PHILANTHROPIC COLLABORATIVE FOR A

HEALTHY GEORGIA

Why Provide Health Care to Children in Schools?

An Issue Paper

HOW HEALTHY ARE GEORGIA'S CHILDREN?

The facts paint a startling picture. From birth, Georgia's children are less healthy than their counterparts in most other states. Georgia ranks close to last – 41st in the nation – for the percentage of babies born at a low birthweight and for infant mortality. We rank 46th in the number of births to teen mothers and 28th in the number of teen deaths.[1]

Forty-five percent of all fourth graders in our state are below grade level, and 12% of all children drop out of high school – ranking Georgia 40th in the nation. This situation is compounded by the fact that 23% of all Georgia's children live in poverty. Indeed, more than three-fourths (77%) of the state's 1.4 million school children are eligible for the free and reduced lunch program, putting their family incomes below 185% of the federal poverty level ($31,542 per year for a family of four). Low-income children often have a disproportionate share of health problems. According to the Georgia Dental Disease Prevalence Survey, low-income children are 80% more likely to have dental disease, and 30% of the tooth decay among poor children in Georgia goes untreated. Great strides have been made to insure children

through PeachCare for Kids and Medicaid. Yet there are approximately 85,000 children who are ineligible for PeachCare for Kids and Medicaid and have no source of regular insurance-based care.[2] An estimated 70% of the state's uninsured children are of school age – between 6 and 18.[3]

Research shows that along with the burden of poverty and insufficient support structures, the lack of health insurance plays a major role in affecting health status, since uninsured children are less likely to see a doctor. "The majority of uninsured children with asthma and one in three uninsured children with recurring ear infections never see a doctor during the year."[4] Poor health status combined with a lack of health insurance can also increase the likelihood of missed days in school. According to a study in Florida, uninsured children are 25% more likely to be absent from school.[5]

Children, particularly adolescents, are vulnerable to health problems linked to risky behaviors. According to the Centers for Disease Control and Prevention, 70% of adolescent health problems are due to violence, substance abuse, tobacco use, inadequate physical activity, poor dietary habits and risky sexual behavior.[6] Furthermore, significant numbers of youth are engaging in these risky behaviors. According to the Youth Risk Behavior Survey, 50.8% of youth currently use alcohol and 26.2% use marijuana. Over half (50.6%) of all high school seniors report having engaged in sexual intercourse within the past three months.[7] Yet, despite these alarming facts, there are few health care services provided for children and youth in the place they spend most of their time – school.

SCHOOL HEALTH: CHARTING A NEW COURSE

Many communities throughout the country are discovering great advantages in situating community-based health services in schools. At the core of this trend is a basic fact: healthy students are simply better learners.

In general, school-age children and adolescents require less frequent preventive and primary health care than any other age group. Yet, many of Georgia's children experience serious health problems: acute and chronic illness and injury; violence and anger management; tobacco, drug and alcohol abuse; family dysfunction, depression and teen suicide; and dental problems. School-based health programs can help address these problems and minimize their affect on student achievement.

Programs can be structured in a variety of ways, from a very basic model to a much more comprehensive one. The most basic model of school-based care typically consists of a single (often part-time) nurse who provides a limited set of health services, including routine physical exams, immunizations, and care for acute illness and injury (see diagram on page 3). The most comprehensive model encompasses a broader array of screening, diagnostic and treatment services, plus mental health and substance abuse counseling, health promotion and education, family planning and prenatal and pediatric care. Services are usually offered in on-site clinics, staffed by a physician, mid-level providers, mental health providers, and nurses. Many programs adopt a model that lies in between these two extremes – a model in which students receive a certain set of services on-site, from mid-level providers and/or physicians, and are referred to community health and mental health providers for additional needs. Broad local parental input shapes the actual array of services offered, and parents sign a detailed consent form authorizing their child or teen to use any of these services.

Healthy students are simply better learners.

Regardless of structure, school health programs share two common ingredients: first, local collaboration for the delivery of services; and, second, collaborative financial support from multiple sources including Medicaid, philanthropy and government grants. School-based health clinics, whether basic or comprehensive, are often operated in conjunction with other organizations in the community, including the local public health department, community health center, or a local hospital. Others are independently owned and operated through a combination of state and federal monies as well as philanthropic support.

The true value of school health programs is that they eliminate barriers to care by providing affordable and accessible services to children on-site. Many of these children have limited access to health care services in their larger communities due to such factors as lack of transportation or a trusting relationship with a physician. Furthermore, school health programs have the added benefit of being able to offer a multidisciplinary approach to care, bringing physical and mental health providers together on a regular basis to ensure the well-being of children.

SCHOOL HEALTH MODELS

Basic Services

Immunizations
Communicable disease control
Hearing, vision and nutrition screening
Medication administration
Emergency care
Health counseling
Identification of children with chronic or special health care needs

Expanded Services

Basic services plus:
Health promotion and disease prevention
Preventive dental care
Mental health counseling
Drug and alcohol counseling and prevention
Sexuality education and counseling
Early Periodic Screening, Diagnosis and Treatment
Case management
Care of children with special needs

Comprehensive Services

Basic and expanded services plus:
Acute diagnosis and treatment
Acute and chronic illness management
Laboratory testing
Sexually transmitted disease testing and treatment
Family planning information and referral
Prenatal and pediatric care
Medical nutrition therapy
Dental services
Referrals to subspecialists
24-hour coverage

DO SCHOOL HEALTH PROGRAMS WORK?

There is compelling evidence that school-based health centers (SBHCs) can positively impact the health status and emotional well-being of children and youth. Parents love these programs because their children are assured appropriate health care on a timely basis, tailored to developmental needs. They also appreciate missing less time from work. Educators value lower absentee rates and the fact that such concerns as mental health and substance abuse can be addressed promptly and on-site. And school-based health care providers are gratified to be serving a population of young people who might not otherwise receive care. This is particularly true in underserved neighborhoods, where school health programs often become the medical "home" – and the only source of regular care – for the students they serve.

School health programs can engage a broad community constituency in health planning for children, and can harness the energy and resources of schools, public health and the private sector to improve quality of and access to health care. Investment in school health, especially in school-based health centers, provides excellent returns at a relatively low cost – returns in improving the health of youth, reducing risky behavior, reducing unnecessary emergency room utilization and hospitalizations, and helping to provide a support system for children's psychosocial needs.

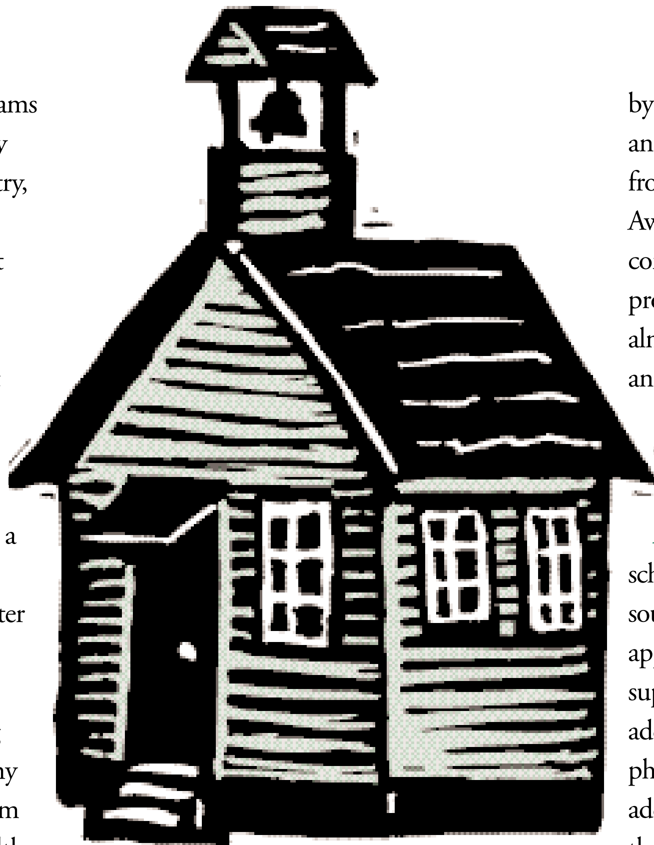
STUDENTS IN SCHOOLS WITH A SBHC:

- are less likely to be absent and more likely to graduate.[8] Georgia teachers indicate that dental and vision problems are the most frequently cited reasons for school absences.[9]
- are less likely to use emergency rooms or be hospitalized.[10]
- have higher levels of immunization and well child/adolescent care.
- engage in fewer behaviors that place them at risk of disease, injury or death.
- can potentially enroll in available health insurance plans, reducing the number of children uninsured.

Along with these potential benefits come some challenges.

- Strong community support is required, not only from the school system but also from parents and healthcare providers, especially physicians.
- In communities with insufficient number of providers, school-based health programs often serve as medical homes for children. Local private physicians may fear that such programs will erode their patient base.
- Inclusion of sexuality education and family planning in school health programs may be controversial.
- Securing ongoing financing to sustain school health programs is difficult. Most programs cannot rely solely on third party reimbursement and/or state and in-kind community support. This often means that programs must "juggle" funding from numerous sources in order to maintain a stable level of service for children

COMPREHENSIVE SCHOOL HEALTH SERVICES: A NATIONAL LOOK



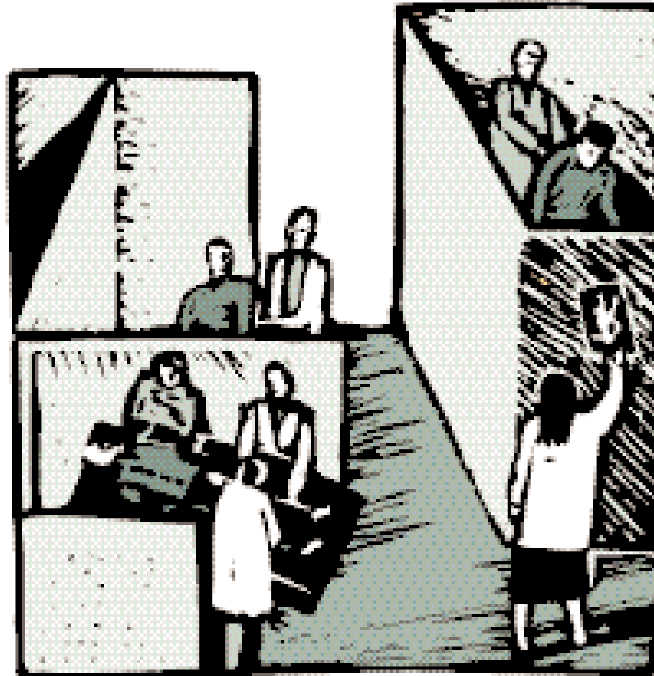
While basic school nurse programs are commonplace in the approximately 89,000 public schools across the country, comprehensive, full-service clinics are relatively new and innovative. The first school-based health center (SBHC) to provide comprehensive medical and mental health screening and treatment opened in Dallas, Texas, in 1970. By 1985, there were 50 such programs and, at last count, there were over 1,300 SBHCs in 45 states – a 24-fold increase in just 15 years. The median annual cost of operating a center is approximately $213,000.

School based health centers receive funding from many sources, including federal grants (e.g., through the Healthy Schools/Healthy Communities program funded by the Bureau of Primary Health Care), state and local monies, philanthropic funding and third party reimbursement. However, state dollars have consistently been the largest single source of funding for school-based programs; 21 states allocated an estimated $30 million in general funds in Fiscal Year 1998 for comprehensive school health services. Some states, such as New York, make significant general fund appropriations to their school health program. Other states, such as North Carolina, rely more heavily on a combination of philanthropic funding and local support, although they too receive financial support from their legislatures.

New York has been the national leader in offering comprehensive health services in schools, with 159 school-based health centers. The vast majority of these programs are located in urban elementary schools. The state government has made a significant commitment to school health by providing approximately $10 million annually in state grants (funded in part from Maternal and Child Health grants). Awards are made annually, based on a competitive application and review process. Another $12 million comes almost equally from Medicaid revenues and in-kind support. Local programs also receive some support from other sources including philanthropies and local government.

North Carolina has one of the largest school-based health center programs in the southeastern U.S. Its General Assembly appropriates $1.5 million annually to support the program, with significant additional financial support from local philanthropies and local governments. In addition, one of the state's larger philanthropies, the Duke Endowment, has invested several million dollars over a three-year period. These funds support 50 SBHCs statewide. Most of the remaining schools in North Carolina have on-site nurses funded by the school systems, the health departments and local hospitals. Local communities have great latitude in shaping their programs and seeking funding to support them. The state Department of Health and Human Services coordinates and monitors both the school nurses and the SBHCs.

SCHOOL HEALTH IN GEORGIA



According to a school nurse survey conducted in 1997, 54% of the 180 school systems in the state had school nurses. These 231 nurses covered 927 schools. They range from part-time nurses who visit several schools in a district to full-time nurses who participate (with physicians) in either expanded or comprehensive school health programs. Only 14% of school nurses in the school nurse survey reported visiting each school within their system on a daily basis.

Public health departments, hospitals, boards of education, boards of health, Family Connection programs, as well as local and national philanthropies support these programs. In some communities, all of these entities cooperatively support local school health services.

The Division of Public Health has been heavily involved in school health activities. Along with supporting many school nurse programs in the health districts, the state awards approximately $1 million in grant-in-aid monies each year to five school health programs in Savannah, Dublin, DeKalb County, Waycross and Gainesville. These programs support a broad array of services to children and adolescents in schools. Additional health districts have contractual arrangements with local school districts to manage and oversee their school health activities. The Northwest Health District of the Division of Public Health is one example. With 32 nurses working in four county school systems – Chattooga, Floyd, Gordon and Catoosa – the program takes a population-based prevention approach rather than providing extensive direct clinical services. Nurses work with teachers, students, parents and staff to foster physical activity, nutrition, a healthy school environment, and healthy behaviors. As part of their duties, nurses are also heavily involved in their communities in order to build strong ties with parents and provide a stronger base of resources for the children. On the clinical side, nurses treat children with special needs in the schools and refer others to public health adolescent health clinics, mental health providers and private physician's offices. The nurses also provide some basic school health activities in the school, including hearing and vision screening. These school nurse activities in the Northwest Health District are funded jointly by county boards of health, several hospitals who contribute Indigent Care Trust Fund dollars, and monies from the Governor's recent appropriation.

Support for school health in Georgia comes from public health departments, hospitals, boards of education, boards of health, Family Connection programs, and philanthropies.

The Department of Community Health has actively supported school nurses

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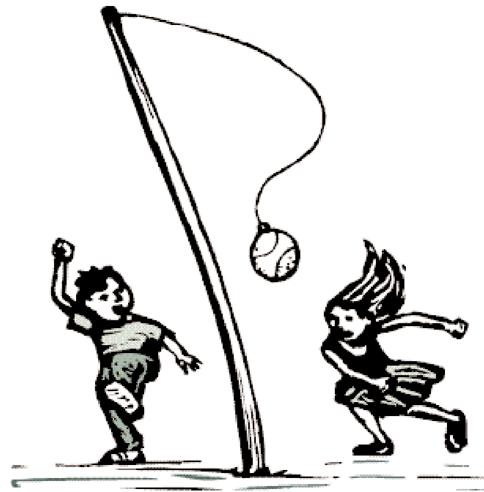
LOOKING TO THE FUTURE

Existing local partnerships and collaboration serve as a strong base for expanding school health services to all Georgia's children, particularly those who are economically disadvantaged. As further impetus, the State of Georgia recently committed $30 million towards the hiring of school nurses. Although not sufficient to place a nurse in every school, this annual funding offers a unique opportunity to shape the future of health care delivery for Georgia's school-age children. In appropriating these monies, the Governor pledged to give local communities flexibility in determining how best to use their portion so that the needs of their residents' children were met most effectively.

Creative partnerships between local communities and philanthropies are needed to influence policy on the development of effective programs to provide health care services in schools. In Georgia and throughout the country, successful school health programs have been sustainable over time when they receive financial support from both government and philanthropic organizations. Such collaborative funding has helped school health programs purchase medical supplies, pay for provider salaries, build physical infrastructure, and gain access to physician supervision. Generous community and philanthropic support has also helped to support two requisite elements of strong school health programs – building local collaboration, especially with the school system, and engaging parents as full partners in the creation of programs that meet their children's needs. Once established, school health programs can have the added benefits of leveraging community goodwill and giving entrée to address a wider range of local issues affecting child well-being.



Successful school health programs have been sustainable over time when they receive financial support from both government and philanthropic organizations.

The benefits of school-based health programs are clear. They provide a practical and low cost method for ensuring the health of Georgia's most precious resource – our children – and for setting them on a positive course of lifelong growth and development. Further exploration is needed to shape the role that Georgia's philanthropic community can play in meeting the opportunities and challenges that school health presents.

KEY QUESTIONS FOR FOUNDATIONS

What role can Georgia's philanthropic community play in helping to implement basic school health nurse programs throughout the state?

How can the philanthropic community support expansion of basic school health programs to encompass a more comprehensive array of services, tailored to meet localized needs?

Does the philanthropic community have an interest in sustaining school health programs over time?

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through its work with schools to bill for Medicaid services and through the encouragement of hospitals to use their 15% share of Indigent Care Trust Fund dollars for school health purposes. Seventeen hospitals contribute approximately $1,500,000 to support school health programs in their communities.

Foundations have been the impetus for several nationally recognized programs. One of the oldest programs is in the predominantly rural area of Waycross. Started in 1986 with seed funding from the Robert Wood Johnson Foundation, this program is run by the local health department in collaboration with the local school system. Nurses in elementary, middle and high schools provide medication assistance, acute care, and health education and make referrals to local providers for mental health and substance abuse services. Another program, the Whitefoord School Health Center, lies in an economically depressed area of Atlanta. Whitefoord was started six years ago through a partnership between the Zeist Foundation and the Department of Pediatrics at Emory University. It is now a full-service, comprehensive clinic that provides preventive and acute outpatient services, ancillary services, dental services and mental health services. Given annual funding from the Bureau of Primary Health Care, the program also receives substantial funding from local philanthropies and Medicaid reimbursement.

Family Connection programs, located in approximately 151 Georgia counties, have facilitated a community-based focus on health-related concerns among school-age children. Many school health programs have emerged from this initiative, with over 30 communities throughout the state having a school health focus.

NOTES

[1] Annie E. Casey Foundation KidsCount 2000 website.
[2] Current Population Survey data from 1997, 1998, and 1999, calculated by William Custer and Pat Ketsche, Georgia State University; Department of Community Health, PeachCare for Kids program, July 1, 2000 enrollment numbers.
[3] Custer, William and Pat Ketsche, "Children in Georgia by Poverty Group, Age, and Location," Center for Risk Management and Insurance Research, Georgia State University, 2000.
[4] Newacheck, P.W., et al., "Children's Access to Primary Care: Difference by Race, Income, and Insurance Status," *Pediatrics* 97,1996:26-32.
[5] www.childrensdefense.org/health_keyfacts.html
[6] www.cdc.gov/nccdphp/dash
[7] www.gsu.edu/`mtg/FS/fsneed.html
[8] McCord, MT, et al., "School-based Clinic Use and School Performance." *Journal of Adolescent Health* 12, 1993:91-98.
[9] Georgia Oral Health Initiative, Division of Public Health, Department of Human Resources.
[10] Santelli, J, A Kouzis, and S Newcomer, "School-based Health Centers and Adolescent Use of Primary Care and Hospital Care." *Journal of Adolescent Health* 19, 1996:267-275.

The Georgia Health Policy Center is coordinating the work of the Philanthropic Collaborative.
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