By Carmella Gutierrez

School Connections: Linking Low-Income Children to Affordable Health Care

In January 1997 Kaiser Permanente's Rocky Mountain Division kicked off a two-year pilot program offering a child-only health plan for low-income children in Metro Denver. This innovative plan costs families $3 per month per child (with a maximum of $9 per family) and is the first time in the nation a health maintenance organization is partnering with school-based health centers to give children comprehensive health care.

Angela Baker didn't know where to get affordable health insurance for her third-grade daughter in Denver. As a single mother, she worked hard, but finances were tight.

"It's very frightening," she says. "It's stressful being on your own and trying to find proper health care. It was a struggle to even buy the store brand of aspirin."

Her answer is *School Connections.*

This new, innovative dues-subsidy program partners Kaiser Permanente's Rocky Mountain Division with school-based health centers (SBHCs) to give school-aged children in Denver comprehensive health care.

As an enrollee in *School Connections,* 9-year-old Adiamond Baker receives most of her primary care from her SBHC located at her school. Nurse practitioners, RNs, and physician assistants staff the centers and provide on-site primary care services such as preventive care, immunizations, care for minor illnesses and injuries, chronic-disease monitoring and education, and some mental health and chemical dependency services. Typically, there is a physician on call, providing consultation as needed.

But Adiamond's ticket to comprehensive care is her very own Kaiser Permanente identification card. She can now walk into any of Kaiser Permanente's medical offices in the Denver metropolitan area and for a $5 copayment receive primary care, specialty care, laboratory, emergency services, x-ray and mental health benefits as needed. Hospitalization and prescriptions are free.

It costs her mother $3 a month in dues.

"I am so grateful for everyone who's collaborated to make this happen because I desperately need some health care for my daughter," says Angela Baker. "I'm very grateful."

School Connections is a two-year pilot program that has room for 1,300 children in the Denver metropolitan area. Children qualify if they are enrolled in one of 20 schools with SBHCs and if their families fall within the financial needs guidelines. For the Bakers, that means making less than $19,166 a year.

School Connections is a great idea, but will it work for you? This article addresses what school-based health centers are, how the idea came about, the physician perspective, and what steps to consider if you want to replicate this program.

Background

What are school-based health centers?

School-based health centers are a relatively new health care delivery model. In 1987, the Robert Wood Johnson Foundation awarded grants to 18 community institutions across the country to establish stand-alone centers at schools. Their mission—provide underserved students with primary care services for free or at minimal cost because healthy students are more likely to stay in school and become healthy, productive adults. Today, it's estimated that there are more than 900 SBHCs operating in 43 states and in the District of Columbia.

Each SBHC has a partner from the medical community who provides staffing and equipment, but funding is a big problem. Resources are seldom adequate, and finding sustainable, predictable support is critical to their survival. Often, the centers rely on a variety of sources, including private foundations, government grants, and community agencies.

Tackling the Growing Problem of the Uninsured

More than 42 million Americans were without health insurance in 1996, according to the U.S. Department of Health and Human Services. In Colorado alone, more than 540,000 people lack insurance, including an estimated 150,000 children and teenagers.

While the ranks of the medically indigent continue to grow, the resources necessary to combat the problem decline. However, Kaiser Permanente helps some families to fill the gap with our dues-subsidy programs that have been part of our social mission for years.

The Rocky Mountain Division's largest dues-subsidy program is called *Connections*. It provides health benefits to 1,700 low-income uninsured or significantly underinsured members at greatly reduced rates—Kaiser Permanente waives 80-95 percent of the normal dues for up to two years.

Connections is designed to make health insurance available to people while they are going through rough financial times until they get back on their economic feet. This highly successful program began in 1991 and has grown steadily in the last four years, today serving about 1,600 people annually. The Rocky Mountain Division's annual cost for *Connections* is about $2 million.

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CARMELLA GUTIERREZ joined the Rocky Mountain Division's public affairs department from the broadcast news arena. She is a former television news producer and radio reporter.

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The dues-subsidy program gets another fiscal boost from physicians and staff. Every year through automatic payroll deductions, they give an additional $100,000 to do their part in tackling the problem.

Karen Shields, coordinator of both *Connections* and *School Connections* programs, says about 60 percent of the physician and staff contribution is used to help more families to buy health care coverage. The remaining funds are used to help other financially strapped members to waive copayments, or buy durable medical equipment, pharmaceuticals, and other services not covered by their regular benefits.

Shields says the program formalizes what physicians and staff had been doing on their own for years. "We often would hear stories about them paying out of their own pocket to help these people get proper health care," she says. "*Connections* allows them to make a personal impact on the problems of the uninsured and the underinsured and give back to the community in a formal way."

Learning From Our Past Experiences

After six years of watching the *Connections* program develop, Community Medicine Director Maureen Hanrahan noticed a few trends that would eventually lead to *School Connections*.

First, the cost of providing care to these populations was rising significantly, about five percent annually. Currently, the program costs $183.93 per member/per month.

"We found we could not afford to cover the same number of people from year to year," Hanrahan says. "Our suspicion was that the cost of the program was going up because of the demands of the high-need patients in that population, who were most likely adults."

The second trend was about children, who make up an estimated 40 percent of *Connections* members. Families often called with requests to include only their children in *Connections* because the parent or parents were covered through their employers' plan but still could not afford the additional cost of adding dependent children to the employer-based plan or because the employer did not offer dependent coverage.

"It occurred to me as I was looking at the uninsured population that there was a pocket of need that really shouldn't be that expensive—the school-aged child," Hanrahan explains. "I started reading about programs and exploring actuarial data that had isolated the cost of providing care for these kids and found that we could serve about three to four kids for every person we served in *Connections*."

The next steps?

"We wanted to try a creative model that involves a child product and price it that way. Then we began looking for a unique delivery system," Hanrahan remembers.

The ABCs of a Positive Relationship

Kaiser Permanente's relationship with school-based health centers began slowly in 1990. Physicians and staff had limited participation on their boards, and advisory groups and the Rocky Mountain Division gave charitable dollars to at least two sites.

But in 1995, Kaiser Permanente funded a study in collaboration with Denver Public Schools that would prove to be a turning point in the relationship.

The study, currently in the process of publication, compared utilization rates of Kaiser Permanente teenagers who had SBHC access with a control group of Kaiser Permanente teenagers without SBHC access over a three-year period. It compared utilization of primary care, specialty care, urgent/emergency care, mental health and chemical dependency treatment, and preventive services as well as common diagnoses and risk assessment. The study helped the Rocky Mountain Division to anticipate the utilization patterns and needs of teenagers using SBHCs and to plan how a future relationship between Kaiser Permanente and the centers may increase risk assessment and preventive care while decreasing potential after-hours/urgent care utilization.

There was another subtle result of the study, one that would prove critical later. A working relationship with the schools was evolving slowly—trust and understanding of each other's goals, systems, quality controls, and management styles.

Making The Connection

With a background in nursing and education, Hanrahan drew on her own personal experience and insight into SBHCs to help the dues-subsidy team to develop *School Connections*. Prior to joining Kaiser Permanente in 1985, she helped to establish one of the first SBHCs in the Denver metropolitan area. Hanrahan and the team had been researching ideas to put the student health plan into action when they came up with a stroke of brilliance—could a marriage between Kaiser Permanente and the SBHCs work?

The idea seemed simple. By using the SBHCs as additional primary care providers, they would act as agents to identify children of the working poor without health insurance and those children whose families made too much money to qualify for Medicaid yet couldn't afford to buy their own health insurance. Families could also receive primary care services through Kaiser Permanente for a $5 copayment if they so chose. The plan, however, would be to encourage children to utilize the SBHCs for primary care services as usual and to keep the program costs

as low as possible. If it worked, Kaiser Permanente would be the first health maintenance organization in the nation to incorporate the SBHCs into a plan to give deserving children and teenagers the comprehensive health care they needed at an affordable price.

The pieces of the puzzle were all there—our working knowledge of SBHCs, the study showing the utilization rates of teenaged members enrolled at SBHCs, and the knowledge that a student health plan would be cost effective.

But the idea would have to pass a critical test to be successfully implemented. For it to work, physicians would have to buy into the idea.

The Challenges

Dr. Harvey Bograd, co-manager of the dues-subsidy programs, says the medical group's initial reactions were positive because the program would focus on uninsured kids and because it would tie in the educational environment, as well.

However, on closer examination there were other issues to consider. With 20 different SBHCs, three school districts, three different medical staffs, and now Kaiser Permanente—all active partners in the relationship—several issues would have to be worked out. Communication. Quality assurance. Confidentiality. Staffing. And leadership. Who would be the boss?

It would require a true collaboration between various entities with differing corporate cultures and processes.

Coordinating the flow of information outside the Kaiser Permanente system is itself a problem. "Continuity of care is important to physicians," Bograd explains. "There was some concern our physicians would lose track of these kids if they were seen outside the system. The real challenge is to make sure our providers know these children are their patients and track them, even though they are receiving services off-site."

The program is still in its infancy and many of the problems are handled as they come up, so it's still too soon to clearly define and elaborate on all the issues.

Hanrahan says the key to working out the answers for everyone comes back to the foundation of the relationship — trust and understanding. "Something like this doesn't happen overnight," she says. "It takes a long time to establish a solid enough relationship to work through all the daily problems."

After a year of discussion, negotiation and planning, *School Connections* accepted Adiamond Baker as its first member on January 1, 1997.

A Physician's Perspective

Dr. Stefan Mokrohisky, pediatrician, is Kaiser Permanente's clinical liaison with the SBHCs. Mokrohisky spends two to four hours a week serving as an on-call consultant and acting as the sounding board for the SBHC's providers in order to help new *School Connections* members understand and use the entire Kaiser Permanente system effectively.

Mokrohisky says within the first week of enrollment, the need for the program was obvious. He tells of two patients who had not had any consistent care before *School Connections*. One was a first-grader who had been diagnosed with insulin-dependent diabetes mellitus at three years of age and had not been seen on a regular basis. The mother also had diabetes and had been giving the child her own insulin because she couldn't afford a separate prescription. Blood and urine testing was sporadic.

As if the situation wasn't bad enough, the school was reluctant to accept the mother's directions for the girl's emergency care because school regulations required a physician's involvement. Whenever the girl became ill, they went to the emergency department, which further disrupted her school attendance. This Catch-22 situation is not unusual for many uninsured families. Today, the child is getting the consistent care she needs, and her family is grateful for the attention.

Mokrohisky tells of another girl who desperately needed care. This 9-year-old had been evaluated for what her mother called "self-confusion." It turns out, she had had surgery at birth to remove testes from the inguinal canals but had never been seen since for the problem of testicular feminization. She was confused about her identity and had never developed close relationships with anyone.

Although she was raised as a girl, she felt more at home on the playground with boys because of her athletic ability—she was always chosen first when the basketball teams were formed. She was uneasy bathing or taking showers with older girls but wasn't sure why.

Mokrohisky referred her to an endocrinology specialist and to a mental health therapist and finally, after nine years of confusion—her entire life, in this case—she is coming to terms with her special situation. With a thorough physical examination, genetic investigation, and emotional evaluation, the girl and her mother are receiving support to meet the challenge of this complicated problem.

"We felt we reached her just in time, as the developmental milestone of puberty was on the horizon and hormone therapy was needed," Mokrohisky says. "What *School Connections* hopes to add to the Kaiser Permanente genetic code is community-coordinated, cost-worthy care for this special group."

Reaching school-aged children and teenagers like these two has been difficult. Providers see them as infants for preventive visits but often lose track of them until acute illness or trauma strikes. Even studies of the insured teenaged population indicate an episodic approach to health care and a failure of risk assessment

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programs to identify those in need of intervention.

"This may change our entire approach to treating children and teens," Mokrohisky says. "Instead of requiring families to understand the health care needs of their children in terms of the traditional medical model, we will adapt to fit the school-based developmental stage of each child. It will also help us focus on the school as an essential neighborhood resource."

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Mokrohisky explains, "This will help us understand the connection between health care and the community and how we can make health care more accessible to the community."

Bograd says *School Connections* allows the educational piece to be integrated with the biological aspect of health care. "We try to maximize each child's potential, and this relationship with the schools will help us do that," he says. "There are all sorts of problems, social and psychological, that these children and teens have. With this model, those issues may be observed and treated more effectively in the school setting because the school staff is there."

Take a child with attention deficit disorder. A typical child may come in to see a Kaiser Permanente physician with a note from his teacher saying that there are problems with his performance and learning.

"We are interested in discovering if it is advantageous or not to treat ADHD within a school-based health system," Bograd says. "In this model, mid-level provider staff located on-site at a school will work cooperatively with Permanente physicians located at our medical facilities."

From Mokrohisky's perspective, the challenge lies in working with existing community health services to assure high-quality care to avoid duplication of services and to keep essential information on individual patients confidential yet available to those who need it.

A major problem in today's health care environment is the "churning" of people in and out of various health care delivery systems. As new members come into the Kaiser Permanente system, a great deal of energy is spent gathering and interpreting previous information in order to get a clear understanding of current health needs and future health risks.

The same is true for *School Connections* children. Each student needs a thorough health assessment to determine current medication needs, specialty referral requirements, level of health risk knowledge, and the need for primary care intervention. Most health care programs have depended on member demand for services. It's the goal of this new program to provide all necessary health care for a population of students whether the care is first requested or not.

Mokrohisky explains, "In other words, we take the view that many risks to health exist for these students that they may not be aware of or appreciate sufficiently, and our job is to coordinate care for them in such a way that it impacts their entire lives positively."

How will we know if the program is successful?

"A program like *School Connections* has a built-in quality measurement tool," Mokrohisky says. "The overall success of health care for students is their adaptation to and enjoyment of learning in the school environment, as well as their functioning in the family setting. While it's difficult to predict long-term outcome for young people in terms of career or personal accomplishments in life, it is clearly possible to measure their immediate mastery of academic and personal milestones in school settings."

But physicians gain more than scientific knowledge by becoming involved with programs like these. "It gives us a sense of participation in the effort to solve the crisis of the uninsured in the country," Mokrohisky explains. "This problem is increasing in scope and the important experience of a health plan like Kaiser Permanente should be brought to the table in negotiating solutions."

Bograd says *School Connections* taps into physicians' strong sense of social mission.

"Permanente physicians can really accomplish a lot and get personal satisfaction by working in these programs. There is a tremendous pool of talent and a great need for their help."

Community Impact

School Connections was launched in January 1997 but already has influenced local and state leaders and has refocused debate on the issue of health care for uninsured children. Colorado's chief executive, Governor Roy Romer, participated in announcing *School Connections* and mentioned the program in his state-of-the-state message nearly a month later.

Bruce Guernsey, Director of the Colorado Department of Public Health and Environment's School Based Health Initiative, summed up the activity surrounding the program best when he said, "There has been a tremendous stirring in the community among health plans, public policy makers, and educators since *School Connections* was announced. Our phones were ringing off the hooks."

The media covered the announcement extensively, including a segment on *Good Morning America* and a front page headline and story in the *Denver Post*, one of the local daily newspapers. Every local television station led with the story or had it in their news-

casts. Calls from media and from others around the country continue to pour in, including a request for information from the US Department of Human Health and Services.

As of March 1, only eight weeks into the program, more than 300 children and teenagers have been accepted into the program. As word spreads about this two-year pilot program, the additional 1,000 available slots will most likely go fast and pave the way for expansion in 1999.

"*School Connections* will resonate for years to come," Guernsey says. "Bills now in the legislature already have leveraged the thinking of *School Connections*."

Colorado State Senator Sally Hopper puts it another way: "I'm especially excited about *School Connections* because it's a first step toward meeting a critical need in our state."

Shields sees the true benefit of the program reflected daily in the many relieved faces and voices of parents like Angela Baker.

"Parents are very excited about the opportunity to finally have access to affordable, consistent health care coverage for their child," she says. "I hear over and over again how relieved they are now that they can finally afford to get glasses for their kids. It's very exciting to be part of an effort to make a difference with these families." ❖

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"We must recognize our shortcomings and work to eliminate them. We must maintain a sense of responsibility for the most effective use of the Health Plan member's dollar. Above all, we must remain dedicated to the highest possible standards of medical care."

Raymond M. Kay, MD (1904-97). Written in his 1979 book, "Historial Review of the Southern California Permanente Medical Group." Dr. Kay co-founded the Kaiser Permanente Medical Care Program in Southern California and served as SCPMG's first Medical Director (1949-69).