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Linda Juszczak

December 22, 2008

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President-Elect Barack Obama
451 6th Street, NW
Washington, DC 20002

Dear President-Elect Obama,

As your administration moves toward reaffirming its support for a health care safety net system, it is incumbent to include children and adolescents. Every day millions of youth are denied affordable, high quality health services. School-based health centers (SBHCs) provide access to comprehensive health and mental health care services where children learn and grow, strengthen health equity for our nation's most disadvantaged youth, and foster greater opportunity for learning readiness and academic success. You have been a long time supporter of SBHCs; the National Assembly on School-Based Health Care (NASBHC) looks forward to working with your administration on advancing federal support for this critical healthcare safety net provider. Allow us to provide you with some background on the model – its strengths and challenges.

Needs and Solutions

There are over 1,700 SBHCs in 44 states, DC, and Puerto Rico serving approximately 1,700,000 students. Yet, the need is much greater. There are 21 million adolescents, 95,000 schools, eight million uninsured children, 15 million children with mental health challenges, and 4,717 communities with health professional shortages in the United States. Because of their safe and familiar location in the child's school, SBHCs are an effective mechanism to provide patient-centered, professional care at little to no cost to the student, deliver essential preventive health services such as well child exams, health education, and immunizations, manage chronic diseases like asthma and diabetes, address mental health issues that complement special education, and reduce risks associated with health compromising behaviors. SBHCs can serve as both a medical home and a secondary access point.

Health inequities

SBHCs are located in schools with students from low income families and diverse ethnicities. These students are at greater risk for physical and mental healthcare inequities and may have limited access to health care for a variety of reasons. Low income levels are associated with higher risks for suicide, smoking, excess alcohol consumption, depression, obesity, and other common behavioral risk factors among youth. 11% of all children lack health insurance and that percentage jumps to 19% among poor children. SBHCs, perfectly positioned to combat these health inequities, are an essential part of public health solutions that assure health care access for all children and adolescents.

Increased utilization and health outcomes

SBHCs serve as a resource to school administration to select and deliver health education curricula and services that are culturally sensitive and responsive to risk factors prevalent in the community. Students more frequently access care and are more likely to engage in active, age appropriate participation in health care and prevention activity decisions when there is a health clinic on or near campus. Studies show that students are more willing to seek counseling and information on nutrition, weight problems, pregnancy prevention, and general disease checks. SBHCs provide on-site preventive and primary health care to their students and have shown

success in providing critical mental health and high-risk behavior screenings to minorities, males, and other hard-to-reach communities. Adolescents are ten-21 times more likely to come to a SBHC for mental health services over their community health center or HMO and students who reported depression and past suicide attempts also demonstrated greater willingness to seek counseling in a SBHC.

Cost savings

SBHCs provide a cost savings to the overall health care system. Studies across the country show that SBHCs reduced inappropriate emergency room (ER) use among students that regularly used SBHCs. ER visits are among the highest health care costs in the safety net. These savings impact public health insurance costs for non-emergency care. A study of SBHC costs by Emory University School of Public Health attributed a reduction in Medicaid expenditures related to inpatient, drug, and emergency department use to use of SBHCs.

Academic success

SBHCs, many of which are in Community Schools/Full Service Schools, increase a student's readiness to learn by decreasing absenteeism and tardiness, suspensions and disciplinary action, and other interferences with learning, prompting increased parental involvement, and assisting special education programs. When children are healthy, they attend school more regularly and are more attentive in class. A study by the Dallas Youth and Family Centers found that medical services provided by Dallas SBHCs contributed to a 50% reduction in absenteeism among students who had three or more absences in a six-week period. Moreover, there was an 85% decline in school discipline referrals among students that received mental health services. SBHCs provide a safe place for students to deal with troubling issues such as suicide, grief, substance abuse, sexuality, violence, bullying, peer pressure, and family relationships.

Adolescent health services

SBHCs incorporate principles and practices of adolescent health care recommended by the American Medical Association, the American Academy of Pediatrics, and the American Association of Family Physicians. These health advancements are aligned with the Healthy People (HP) 2010 child and adolescent health objectives to reduce mortality, unintentional injury, violence (including suicide), pregnancies and sexually transmitted infections including HIV, expand the proportion of children receiving treatment for mental health problems (including substance use), and increase prevention of chronic disease (including reducing tobacco use and decreasing obesity).

Challenges

SBHCs experience difficulty integrating and sustaining a comprehensive scope of services due to inadequate funding. There is no specific federal funding program for SBHCs. For example since the proliferation of Medicaid managed care, SBHCs have had greater difficulty being recognized as Medicaid service providers. Even when the clinics are recognized as providers, services outside of the traditional doctor-patient visit are not reimbursed by the Medicaid program. These services are central to the success of the model and are identified by sponsors and insurers alike as the model's added value.

Due to insufficient long-term funding from public health and patient revenue, and decreasing insurance coverage among the school-aged population, SBHCs struggle to keep their doors open. Federal policy must recognize and support SBHCs as part of the national health care safety net through reimbursement under the State Children's Health Insurance Program (SCHIP) and Medicaid and a SBHC Authorization.

In the majority of states, SBHCs face state policy barriers that shut them out of SCHIP and Medicaid reimbursement for services delivered to enrollees. Despite the fact that every SBHC in the country sees SCHIP enrollees, only one in four receive any reimbursement from their state SCHIP program.

Solutions for sustainability and increased access

SBHCs need to be recognized providers under Medicaid and the SCHIP for enrolled school children and adolescents. **Mandated SCHIP payments for SBHC services would provide an**

excellent solution to the systemic barriers that impact health outcomes in this vulnerable population; greatly increase chances for academic success; and provide significant economic benefits. Without mandatory funding sources, this valuable health care delivery model may be discontinued in some communities, leaving many children and their families without a safety net.

You supported this solution as an original co-sponsor of S.1669. We encourage you to continue your support.

Additionally, SBHCs can achieve sustainability through the establishment of an authorized federal program that will enable SBHCs throughout the country to provide primary health and mental health services to greater numbers of children in our nation's schools. All states with limited access to health care would benefit greatly from the services provided by an increased number of SBHCs. NASBHC advocated for the passage of S. 600/ HR. 4230 in the 110th Congress and will pursue an SBHC authorization again in the 111th Congress. The vehicles for its passage can be as part of a larger health care reform package or as independent legislation.

Expanding SBHCs nationwide will require a significant investment, a strong desire from the school and the community, and most importantly, the political will at the local, state, and national level to support the endeavor. We have seen the field enthusiastically embrace advocacy work, and the broad coalition of legislative champions at the local, state, and national level is building every day. With your appointment of SBHC supporter Arne Duncan as Secretary of Education, we are enthusiastic that there are opportunities to bridge education and health care to promote a shared agenda for our nation's youth. We are confident that the momentum of the school-based health care movement will continue to grow so that we can achieve our vision of all children and adolescents achieving at their full potential. It is our hope that the you and your administration will join us in this vision toward building an effective health care safety net that will reach all of our nation's children.

Sincerely,



Linda Juszczak, DNSc, MPH, CPNP
Interim Executive Director
National Assembly on School-Based Health Care

cc: Arne Duncan
Secretary of Education, Designate

Senator Tom Daschle
Secretary of Health and Human Services, Designate

Enclosed: Correspondence between Senator Obama and NASBHC