



**Testimony Prepared by:
The New York State Coalition for
School-Based Health Centers**

**Partnership For Coverage
Increasing access to Health Insurance**

**October 3, 2007
Erie County Community College**

Introduction

Thank you for the opportunity to testify before this panel on the Partnership for Coverage. My name is Melva Visher and I am here on behalf of the New York State Coalition for School-based Health Centers. The Coalition is made up of 196 School-based Centers (SBHCs). They provide comprehensive primary health and mental health services to over 200,000 underserved youth in rural, urban and suburban areas of the State. SBHCs provide free care to every child who enters their door.

Located on-site in elementary and secondary schools, School-based Health Centers provide a wide array of services to children and adolescents including diagnosis and management of chronic diseases and acute illnesses, physical exams, immunizations, routine health screenings, counseling, and major health promotion and disease prevention programs to combat obesity, sexually transmitted diseases, drug and alcohol use and adolescent pregnancy. They have been shown to prevent unnecessary hospitalizations, reduce emergency room visits, improve school performance and attendance and avoid lost work days for parents.

The Coalition applauds Governor Eliot Spitzer and the members of this panel for your leadership in working towards a universal health care plan in New York State. In my remarks today, I will discuss the unique barriers to care that adolescents and children face, the role of School-based Health Centers in overcoming these hurdles, and the Coalition's recommendations for investing in solutions that expand access to quality, affordable health and mental health care for all children.

School-Based Health Centers: A child centered model of care

As safety-net providers for at-risk youth, we know that adolescents face unique barriers in accessing care including confidentiality concerns, transportation problems and cultural differences. These are often referred to as “non-financial barriers” because they affect access to care **even when a child is insured** [1]. Any plan to expand health insurance coverage should include solutions to address this problem.

School-based Health Centers are uniquely qualified to overcome these hurdles for all underserved children. They are “child-centered” health care providers that bring services directly to where the kids are- in school. SBHCs have a proven track record of delivering critical services to children and adolescents because they are within easy reach of students and are trusted by them as a confidential, non-threatening place to go for any problem. **Many studies, including one recently conducted in New York State, indicate that adolescents who use SBHCs are more likely than those enrolled in Medicaid or commercial insurance to receive critical screenings, mental counseling and other services.** I will provide greater detail on the study later in my testimony.

The money doesn't follow the child

School-based Health Centers are a valuable partner in helping the State to increase children's access to health care, improving their overall health and mental health and saving the State millions of dollars a year. But they can not continue to do so without a stable reimbursement base. SBHCs are suffering severe financial losses, in part, because

of State policies that restrict their ability to receive payment for the services that they deliver to children enrolled in the Child Health Plus Program (CHP) and that deny Medicaid reimbursement for counseling services provided by social workers. In addition, many more underserved communities need School-based Health Centers, but do not have the resources to open them. The Coalition urges you to partner with us to sustain and expand School-based Health Centers so that every child not only has health insurance coverage, but **access** to critical services when they need them.

Adolescent access to health care: A national crisis

Adolescents have the lowest rates of primary care use of any group in the US and are the least likely to have access to health care [2]. Patterns of care of adolescents show that they do not seek routine medical care and often wait until problems become severe before soliciting treatment [3]. Most do not receive screening and preventive counseling recommended by the American Medical Association (AMA) and the American Academy of Pediatrics (AAP) [4-7].

New York State's record: Access in CHP and Medicaid

New York State mirrors the nation in this regard. In 2005, the statewide average for adolescent well-care visits for Medicaid enrollees was 45% - far short of the 100% standard recommended by the AAP and other national health organizations. Adolescents enrolled in CHP scored low on access to assessments for depression, body mass index (BMI), and risk behaviors and preventive actions associated with sexual activity. The statewide average for depression screening was 29%, with one plan scoring 8%. The statewide average for children who received a BMI screen was 23% and only 53% for counseling on risk behaviors [8]. This results in lost opportunities to promote healthy lifestyles, prevent disease, and diagnose and treat mental health problems at an early stage.

“Non-Financial” barriers stop teenagers from seeking care

As noted earlier, studies show that “non-financial” barriers such as fear that confidentiality won't be maintained, lack of transportation, and cultural and language differences interfere with a child's ability to get health care **even if that child is insured**. For example, confidentiality is a key factor in determining whether teenagers seek counseling, education and other services [9, 10]. Most teenagers do not know where to go for confidential care, especially mental health and reproductive services, and a significant proportion do not believe that confidential care is available from their health care provider [10]. Transportation has been found to be a significant problem, with one out of five children missing *routine* doctors' appointments because their parents can't get them there [1]. **Unless these “non-financial” barriers to care are addressed, our children will continue to be underserved in the health care system.**

SBHCs are key community partners in increasing quality and access

School-based Health Centers are a proven model of care that bridges these gaps. They provide a point of access for kids who do not feel comfortable going to any other source of care for services and information such as mental health counseling, concerns about body weight, drug and alcohol use, and reproductive health issues. Their close proximity

to the students enables them to develop the trust of kids and parents who may be reluctant to see a doctor, nurse or social worker because of language barriers, cultural differences or citizenship status. In addition, their location on site in the schools promotes better adherence to medical regimens and eliminates transportation problems that can interfere with the delivery of needed services.

Helping managed care plans perform better for adolescents

Numerous peer-reviewed studies document the success of SBHCs in increasing access to care for **all** adolescents- **including those that are insured**. One study comparing SBHCs and managed care found that when adolescents who were enrolled in managed care could still use the SBHCs, they had up to 55% fewer emergency and urgent care visits and were over 10 times more likely to have a mental health or substance abuse visit than managed care enrollees with no access to a SBHC. They also had a greater percentage (80.2 to 68.8) of at least one comprehensive health care visit [11]. Access produces better health and mental outcomes: Students in schools with School-based Health Centers show significant declines in depression, improvements in self-concept, and are less likely to report considering suicide [12, 13].

A New York based study published this year in the Journal of Adolescent Health found that School-based Health Center users are more likely than those enrolled in Medicaid or commercial insurance plans to receive critical screening and counseling and that they trust their centers as a confidential place to go for care [14]. The study evaluated the care provided to adolescents enrolled in commercial insurance, Medicaid, and those who had used one of two SBHCs who were also enrolled in a commercial plan. Key findings of this study are that:

- SBHC users were more likely to report that their provider told them their discussion were confidential;
- SBHC users were more likely than Medicaid or commercially insured adolescents to receive screening/counseling on sexually transmitted diseases, HIV/AIDS, condom use, and birth control;
- Commercially insured adolescents were least likely to report discussion of sexual issues;
- **SBHCs had the highest mean Young Adult Health Care Survey (YAHCS) quality measure scores for screening/counseling on pregnancy, STDs, diet and exercise, and helpfulness of counseling provided;** and
- Medicaid-insured teens had the lowest scores on four of seven measures including preventive screening/counseling on risk behaviors, diet and exercise, depression, mental health and relationship issues, and communication and experience of care.

Health promotion/Disease management and prevention

School-based Health Centers also play a major role in keeping children healthy and helping them to prevent and manage chronic diseases and acute illnesses. Many centers carry out major health promotion and prevention programs to combat obesity, tobacco, drug and alcohol use, sexually-transmitted diseases and adolescent pregnancy. In addition, centers help students manage chronic diseases such as asthma, diabetes, sickle cell, and HIV.

A study at a School-based Health Center sponsored by Montefiore Medical Center in the Bronx found that children with asthma in schools without a School-based Health Center were twice as likely to be hospitalized as those who had a center in their school. The Bronx study also showed that emergency room visits were double for children in schools without a School-based Health Center [15].

Improving school attendance and performance

The fact that the children diagnosed with asthma had fewer complications and were healthier meant that they could stay in school and learn. Asthmatic children in elementary schools without a School-based Health Center missed three more days of school on average compared to those in a school with a center. The students who used the School-based Health Center were more likely to graduate or be promoted than students who did not use the services [16].

Saving government money

The interventions also save money. **In New York, the State's School-based Health Centers saved nearly \$3 million in hospital inpatient costs alone in one year for children with asthma** [17]. In Ohio, the total annual cost of hospitalizations decreased by 85% (nearly \$1000) per child at schools with SBHCs [18]. In addition, two years after implementation of a School-based Health Center in Atlanta, students had total Medicaid expenditures of less than one-half (\$899) that of their counterparts (\$2,360) in schools without centers [19]. These cost-savings figures don't even account for the increased productivity of parents who would otherwise have a significant number of lost work days

Investing in Child Centered Care: Recommendations

School-based Health Centers should be recognized as a valuable community partner in expanding access to cost-effective, quality health care. If the crisis in adolescent access to care is not addressed as part of the Partnership for Coverage, our children will continue to be underserved in the health care system. School-based Health Centers are a child centered model that can help solve this problem and assist the State in increasing the performance of the managed care system. We urge you to consider our recommendations for sustaining and expanding this unique safety net for children.

- **Provide Medicaid reimbursement for social work services**

The mission- and State mandate- of SBHCs is provide free, open access to health and mental health care. No child is ever turned away. But the money doesn't follow the child. State Medicaid rules prohibit SBHCs from receiving payment for psychotherapy services

provided by social workers. This is counter-intuitive as mental health is a core service required of centers by State DOH. In addition, this same service is reimbursable when it is provided by social workers in Federally Qualified Health Centers (FQHCs). In promulgating the FQHC regulation, State DOH noted that *“It is clear that permitting certified social workers to be reimbursed for behavioral health services is the generally accepted practice model.”* There is no rationale for funding a standard of care for underserved children at some community safety-net sites but not others.

Despite lack of payment, SBHCs continue to provide mental health services and have been shown to increase access and positive outcomes for the hardest to reach youth. But they cannot continue to do so without additional funds. **We urge you to change state regulations so that SBHCs can bill Medicaid for psychotherapy services provided by social workers.**

- **Reimburse SBHCs for CHP Enrollees**

Likewise, SBHCs serve all CHP enrollees who come to their clinics. But most don't receive reimbursement because they are not part of the managed care plan's (MCO) network- or even if they are – they may not meet the requirements to be a Primary Care Provider (PCP) because they employ nurse practitioners rather than physicians to deliver care. School-based Health Centers are not financially sustainable without access to reimbursement for the services that they provide to the target population that they were established to serve. **The Coalition urges a collaborative partnership with the members of this panel to develop an equitable system where CHP managed care plans reimburse SBHCs for the services that they provide to enrollees.**

- **\$5 Million for New and Under-funded New Centers**

Although other funds are made available to the centers through state grant dollars and the Health Care Reform Act (HCRA) pool, they have not kept pace with the constant growth in the number of children's visits and clinics or the need for new programs. In the last seven years the number of clinics has grown by 34% and annual patient visits have surged by 85% while reimbursement per visit has actually declined. Many more low-income, high need communities have expressed an interest in opening a SBHC, but current funding is insufficient. **The Coalition proposes that \$5 million in new HCRA funds be added to the 2008-09 State Budget to maintain under-funded centers and open new ones in underserved rural, suburban and urban communities.**

Conclusion

In closing, the Coalition would like to thank Commissioner Daines and the dedicated staff at the State Department of Health for their support of School-based Health Centers. The State Health Department is a true champion for children's health and has always recognized how crucial School-based Health Centers are in providing free, open access to care for the neediest children in the State. We are looking forward to working with the members of this panel to keep School-based Health Centers within the reach of every child who needs them.

References

- [1] Children's Health Fund Survey, 2001
- [2] US Office of Technology Assessment. Adolescent Health: I: Summary and policy options, 1991.
- [3] Department of Health and Human Services, DHHS 05-92-00680, School-based health centers and managed care, December 2003)
- [4] Halpern-Felsher BL, Ozer EM, Millstien SG, et al. Preventive services in a health maintenance organization: How well do pediatricians screen and educate adolescent patients? *Arch Pediatr Adolesc Med* 2000; 154:173-9
- [5] Fleming M, Elster AB, Klein JD, et. al. Lessons Learned: National Development to Local Implementation; Guidelines for Adolescent Preventive Services (GAP). Chicago, IL: American Medical Association; 2001
- [6] Klein JD, Wilson KM, McNulty M, et al. Access to medical care for adolescents: Results form the 1997 Commonwealth fund survey of the health of adolescent girls. *J Adolesc Health* 1999; 25: 120-30.
- [7] Klein JD, Wilson KM. Delivering quality care: Adolescents' discussions of health risks with their providers. *J Adolesc Health* 2002; 30:190-5
- [8] 2006 New York State Managed Care Plan Performance, A Report on Quality, Access to Care and Consumer Satisfaction.
- [9] Sigman G. Silber TJ, English A, et at. Confidential health care for adolescents: Position paper of the Society for Adolescent Medicine, *J Adolesc Health*, 1997; 21: 408-15
- [10] Klein JD, McNulty M. Flatau C. Adolescents' access to care: Teens' self-reported service use and perceived access to confidential care. *Arch Pediatr Adolesc Med* 1998; 152:676-82
- [11] Kaplan DW, Calonge BN, Guernsey BP, Hanrahan, MB. Managed care and SBHCs. Use of health services. *Arch Pediatr Adolesc Med*. 1998 Jan; 152(1):25-33.
- [12] Weist, Paskewitz, Warner, et al., "Treatment outcomes of school-based mental health services for urban teenagers," *Journal of Community Mental Health*, 1996, 18, pp.149-157.
- [13] Kisker EE, Brown RS, Do SBHCs improve adolescents' access to health care, health status, and risk-taking behavior? *J Adol Health* 1996; 18:335-343.
- [14] Klein JD, Handwerker L, Sesselberg TS, Sutter E, Flanagan E, Gawronski B. Measuring quality of adolescent preventive services of health plan enrollees and school-based health center users. *J Adolesc Health* 2007;41 153-160
- [15] [Webber MP](#), [Carpiniello KE](#), [Oruwariye T](#), [Yungtai L](#), [Burton WB](#), and [Appel DK](#). Burden of asthma in elementary school children: Do SBHCs make a difference? *Arch Pediatr Adolesc Med*. 2003; 157: 125-129.
- [16] McCord, M.T., Klein, J.D., Joy, J.M. and K. Fothergill, "School-based Clinic Use and School Performance," *Journal of Adolescent Health*, 1993, 14, pp. 01-98.
- [17] Estimate based on 2004 NYS SPARCS data and hospitalization reductions in Ohio and Atlanta.

- [18] Guo JJ, Jang R, Keller KN, McCracken AL, Pan W, Cluxton RJ. Impact of school-based health centers on children with asthma, *J Adolesc Health* 2004
- [19] Adams EK, Johnson V. An elementary school-based Health clinic: Can it reduce medicaid costs? *Pediatrics* 200: 105; 780-788

School-Based Health Centers Fact Sheet

September 5, 2007

There are 196 approved, operating SBHCs in New York State:

- 124 (64 percent) are located in New York City; and
- 72 (36 percent) are located in the rest of the state.

The urban, suburban and rural distribution of the 196 SBHCs are:

- 152 (76 percent) located in urban areas;
- 3 (2 percent) located in downstate suburban areas;
- 5 (3 percent) located in upstate suburban areas;
- 9 (5 percent) located in upstate small city areas; and
- 27 (14 percent) located in rural areas.

SBHCs are located in six different school grade configurations:

- 37 (19 percent) in primary/elementary schools;
- 58 (30 percent) in elementary/middle schools;
- 33 (17 percent) in junior high schools/middle schools;
- 12 (6 percent) in junior high/high schools;
- 39 (20 percent) in high schools;
- 14 (7 percent) in K-12 central schools; and
- 3 (1 percent) in other (a combination of the above)

The 196 SBHCs are sponsored by 56 providers, which include:

- 33 hospitals;
- 23 diagnostic and treatment centers

There are approximately 180,935 students in the 196 schools with SBHCs and approximately 75 percent of these students are enrolled in SBHCs. During the 2004-05 school year, approximately 656,000 visits were made by students to SBHCs.

Listed below are SBHC statistics derived from self-reported data for the program year 2004-2005.

The racial/ethnicity breakdowns of students enrolled in SBHCs:

- Asian Pacific/Islander (2 percent);
- African American/Non-Hispanic (34 percent);
- Caucasian/Non-Hispanic (14 percent);
- Hispanic/Latino (43 percent);
- Native American (<1 percent);
- Unknown (3 percent); and

- Other (4 percent)

The health care coverage of the students enrolled in SBHCs includes:

- Medicaid (47 percent);
- Private Insurance (13 percent);
- Child Health Plus (7 percent);
- Other (8 percent);
- None (19 percent); and
- Do not know (6 percent).

The top five primary reasons that visits were made include:

- Health supervision (34 percent);
- Emotional problems (25 percent);
- Respiratory problems (17 percent);
- Injuries and poisonings (17 percent); and
- Diffuse symptoms (7 percent).