The Public Health Service comments are included in Appendix H. We welcome the HCFA and PHS support for the recommendations in

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10 *These proposed studies should build on HHS' base of knowledge and complement research already underway. For example, the Agency for Health Care Policy and Research sponsors grants relating to adolescents as well as managed care. In addition to providing grants for specific projects targeting substance-using adolescents, the Substance Abuse and Mental Health Services Administration is evaluating prevention and early intervention programs to address substance abuse and mental health issues in schools.*

our draft report. We made appropriate revisions to the report based on their comments.

In response to PHS comments and suggestions, we revised the Background section to reflect the differences between health education curriculum and health services, both of which a school-based health center may provide, and the Methodology section to describe the qualitative data we collected. We clarified the need to collect data on both the processes of delivering services in a school-based health center as well as developing outcome measures for these services. In addition, we expanded the options for conferences for school-based health centers and managed care providers. We now provide an option to deal with overcoming the barriers presented by the patient's need for personal privacy when it conflicts with the need to exchange medical information. We also acknowledged current research underway in the Department.

The PHS suggested revising the recommendation to name designated contacts in PHS and HCFA for school-based health center issues since they perceived it primarily as an option to enhance information exchange with HCFA on these matters. Instead, we refocused this recommendation to emphasize the importance of a designated contact for coordination on school-based health center issues. The designated contacts should first serve as a focal point in their agencies in resolving issues involving school-based health centers and managed care. In addition, they should work with the other designated contact when cross-cutting measures are needed to resolve these issues. To help share information with communities and other agencies, the designated contacts can work with existing bodies like the Interagency Committee on School Health.

APPENDIX A

SCHOOL-BASED HEALTH CENTER AND MANAGED CARE RESPONDENTS

School-based Health Center Respondents

Adolescent Health Program
Minneapolis Public Schools
254 Upton Avenue South
Minneapolis, MN 55405-1998
contact: Anne St. Germaine

Comprehensive School Health Services Program
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Baltimore, MD 21202
Contact: Bernice Rosenthal

Denver School-Based Clinics: a partnership in Health Care for Denver's Youth
University of Colorado Health Sciences Center
Box B-206
4200 E. 9th Ave.
Denver, CO 80262
Contact: Bruce P. Guernsey

Department of Health and Rehabilitative Services
Hillsborough County Public Health Unit
PO Box 5135
Tampa, FL 33675-5135
Contact: Mary Emma Howard

Family Health Bureau
San Francisco Dept. of Public Health
101 Grove St. Room 115
San Francisco, CA 94102
Contact: Stephen Purser

Far Rockaway High School-Based Clinic
821 Bay 25th St.
Far Rockaway, NY 11691
Contact: Linda Jusczak

Health Start
640 Jackson St.
St. Paul, MN 55101
Contact: Donna Zimmerman

North East Medical Services
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San Francisco, CA 94133
Contact: Sophie Wong

Spectrum Health Services
5619 Vine St.
Philadelphia PA 19139
Contact: Karolyn Baxter

The Teen Health Center
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Galveston, TX 77550
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School Health & Community Pediatrics
Department of Pediatrics, C-19
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Galveston, TX 77550

Managed Care Respondents

The Bronx Health Plan
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Bronx, NY 10458
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Denver, CO 80206
Contact: Jules Amer, M.D.

Kaiser Permanente
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Denver, CO 80231-1314
Contact: Kristin Paulson Snyder

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Oakland, CA 94612-2998
Contact: Jean Nudelman

Kaiser Permanente
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Portland OR 97217
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Medica
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Minneapolis, MN 55440-1587
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PCA Health Plans
8303 Mopac, Suite 450
Austin, TX 78759
Contact: Jan Scott

PCA Health Plans and Century Medical Health Plan, Inc.
2002 N. Lois Avenue
Suite 100
Tampa, Florida 33607
Contact: Steve Griffin

Total Health Care
1501 Division St.
Baltimore, MD 21217
Contact: Joan Phillips

Respondents Operating Both Managed Care Plans and School-based Health Centers

Greater Philadelphia Health Action, Inc.
Executive Offices: 4510 Frankford Ave.
Philadelphia, PA 19124
Contact: Ronald E. Heigler

Multnomah County Health Department
426 SW Stark, 8th Floor
Portland OR 97204
Contact for managed care: Mary Lou Henrich
Contact for school-based health centers: Billie Carlson

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Brooklyn, NY 11220
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APPENDIX B

OTHER SCHOOL-BASED HEALTH CENTER, ADOLESCENT HEALTH, OR MANAGED CARE CONTACTS

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Debra Delgado, Associate Director
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Florence Frucher, Director
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Holly Allen Grason, Deputy Director
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APPENDIX C

SELECTED BIBLIOGRAPHY ON SCHOOL-BASED HEALTH CENTERS AND ADOLESCENT HEALTH

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APPENDIX D

PROPOSED NEW YORK STATE
SCHOOL-BASED HEALTH CENTER STANDARDS

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RECOMMENDED GUIDELINES FOR STANDARDS AND OPERATIONS OF SCHOOL-BASED CLINICS IN NEW YORK STATE

PREPARED BY:

THE STANDARD AND OPERATIONS COMMITTEE

DORIS PASTORE, M.D., CHAIR

Guidelines for Standards and Operations

In an effort to develop consistent standards to assure program quality, assist in program evaluation, and provide guidelines for grantors, the ideal standards for a model school-based clinic (SBC) are proposed.

These discussions were about an hypothetical urban school with 2,000 students where the SBC would have 60-70% of the student body enrolled or formally registered for services. SBC enrollment currently requires parental consent. These guidelines aim to describe what core services a student and his/her family enrolling in the SBC can expect, what staff or staffing patterns these services would require, as well as what space would be needed to provide comprehensive school-based clinic health care.

The SBC model is one model for delivering school health services. The SBC model includes several essential components: providing comprehensive primary care; inter-relating with the family, school, community and medical facility; providing the identified core services; and being located on the school site.

I. Mission Statement:

The goal of the SBC is to provide or make available comprehensive primary medical, social and mental health and health education services to enrolled students. Primary care includes first contact care, preventive health care and longitudinal care over time.

By comprehensive care we mean that not only will the students medical needs be met but the student would be assessed for any social or mental health concerns. For teenagers this means not only a complete medical history and exam but also an assessment in the areas of home, school, family, friends, depression/suicide, sexual activity, physical/sexual abuse, violence. For elementary students this would include a developmental assessment if appropriate, addressing behavioral issues, school problems and being a resource for parents. These areas need to be addressed in an age appropriate manner and where needs are identified

services must be provided or referrals made. Follow-up of problem areas must take place. The SBC must actively interact with not only the student as a patient, but also the family, community and educators.

These services are to address the health and behavioral needs of students. They are to include health screening, treatment and prevention; counseling and crisis intervention; social service needs; sexuality and reproductive health care; and dental needs. These are to be provided by a multidisciplinary team.

II. Concept:

The approach to the delivery of this type of health care recognizes the school-based clinic to be multifaceted in its roles and responsibilities. The school-based clinic inter-relates with the family, host school, local community, as well as the "back-up" medical facility:

. Family - The enrolled student is viewed in the context of his/her family. The involvement of the family will be enlisted as it pertains to the care of the student and as appropriate to the age of the student. This would be an especially crucial aspect of providing care in the Elementary programs.

. School - The SBC is a functional component of the school and as such not only delivers direct care but aims to work cooperatively, both formally and informally, with school administration, faculty and staff. However, the confidentiality of the provider-patient relationship and of medical records is fully maintained. Both the SBC and the school maintain separate but interdependent roles.

Programmatically, the school assists in obtaining informed parental consent, obtaining insurance or medicaid information, in follow-up of broken appointments, marketing the SBC, and giving access to school health records. The school is responsible for maintenance of the facility, including providing a clean, safe, secure environment.

. Community - The SBC recognizes that the school functions within a community and therefore wants to draw upon its resources and establish mutually dynamic relationships.

. Medical facility - The "back-up" institution operates the school-based clinic and has the duty and responsibility to ensure program quality. This is to include but is not limited to an appropriate referral system, quality assurance, continued medical education, and contractual compliance. The organization sponsoring the SBC must ensure that this linkage takes place.

Specifically, the medical facility is also to provide billing support, availability of in-patient care if needed, continuity of care including (24 hours/7 days), and training if an academic program.

III. Activities

Involvement of the SBC with the family, school, community and medical facility in the goal of providing comprehensive primary care necessitates that the SBC undertake the following activities:

. direct services	- medical - mental health - sexuality and reproductive health
. health education	- students - parents and community - school faculty
. training	- medical students/residents/fellows - NP/PA students - social work/health education students - health professionals

. advocacy - individual student/family both internally a externally
- SBC within the community
- growth of SBC's

These activities would take place in SBC's of Elementary, Middle a Senior High Schools. There would be a particular emphasis in meeting needs of parents among the Elementary programs by making availa referrals for direct services, providing health education and advocacy.

IV. Services

All school-based clinics should provide the following core service

. Comprehensive medical and psycho-social histories and individual assessment of strengths and risk

. Physical examinations

. Behavioral and developmental assessment as age appropriate

. Diagnosis and treatment including the prescribing of medications of minor and acute problems

. Case management including utilization of back-up medical facility and community resources for specialty services

. Dental health assessment and referral

. Family planning and reproductive health services as age appropriate

. Health education, promotion and prevention

. Laboratory testing

. Immunizations

. Management of chronic problems

. Mental health and social service assessment, treatment or appropriate referral

. Nutrition counseling

. Outreach

. Physical/sexual abuse identification and referral

. STD/HIV/AIDS education and HIV pre/post-test counseling or appropriate referral

. Substance abuse assessment and referral

. 24 hour medical coverage

Additionally, optional services could be provided dependent up community need and funding resources. These would include classroo education, dental services on-site, health care for siblings of enroll students, health education for family members, pre-natal care, te parenting programs, risk behavior modification programs such as tho addressing smoking and obesity.

V. Staffing

In order for the SBC to function in a multifaceted manr appropriately deliver medical, mental health and reproductive servic provide health education, training, and participate in advocacy, the S must be staffed by a multidisciplinary team. The staff needs to be flexil Sources of support for staff might include the sponsoring facility, the Bo of Education, or an community agency.

Based on the collective experience of the Coalition and the services SBC's are to provide, a staff of 7-8 full-time personnel is recommended for a typical urban school of 2,000 enrolled students.

This staff is to include but not limited to:

. Nurse Practioner/Physician Assistant - providing direct service and program management, where appropriate. It is felt that each NP/PA can provide care for 700 enrolled students.[1]

. Mental health provider - the SBC must be able to address differing needs, including group, individual, family counseling; crisis intervention; short-term counseling, long-term counseling, case management; as well as make referrals where appropriate. Consultative and supervisory services must involve a doctorate level professional and be staff appropriate. To provide for the mental health needs of 700 enrolled students a minimum 1.5 mental health providers would be required.

. Physician - there are different models for physician presence in the SBC and range from a minimum supervisory presence to full-time primary provider. Minimum supervision would require presence for one three-hour session (chart review, supervision, consultation) per week for the first NP/PA, adding a session for each additional one or two NP/PA's (i.e., two sessions for 2-3, three sessions for 4-5, etc).

. Program Manager - for large programs of greater than 2,000 enrolled students, there needs to be at least one full-time program manger who is not a provider. Alternatively, these duties can be fulfilled by appropriately qualified staff or assumed by the back-up institution. The SBC is accountable to the responsible physician of their agency e.g. Division of Adolescent Medicine; Department of Pediatrics; Department of

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[1] **The NP/PA : Student ratio of 1:700 was derived from the collective experience of those involved with the Coalition and from review of the Federal guidelines set forth for Community Health Centers.**

Family Practice. These duties include: budget and finance; data collection, statistical reports and narratives; purchasing; writing grant proposals; staff supervision/scheduling; liaison with school, back-up, community, and funding sources; seek out funding sources; advisory committee participation; quality assurance coordination; program development and program evaluation.

. Health Educator - to provide individual and classroom information on family planning issues, nutrition and weight, etc.
The Coalition recommends one full-time health educator be part of the staff providing care for 700 enrolled students.

. Clerical/School Health Aide - to work closely with school staff and SBC team in such areas as clinic patient flow, appointment making, checking insurance, recalling students, immunizations, data collection and state reporting requirements, supervision of other students in the clinic, etc. It is felt that one full-time aide is needed in a program providing care to 700 students. These responsibilities may also be fulfilled by a medical assistant/receptionist.

In a school where there are 400 enrolled students the responsibilities of SBC program management can shared across disciplines. For example, an SBC might be staffed by a NP/PA .75 FTE - 1.0 FTE (dependent upon exact duties), Mental health provider .75 FTE - 1.0 FTE (dependent upon exact duties), clerical/school health aide 1.0 FTE, and Physician .10 - 1.0 (dependent upon SBC structure).

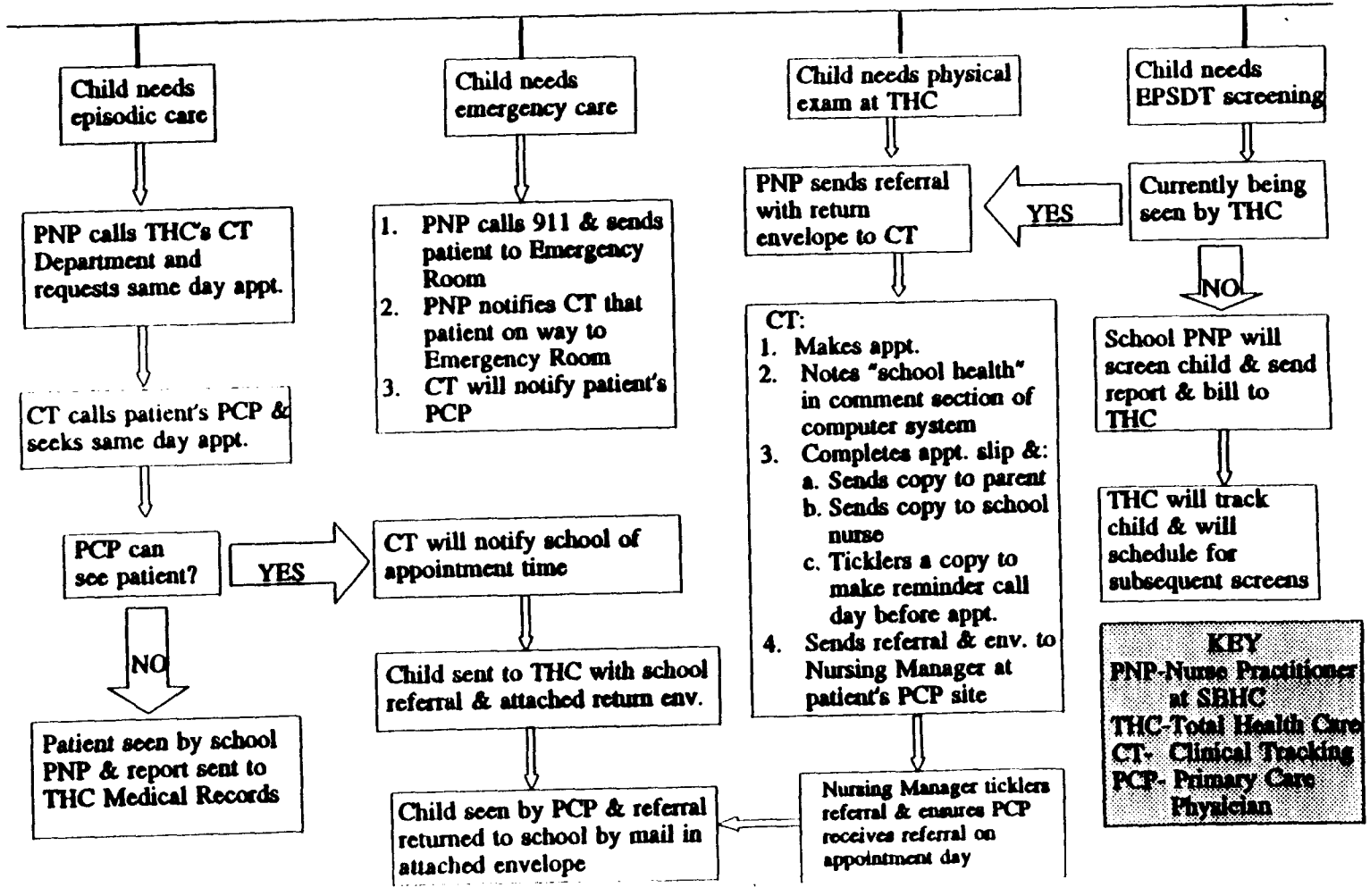
IV. Space

The space for the SBC must be adequate to accommodate appropriate staffing. For a school with an SBC enrollment of 700, approximately 2,000 Sq. Ft. would be required and would include 2 exam rooms per full-time provider (with sinks), 1 counseling room, 1 laboratory area, 1 patient bathroom, 1 waiting room, 1 storage room, 1 clerical area. The actual floor plans need to provide for patient privacy and be functional in allowing good use of clinic space. The SBC also needs a private telephone line to ensure confidentiality and adequate access to the community and "back-up" institution. Additional space would be required should the SBC be a training site.

APPENDIX E

EXAMPLE OF SCHOOL-BASED HEALTH CENTER AND MANAGED CARE PROTOCOLS FOR REFERRING AND TREATING PATIENTS

BALTIMORE CITY HEALTH DEPARTMENT SBHCS & TOTAL HEALTH CARE HMO CLIENTS FLOW SHEET



APPENDIX F

OREGON LAW AND IMPLEMENTING PROCEDURES REQUIRING MEDICAID MANAGED CARE COORDINATION WITH SCHOOL-BASED HEALTH CENTERS

Enrolled
Senate Bill 760

Sponsored by Senator KENNEMER; Senators BRENNEMAN, CEASE, COHEN, GOLD, HAMBY, McCOY, TROW, Representatives BARNES, BAUMAN, CARTER, CLARK, HAYDEN, MASON, McTEAGUE, MEEK, MILLER, SHIPRACK, SOWA, STEIN (at the request of Clackamas County, Coalition of Local Health Officials)

CHAPTER 837

AN ACT

Relating to poverty level medical programs.

Be It Enacted by the People of the State of Oregon:

SECTION 1. It is the purpose of this Act to take advantage of opportunities to:

(1) Enhance the state and local public health partnership;

(2) Improve the access to care and health status of women and children; and

(3) Strengthen public health programs and services at the county health department level.

SECTION 2. The Adult and Family Services Division, the Office of Medical Assistance Programs and the Health Division shall endeavor to develop agreements with local governments to facilitate the enrollment of poverty level medical assistance program clients. Subject to the availability of funds therefor, the agreement shall be structured to allow flexibility by the state and local governments and may allow any of the following options for enrolling clients in poverty level medical assistance programs:

(1) Initial processing shall be done at the county health department by employees of the county, with eligibility determination completed at the local office of the Adult and Family Services Division;

(2) Initial processing and eligibility determination shall be done at the county health department by employees of the Adult and Family Services Division; or

(3) Application forms shall be made available at the county health department with initial processing and eligibility determination shall be done at the local office of the Adult and Family Services Division.

SECTION 3. To capitalize on the successful public health programs provided by county health departments and the sizable investment by state and local governments in the public health system, state agencies shall encourage agreements that allow county health departments and other publicly supported programs to continue to be the providers of those prevention and health promotion services now available, plus other maternal and child health services such as prenatal outreach and care, child health services and family planning services to women and children who become eligible for poverty level medical assistance program benefits pursuant to section 4 of this Act.

SECTION 4. In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to insure access to public health services through contract under ORS chapter 414, the state shall:

(1) Unless cause can be shown why such an agreement is not feasible, require and approve agreements between prepaid health plans and publicly funded providers for authorization of payment for point of contact services in the following categories:

(a) Immunizations;

(b) Sexually transmitted diseases; and

(c) Other communicable diseases;

(2) Continue to allow enrollees in prepaid health plans to receive family planning services from fee-for-service providers;

(3) Encourage and approve agreements between prepaid health plans and publicly funded providers for authorization of and payment for services in the following categories:

(a) Maternity case management;

(b) Well-child care; and

(c) Prenatal care; and

(4) Recognize the social value of partnerships between county health departments and other publicly supported programs and other health providers, and take appropriate measures to involve publicly supported health care and service programs in the development and implementation of managed health care programs in their areas of responsibility.

Passed by Senate May 23, 1991

Secretary of Senate

President of Senate

Passed by House June 4, 1991

Speaker of House

Received by Governor:

11:00 AM June 18, 1991

Approved:

9:19 AM June 25, 1991

Governor

Filed by Office of Secretary of State:

11:21 AM June 25, 1991

Secretary of State

1.8 Measurement Standard

In order to make advantageous use of the system of public health services available through county health departments and other publicly supported programs and to ensure access to public health services through contract under ORS Chapter 414:

a. Unless cause can be shown why such an agreement is not feasible, the PHP shall execute agreements with publicly funded providers for authorization of payment for point of contact services in the following categories:

(1) Immunizations;

(2) Sexually transmitted diseases; and

(3) Other communicable diseases.

b. PHP members may receive family planning services from appropriate non-plan providers.

c. The PHP is encouraged to execute agreements with publicly funded providers for authorization of and payment for services in the following categories:

(1) Maternity case management;

(2) Well-child care; and

(3) Prenatal care.

d. Recognizing the social value of partnerships between county health departments and other publicly supported programs and other health providers, the PHP shall take appropriate measures to involve publicly supported health care and service programs in the development and implementation of your managed health care programs.

1.8 Required Response

A. Describe the agreements and/or subcontracts you will present for OMAP approval to comply with Measurement Standard 1.8a; or explain steps your organization will take to comply with this statutory requirement.

B. Response due 4/20/92: Unless exempted from compliance with Measurement Standard 1.8a, attach any agreements and/or subcontracts (or draft versions) you are submitting for approval to OMAP to comply with this statutory requirement.

C. Describe any agreements and/or subcontracts you will have with publicly funded providers to provide maternity case management, well-child care and/or prenatal care.

D. Response due 4/20/92: Attach any agreements and/or subcontracts (or draft versions) with publicly funded providers to provide maternity case management, well-child care and/or prenatal care.

E. Describe your organization's policies which address the intent of Measurement Standard 1.8d.

APPENDIX G

HEALTH CARE FINANCING ADMINISTRATION RESPONSE TO THE DRAFT REPORT

The Administrator
Washington, D.C. 20201

NOV 8 1993

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "School-Based Health Centers and Managed Health Care," (OEI-05-92-00680)

TO: Bryan B. Mitchell
Principal Deputy Inspector General

The Health Care Financing Administration (HCFA) has reviewed the subject draft report which reveals that school-based health centers increase access to health care for adolescents.

We support the three recommendations contained in the report. We agree that more information about school-based health centers is needed in order to improve the coordination between managed care and better serve the health care needs of adolescents. In particular, we believe the Public Health Service and HCFA should each designate a contact to coordinate on issues involving both managed care and school-based health services. These contacts should lead the Department's efforts in this area and work with appropriate agencies to study the issues described in the report. The number of school-based health centers and managed care plans are increasing, and linkages between these two types of providers will be essential to both Medicaid and the entire health care system.

Thank you for the opportunity to review and comment on this draft report. Additional comments are attached for your consideration. Please advise us if you would like to discuss our position on the report's recommendations.

Attachment

Comments of the Health Care Financing Administration (HCFA) on
Office of Inspector General (OIG) Draft Report
"School-Based Health Centers and Managed Health Care"
OEI-05-92-00680

General Comments

Page 6 states that most, but not all, of the investigators' discussions with mana care respondents related to Medicaid managed care. It might be worth mentioning here that although the focus of the report was the extent to which school-based health centers coordinate with Medicaid managed care programs, the findings are relevant to managed care plans in general. Also, throughout t report, it would be useful if any of the findings that might be unique to Medic managed care were separately highlighted.

On page 12, after the last sentence in the Communication Barriers section, we suggest adding the following to include further information about primary care case management systems: "Although many providers are involved in these pla Medicaid recipients may choose a provider and then the provider's name and telephone number will be included on the recipient's Medicaid card."

On page 14, the last sentence in the second paragraph should include acknowledgement that State Medicaid agencies can also pay "twice" through duplicative claims. We suggest the following as an addition to the last senten ". . . a second time from its own funds, or bills Medicaid and the State pays fo the service."

APPENDIX H

PUBLIC HEALTH SERVICE RESPONSE TO THE DRAFT REPORT

DEPARTMENT OF HEALTH & HUMAN SERVICES — Public Health Service

Memorandum

Date NOV 15 1993

From Assistant Secretary for Health

Subject Office of Inspector General (OIG) Draft Report: "School-Based Health Centers and Managed Care," OEI-05-92-00680

To Acting Inspector General, OS

Attached are the PHS comments on the subject draft report. The OIG report is very timely, especially in light of health care reform and the high priority placed on improving the health status of our Nation's children and youth by the new Administration.

We generally concur with the OIG recommendations.

Philip R. Lee, M.D.

Attachment

COMMENTS OF THE PUBLIC HEALTH SERVICE (PHS) ON THE OFFICE OF INSPECTOR GENERAL (OIG) DRAFT REPORT ON "SCHOOL-BASED HEALTH CENTERS AND MANAGED HEALTH CARE," OEI-05-92-00680

GENERAL COMMENTS

We commend the OIG for recognizing the importance of examining the issues addressed in this study more closely. Their effort reflects one of the earliest attempts to do so and, as such, offers useful and important directions for further study. The report is very timely, especially in light of health care reform (HCR) and the high priority placed on improving the health status of our Nation's children and youth by the new Administration, the Assistant Secretary for Health, and our new Surgeon General.

PHS generally concurs with the three OIG recommendations, although there are a number of specific comments that pertain to the recommendations. PHS believes, however, that the body of the report can be strengthened by: (1) making clearer the unique contribution that "school-based or linked health centers" (SBHCs) can make; (2) explaining how SBHCs fit into the broader context of "school health" and "adolescent health;" (3) clarifying and improving understanding of these concepts and terminology; and (4) acknowledging and building upon the limitations of the study as a basis for further research. Some guidance in this regard is provided below.

- ***Importance of SBHCs***. Because they are located in or near our schools, where most of our children and youth come together on a regular basis, SBHCs can provide an effective means for improving access to health services and a tremendous opportunity to reach these vulnerable populations in an attempt to prevent or minimize high-risk behaviors that endanger health status. Coordination of services provided by SBHCs with those of managed care systems in the community offers yet another opportunity to enhance effectiveness, efficiency, and the health of school-aged populations.

- ***Broader Context Needed***. SBHCS or services are not necessarily synonymous or interchangeable (nor should they be) with school health issues, adolescent health concerns, or with services geared only to children and youth who are medically underserved, economically disadvantaged, uninsured, or in urban settings. The report needs to acknowledge a broader understanding and appreciation of these concepts and place the study and its findings within this broader context.

Specifically, it is important to make distinctions between "school-based/linked health centers" (essentiall health care services delivered in and/or near school settings), "school health" programs and activities (which, if "comprehensive," may include not only health services, but other elements provided in schools to enhance the health of school-aged populations, such as age- and developmentally-appropriate health education framework or classroom curriculum, nutritious meals, physical fitness and sports programs, an environment fr of drugs, violence, pollutants, etc.) and "adolescent health" efforts (which are aimed at achieving, maintaining, and improving the health of adolescents specifically and are not limited only to adolescents in school or to what can be done in schools).

On a related note, while the report indicates that the SBHCs in the study and, most SBHCs currently in existence, emphasize services to adolescents and includ family planning, care needs to be taken not to reinforc fears or wrongful notions that "school-based/linked health centers or services" are geared only to adolescents and/or exist to provide services related to teenage sexual behavior. It would be useful, therefore to reference the range of health services that SBHCs ca or do provide (i.e., immunizations, nutritional/dietary counseling, substance abuse--including alcohol and tobacco--and mental health counseling and referral, treatment of minor injuries, safety education, etc.)

It would also be useful to present SBHCs within the context of comprehensive school health programs which offer benefits to ALL school-aged (including elementary and perhaps, post-secondary) populations and those in rural as well as urban areas. The issues of coordinati with community services are applicable to the other components (such as a health education curriculum or a healthy school environment) of such a comprehensive program as well. Furthermore, the importance of the family, home, and neighborhood environments also needs be acknowledged.

- ***Mainstream Systems***. In the section on "mainstream medical delivery systems" (pages 3-4), a stronger case could be made regarding the need to address adolescent health care concerns through means that complement traditional delivery systems. What is the "dilemma" posed in trying to promote adolescent health? What is the nature and extent of the health problems faced by unique to adolescents (including but not limited to se and drug-related issues)? How are such problems

exacerbated by the social, emotional, and developmental issues most adolescents experience? What is the critical role that primary and secondary prevention can play for adolescents? How do mainstream systems fail adolescents as compared to other populations and why are school-based/linked health centers most suited to filling the gap?

- ***Study Limitations***. The report states that school-based/linked health centers increase access, provide some services more easily than managed care systems, and offer other significant benefits if coordinated with local managed care providers and/or systems. It also identifies a number of barriers to coordination and cooperation. However, the data to support conclusions regarding benefits and barriers are largely anecdotal, reflecting respondent perceptions and feelings rather than hard evidence. It may be useful to mention the limitations of the study based on the methodology and to specifically propose studies regarding actual benefits and barriers under the last recommendation.

  Another limitation of the study that may be worth noting is in the number and types of respondents interviewed. Given that State Medicaid agencies, State Maternal and Child Health (MCH) offices, and Community Health Centers were emphasized, the results will naturally reflect a heavier focus on services to the economically disadvantaged and medically underserved and to populations seeking prenatal and other MCH-related care.

- ***Confidentiality and Other Barriers***. Page 10 of the draft presents a number of reasons for limited coordination and exchange of medical information between managed care systems and school-based/linked health centers, but does not include the critical issues of personal privacy, confidentiality, and security of information technology systems. On page 19, it is stated that coordination is essential to overcoming treatment barriers; however, it might be argued that overcoming certain barriers, including issues of privacy and confidentiality, is essential to coordination. Thus, it might be worth considering a recommendation to form some sort of mechanism (e.g., task force, working groups) for addressing these and other actual or potential barriers to coordination.

- ***Measuring Health Outcomes Versus Utilization***. The report states that there are few, if any, attempts to measure health outcomes related to school-based/linked services, and stresses the need to move beyond utilization

assessments to measures of quality and effectiveness. Given that a major justification for such services is to improve access and delivery, the importance of utilization data should not be minimized. We believe that more and better efforts need to be made in both utilization assessment and measurement of quality and effectiveness.

OIG RECOMMENDATION

The Assistant Secretary for Health and the Administrator for Health Care Financing should each designate a contact to coordinate school-based health center issues in their agencies. These contacts should provide a point-of-entry for those outside HHS who need information about school-based health centers.

PHS COMMENTS

We generally agree with the OIG recommendation. However, we believe the thrust of the recommendation is information sharing. For that reason, OIG may wish to consider changing the word "issues" in the first sentence of the recommendation to "information."

We agree that designating single points of contact in PHS and the Health Care Financing Administration (HCFA) for information exchange on SBHCs and managed care is one possible way to enhance coordination. Within PHS, however, there are many possibilities regarding the manner in which efforts related to SBHCs, school health, and adolescent health can be coordinated, managed, or addressed. All of these possibilities will be considered by the new Surgeon General as she assumes responsibilities relative to these efforts.

Consequently, we suggest that this recommendation be modified to reflect the need for the heads of PHS and HCFA to: (1) identify means by which to effect coordination within and between their agencies on issues related to SBHCs and managed care and (2) enable outside parties to more easily obtain accurate, adequate, and up-to-date information on SBHCs. Designating points of contact could then be presented as one of many possible ways in which these needs might be met.

OIG RECOMMENDATION

The PHS, HCFA and the States should encourage cooperation between school-based health centers and managed care providers.

PHS COMMENTS

We support this recommendation, especially its intent to address treatment barriers. However, as mentioned in our general comments, while coordination is essential to overcoming treatment barriers, it might be argued that the reverse is also true, i.e., that overcoming certain barriers, such as confidentiality, is essential to coordination. Studies of these barriers should precede any Federal mandates for record sharing and other coordination for all treatment populations, including adolescents.

OIG RECOMMENDATION

The PHS and HCFA should work with HHS agencies to fund appropriate studies and grants that will add to HHS' knowledge on school-based health centers and managed care providers.

PHS COMMENTS

We agree that more studies are needed to add to our knowledge regarding SBHCs and managed care systems and/or providers, particularly in light of HCR. Identifying the priority issues to be studied and the research questions to be answered is a logical step to ensuring the implementation of a coordination research agenda. Coordinative bodies such as the Interagency Committee on School Health (ICSH) or the National Coordinating Committee on School Health (NCCSH)--both recently established by the Office of Disease Prevention and Health Promotion on behalf of DHHS--may be able to assist in this regard.

With reference to specific studies, it is critical that studies be proposed and conducted to provide more solid evidence of actual benefits and barriers and data upon which to base our policy and program decisions relative to coordination of SBHCs and managed care systems. Studies to provide more information about effects on access and utilization, and research on quality controls and standards are also needed. The Health Resources and Services Administration suggested an expansion of the OIG study to full case studies and evaluating these cases in order to obtain greater insight into the local conditions which make SBHCs, managed care systems, and coordination possible and successful. In all instances, great care must be taken in the design studies. For example, strictly comparing utilization patterns or cost effectiveness of managed care organizations and SBHCs may not be appropriate since it is likely that many adolescents will use both service delivery systems for different purposes.

While our knowledge in these areas is rather limited, care will need to be taken not to duplicate existing efforts which address adolescent health needs, such as the American Medical

Association's Guidelines of Adolescent Preventive Services. Care will also be needed to conduct studies within the context of other DHHS and/or PHS activities that address adolescent access to care, such as the guidelines of the U.S. Preventive Service Task Force and the Centers for Disease Control and Prevention's evaluations relative to SBHCs and comprehensive school health education.

The OIG may wish to recognize the fact that the Agency for Health Care Policy and Research (AHCPR), the Substance Abuse and Mental Health Services Administration (SAMHSA) and perhaps others in PHS already have existing grant programs which could expand our knowledge bases vis-a-vis SBHCs and managed care providers. For example, AHCPR recognizes that our lack of national data regarding the effects of SBHCs and managed care providers on the health outcomes of adolescents is due, in part, to the absence of good measures of health status for this age group. In February 1992, the AHCPR began funding a 3-year grant project which is validating and refining a self-administered instrument to measure the health status of adolescents who were drawn from school and clinic populations (including managed care organizations). If this project is successful, the instrument could be used to assist in determining the effects of school and managed care programs on the health status of adolescents and generally assist in planning, developing, and evaluating health programs.

The AHCPR also sponsors grants related to managed care. Although the AHCPR's current portfolio does not contain projects that focus specifically on the coordination of managed care and SBHCs, several of these studies examine other coordination of care issues.

Within SAMHSA, the Center for Substance Abuse Prevention has numerous demonstration grants that are evaluating prevention and early intervention programs and policies in schools. Also, the SAMHSA Center for Substance Abuse Treatment explicitly targets substance-using adolescents as one of the critical populations for its demonstration grants. Furthermore, the SAMHSA's Center for Mental Health Services develops and test comprehensive child and adolescent mental health services programs.

TECHNICAL COMMENTS

--Page 1, second paragraph

We suggest the following paragraph be added:

> "Community support in all stages of the planning, development, and implementation of school-based health care systems is critical to the success and

longevity of such systems. Efforts must be a direct response to the policies, constraints, and concerns of the community. It is essential that active solicitation of input and involvement of community and business leaders, health care and social service providers, school administrators/board members/ teachers, churches, parents, and youth be obtained in this partnership effort."

--*Page 1, third paragraph*

We suggest that the statement "Visits for physicals and mental health . . . ." be modified to read as follows:

"Visits for physicals, acute illness, psychosocial, and mental health needs are the most common services provided in SBHCs."

--*Page 3, first paragraph*

We suggest that the statement "Chief among these needs is care. . . ." be revised to read:

"Chief among these needs is care that is confidential, convenient, comprehensive, and age appropriate."

--*Page 4, "Even managed care delivery systems. . . ."*

We suggest the second paragraph under this section be revised to read as follows:

"Because the problems of adolescents are often complex and not strictly of a physical nature, diagnosis may be difficult. Treatment of these problems may require outside referrals for special needs or auxiliary services. In medically underserved or rural areas, such outside services may not exist, leaving many adolescents unable to attain needed care. SBHCs which are dependent upon outside referrals for needed services will not be successful without first developing a strategy for the provision of these services."

--*Page 4, "Funding sources for school-based health centers"*

The source(s) for the information on the funding estimates should be referenced.

--*Page 5, first paragraph under "The expanding HHS role in school-based health centers"*

-- The third sentence should read that "In 1987" not 1988 the Centers for Disease Control and Prevention created the Division of Adolescent and School Health.

-- We suggest that the last sentence be revised to read:

"In conjunction with the Carnegie Foundation, CDC is funding an initiative at the Columbia University School of Health Policy which has brought together a national workgroup to identify barriers to establishing SBHCs and to develop recommendations for a core set of services for SBHCs."

--*Page 5, second paragraph*

We recommend that the statement "In addition, the HHS Office of Disease Prevention . . . ." be revised to read:

"In addition, the Interagency Committee on School Health (ICSH) was created under the leadership of the DHHS Office of Disease Prevention and Health Promotion (ODPHP) as a joint activity of DHHS and the Department of Education (DEd). Staff support for this effort is provided by ODPHP and the DEd Office of Elementary and Secondary Education. Representation from DHHS, DEd, the Department of Agriculture, and a number of other Cabinet-level departments and Federal agencies is included on the ICSH."

--*Page 8, first paragraph*

We suggest the statement "Parental consent is the only . . . ." be modified to read "Parental/guardian consent . . . ."

--*Page 8, "Services provided at school-based health centers are geared toward adolescents."*

We recommend that the second paragraph under this section be modified to read:

"School-based health services are provided by a multidisciplinary team consisting of providers from the fields of medicine, nursing, social work, psychology, health education, and nutrition."

--*Page 9, Last paragraph*

We recommend that the statement ". . . a CDC-funded initiative. . . ." be modified to read "As part of a CDC-

funded initiative, Columbia University's School of Health Policy has convened three meetings of the national workgroup to recommend national standards for SBHCs."

--*Page 13, bullet "Legal Barriers"*

We recommend that the statement "Respondents from two States mention State laws. . . ." be revised to read as follows:

> "Respondents from two States mentioned that State laws prevent SBHCs from being reimbursed by Medicaid for services provided by non-physician health care professionals (i.e., nurse practitioners)."

--*Page 19, first recommendation*

The last sentence of the first paragraph states that ". . . the Department of Education, who have also taken an active role in school-based health activities." We suggest that the word "activities" be changed to "centers" since SBHCs and school-based health activities are not synonymous.

--*Page 20, second bullet*

The Bureau of Primary Health Care (BPHC) is incorrectly cited as the Bureau of Primary Care. Also, both the BPHC and the Bureau of Maternal and Child Health should be identified as part of the Health Resources and Services Administration (HRSA).

--*Page 20, third bullet*

-- The first sentence states that ". . . HHS agencies can host several regional or a national training conference on managed care . . . ." We suggest the word "meetings" be added after "regional" so the sentence reads ". . . can host several regional meetings or a national training conference. . . ."

-- We suggest the remainder of the paragraph be modified to read:

> "These meetings or conferences should include a focus on team building at the local level with an emphasis on community collaboration. Participants should include, but not be limited to, representatives from managed care systems and SBHCs. Organizers should also bring together State Medicaid and MCH officials, and representatives from Foundations, interest groups, and other agencies to discuss issues and efforts related to coordination

between managed care and SBHCs, obstacles to coordination, and strategies for overcoming barriers to coordination."

--*Page 21, first bullet, first sentence*

Given the effects of substance abuse (including tobacco and alcohol abuse) on health care costs, OIG may wish to consider modifying "mental health services" to mental health and substance (including tobacco and alcohol) abuse prevention and treatment services."

--*Page 21, fourth bullet*

We suggest this bullet be revised to read: "Within PHS, the Center for Mental Health Services could expand their current child studies that examine effective ways to deliver mental health services to adolescents in school settings."

--*Page 21*

Since coalition building is a crucial and integral part of the implementation process for SBHCs, we recommend adding another option for PHS, especially HRSA and CDC, through their grant programs, to support the capacity of the States to build the linkages and infrastructures supportive of SBHCs within their local communities.