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In Brief

SCHOOLS AND THE AFFORDABLE CARE ACT

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This *In Brief* provides school leaders, staff, and other stakeholders who seek to support the health and wellness of elementary and secondary school students with information on three school-related health strategies supported by the Affordable Care Act (ACA): school-based health centers, community-school health partnerships, and pregnant and parenting teen supports. For each strategy, the brief provides background information, evidence-based recommendations, and information about how the ACA can support implementation.

Introduction

Education stakeholders have good reason to support positive student health outcomes, as student health and well-being have been positively linked to students' academic outcomes, including attendance, grades, test scores, and high school graduation (Breslau, 2010; Fox, Barr-Anderson, Neumark-Sztainer, & Wall, 2010; Fox, Connolly, & Snyder, 2005; Haas & Fosse, 2008). Health problems can lead students to miss more days of school for illness and to pay less attention and learn less while in class (Fowler, Johnson, & Atkinson, 1985). Those with poorly managed chronic illnesses such as asthma (Halterman et al., 2001; Moonie, Sterling, Figgs, & Castro, 2008; Taras & Potts-Datema, 2005a), early-onset diabetes (Glaab, Brown, & Daneman, 2005; Hannonen et al., 2012), and tooth decay (Selrawan, Faust, & Mulligan, 2012; U.S. Department of Health and Human Services [USDHHS], 2000) are particularly at risk of missing school and suffering related academic consequences.[1] Depression (Fröjd et al., 2008; Hishinuma, McArdle, & Chang, 2012), obesity (Geier et al., 2007; Pan, Sherry, & Blanck, 2013), and substance abuse (Jeynes, 2002) also have been tied to negative outcomes in school. Conversely, healthy students are more likely to succeed in school (California Department of Education, 2005).

The ACA strives to support the well-being of children and youth through an extensive range of health-promoting programs and provisions, including the expansion of health insurance coverage and access to health services. (For more detail, see "Snapshot: How the ACA Supports Health Insurance Coverage and Access to Health Services.") Schools will see the impact and effects of these ACA provisions, as these and many other elements of the law affect schools peripherally and will continue to clarify schools' involvement in ensuring student health and well-being. Specifically, three ACA elements are targeted to K–12 schools: school-based health centers, community-school health partnerships, and support for pregnant and parenting adolescents.

[1] Increased absences do not always lead to measurable differences in grades or test scores. (For a discussion, see Moonie et al., 2008.)

This brief focuses on those three elements of the ACA. For school leaders, staff, and other stakeholders interested in learning more about these provisions and how they can support student health and well-being, this brief provides:

- **Background:** Information on what each of these interventions entails, including benefits and challenges.
- **Best Practices:** Recommendations for how staff may choose to implement these types of interventions, based on research, expert opinion, and examples of current practice. (Note that these lists of best practices are not exhaustive; rather, they are identified as important considerations for schools preparing to implement, or in the process of delivering, these interventions.)
- **ACA Opportunities:** Information on what opportunities the ACA provides to help schools and their community partners organize, structure, and fund these types of interventions.

Snapshot: How the ACA Supports Health Insurance Coverage and Access to Health Services

- Youth up to age 26 are able to remain on their parents' health insurance plan.
- The eligibility parameters of Medicaid and the Children's Health Insurance Program (CHIP) are expanded, meaning more children and youth have health coverage.
- Twenty-seven preventive-care services are now covered at no cost to subscribers.

Find a full list of preventive services available to children and families, and learn more about the ACA's key features.

It is important to note that there are many connections between school-based health centers, community-school partnerships, and support for pregnant and parenting teens. For example, the majority of school-based health centers provide oral health care, one of the primary community-school health partnerships outlined in the ACA. In addition, their implementation—as with so many ACA elements and most notably the expansion of Medicaid eligibility—is not uniform across the country. Finally, the ACA continues to shape practices as the law is interpreted and implemented. Programs and activities continue to be developed, and funds remain to be allocated.

School-Based Health Centers

Background

School-based health centers (SBHCs) strive to improve the health and wellness of children and adolescents by providing a combination of health care and health promotion activities, including primary care, mental health care, substance abuse counseling, case management, and dental care. Almost 2,000 SBHCs operate in 48 states and territories of the United States, with 57 percent located in urban communities, 16 percent in suburban communities, and 27 percent in rural communities (USDHHS, 2013b). They serve more than 1.8 million students from kindergarten through Grade 12, although the vast majority (80 percent) serves adolescents (i.e., those in Grade 6 or higher). Research has shown that SBHCs can expand services to vulnerable populations, increase the provision of acute care, improve management of students' chronic conditions, and improve access to mental health care (National Assembly on School-Based Health Care, 2009).

Best Practices

Schools can learn from a number of best practices that have been shown to support the success of SBHCs.

Conduct a Needs Assessment of the Community

Needs assessments help identify specific health problems (such as the proliferation of specific sexually transmitted diseases [STDs] or substance use, or a high rate of motor vehicle accidents), as well as demographic, cultural, linguistic, and financial needs of the students and families in the community. Such assessments help SBHCs to prioritize activities and equip themselves to address the problems of greatest interest to the community (Keeton, Soleimanpour, & Brindis, 2012).

Develop a Business Plan

Establishing a business plan helps SBHCs generate grants, contracts, and billings that cover SBHC expenses. These revenue-generating activities serve to keep resources, income, and services consistent over time (The Center for Health and Health Care in Schools, 2007; Clauss-Ehlers, 2003). For help with business plan development, including budget recommendations and cost estimates, see Flaspohler, Meehan, Maras, and Keller (2012) and Nystrom and Prata (2008).

Establish a (or Involve a Preexisting) Multidisciplinary School Health Advisory Council

An advisory council can provide community support, planning, oversight, input on local needs, policy development, and community education on child and adolescent health. The council should include a broad range of community leaders (Nystrom & Prata, 2008).

Coordinate Care

Needs assessments, while revealing gaps in services, can also highlight what is already being done well in a community (The Center for Health and Health Care in Schools, 2007; Cousins, Jackson, & Till, 1997; Flaspohler et al., 2012; Keeton et al., 2012; Summers et al., 2003). SBHCs should build partnerships with primary care providers, hospitals, universities, and other community organizations to provide comprehensive and holistic programming that includes mental health (Clauss-Ehlers, 2003; Summers et al., 2003) and dental care (Brown & Bolen, 2003; Brown & Bolen, 2008), pregnancy and STD prevention (Albert, McManus, & Mitchell, 2005), and nutrition and obesity prevention (Barnet, Duggan, & Devoe, 2003; Daley, 2011; McCarthy, Telljohann, Coventry, & Price, 2005). When linking families to other organizations, it is important for SBHCs not to simply refer them, but to serve as a liaison (Clayton, Chin, Blackburn, & Echeverria, 2010; Graham Lear, Barnwell, & Behrens, 2008).

ACA Opportunities

The ACA, through section 4101(a), funded the Health Resources and Services Administration's (HRSA) School-Based Health Center Capital Program, which provides $50 million a year for four years (2010 through 2013) for one-time funding for construction, renovation, and equipment for SBHCs. With these dollars, SBHCs in 47 states, the District of Columbia, and Puerto Rico can address capital needs such as modernizing or building new facilities, purchasing equipment, and/or increasing access to health services for children. These funds may not be used for the provision of services—only for the space, equipment, and facilities (which may include mobile clinics) required to provide those services (USDHHS HRSA, 2012).

In July 2011, $95 million was awarded to 278 SBHCs, enabling them to medically serve an additional 440,000 students (USDHHS HRSA, 2012). In 2012, an additional $80 million was awarded to 197 SBHCs, enabling them to serve an additional 384,000 students (USDHHS, 2013b). The maximum that

each grantee can receive is $500,000 for a two-year period. This amount is irrespective of the number of SBHCs that a grantee operates, although the maximum is five (USDHHS, 2012). The average award amount is $350,000 (USDHHS HRSA, 2012).

Snapshot: Banner Health System

This organization in Phoenix, Arizona, received an SBHC capital and construction grant in December 2011. The $375,000 award funded a mobile health unit that expands prevention and wellness services to an anticipated 2,000 students, many of whom previously could receive health care only through the region's emergency department. The funds also support equipment and health information technology upgrades at permanent school sites.

Funding preference is given to applicants that "serve a large number of children eligible for Title XIX and Title XXI of the Social Security Act, or a waiver under Title XIX," although HRSA has not defined what constitutes a large number (USDHHS HRSA, n.d.a).[2] Sites funded for construction projects are not eligible for funding in subsequent years; however, this restriction does not apply to sites that received funding for equipment-only projects.

Helpful Resources

- HRSA's School-Based Health Centers program
- School-Based Health Alliance

Community-School Health Partnerships

Background

Developing healthy behaviors early, before unhealthy behaviors begin, benefits individuals and society. Despite high rates of preventable death in the United States, investment in prevention has been modest (USDHHS HRSA, 2012). A growing body of evidence supports the innovative application of public health prevention principles within communities, including within schools (The New York Academy of Medicine, 2010). This includes the prevention of tooth decay, the most common chronic disease of children in the United States (Committee on Valuing Community-Based Non-Clinical Prevention Programs, Board on Population Health and Public Health Practice, & Institute of Medicine, 2012).

Best Practices

Many of the best practices of community-based partnerships are closely aligned with those of school-based health centers. This is unsurprising, given their similar missions. These include designating school leaders/staff to participate in local community-health partnerships; collecting, examining, and sharing school-level data on student health and wellness (e.g., through school climate surveys) (Brown & Bolen, 2003; Brown & Bolen, 2008; Flaspohler et al., 2012; Jaycox et al., 2006); and identifying problem areas in student health and well-being, as well as their underlying causes. Schools can learn from a number of additional best practices that have been shown to support the success of community-school health partnerships.

[2] Title XIX and Title XXI of the Social Security Act authorize the public health insurance programs Medicaid and the Children's Health Insurance Program (CHIP), respectively.

Identify Evidence-Based Practices That Address Gaps in Student Health and Well-Being

Clearinghouses for evidence-based practices[3] can help identify interventions that address the specific challenges in schools or communities. Schools can also work with partners to identify the underlying causes of these gaps and engage with relevant partners to implement decided-upon programs. For most evidence-based practices, however, it is critical to have infrastructure supports to ensure that the programs are disseminated and implemented effectively (Dye et al., 2007). In addition, community frameworks that encourage health and healthy development at the community level and that engage critical stakeholders such as schools are available. These include Communities That Care and the PROSPER Partnerships program.

Measure the Effectiveness of Interventions and Track Progress Over Time

Many successful programs use data regularly to assess their performance. Assessments should include both teacher/staff and student feedback (Flaspohler et al., 2012). These assessments can help determine whether the intervention objectives are being achieved and allow for modifications if or when necessary (Mandel & Qazilbash, 2005; Soleimanpour, Brindis, Geierstanger, Kandawallab, & Kurlaender, 2008).

Establish Oral Health Programs

As mentioned, tooth decay is the most common chronic disease among children in the United States. As of 2000, tooth decay—five times more common than asthma—results in approximately 51 million school hours missed per year (USDHHS, 2000). Particularly in communities with limited financial resources, inadequate health insurance, limited options for primary care and preventive services, and a shortage of dental health professionals, oral health services offered in schools by community organizations may be the only access children have to such services. Many school-based oral health programs are dental sealant programs (sealants are thin plastic coatings applied to the surfaces of the back teeth to protect them from decay) (Blank, Baxter, Payne, Guillaume, & Pilgrim, 2010; Geierstanger, Amaral, Mansour, & Walters, 2004; Jaycox et al., 2006; Summers et al., 2003). Sealant programs tend to focus on students in Grades 2 and 6, as high percentages of children in these grades are likely to have newly erupted permanent molars (Centers for Disease Control and Prevention [CDC], 2009). It is unlikely that school-based dental programs can cover more complex dental needs; in these cases, following up with parents regarding children's dental care and establishing partnerships with dental clinics are important (Gooch et al., 2009).

ACA Opportunities

Two elements comprise the ACA support for school-community health partnerships: school-based dental sealant programs and the Prevention and Public Health Fund (and the many programs that it funds).

School-Based Sealant Programs

The ACA changes the language of the Public Health Service Act (42 U.S.C. 247b-14(c)(1)) in order to mandate grants to all states and tribal entities to institute dental sealant programs. Funding for these programs is made as part of block grants to states from the Maternal and Child Health Bureau (MCHB) within HRSA.

[3] Helpful clearinghouses across a range of disciplines include: What Works Clearinghouse, Blueprints for Healthy Youth Development, Database of Evidence-Based Teen Pregnancy Prevention Program Models, and the National Registry of Evidence-Based Programs and Practices.

Prior to the ACA's passage, 16 states received dental sealant grants (Albert et al., 2005). Although all states now receive grants, state-level policies may restrict the extent to which children can benefit from services. As of 2012, 35 states and the District of Columbia did not have sealant programs in a majority of the schools most likely to have a high proportion of children at risk for dental decay. In four states, there are no programs in these schools (Oral Health Watch, 2013).

The MCHB Block Grant requires states to conduct a statewide needs assessment every five years, which includes an oral health component (Pew Center on the States, 2013). This assessment is in addition to their initial application and an annual report.

States and jurisdictions also must match every four dollars of federal funds with at least three dollars of state and/or local money. On average, states receive just under $9.2 million in MCHB Block Grant funding. Awards are made annually and distributed quarterly (Carter, 2011).

Helpful Resources

- Seal America: The Prevention Invention, a manual designed to assist health professionals in initiating and implementing a school-based dental sealant program
- CDC information on school dental sealant programs
- Moving on the Oral Health Provisions in Health Reform: A Roadmap for Implementation

The Prevention and Public Health Fund

The ACA established the Prevention and Public Health Fund (PPHF) to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality (USDHHS HRSA, n.d.b). PPHF is a mandatory allocation; unlike most other programs, the funding does not have to be annually appropriated by Congress. To date, PPHF has invested in a broad range of evidence-based activities, including community and clinical prevention initiatives, public health infrastructure, immunizations and screenings, and tobacco prevention. For fiscal year 2013, PPHF funded 24 programs or activities across six federal agencies with approximately $949 million (USDHHS, 2013a). These efforts are executed in partnership with states and locales that are using funds for a range of public health activities, including improving access to mental health services and immunizations, and preventing and reducing obesity. In addition, although six federal agencies are funded, many more are involved in PPHF by proxy. One significant example is PPHF's National Prevention Strategy implementation plan, in which 17 federal agencies commit to advancing the prevention of chronic disease and the fundamental prevention principles laid out in PPHF.

Of PPHF's 24 programs, many have and will continue to have implications for K–12 institutions as ACA programs continue to be funded and implemented. Looking ahead, the yearly amounts allocated for the fund are $1 billion in 2012 through 2017, $1.25 billion in 2018 and 2019, $1.5 billion in 2020 and 2021, and $2 billion in 2022. The next section explores one PPHF program: Community Transformation Grants.

Community Transformation Grants

The Community Transformation Grants program is administered by the Centers for Disease Control and Prevention (CDC), and grants are intended, in part, to increase access to high-quality physical activity instruction in schools.

In 2012, the Small Communities program, a two-year subset of the larger Community Transformation Grants effort that will end in 2014, extended funding to locales with populations of less than

Snapshot: School Board of Miami-Dade County, Florida

A Community Transformation Grant of more than $3.1 million was awarded to the School Board of Miami-Dade County to implement the *305—Play, Eat, Succeed* project to impact the prevalence of childhood obesity for students with disabilities and the Head Start program. The project will work with approximately 370,000 students in the county—mostly low-income, racial/ethnic minority, and students with disabilities—to improve nutritional habits, increase physical activity levels, and help them achieve a healthy weight.

500,000 and allowed schools to serve as the grantees. Forty communities were awarded approximately $70 million as part of the Small Communities program. Consistent with the overall Community Transformation Grants program and the National Prevention Strategy, these new awards support five "Strategic Directions": (1) tobacco-free living; (2) active living and healthy eating; (3) high-impact, quality clinical and community preventive services; (4) social and emotional wellness; and (5) healthy and safe physical environments.

Helpful Resources

- The Affordable Care Act's Prevention and Public Health Fund in Your State
- National Prevention Strategy Partners in Prevention factsheet for early learning centers, schools, colleges, and universities
- Community Transformation Grants—Small Communities Awards program

Support of Pregnant and Parenting Teens

Background

Teen childbearing is associated with a wide range of negative outcomes for both teen parents and their children, including the reduced likelihood that these parents will finish high school. Moreover, estimates suggest that teen childbearing costs U.S. taxpayers about $11 billion a year through public assistance payments; lost tax revenue; and greater expenditures for public health care, foster care, and criminal justice services (USDHHS, 2013a).

Best Practices

Several best practices have been shown to help elementary and secondary schools support the success of pregnant and parenting teens.

Use Pregnancy and Parenting Education Coaches or Case Managers

Building positive, ongoing relationships between teens and program staff has been found to be one of the best ways to retain pregnant and parenting teens in programs (Maynard & Hoffman, 2008; Monea & Thomas, 2011; The National Campaign to Prevent Teen and Unplanned Pregnancy, 2011). Weekly facilitated group meetings, social work services, individual case management, home visits, and counseling are particularly effective in preventing repeat teen pregnancies, especially when provided by a culturally matched school-based social worker (USDHHS Office of Adolescent Health [OAH], 2012). Coaches should serve as role models, exhibiting physically and emotionally healthy lifestyles (Blank et al., 2010).

Institute School Continuation Programs for Pregnant and Parenting Students

Pregnant and parenting teens often drop out of school or fail to continue their education (USDHHS OAH, 2012). Holding students to high academic expectations (postsecondary education as opposed to attainment of a high school diploma) and involving multiple generations of the teen's family in academic support can also be helpful (Maynard & Hoffman, 2008; Monea & Thomas, 2011).

Provide Wrap-Around Services

Using a holistic approach to support pregnant and parenting teens helps to promote positive outcomes for this population. Child care and housing supports, for instance, help keep teen parents in school (USDHHS OAH, 2012). Additional wrap-around services such as prenatal care and contraception services can be provided through SBHCs.

SBHCs that offer prenatal care often reach younger students than do hospital-based services, reducing the risk that teens will have a child with a low birth weight (USDHHS OAH, 2012). In addition, studies have found that SBHCs that have contraception available on-site can help reduce teen childbearing and repeat teen pregnancies (Barnet et al., 2003), and students have reported being more likely to use condoms if they are available at an SBHC (Blank et al., 2010; Daley, 2011). Other studies recommend that SBHCs offer, or make referrals for, the emergency contraceptive pill (Soleimanpour et al., 2008). Whether SBHCs are able to offer contraception services varies; as of 2008, 60 percent were prohibited from doing so, mostly because of policy decisions made by their school district (National Assembly on School-Based Health Care, 2010).

Involve Fathers

When young fathers are involved in programming, their parenting improves. Specific tactics for engaging fathers, such as using job training as an entry point and assessing males' unique needs, can help with recruitment and retention of young fathers in parenting programs (McCarthy et al., 2005).

Involve Program Alumni

Alumni can help build formal or informal relationships with current program participants. They also can help showcase success (USDHHS OAH, 2012).

ACA Opportunities

ACA funding created the Pregnancy Assistance Fund, a $25 million competitive grant program administered by the Office of Adolescent Health (OAH) within the U.S. Department of Health and Human Services. The Pregnancy Assistance Fund provides pregnant and parenting teens and older women with a network of supportive services to help them complete high school or postsecondary degrees and to help them gain access to health care, child care, family housing, and other critical supports. The program also provides funding to improve services for victims of domestic violence, sexual assault, and stalking.

Original awards were made in 2010 to 17 states and tribes for a three-year period (USDHHS OAH, 2012). The next round of funding is scheduled to be distributed in July 2013 (the application period closed in April 2013) (USDHHS OAH, 2013a). OAH anticipates that up to $24 million will be available to fund up to 32 grants in amounts of $500,000 to $1,500,000 per year for a four-year project period.

Snapshot: Connecticut State Board of Education

Funding from the Pregnancy Assistance Fund helps school districts in five Connecticut cities develop comprehensive programs that improve the health, education, and social outcomes for pregnant and parenting teens and their children. In Year 2 of the program, 80 percent of enrolled seniors are graduating or remaining in school, and 99 percent of the children are meeting developmental milestones or receiving appropriate services to address developmental delays.

The Pregnancy Assistance Fund directives encourage states to focus on communities with the greatest need and to prioritize underserved populations and geographic areas (USDHHS OAH, 2013b). Its guidelines also require states to undertake evidence-based approaches and clarify that the fund's intent is to assist pregnant teens and women who have already made the decision to carry their pregnancy to term.

States and tribes can use awards to fund programs in high schools and community centers or institutions of higher education. For schools and community centers, no matching dollars are required; postsecondary institutions are required to match one dollar to every four federal dollars.

Helpful Resources

- Office of Adolescent Health—Pregnancy Assistance Fund Resource and Training Center
- Family and Youth Service Bureau—Working With Pregnant & Parenting Teens Tip Sheet

Conclusion

Schools and their many stakeholders have an important stake in their students' health, as healthy students are productive (and present) students. K–12 institutions can leverage key provisions of the ACA, including school-based health centers, school-community health partnerships, and support for pregnant and parenting teens, to create safer and more supportive learning environments for the students they serve.

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