Determining A Policy Agenda to Sustain School-Based Health Centers: NASBHC Assesses the Health Care Safety Net Environment

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Michael E. Porter and Mark R. Kramer describe a societal desire for foundations to achieve a social impact disproportionate to their spending. The same can be said of our public investments in human service programs. Our expectation is that they will achieve results beyond their spending. – Jacob Moody, The California Endowment

The National Assembly on School-Based Health Care, under the leadership of its past presidents, invited representatives from health care institutions, including local public health departments, hospitals, community health centers, and public health corporations (see roster, page 6), to explore current challenges to the health care safety net and their implications for school-based health centers. Primarily, we wish to help National Assembly members plan for emerging issues and environmental shifts that will contribute to or threaten the long-term success and sustainability of school-based health centers. In considering the question, "what does the future hold for school-based health care?" we aspire to collaborate with those most likely to influence the direction of public health, health care and education. How does school-based health care fit within the emerging systems changes and reforms that will affect the vitality of safety net providers? Does there continue to be value in population-specific access programs that blend public health, personal health care, pupil support and classroom education? Where will the financial support come from?

We asked the participants to describe the global challenges faced by their organization in sustaining its safety net mission:

Increased Competition, Decreasing Funds. Although each of the provider types acknowledged distinct challenges, they share an uncertain future shaped by increased competition for the health care market share, coupled with simultaneous growth in uninsured populations, and decreasing public funds for uncompensated care. The restriction and elimination of federal disproportionate share funds for hospitals and cost-based reimbursement to community health centers – financing mechanisms that fostered expansion of community health programming – is straining these systems. One participant described the systems as being held hostage to the discounted reimbursement from state managed care programs. Safety net organizations that once coexisted with limited fiduciary risk now struggle to compete with each other for a shrinking Medicaid market. The complementary functions of hospital, health department and community-based health care are becoming more ambiguous as each segment strives to serve a similar primary care role to a publicly insured population.

Community Health's Changing Mission. The long-term effects of safety net strain are already being felt, according to the meeting participants. The once explicit public/ indigent care mission of many traditional safety net providers is becoming less explicit. Community-based services are vulnerable to

decreasing profit and breakeven margins. Some advocates worry that, out of financial necessity, systems are clamping down on uncompensated care and sliding scale fee structures are increasingly commonplace – a practice that some worry may decrease access for low-income populations. A few participants spoke of an emerging niche market for specialty services and providers created by safety net organizations to attract Medicaid and commercially insured patients. The result, stated participants, is an irrational allocation of dollars away from primary care to expensive high-end care that will create long-lasting health status problems for whole communities.

Public Health in Transition. Perhaps most affected by these global challenges is the local public health department. Representatives described a period of transition, even struggle, in which public and personal health care roles are being reexamined. With the exception of services undesirable to other systems (STD/HIV related services, school-based services and dental), health departments are experiencing a contraction of personal health care functions. Once a dominant player in safety net primary and preventive care (for women and children especially), public health was described by participants as fragile, and viewed increasingly as an outlier within the provider community. The transition, however, has not been entirely without opportunity. A few public health officials are using the austere climate to exert leadership around community-wide collaboratives for children and adolescent services, including school-based health centers. The changing public health role is not one of service delivery, but rather of quality assurance and partnership development for school-based health centers.

Emerging Opportunities. A number of participants spoke optimistically about the current health care trends and reforms, and predicted that the evolution is far from over. As accountability and assurance measures continue to evolve, greater opportunities are likely to emerge. One health plan, comprised of community health centers and public health agencies, believes it has successfully met the challenge, "Why a safety net?" Policy makers in this state conceded that, after years of forcing a fit within a managed care health care market, the needs of underserved and low-income populations indeed require a more complex and varied array of services.

We asked the participants to describe from their organization's perspective the view of school-based health care.

Although front-line providers might describe the school-based health care function as primary care, the sponsoring agency has a different perception. The school-based health care view shared by hospital representatives was framed around corporate service and philanthropy, a chance to give something back to community. Leaders from community health centers described opportunities for expanding their primary care mission and building a consumer base. Public health administrators described school-based health care as a natural partner in achieving public health functions such as STD control, immunization compliance, and health promotion. The view is not always positive, offered one participant, who noted that school-based programs can also be perceived to be competitors for dwindling resources and shrinking consumer markets.

In spite of fiscally tight times, the participants continue to see value in the school-based health care model and identified several reasons for maintaining their investment. In listing the advantages of sponsor-

ing a school-based health centers, the participants described them as:

- one of the best strategies for improving both public and personal health outcomes and indicators;
- an important gateway to mental health and substance abuse services;
- a unique service niche for a hard-to-reach adolescent population;
- an opportunity to keep children and youth in school;
- an effective agents for getting school-age youth enrolled in public insurance;
- a vital link between the school and the community; and
- a cost-effective and convenient strategy for parents and employers.

We asked the participants to describe specific challenges to the future of SBHCs.

Despite the advantages associated with school-based health centers, the global challenges summarized here are having an effect on the representative health care organizations' continued ability to support community-based services. As one representative observed, mission and good intentions go out the window when the financial bottom line is affected.

Inadequate Reimbursement for the Model. The cost of the comprehensive model is creating difficulty in keeping school-based services in the sponsor's vision. Without indigent care subsidies and adequate Medicaid reimbursement, community health representatives admitted that keeping comprehensive centers open was going to be a challenge. Several participants spoke of programs in their community that were no longer operating because of funding problems.

Scaling Back the Model. Several people observed that, in fiscally difficult times, one response of sponsors is to pare back the model to its core and most reimbursable services. Without compensation for the full scope of services, providers are pressured to deliver only that which will get funded -- driving the model away from its initial mission of prevention and early intervention. Mental health services, in particular, were felt to be the most vulnerable to program cuts.

Dilution of the Model. A separate concern was raised about the quantity of health centers being created by diffusing limited resources to as broad a network of programs as possible. In attempting to do more with less, argued some advocates, the model becomes diluted, and an increasingly accepted comprehensive standard of care becomes compromised. Participants worried that rapid expansion with little regard for high quality or measures of success does not help the field.

Expanding Services to Community. Some participants described an expansion of school-based services to other members of the community beyond the school population. While the strategy may be effective in broadening the appeal of the health centers, and perhaps justifying the expense, several people raised concern that the objective to create a safe and confidential setting, most especially for adolescents, is compromised by the presence of non-adolescents.

Limited Awareness of Model. And finally, participants believed that a general lack of awareness regarding school-based health care continues to exist and that, despite efforts by the field to tell its story, the model is not universally recognized as a legitimate part of the health care system.

We asked the participants to describe strategies that they perceive as necessary in building long-term support from their

institution and community. Several roles for school-based health centers, the National Assembly, and its state chapters were identified.

Advocacy. The National Assembly and its state and local partners should assist in the development of stable sources of federal and state Medicaid, public health and indigent care funds to sustain efforts nationwide. Champions essential to achieving this goal are state elected officials, members of congress, primary care associations, and relevant national health and education associations.

CEO Leadership. School-based health center advisory boards and staff must advocate that the health center become an integral part of the sponsoring organization's mission and goals to ensure a more salient role in the broader operations. Participants described the long-term commitment of the sponsoring agencies to school-based health care and its ability to be sustained as varied. Some reported core institutional support for the model at all levels. Others described an attitude of indifference from the executive leadership – that the sincerity of commitment is only as strong as the ability of someone else to fund it. We observed that the relationship between sponsor/administrator and the school-based health center can be categorized by three levels: sponsorship, ownership and leadership.

- *Sponsorship.* Sponsorship implies a passive role in the operation and support of the school-based health center. Its motivation is one of public relations and marketing. The sponsor serves primarily as an administrative pass through of grant funds. Operational support through its own core funding is limited.
- *Ownership.* Sponsorship takes on the characteristics of ownership when the school-based health center becomes an integral part of the organization's mission and business plan, and is endorsed by the leadership. Sponsors as owners regard the school-based health center as a long-term investment and its own funds support the program budget.
- *Leadership.* Ownership evolves to leadership when the organization's executive representatives become involved as advocates and spokespersons for the program and its growth, to expand the mission beyond its own efforts to create a sustainable and broadly supported initiative. Community health CEOs and boards of directors must be engaged in state and federal advocacy efforts to develop sustainable funding for school-based health centers. Community health leaders can be extremely influential in changing the perception among state and federal lawmakers that health care access for children and adolescents is resolved through insurance expansions.

Research and Evaluation. The National Assembly and its research and evaluation section should communicate and build upon the data that have established school-based health centers as unmatched in improving access and utilization for low-income school-age youth, especially for males and high risk students. The National Assembly and its state and local partners should promote national, state and local evaluation activities that demonstrate an impact on broader community goals, such as school readiness, safety, and elimination of racial health disparities. Creative means should be employed to plumb the wealth of data being collected daily by the health centers to assess economic impact, including cost avoidance models.

Reimbursement. The National Assembly should document the cost of delivering comprehensive health and mental health care to children and adolescents so that it can inform and work with payers in developing an adequate reimbursement system.

Communication. The National Assembly, its state affiliates and local programs must engage in communication and marketing strategies that will heighten awareness of school-based health centers among decision makers. We should share best practices in communication – those messages and vehicles that have successfully captured the attention of our audience – and engage supportive health care executives in peer-to-peer education.

Forging Partnerships. The National Assembly should promote best practices in community partnership development. Collaboration across the health care sectors makes for the most durable school-based health care program. This theme emerged continually throughout the day's discussion as several representatives referenced the power of seeking common goals through coalitions with sometimes unnatural partners. With hospitals, community health centers and public health departments sharing information and resources and utilizing those best equipped to deliver the appropriate range of services, each has a unique role to offer the partnership. Denver and Indianapolis leaders described a citywide vision for school-based health care that expands beyond any one institution. In creating collaborative opportunities for multiple partners that share interests in the same school-age population, accountability (and credit) for community-wide outcomes becomes shared and ownership for the program becomes deeply and broadly entrenched. Several participants reminded us that partnerships should extend beyond the usual stakeholders to include the corporate sector. The concept of partnership was underscored by one health official who acknowledged that the organizational leadership's desire to take school-based health centers to scale simply could not be achieved without additional help.

Next Steps

The National Assembly on School-Based Health Care welcomes your comments and suggestions these recommendations and their implementation. Please share this discussion summary with your sponsoring agency's leadership. Do they share their colleagues' view or do they have a unique perspective?

This dialogue is the first in a series of policy discussions with critical supporters and stakeholders. Future sessions will include representatives from the education sector, health care payers, and federal children and youth agencies. We believe the future holds great promise and are committed to working with each of our federal, state and local partners to sustain and expand school-based health centers.

NASBHC Past Presidents

Donna Zimmerman, 1995-96
Jacob Moody, 1996-97
Karen Hacker, 1997-98
Denise Chuckovich, 1999-2000

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