The Growth of School-Based Health Centers and the Role of State Policies

Results of a National Survey

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Objectives: To document recent growth among school-based health centers across the United States and identify state policies that may be facilitating that growth, using a nationwide survey. This was the fourth in a series of surveys undertaken by the Making the Grade office, Washington, DC.

Design: During the period from July to September 1998, a written survey instrument was sent to 50 state governments plus the District of Columbia requesting data on numbers of school-based health centers as well as their basic characteristics and a description of state funding and other policies as they relate to the centers. Follow-up telephone calls and additional mailings secured a 100% completion rate.

Main Outcome Measures: The numbers of centers by state and region, basic health center characteristics, levels of state financial support, and numbers of states implementing specific policies to sustain and replicate the centers.

Results: School-based health centers increased from 900 during school year 1995-1996 to 1157 in 1997-1998, a 29% gain. Mid-Atlantic and New England states continue to lead the regions with 37% of the total. The fastest growth occurred in the Midwest and the Southwestern/Rocky Mountain states. State grant funding of centers decreased slightly during this period. Other policies, including support from Medicaid and the State Child Health Insurance Program, are increasing third-party revenues.

Conclusions: The spread of school-based health centers into the Southwest and Rocky Mountain states is increasing the importance of the centers to rural communities. Because these areas are generally more conservative than either coast, these developments suggest a continued migration of school-based health centers from the political margins into the mainstream. The growth of the centers during a period of stagnation in state grant funding may also suggest that other sources of support, including third-party payments and support from private institutions, are becoming more significant.


The number of school-based health centers (health clinics located on school property, mostly sponsored by mainstream medical institutions, and staffed with nurse practitioners, mental health professionals, and a mix of part-time professionals) expanded rapidly during the 1990s. As documented by 4 surveys, the numbers of centers grew from 350 in 1992-1993 to 1157 in 1998, a 230% increase. While private philanthropy fostered the early growth of the centers, state governments have played an increasingly vital role, funding new centers and putting in place public policies to provide long-term stability. This article reports findings from the most recent survey of school-based health centers and looks at what states are doing to support their replication and sustainability.

GROWTH TRENDS AND SCHOOL-BASED HEALTH CENTER CHARACTERISTICS

The 1998 survey documented that there are 1157 school-based health centers in the United States, nearly double the number identified in 1994 and a 29% increase since 1996. Figure 1 illustrates the number of school-based health centers found in each state. The 11 states with the largest numbers of school-based health centers are
MATERIALS AND METHODS

Between July and September 1998, the Making the Grade National Program Office at George Washington University School of Public Health and Health Services, Washington, DC, surveyed health departments in the 50 states plus the District of Columbia. In states where health departments were not solely responsible for school-based health centers (Florida, Iowa, Missouri, New Jersey, and Pennsylvania), multiple agencies were surveyed. A written instrument was supplemented by telephone interviews. While all states and the District of Columbia responded to the survey, not all jurisdictions answered all questions. In most instances, however, the 45 states plus the District of Columbia that had at least 1 school-based health center responded to most questions.

In those states in which the state government was not financing school-based health centers or in which state officials were not knowledgeable about centers they did not support, Making the Grade staff contacted individual sites to confirm characteristics of the centers as well as to document the effect of state policies on the centers. This survey was cosponsored by the National Assembly on School-Based Health Care, a membership organization based in Washington, DC.

New York (158), Arizona (82), Texas (77), California (64), Florida (64), Connecticut (51), Maryland (43), Michigan (41), New Mexico (40), Oregon (39), and North Carolina (39). These 11 states, located in all regions of the country, represent 60% of all school-based health centers. During the last 2 years, Arizona experienced the largest growth in school-based health centers, followed by California, Indiana, and South Carolina.

In contrast to the early 1990s, school-based health centers are no longer concentrated in the Mid-Atlantic and New England states but are spreading to all regions of the country. While the largest numbers of school-based health centers are still in the Mid-Atlantic and Northeast, during the past 2 years the greatest growth has occurred in the Midwest and Southwestern/ Rocky Mountain states. In 1998, the Mid-Atlantic and New England states continued to lead the regions with 37% of the centers; 20% are found in the Southwestern and Rocky Mountain states; 18% are in the Southeast and South Central states; 15% are in Midwestern states; and 10% are on the Pacific coast.

Historically, school-based health centers have been concentrated in high schools, reflecting concern about the availability and adequacy of health care for adolescents. It remains true that the largest number of centers, 432 (37%), are located in high schools. However, the number of centers in elementary schools has been increasing, reaching 391 centers (34%) in 1998. Middle and junior high schools account for 184 centers (16%), a proportion that has held steady for the past several years. "Comprehensive" schools (kindergarten through 12th grade), mostly found in rural areas, comprise 6% of the total number of school-based health centers, with “other” schools, a category that includes schools comprising kindergarten through eighth grade, 7th through 12th grades, and alternative schools, representing 7% of the total.

School-based health centers are increasingly found outside of urban areas. While 63% of centers are located in cities, 26% are now in rural areas, reflecting the rapid growth of centers in the South and Southwest. Eleven percent of the centers are located in suburban communities. A majority of the centers (57%) provide primary care services on a full-time basis. The survey defined centers as “full-time” if they had a primary care provider on site 25 hours a week or more. Many of the “part-time” centers, however, are open during all school hours but have primary care providers on site 16 or 20 hours a week. Other centers have full-time mental health professionals with part-time primary care professionals. These centers were categorized as part-time. Greater detail on health center hours, staffing, and services will be available from the National Assembly on School-Based Health Care in mid-1999, when it reports the results of its fall 1998 survey of individual school-based health centers throughout the United States.

STATE FINANCIAL POLICIES TO SUPPORT SCHOOL-BASED HEALTH CENTERS

Grant Dollars

From the beginning, state dollars have been critical to the growth of school-based health centers and have remained a chief funding source throughout the 1990s. It is significant that, of the top 11 states with school-based health centers, 8 (New York, Arizona, Texas, Connecticut, Michigan, New Mexico, Oregon, and North Carolina) have specific grant funding initiatives to support the centers. In 1998, an estimated 650, or more than half, of all school-based health centers received some state grant funding. Thirty-seven states plus the District of Columbia helped to fund at least some of the centers in their states, at varying levels of support. Eight states did not contribute any money to their centers.

Twenty-seven states plus the District of Columbia, representing 488 centers, reported the following: 37 (8%) of the centers received 25% or less of their budgets from...
state grant funds; 121 (27%) received between one quarter and one half of their budgets from state funds; 218 (49%) drew between one half and three quarters of their budgets from state funds; and 72 (16%) received three quarters or more of their budgets from state funds.

State funding for the centers increased from $17 million in 1992 to $40 million in 1996 and was primarily composed of money from state general funds and state allocation of Bureau of Maternal and Child Health (MCH), Washington, DC, block grant dollars. In 1998, despite a slight increase in general fund support, overall state grant funding declined to $38.9 million because states directed 29% less in block grant dollars to the centers (Figure 2).

The Making the Grade survey did not ask respondents to discuss reasons why state funding may have increased or declined. However, 2 explanations seem likely. First, a larger number of health programs serving low-income women and children may have sought support from the MCH block grant program to replace declining Medicaid revenue. Several publicly funded programs have lost Medicaid revenue in the shift from Medicaid fee-for-service to Medicaid managed care. In addition, the Child Health Insurance Program (CHIP) expansions have become a national priority, and some state governments have drawn on MCH block grant dollars to fund marketing and enrollment activities. In either instance, it is likely that the decline in MCH funding for school-based health centers reflects greater competition among publicly funded health programs for grant support.

Third-Party Reimbursement

In the past, many states believed that school-based health centers should be fully financed by general fund or state MCH dollars and that additional support through Medicaid reimbursement would constitute double payment for services. These states, particularly those that launched school-based health center initiatives in the 1980s or early 1990s, either did not permit or did not encourage billing of private or public insurers. States in this category included Connecticut, Delaware, Louisiana, Michigan, New York, North Carolina, and Oregon. Only in the past several years have these states either reversed earlier prohibitions against Medicaid billing or begun to encourage health centers to equip themselves to maximize third-party payments.

While the numbers are incomplete, 15 states reported that school-based health centers received more than $8 million in fee-for-service Medicaid reimbursements, and 5 states reported nearly $700,000 in Medicaid managed-care payments during the 1997-1998 school year. Additionally, 7 states reported nearly half a million dollars in commercial insurance revenues. One state, Vermont, reported $7000 in outreach and other payments to school-based health centers during the first months of CHIP.

As documented by the survey, most states now allow school-based health center participation in Medicaid and CHIP. Of the 45 states plus the District of Columbia that have school-based health centers, 43 jurisdictions allow centers to bill for Medicaid reimbursement. Only school-based health centers in Arizona, Hawaii, and Oklahoma are prohibited from billing Medicaid for services provided to its beneficiaries. In Arizona, the state government maintains that its substantial primary care grant program pays for all costs associated with school-based health centers funded under that initiative.

Thirty-nine of 43 reporting jurisdictions indicated that the centers may be paid for services provided to CHIP beneficiaries. Centers are not allowed to bill CHIP in 4 states (Arizona, Hawaii, North Carolina, and Oklahoma). Three additional states (Minnesota, New Mexico, and West Virginia) noted that final decisions had not been made regarding their CHIP program.

In states that have converted their public insurance programs to managed care, most school-based health centers need to negotiate agreements with health plans to be paid for services provided to Medicaid or CHIP beneficiaries. These efforts have posed a challenge for centers. To date, 22 states report that at least 1 of the centers in their states has signed a contract with a managed-care plan. Twenty-three states plus the District of Columbia indicate that there are no contracts between these 2 entities. Some states nurture these negotiations more than others. For example, while 28 states report taking specific measures to encourage school-based health center participation in Medicaid managed care, 17 states and the District of Columbia report not taking such measures. Similarly, 27 states note that they have taken specific measures to encourage health center participation in CHIP, while 18 states plus the District of Columbia have not. Most of the states that are not taking action are those with relatively few school-based health centers.

Regarding a narrower set of questions related to managed care, 34 states plus the District of Columbia report that they permit school-based health centers to participate in managed-care arrangements as primary care providers. Ten states, however, do not permit these arrangements. These positions largely reflect different views on whether school-based health centers and their sponsors can provide 24-hour, 7 days per week coverage and whether the health center staff is indeed providing primary and preventive care as well as acute services. In general, despite the permissive state policies, most school-based health centers contract to provide specific ancillary services within a managed-care network rather than serve as the primary care provider.
STATE NONFINANCIAL POLICIES TO SUPPORT SCHOOL-BASED HEALTH CENTERS

Several other key policy issues affect the viability of school-based health centers. Given the leading role of nurse practitioners as providers in the centers, perhaps the most fundamental policy question concerns whether state regulations permit nurse practitioners to participate in managed-care networks as primary care providers. Of 44 states plus the District of Columbia reporting, 39 states and the District of Columbia permit nurse practitioners to function in this capacity, while 5 states do not.

Concerning state efforts to nurture the school-based health center model, of the 45 states plus the District of Columbia that have school-based health centers, 24 states have created a governmental unit explicitly charged “to develop and support” the centers. Consistent with this formal recognition of the centers, 23 states have established operating standards for school-based health centers. In 15 states the standards are voluntary, while in 8 states they are required. Seven states license their school-based health centers through the state health licensing authority (Connecticut, Kentucky, Massachusetts, Nebraska, New York, Rhode Island, and West Virginia).

COMMENT

Three critical facts emerge from this survey: (1) school-based health centers are continuing to show strong growth despite the overall decline in state grant dollars, (2) they are increasingly important in the Southwest and Rocky Mountain states, and (3) they are becoming particularly vital in rural areas. These facts suggest the following.

Communities across the country continue to identify school-based health centers as useful strategies to address health care needs of some young people or certain school populations. The spread of the centers into the Southwest and Rocky Mountain states, areas generally more conservative than either coast, also indicates the continued migration of school-based health centers from the political margins into the political mainstream.

The growth and spread of centers during a period of relatively static state funding implies that sources of support for school-based health centers are emerging beyond state government. Anecdotal evidence suggests that these sources include local public and private dollars. During the past 5 years, Denver, Colo; Baltimore, Md; Multnomah County (Portland), Ore; and Seattle, Wash, have opened and maintained 40 school-based health centers using local dollars as a primary source of support. The option of local initiatives is one that may warrant greater attention, although not all communities will have the resources available to undertake such programs. Thus, the importance of state and federal support will remain.

An emerging trend that is more elusive to track is the increased role of community and teaching hospitals in organizing and funding school-based health centers. These institutions, which often combine substantial financial resources with Internal Revenue Service requirements to invest in “community benefit” activities, are devoting both management talent and dollars to initiating school-based health centers. Examples include the Duke Medical Center (Durham, NC), the North Broward Hospital District (Broward County, Fla), Helix/Medlantic Health System (Maryland/District of Columbia), Henry Ford Hospital (Detroit, Mich), and St Anthony’s/Centura (Denver).

Recent developments suggest reasons for hope and concern regarding the future viability of school-based health centers. The strong growth of centers and their increased popularity in all regions of the country signal their emergence as mainstream providers of care. Moreover, the federal government’s 5-year, $24 billion investment in CHIP holds promise of infusing more dollars into the centers by paying for care to formerly uninsured patients.

At the same time, the appearance of managed care as the dominant model for organizing and financing services under both Medicaid and CHIP has blunted school-based health center access to these programs. The limited experience of centers in negotiating contracts with health plans, and plans’ uncertainty regarding the scope and quality of care provided by centers, has slowed collaboration. As a result, for the last several years, optimism regarding the continued growth of school-based health centers has been tempered by an apprehension over future funding viability. As Medicaid managed care and CHIP implementation progress, and as states assess the utility of school-based health centers, prospects for future sources of support will become clearer.

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REFERENCES

from moderately complex rapid antigen tests for streptococcal pharyngitis to 1 of 10 different waived rapid antigen tests for streptococcal pharyngitis. The complete blood cell count and the throat culture are now the major 2 moderately complex tests used in pediatricians’ office laboratories. Since at least 2 companies are testing instruments to measure complete blood cell counts, which they hope will soon become approved as waived tests, the throat culture may well be the only remaining moderately complex test frequently used in pediatricians’ office laboratories. The option of sending throat cultures out to reference laboratories exists, but the turnaround time for doing this may be problematic.

I am old enough to have practiced pediatrics before the development of rapid antigen testing for streptococcal pharyngitis. Waiting up to 3 to 4 days for a throat culture result can be difficult for the patient, family, and pediatrician. Parents often need to miss work, the child remains febrile and uncomfortable, and the pediatrician gets called back frequently. In this scenario, pediatricians are often asked to prescribe antibiotics that may be unnecessary. In addition, untreated infected children are often sent back to school before the results of the throat culture become available. I feel strongly that having a diagnosis from a rapid antigen test for streptococcal pharyngitis in 5 to 10 minutes serves the patient and family better than waiting several days for a throat culture result.

No matter what the pediatrician’s underlying bias about the preferred method of diagnosing streptococcal pharyngitis, future cost analyses should include the administrative costs of performing moderately complex tests in the office laboratory.

John T. Benjamin, MD
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In reply
We appreciate Dr Benjamin’s interest in our cost-effectiveness analysis of managing children with sore throats. We would like to emphasize that we did indeed include personnel costs, but only the variable costs of personnel time, ie, only those personnel costs directly attributable to each additional test performed. In general, costs of CLIA inspections and proficiency testing should only be included if they are directly related to the volume of tests performed, in which case only the variable cost for each test should be included. Such costs would likely be most applicable to the office-based testing strategies, and in particular, to office-based throat cultures and certain rapid antigen tests since they are not waived by CLIA.

Benjamin’s comments also highlight the importance of perspective. Our recommendation to perform throat cultures is based on the societal perspective, which is considered the reference case.1 As our analysis in which we took the parent’s perspective shows, the 2 least expensive strategies are “Do Nothing” and “Empiric Therapy,” followed by the 2 EIA rapid antigen test strategies; the most expensive strategy is culture. At the risk of clouding the issue, one could consider different perspectives, such as the physician’s or payor’s, and it is likely that the results from the various perspectives would conflict with one another. Hopefully, though, results of such analyses can serve as a useful tool for decision making at any of several levels.

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Correction

Error in Figure. In the article titled “The Growth of School-Based Health Centers and the Role of State Policies,” published in the November issue of the ARCHIVES (1999;153:1177-1180), there was an error in Figure 2. Under the 1998 heading, the figure for state revenue should have read $29.61; the figure for Title V Bureau of Maternal and Child Health block grants should have read $9.27. The ARCHIVES regrets the error.