THE EDUCATION SECTOR:

Affordable Care Act Opportunities to Improve Public Health

Produced by Health Resources in Action for the Maricopa County Department of Public Health (MCDPH)

Background

The federal **Patient Protection and Affordable Care Act (ACA)** represents a major expansion and regulatory overhaul of the U.S. health system that aims to increase the rate of insurance coverage, contain the unsustainable rise in health care costs, and improve health care quality and outcomes through a number of mechanisms that are currently being rolled out over the course of several years. Through the ACA, an estimated 1.3 million currently uninsured Arizonans are expected to enroll in either the Arizona Health Care Cost Containment System (AHCCCS, Arizona's Medicaid system) or private insurance exchanges through an Insurance Marketplace. While insurance coverage and subsequent demand for primary care and prevention services are anticipated to rise, approximately 650,000 Arizonans will remain uninsured and will continue to rely on safety net providers as well as public health services.

With the ACA's emphasis on expanding health care access, improving quality of care and health outcomes, as well as promoting the role of prevention and population health in controlling costs, there are many opportunities for public health to help shape the development of a more effective health system in Arizona. To that end, the Maricopa County Department of Public Health (MCDPH) commissioned a number of reports and briefs that will help them better understand what opportunities they have for supporting health care providers, payers, and businesses as they collectively seek to navigate a new and effective health system landscape. This brief is intended for the school or education sector to highlight new opportunities to partner with health departments to foster a healthier population and more effective health system. A longer technical report goes into greater detail about all of these subjects.

Promotion of Healthy School Populations through the ACA

Children and school employees spend most of their days in school; thus, schools can play a significant role in promoting health and preventing chronic disease in ways that improve students' academic performance, enhance employees' readiness to work, and reduce health care costs for both children and adults. ACA provisions that are relevant to schools include enhancing the effectiveness of School Based Health Centers and Coordinated School Health Models, addressing healthier school environments, and linking students and staff to expanded insurance coverage and preventive benefits.

BACKGROUND ON SCHOOL-BASED HEALTH CENTERS (SBHC)

The ACA aims to increase access to clinical and community preventive services through the expansion of SBHCs. Currently, 82% of Arizona children using SBHC services are uninsured and receive services free of charge or on a sliding scale.[1]

In Maricopa County, SBHCs are located in Granada Primary serving Alhambra School District, Lowell Elementary, Marc T. Atkinson School, Educare School, Palomino Elementary serving Paradise Valley Unified School District, Arthur M. Hamilton, and Chris-Town YMCA Community Health Center (serving seven districts and communities) in Phoenix, Chandler CARE Center at Galveston Elementary in Chandler, Isaac E. Imes Elementary in Glendale, Mesa Education Center in Mesa, Paiute Neighborhood Center (serving

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Scottsdale Unified School District and Orangedale Elementary) in Scottsdale, and Banner Children's HealthMobile in Mesa.

SBHCs provide developmentally appropriate and comprehensive health services to youth regardless of their insurance coverage or ability to pay. These services can include some or all of the following services: primary medical care, mental/behavioral health care, dental/oral health care, health education and promotion, substance abuse counseling, case management, and nutrition education.[2] While students are treated for acute illnesses at SBHCs, SBHCs also emphasize prevention, early intervention, and risk reduction.

The ACA defines a SBHC as a health clinic that is[3]:

- Located in or near a school facility of a school district or board, or of an Indian tribe or tribal organization;
- Organized through school, community, and health provider relationships;
- Administered by a sponsoring facility (e.g. a hospital, public health department, community health center, nonprofit health care agency, local educational agency, or a local program administered by the Indian Health Service of the Bureau of Indian Affairs or operated by an Indian tribe or a tribal organization);
- Provides primary health services by health professionals to children in accordance with state and local law; and,
- Satisfies any other requirements that states may establish.

SBHCs are most frequently sponsored or operated by a local health care organization; in the U.S., 28% are sponsored by community health centers, 25% by hospitals, 15% by local health departments and 12% by a school system.[4] The sponsoring agency typically leads the administrative operations and partners with community health and wellness practitioners to provide services outside of their agency's scope of activities (e.g. a medical lead organization contracting with a local mental health provider to provide on-site services).

SBHCs can function in a variety of ways. In some communities, the SBHC is located, and serves, a single school campus. Other SBHCs may be located on one campus but serve other nearby feeder schools. With "school-linked" services, a provider may periodically visit a school to conduct screenings and educational sessions with follow-up visits occurring in their usual clinic setting.

The majority of SBHCs bill public insurance programs, including Medicaid (81%) and SCHIP (State Children's Health Insurance Program; 68%), private insurance (59%), and students or families directly (38%).[4] In addition to insurance billing, most SBHCs have diversified funding sources. In Arizona, funding is provided by hospitals, public and private foundations, the federal government (including Indian Health Service), and school districts.[1]

Billing insurance for SBHC services comes with challenges. Even with the ACA, many SBHC users, such as uninsured youth (e.g. those from undocumented or some immigrant families), will remain uncovered and have limited payment options. Also, SBHCs struggle to bill insurance for the following reasons: SBHCs are not a student's designated primary care provider; patients are enrolled in multiple public and private health plans; there is not sufficient staff to bill for services and monitor outstanding payments; and, the many educational and preventive services performed (e.g. case management, health education, and teacher consultation) are often not within the scope of a billable visit.[4]

The ACA has two funding provisions specific to SBHCs:

- A one-time, mandatory appropriation of $200 million in federal funds to SBHCs from 2010–2013 for the SBHC Capital Program (SBHCCP); and,
- Authorization of a federal grant program for SBHC operations.

Between fiscal years 2011–2013, $189 million in SBHCCP funds were awarded to 520 U.S. SBHCs to support capital investments (e.g. acquisition and improvement of land, construction costs, purchasing licenses for electronic medical records, etc.) and improve and expand SBHC services.[3,5]

By December 2012, almost $1.8 million in capital grants were awarded to four Arizona applicants, none of which were in Maricopa County.* To date, no formal appropriation has been established for SBHC operations grants.

The ACA promotes healthy and safe community and school environments through workplace wellness efforts and community based initiatives supported by Community Transformation Grants, the National Prevention Council, and the Prevention and Public Health Fund.

Strategies for Schools to Promote a Healthier School Environment

There are a number of ways that schools can maximize the health of their population utilizing these new ACA opportunities and by partnering with their local and state health departments:

INCREASE AND PROMOTE ACCESS TO SERVICES THROUGH SCHOOL-BASED HEALTH CENTERS

School-Based Health Centers are critical to providing health care, promoting disease prevention, and reducing health disparities for underserved and vulnerable youth. MCDPH and their partners have an important role to play in ensuring that SBHCs continue to provide these services effectively and efficiently. These opportunities include:

- **Strengthening the infrastructure and utilization of SBHCs.** SBHCs can be the necessary link between health and education systems to improve preventive and primary care for newly insured and uninsured young people.[4] SBHCs will remain important safety net providers and serve as an entry point and source of primary care, while facilitating ongoing connections to a health home for children who do not otherwise have access to consistent care.[4,9] MCDPH can work with SBHCs to prepare them for the likely influx of patients due to insurance expansion. Furthermore, MCDPH can offer training programs for school staff by helping them to understand and explain ACA provisions that promote health access and point families to appropriate insurance coverage, preventive benefits, and primary care providers.

- **Providing information and referral.** MCDPH can work with SBHCs and other district and school staff to educate families within the school community about new Medicaid and private Insurance Exchange coverage options and benefits, as well as the new preventive benefits through the ACA. MCDPH can also equip staff to facilitate family enrollment and provide referrals for other services. In collaboration with MCDPH and other partners, schools can send culturally competent information to families and refer them to hotlines and other agencies or services for more detailed information and support.

- **Integrating SBHCs into new models of care: Patient Centered Health Homes and Accountable Care Organizations (ACOs).** The ACA's emphasis on enhancing the role of primary care through the Patient Centered Health Home model provides an opportunity for SBHC integration into systems of care in the community.[4,8] This is important, as SBHCs are only open during school hours and not accessible after school and during holidays and vacations. MCDPH can facilitate this integration process by working with SBHC sponsoring organizations and providers to link SBHCs to relevant community based services and partnerships that serve children and adolescents. Thus, even if youth receive the majority of their care through the SBHC, the SBHC can teach youth and families to access care through a health home and link them formally with a primary care provider.[5] Furthermore, SBHCs provide an ideal setting for community health providers to offer services such as screenings, health education, and health promotion activities, and MCDPH can help SBHCs identify providers and public health practitioners to engage more on school campuses.

* *Health homes are designed to be person centered systems of care that facilitate access to, and coordination of, the full array of primary and acute physical health services, behavioral health care, and long-term community based services and supports. The health home model of service delivery expands on the traditional medical home models that many states have developed in their Medicaid programs by building additional linkages and enhancing coordination and integration of medical and behavioral health care to better meet the needs of people with multiple chronic illnesses. The model aims to improve health care quality and clinical outcomes, as well as the patient care experience, while also reducing per capita costs through more cost-effective care.[8]*

The ACA also promotes ACOs as a model of care to increase the efficiency and effectiveness of health care delivery. MCDPH should advocate for ACOs to incorporate SBHCs into their practices to avoid duplication of services, promote continuity and efficiencies and comprehensive care, and improve the health outcomes of beneficiaries. If SBHCs are recognized as part of an ACO — and if they can document their effectiveness in promoting the health and wellness of their enrollees through care delivery — they could potentially obtain part of the reimbursement that the health system receives from the insurance company.[4]

- **Health Information Technology (HIT) and evaluation.** HIT and Health Information Exchange (HIE) efforts should be integrated into the SBHCs infrastructure. The Louisiana School Health Connection, developed in 2008, successfully established an electronic medical record (EMR) system for SBHCs in Greater New Orleans.[11] This EMR management system resulted in systematized data collection and sharing with other SBHCs, safety-net providers, and school district personnel, allowing for better continuity of care and standardized recordkeeping (thus bolstering revenue and system sustainability through integrated and coordinated billing). To accomplish this, an advisory committee was convened to recommend data to be collected, vendor(s) to select, and methods for training clinic staff.

  MCDPH can work with SBHCs to develop an EMR system or other HIT infrastructure. Possible roles could include serving on an advisory committee, training clinic staff on HIT systems utilization, facilitating the exchange of data between SBHCs, student health homes and other community based providers, and information sharing to document best practices and SBHC innovations. Furthermore, MCDPH can also perform data collection and analyses to document the impact of SBHC services on health and educational outcomes and calculate the return on investment for prevention initiatives.

- **Financial sustainability.** At this point, the SBHCCP grants have been exhausted and there are no federal funds allocated for SBHC operations grants. Regardless, MCDPH and SBHCs should partner and prepare to apply for potential future public funding opportunities as well as seek out private ones. For example, in addition to tracking quality measures, MCDPH can work with SBHCs to track the cost of their programs and develop a SBHC specific business plan using the National Assembly on School-Based Health Care Cost Survey Tool.[10]

  Furthermore, with the expansion of insurance coverage through the ACA, more students will be seen at SBHCs. This increase in demand for services will require financial resources; MCDPH should work with SBHCs to prepare for the increase in patient volume and help SBHCs develop systems for billing Medicaid and commercial insurers to maximize resources. In 2007, the School-Community Health Alliance of Michigan (SCHA-MI) received a grant to establish a centralized billing and reporting system that tracked clinical and financial data and enabled SBHCs to bill both public and private insurers for covered services.[13] These funds were utilized to purchase software and licensing fees, hire billing staff, and train SBHC staff. SCHA-MI coordinates the centralized billing system and revenue distribution to SBHCs. This effort built on another pilot project that provided centralized billing to 18 MI SBHCs from 2003 through 2005, earning over $90,000 in additional revenues for participating centers and streamlining the billing process.

  Given the requirement that insurers cover the ACA's preventive care mandates and essential health benefits, MCDPH can also educate SBHCs on new services that are reimbursable.

Promotion of Healthy and Safe School Environments and Workforce

The ACA provides opportunities for MCDPH and its partners to work with schools to create healthy school environments. These opportunities include the following:

- **Implement principles of the National Prevention Strategy.** One of the four strategic directions under the National Prevention Strategy (NPS), developed by the U.S. Surgeon General, is the promotion of healthy and safe community environments through improving the quality of air, land and water.

As many school buildings are crumbling and thus contributing to poor indoor air quality and unsafe physical environments, MCDPH can work with schools and/or local coalitions engaged with schools to implement and enforce policies and practices recommended by the NPS. These include eliminating safety hazards; ensuring that buildings are free of water intrusion, indoor environmental pollutants, and pests; performing regular maintenance of heating and cooling systems; reducing exposure to pesticides and lead; ensuring that drinking water sources are free from bacteria and other toxins; and, implementing and enforcing tobacco-free policies.

For example, the Massachusetts Department of Public Health's Asthma Program funds and supports the Boston Healthy Homes and Schools Coalition to work with Boston Public Schools to address policies that not only promote better asthma management, but also creates systems, policies, and staff trainings to address indoor air quality problems. MCDPH can also work with schools to utilize best practices such as the U.S. Environmental Protection Agency's Indoor Air Quality *Tools for Schools* program which provides a framework for schools and school districts to systematically implement evidence-based strategies to improve environmental health in their buildings.

Additionally, the NPS specifically calls on schools to focus on the following key strategies to create a healthy school environment[12]:

» Tobacco-free living through tobacco-free environments and restrictions on marketing and promotion of tobacco products to children and youth;

» Prevention of drug abuse and excessive alcohol use through policies and programs targeting students and parents;

» Healthy eating by increasing the availability of healthy foods, limiting access to and marketing of unhealthy foods and beverages, and providing nutrition education (this aligns with implementation of the Healthy, Hunger-Free Kids Act of 2010/HHFKA);

» Active living by increasing opportunities for physical activity, supporting biking/walking to school (e.g. Safe Routes to School), limiting passive screen time, and making school physical activity facilities available to the local community (e.g. joint use programs);

» Injury- and violence- free living by promoting seat belt and helmet usage, driving without distractions nor under the influence, and implementing policies that reduce school violence and crime (e.g. classroom management practices, conflict resolution, etc.);

» Reproductive and sexual health through developmentally appropriate, medically accurate, and evidence-based sexual health education, supporting teen parenting programs and assisting parents in completing high school, providing reproductive and sexual health information and services, and promoting healthy relationships;

» Mental and emotional wellbeing through bullying prevention; promotion of social connectedness; identification of risks and early indicators of mental, emotional and behaviors problems; and guaranteed youth access to mental health and counseling services.

To implement the recommendations from the NPS, MCDPH can conduct an audit of school environments to identify opportunities to promote a comprehensive culture of health.

MCDPH can also work with School Wellness Advisory Councils to embrace key policies and practices consistent with the NPS and promote their adoption by school administrations and school boards. Finally, MCDPH can work with schools and the school district to ensure that health provisions from related school health legislation, such as federal school meal and child nutrition standards from the HHFKA, are integrated into this comprehensive approach. In addition, summer food programs sponsored by the USDA are important ways to keep low-income children healthy when schools are out of session. Partnering with school systems to establish programs and obtain reimbursements for meals can help keep children healthy all year long.

- **Expand Implementation of the Coordinated School Health (CSH) model.** CSH embodies the NPS goals for school health and focuses on supporting student wellness and learning via eight domains: health education, physical education, health services, nutrition services, counseling/psychological/social services, healthy school environment, and health promotion for staff and family and community.[15] Since 2008, the U.S. Centers for Disease Control and Prevention (CDC) has funded Coordinated School Health in 22 states and one tribal government, including Arizona. To support CSH, MCDPH promotes the utilization of the CDC's School Health Index to help schools assess how they can improve health and safety policies and programs. Furthermore, MCDPH prioritized the creation of healthy school environments through School Health Advisory Councils, School Health Improvement Plans, parental involvement, and training in its 2012–2017 Community Health Improvement Plan.[14]

  As CSH funding comes to an end, MCDPH can focus its attention on strengthening and expanding its multi-sector coalition of education leaders, community based organizations, employers, and health care systems to design strategies to measure the impact of CSH efforts, and seek funding to sustain and replicate best practices in school sites. Partners can continue to promote components of CSH, such as School Wellness Plans mandated by the 2004 Child Nutrition and WIC Reauthorization Act and new HHFKA requirements for Plans.

- **Engage schools as active members of multi-sector collaborations for health improvement.** MCDPH should continue to engage schools in multi-sector meetings with other governmental and community partners in a coordinated effort to get at the root causes of disease and make the healthy choice the easy choice. This was done successfully in Boston, MA through the Communities Putting Prevention to Work (CPPW) funding awarded to the Boston Public Health Commission (BPHC). BPHC contracted with Boston Public Schools (BPS) and nonprofit organizations to engage youth and adults in school- and district-wide policy change efforts to promote health. These efforts, which engaged diverse stakeholders including parents, teachers, students, principals, and representatives from BPS operations departments, ranged from incorporating salad bars into school cafeterias to creating a new tobacco-free environment policy that banned the use, consumption, display, and promotion of all tobacco products and nicotine delivery devices on and within 50 feet of school property.[15] Youth engagement was critical to the success of these initiatives, as youth often identified health concerns and practical solutions that would positively impact their peers. As new funding opportunities such as Community Transformation Grants emerge, MCDPH should continue to engage multi-sector partners — including youth — to tackle policy, systems and environmental change initiatives to promote health.

- **Offer strong employee wellness programs and provide a healthy workplace.** MCDPH can work with schools, through its Healthy Arizona Worksite Program, to ensure student health efforts are ex tended to staff through workplace wellness programs and policies. Providing staff with opportunities for physical activity and healthier food in cafeterias and vending machines, and establishing healthy outdoor (e.g. bus and car idling policies) and indoor air quality (e.g. integrated pest control) policies will benefit employees and students alike. MCDPH can share best practices and new research developments around healthy eating, active living, and IAQ policies; promote the utilization of programs and tools such as *Tools for Schools*; work with schools to conduct environmental assessments; and, provide suggestions for appropriate strategies to address identified concerns. In addition, schools can develop worksite wellness programs in partnership with MCDPH as part of the Healthy Arizona Worksite Program. MCDPH can provide consultation and technical assistance to schools on establishing evidence-based employee wellness programs that create a culture of health in worksites.

- **Promote insurance coverage addressing Essential Health Benefits (EHB) and preventive services.** While the majority of employer sponsored insurance plans will comply with the ACA's preventive care mandates and EHB package, plans that are grandfathered (plans that went into effect on March 23, 2010 or earlier and meet specific criteria) do not need to comply.[16,17] Healthcare makes up 8.5% of total employer costs for each worker nationally.[18]

Thus, in order to reduce health care costs and promote employee health, MCDPH can encourage school employers to phase out grandfathered plans that currently do not meet the provisions of the ACA. Instead, MCDPH can encourage them to offer plans that robustly cover preventive and wellness services along with all of the other Essential Health Benefits required of qualified health plans that belong to the Insurance Marketplace. MCDPH can also provide consultation to schools or municipalities that purchase insurance on behalf of school departments by emphasizing the cost-effectiveness of insurance coverage that promotes prevention.

In addition, MCDPH can train school personnel to promote employee utilization of preventive services by helping them understand the cost-free health benefits.

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