

Expanding School Based Health Centers in Pennsylvania

PA Senate Democratic Policy Committee Hearing

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Testimony

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My Background

I am Assistant Professor of Public Policy in the School of Public Policy at The Pennsylvania State University. I recently completed my term as a Fellow in the Interdisciplinary Research Leaders Program, a national leadership development program supported by the Robert Wood Johnson Foundation to equip teams of researchers and community partners in applying research to solve real community problems, and I was also part of the inaugural cohort of the American Enterprise Institute's Emerging Poverty Scholars program. The overarching focus of my work has been on the politics and policies surrounding health access issues. Within this theme, I have mostly focused on health access for vulnerable populations, the impact of provider networks on health access, and school-based health access. My work on school-based health, which has been partially funded by three grants from Robert Wood Johnson Foundation, has explored school-based health centers in rural Appalachia, a region confronting countless health and access challenges while being home to a disproportionate number of SBHCs. Other work explores how

local political and healthcare environments shape the emergence and sustainability of SBHCs, as well as how SBHCs shape access to crucial health services for vulnerable children during and post-COVID-19. Prior to my academic career, I worked on issues related to health care access, including the implementation of telemedicine projects, improving farm worker health care, and uninsured children, for Fresno Healthy Communities Access Partners and Central California Legal Services. Lastly, I am married to an elementary school teacher, which provides me with important insights from inside the classroom that enhance my understanding of children's needs and challenges.

Background on School-Based Health Centers

Debates about the appropriate degree of intermixing between education and healthcare in the U.S. have been with us for a long time (Fisher, Danza, McCarthy, & Tiezzi, 2019; Jackson, 1969). This is somewhat surprising as the predictors of poor health and low educational outcomes significantly overlap indicating potential policy synergies across the two sectors (Richardson & Juszczak, 2008; Sprigg, Wolgin, Chubinski, & Keller, 2017). Historically, calls for expanding services provided to students in their educational setting first became pronounced during the Progressive Era with its focus on social improvements. These prominently included a focus on public health and education (Tyack, 1992). Unsurprisingly, reforms in the healthcare sector were also part of the reforms advocated for and partially implemented by Progressive reformers (Tyack, 1992). At times, boundary spanning policy solutions emerged. For example, local physicians visited schools in Boston, MA regularly before the turn of the twentieth century to improve student health, while New York City initiated its rudimentary school health program in 1892 (Ryan, Jones, & Weitzman, 1996). Given public health concerns at the time, most school-based health initiatives focused on the identification and containment of communicable diseases (Dunfee, 2020). Confronted with significant opposition by organized medicine (Morone, Kilbreth, & Langwell,

2001), most of the earlier programs in schools utilized a “screen and refer” system that pushed treatment outside of the confines of the school building, and thus preserve the prerogative of organized medicine, or focused on health education over the direct provision of services (Lear, 1996, 2011).

Yet it was not until the 1960s that a concerted effort emerged to address the growing problems of inadequate access to medical services and growing teenage pregnancy rates at the place most children spend most of their day: their school (Dunfee, 2020). On the one hand, this meant increasing the number of dedicated school nurses (Lear, Barnwell, & Behrens, 2008; Lear, Gleicher, St. Germaine, & Porter, 1991). However, in most states, school nurses have generally been limited to mostly episodic care and medication administration (Schainker, O’Brien, Fox, & Bauchner, 2005). Nurses were joined by other professions providing limited school-based health services such as psychologists, social workers, and counselors (Lear et al., 2008). With health services so limited, more comprehensive efforts emerged in some places in the form of SBHCs. These centers were generally run by private organization and began to offer primary care services and, at times, vision, dental and mental health care as well; in some cases they even began to offer reproductive health services (Love, Schlitt, Soleimanpour, Panchal, & Behr, 2019; Morone et al., 2001). Over time, the number of SBHCs grew, first slowly to 31 in 1985, and then faster, reaching 1,135 by 1999 and more than 2,500 in 2019 (Love et al., 2019). Today, SBHCs differ widely in terms of operations, ownership, and services provided to students (Dunfee, 2020; Keeton, Soleimanpour, & Brindis, 2012). Yet even today a mere 6.3 million students, or 8 percent of the U.S. students, have access to SBHC care (Love et al., 2019). Recent growth has particularly benefited from funding included in the Affordable Care Act (Price, 2017). As part of the [Consolidated Appropriations Act, 2021](#), Congress enacted the [School-Based Health Centers](#)

[Reauthorization Act](#) of 2020, which extended authorizations for federal funding for school-based health centers through 2026. And recently, Senators Debbie Stabenow (D-MI) and Shelley Moore Capito (R-WV) [introduced the Hallways to Health Care Act](#), yet another bipartisan bill to expand federal funding for school-based health centers, including additional funding for behavioral health care in schools. The act would also fund demonstration projects to further explore the use of telehealth services in school-based health centers and would provide resources for technical assistance.

Benefits of SBHCs: Offering Solution to Important Problems

There is a growing acknowledgement of the effect that structural and systemic inequities have on Americans' lives. The educational (Sólorzano, Villalpando, & Oseguera, 2005) and healthcare systems (Bailey et al., 2017) are perhaps two of the most prominent cases that strikingly exemplify these barriers. The recent pandemic has only further highlighted if not exacerbated existing disparities (Hoffman & Miller, 2020; Lynch, 2020). Importantly, there is ample evidence of the existing and growing interactions between education and health at the individual as well as the systemic level (Anderson, Caseman, Haeder, Mathur, & Ulmen, 2020; Soleimanpour, 2020). Unsurprisingly, predictors of poor health are also predictors of low educational outcomes (Richardson & Juszczak, 2008). However, often the two spheres are not connected by policymakers or scholars alike. Yet, by definition, SBHCs sit at the very boundaries between both education and health (Love et al., 2019). Of course, schools serve as an excellent location for delivering healthcare services because the vast majority of Americans children and adolescents attend them 5 days a week, thus minimizing barriers like travel and parents' lack of paid time off. However, as mentioned above, even today SBHCs are only available to a small subset of students.

Despite their limited reach, the growing scholarly assessments of the effects of SBHCs are generally positive. Primary care and preventive services such as well-child visits and screenings are at the heart of all SBHCs. Primary care services in SBHCs are provided by a mix of physicians, physician assistants, or nurse practitioners. Students can make appointments or visit the health practitioner as needed during the school day. This eliminates the need to miss class time for students and the burden to take time off from work for parents. However, often SBHCs also facilitate referral to specialty care. Research has shown that SBHCs increase access to primary care and preventive services (Adams et al., 2020; Allison et al., 2007; Gold et al., 2011; Kaplan, Calonge, Guernsey, & Hanrahan, 1998; Keeton et al., 2012; Santelli, Kouzis, & Newcomer, 1996). SBHCs have also shows to improve the management of chronic conditions in students like asthma (J.J. Guo et al., 2005; Keeton et al., 2012), and they also serve as medical homes for some students (O'Leary et al., 2014).

SBHCs and other school-based health services have long been at the forefront of reigning in contagious disease through vaccinations, especially in accelerating the introduction of newly developed vaccines, increasing vaccination rates, and controlling school-related outbreaks (Kempe et al., 2012). Today, vaccinations are one of the more common services provided by SBHCs across the nation (Adams et al., 2020; Federico, Marshall, & Melinkovich, 2011; Keeton et al., 2012) (Allison et al., 2007; Federico, Abrams, Everhart, Melinkovich, & Hambidge, 2010; Haeder, 2021) and there is evidence that they have increased access to vaccinations (Allison et al., 2007) as well as vaccination rates, particularly for hard-to-reach populations (Adams et al., 2020; Federico et al., 2010). Because they have capacity for reminding and recalling students, they are particularly effective for multi-dose vaccines including the 3-dose HPV vaccine (Gold et al., 2011).

SBHCs also provide crucial access to mental and behavioral health services. Nationwide, behavioral health services are some of the most commonly sought services in SBHCs (Koenig et al., 2016; Walter et al., 1995). Importantly, there is evidence that behavioral health services offered in SBHCs have increased access as well as utilization,(Jeff J. Guo, Wade, & Keller, 2008; Santor, Poulin, LeBlanc, & Kusumakar, 2006; Silberberg & Cantor, 2008; Wolk & Kaplan, 1993) (Anglin, Naylor, & Kaplan, 1996; Flaherty, Weist, & Warner, 1996; Kaplan et al., 1998; Soleimanpour, Geierstanger, Kaller, McCarter, & Brindis, 2010) particularly for serious mental health issues (Amaral, Geierstanger, Soleimanpour, & Brindis, 2011). They are particularly important for children who otherwise would not seek care (Soleimanpour et al., 2010) or who have no access to care outside of their SBHC (Hoagwood & Erwin, 1997). There is also some evidence that SBHCs may improve mental health outcomes including decreases in reported depressive episodes, suicidal ideation, and suicide attempts (Paschall & Bersamin, 2018; Soleimanpour et al., 2010; Weist, Paskewitz, Warner, & Flaherty, 1996). At the same time, they may also contribute to lowering overall mental health costs (Jeff J. Guo et al., 2008). More generally, SBHCs have help improve academic outcomes (Brown & Bolen, 2008; Sisselman, Strolin-Goltzman, Auerbach, & Sharon, 2012).

The research on dental health services in the SBHC setting is limited overall indicated the limited provision of such services (Behrens & Lear, 2011). However, one study found improved dental outcomes (Keeton et al., 2012)

More generally, there is evidence that SBHCs provide significant benefits to students including increased access to and utilization of health services (Anglin et al., 1996; Flaherty et al., 1996; Jeff J. Guo et al., 2008; Kaplan et al., 1998; Santor et al., 2006; Silberberg & Cantor, 2008; Soleimanpour et al., 2010; Wolk & Kaplan, 1993) while some studies found improved health

(Knopf et al., 2016; Van Cura, 2010) and academic outcomes (Knopf et al., 2016). At the same time, both students and parents are highly satisfied with the provision of services (Santelli et al., 1996; Zarate et al., 2020). Unsurprisingly, SBHCs have also found strong support from educational and medical associations including the American Medical Association, the American Academy of Pediatrics, and the National Association of School Nurses (Lear et al., 1991).

One crucial contributions that SBHCs make is their role in providing more equitable health access (Knopf et al., 2016). Indeed, many studies find that the previously mentioned benefits of SBHCs particularly apply to marginalized population who generally face challenges access care in more conventional settings (Arenson, Hudson, Lee, & Lai, 2019; Keeton et al., 2012; Knopf et al., 2016; Zhang, Finan, Bersamin, & Fisher, 2018; Zhang, Finan, Bersamin, Fisher, & Paschall, 2020).

School-based health centers have confronted significant challenges during the ongoing pandemic. Institutional responses have been as diverse as school-based health centers themselves. As we learned as part of dozens of interviews of SBHC staffers as [part of a Robert Wood Johnson Foundation funded project](#) (Anderson et al., 2020; Simon F Haeder, Emily Maxfield, Kara Ulmen, & Sara Anderson, 2022) some closed and laid off their staffs. Others moved their operations to their more traditional clinical sites. Yet most tried to stay connected to their students by checking in on them via phone video calls. And once schools reopened, they were diligently to catch up students on missed preventive and mental health care. In research also indicates that school-based health centers can also play an important role in fighting the ongoing pandemic itself. Because school-based health centers have been shown to be particularly well-suited at increasing vaccination access and rates, they can be particularly helpful in vaccinating the remaining unvaccinated students going forward. Because of their existing relationships with students and

parents they may serve as trusted sources of medical advice and vaccine administration thus reducing vaccine hesitancy. They may also lower administrative burdens for parents wanting to vaccinate their children who lack the resources to do so. Perhaps equally important, because of their established legal relationships with school districts they can move quickly in places where they are already established and expansion to additional schools in the same districts may prove relatively smooth. Importantly, SBHCs are also well-situated to deal with the ancillary fallout from the pandemic including missed preventive care and new and exacerbated mental health challenges.

Lastly, it deserves mentioning that school-based health centers provide highly efficient and low-cost care and have gotten better at billing payors for provided services (Fisher et al., 2019). However, many centers are sponsored and operated by organizations such as Federally Qualified Health Centers or Rural Health Clinics with tight budgets. With startup costs generally ranging from \$50,000 to \$130,000 and operating costs ranging from \$90,000 to \$210,000 annually (Nystrom & Prata, 2008), even marginally subsidizing start-ups and operations could incentivize potential sponsors to offer services. Indeed, as mentioned previously, the limited funding included in the Affordable Care Act for school-based health centers appears to have done enough to lower financial barriers in many settings and led to substantial growth.

Three Major Barriers to SBHC Growth

Political Challenges

Few policy issues are more contentious in US politics than health (Haeder, 2020). Despite positive recent developments with passage of the [School-Based Health Centers Reauthorization Act](#) of 2020, which extended authorizations for federal funding for school-based health centers through 2026 and [the Hallways to Health Care Act](#), which includes additional funding for behavioral health care and demonstration projects, one of the Achilles heels in the growth of

SBHCs can be found in the politics that surrounds them. From the very beginning, tensions emerged over the provision of health care unsupervised by parents (Lear, 1996). Opposition emerged particularly over the potential for providing reproductive health services, (Boonstra, 2015; Herrman, 2015; Lear, 2003). As a result of these concerns, many SBHCs have either voluntarily restricted their provision or have been barred from offering these services by state or local governments (Ethier et al., 2011; McCann, Moore, Barr, & Wilson, 2020; Parasuraman & Shi, 2015). This is particularly the case in rural areas (Fothergill & Feijoo, 2000). And even despite the restrictions, SBHCs have been kept out of the vast majority of the nation's schools. At the same time, the limiting of reproductive health services comes at a cost in itself because reproductive health services are some of the most commonly sought after services by students when available (Keeton et al., 2012; Kisker & Brown, 1996; McCann et al., 2020; Soleimanpour et al., 2010). The restrictions, externally or internally imposed are also unfortunate because there is evidence that SBHCs may be increasing social value by effectively preventing teenage pregnancies (Boonstra, 2015; Owen et al., 2010), better treatment of STIs (Sabharwal, Masinter, & Weaver, 2018), and improve prenatal care and reduce developmental delays in newborns to students (Arenson et al., 2019; Strunk, 2008). Conversely, there is no evidence that reproductive services in schools increase sexual activity nor lower the age of sexual intercourse (Denford, Abraham, Campbell, & Busse, 2017; Owen et al., 2010).

Funding Challenges

Political challenges have directly carried over into funding. Indeed, another key reasons identified in the literature for the limited spread of SBHCs has been the historical lack of stable financing streams, leading to significant challenges in creating and sustaining SBHCs (Brindis et al., 2003; Keeton et al., 2012). To make up for the lack of stable financing, the SBHCs generally

patch together funding from an array of sources including federal, state, and local governments, private foundations, sponsoring organizations, schools, school districts, private and public insurance, and students and families (Keeton et al., 2012; Making the Grade National Program Office, 1995; Price, 2017). In the past, some states have used Maternal and Child Services Title V block grants or created limited state-based grant programs (Keeton et al., 2012). A limited number of states have also used general fund dollars (Schlitt, Rickett, Montgomery, & Lear, 1995). Notably, federal funding has generally been rather limited. Temporary exceptions include several million dollars in Health Resources and Services Administration and earmarked federal funding in the 1990s (Federico et al., 2011; Love et al., 2019). Most recently, several provisions in the Affordable Care Act have provided funding for \$200 million in capital expenses including construction from 2010-2013 and, more generally, several billion dollars for federally qualified health centers which operate the majority of the nation's SBHCs (Love et al., 2019). However, not all provision of the ACA received Congressional appropriations (Boonstra, 2015). On the other hand, others states completely banned SBHCs from receiving public funding (Morone et al., 2001) while others have banned SBHCs from billing state Medicaid programs (Lear, Eichner, & Koppelman, 1999). The financial situation of SBHCs has been further challenged by the growth of managed care arrangements (Lear et al., 1999; Morone et al., 2001) and the fact that many of their activities to support students are not billable (Making the Grade National Program Office, 1995). The impact of the recent pandemic has likely put further strain on SBHCs (Anderson et al., 2020).

Staffing Challenges

School-based health centers are unique work environments that present staff with challenges and opportunities distinct from those experienced by providers working in more

traditional health care settings. As a result of being embedded within the educational environment, staff may need to work with limited clinical space and inconsistent daily routines. However, SBHCs also allow staff easy access to students in need of medical and mental health services, as well as the opportunity to build supportive relationships and holistically assess student's needs and well-being. In recent work (Simon F. Haeder, Emily Maxfield, Kara Ulmen, & Sara Anderson, 2022), we found that working on the boundary between the education and health sector requires large amounts of flexibility, the ability and willingness to work with and adapt to children, and a focus on being proactive and willingness to work on building relationships inside and outside the school building, perhaps especially during the COVID-19 pandemic. Crucially, there is an important local component to SBHC work that requires constant attention and a willingness to adjust quickly. In terms of challenges related to training and education, we found that providers generally lack any exposure to SBHCs during their education and often are fully unaware of this form of healthcare provision. Moreover, local context requires additional and continued investment in training SBHC staff. The potential supply of providers who will do well and succeed in the SBHC context is inherently limited. Given this small pool, substantially more resources are needed to identify and appropriately train potentially interested providers during their initial education experience.

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