DOCUMENT RESUME

ED 481 225 PS 031 568

TITLE	Georgia Health Policy Center Child Policy Briefs, 2001.
PUB DATE	2001-00-00
NOTE	12p.; Produced by Georgia State University, Education Policy Group, Andrew Young School of Policy Studies.
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PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	EDRS Price MF01/PC01 Plus Postage.
DESCRIPTORS	Access to Health Care; At Risk Persons; Child Care; Child Care Quality; *Child Health; *Child Welfare; *Children; Dental Health; Employed Parents; Foster Care; Program Descriptions; *Public Policy; School Health Services; Special Health Problems; *Well Being
IDENTIFIERS	*Georgia; Kinship Foster Care; School Based Health Clinics; School Based Services; State Policy

ABSTRACT

This set of briefs discusses state public policy and implications as they pertain to children in Georgia. The five briefs each address a single policy issue: kinship care, dental care, child care, special health care needs, and school health practice in Georgia. Each two-page brief provides background information on the issue, details the types of prevention and intervention programs available in Georgia, presents information on strategies to address similar problems in other states, and offers recommendations for improving Georgia's capacity to respond to the needs of children and their families. (KB)

Georgia Health Policy Center
Child Policy Briefs, 2001.

Andrew Young School of Policy Studies
Georgia State University

2001

Child Policy Brief

Children Raised by Grandparents and Other Relatives Need Support

An increasing number of children are living with grandparents and other relatives because their parents are unable or unwilling to care for them. This phenomenon of "kinship care" provides stability and permanence for children whose lives are disrupted due to abuse, neglect, or other problems. However, children raised by their grandparents or other kin are more likely than children in traditional foster care to live in poverty, to have special health and educational needs, and to lack access to health care. The needs of kinship families are receiving increased attention from policymakers as the importance of these relationships becomes more widely understood.

A Definition of Kinship Care

The term "kinship care" broadly refers to circumstances in which children are in the primary care of a relative because their own parents are not able or willing to raise them. Causes usually include a parent's substance abuse or mental illness, often leading to child abuse and neglect. Teen pregnancy, domestic violence and HIV/AIDS are less frequent causes.

The definition includes both formal placement with relatives through the child welfare and/or court systems, and informal arrangements initiated by concerned family members. The relative may have obtained some form of legal custody, or not. Kinship care is increasingly important in Georgia because the number of foster families is declining. Placement with relatives allows children to maintain familial and cultural ties.

Between 42,000 and 65,000 Georgia children live in their grandparents' households with neither of their parents present. An unknown number live with relatives other than grandparents. The tradition of grandparents raising grandchildren has been particularly strong in the Southeast, and Georgia ranks seventh in the nation for percent of children living in a grandparent's household.

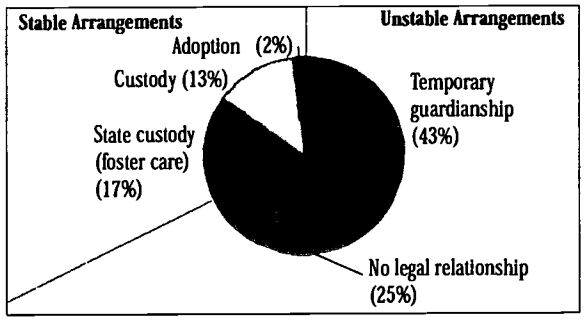
Needs

Research on kinship care shows that these families face problems in three major areas:

Secure Legal Status

Many kinship families lack formal, permanent custody or guardianship of the children in their care. Permanent living arrangements are important because children fare better in a secure home environment, even without their own parents. The caregiver needs authority to make decisions affecting the child's well being, including medical treatment and school enrollment.

In a sample of grandparent-headed families in Atlanta, custodial relationships varied widely, with one quarter of grandparents having no legal relationship with their grandchildren whatsoever. Over two thirds of their children had unstable living arrangements which could be revoked by a parent at any time.



From Yorker, et al. "Custodial Relationships of Grandparents Raising Grandchildren: Results of a Home-Based Intervention Study", Juvenile and Family Court Journal. Spring 1998, p. 20.

Financial Support

Grandparents typically do not anticipate the expenses of raising a second generation of children and have not saved money for their care. They often live on a fixed income. A 1997 national study showed that while 17% of children residing with their parents lived below the federal poverty level, 27% of children residing with their grandparents lived in poverty. Children living with a grandmother only and no parents present were the most severely impacted, with 63% falling below the federal poverty level.

Of the approximately 42,000 - 65,000 children living with grandparents only in Georgia, approximately 18,000 - 28,000 fall below the federal poverty level. Three sources of cash assistance are available to help support poor children in these families, and each has limitations. (See table on following page.)

Health Care Access

There are significant barriers to routine primary health care for kinship children in Georgia. Children living with grandparents are two and a half times more likely than children living with their own parents to be uninsured. Medicaid and PeachCare provide alternatives for low-income children, but if the caregiver also applies for Medicaid for herself, her income will count in assessing the child's eligibility. While almost all foster children automatically enroll in Medicaid,

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Kinship Care

Sources of Cash Assistance

Cash assistance program	Georgia eligibility requirements	Benefits	Limitations
Adoption Assistance	Children must be adopted by a court-approved relative or other adult(s)	$365 per child per month	Requires termination of parental rights, which may cause family strife and threaten parents' acceptance of kinship placement.
Foster Care	Children are placed in state custody. Relative's home must meet all state standards for approved foster home.	$365 per child per month	Family loses custody to the state, which can change the placement at any time. Caregiver must undergo regular supervision by caseworkers.
Temporary Assistance to Needy Families (TANF)	Child-only grants scaled to child's income; income limits set annually by Georgia legislature. Work activity requirements waived for kinship caregivers in TANF State Plan issued January 2001.	$155 per child per month	Child must live with a "specified relative" (within 5th degree) for child and/or caregiver to be eligible for benefits

children outside the foster care system must apply separately. Health insurance and routine care are essential for children living with grandparents and other relatives because they typically have a range of special health care needs, including low birth weight, learning disabilities, prenatal drug or alcohol exposure, and emotional and mental health problems.

Solutions in Other States

Since 1996, 19 states have created new programs specifically designed to support grandparents and other relative caregivers who are raising children. These programs promote permanency through kinship care arrangements while minimizing state involvement, recognizing that most kinship families do not require the strict oversight placed upon traditional foster parents.

Relative Caregiver Program Experiences High Enrollment in Florida

In 1998, Florida created a new program administered by the Department of Family and Children's services that supports "caregivers who are relatives and who would be unable to serve in that capacity without...payment because of financial burden."

- Already serves over 7,000 children statewide
- Diverse custody and guardianship arrangements qualify
- Exempts caregivers from foster care licensing requirements
- Funded through TANF block grant

Increasing Permanent Placements Through Subsidized Guardianship in Illinois

Illinois uses federal funds for a demonstration project to support families that have opted for permanent legal guardianship instead of foster care or adoption.

- Achieved 14% higher permanency rate for children in subsidized legal guardianship than in conventional foster care population
- Pays same as adoption assistance rate to legal guardians
- Created through waiver from Department of Health and Human Services
- Early evaluation results show significant cost savings over foster care.

Building Kinship Support Networks in Tennessee

Tennessee is launching a pilot program to enhance supportive services for kinship families and build a new private sector network to address kinship families' needs.

- Private nonprofit service providers are currently applying to administer a comprehensive program including therapeutic child care, respite care, information and referral services, support groups, legal assistance, and counseling.
- Funded through TANF block grant.
- Cash subsidy will be designed by private providers, tailored to family needs.
- Program will serve Nashville, Memphis and one rural county.

How Can Georgia Respond?

"Subsidized legal guardianship" programs are the most common vehicle used to support kinship families. These programs introduce subsidies that pay a cash benefit to relatives who become their child's court-appointed custodian or guardian. An effective subsidized legal guardianship program should include:

- Cash assistance, comparable to Foster Care rates
- Automatic Medicaid or PeachCare eligibility
- Reimbursement of costs related to attaining legal guardianship
- Supportive services including quality child care, respite care, and counseling

If a foster care-comparable cash benefit were available to Georgia children living with grandparents who fall below the federal poverty level, it could cost the state from $8 to $12 million per year. Additional funds would be required to cover health insurance, legal cost reimbursement and supportive services. However, an unknown number of these children already receive or will eventually receive services through TANF, Child Protective Services, Foster Care, and even the juvenile justice system. Further research must be conducted to determine overall costs and benefits of subsidized kinship care, but early results from other states confirm the efficacy of these programs in promoting child well-being and preventing future problems.

Conclusion

The increase in children entering foster care in Georgia over the last year, and a significant decrease in the number of foster parents available, indicate a growing need for grandparent and other relative caregivers. However, kinship caregivers can only serve when they have adequate resources to meet the expenses of raising children. Georgia could help kinship families by creating a program that specifically addresses their unique needs.

For more information, please contact Jennifer Edwards, Andrew Young School of Policy Studies, 404-651-1540.

Child Policy Brief

Inadequate access to dental care is a major problem for Georgia's low-income children. Dental caries (tooth decay) is the single most common chronic childhood disease — 5 times more common than asthma. Pain and suffering due to untreated diseases lead to problems in eating, speaking, and paying attention in school. According to Georgia's teachers, dental problems are one of the two most frequently cited reasons that children miss school (along with vision problems.)

Low-income families seeking dental care in Georgia are very frustrated. Insurance, either Medicaid or PeachCare for Kids, is not a guarantee of access to care. Only about one quarter of Medicaid and PeachCare children (200,000 out of 800,000 children) were able to see a dentist in FY2000, though more than twice that number sought care. Low-income families without insurance are even less likely to get dental care, according to national studies. In Georgia, the uninsured (about 300,000 children) only have access through the Oral Health Program of the Department of Public Health. In FY2000, it provided screening and referral services to 81,000 children, but it can not treat many of the children who have dental diseases.

Georgia has begun addressing the dental crisis by raising dentists' Medicaid and PeachCare rates. Rate hikes in July 1998 and July 2000 have made public payments competitive with private payments, addressing the number one reason dentists give for not seeing more public patients. In this paper, we examine the likely impact of recent changes and propose actions that are needed to gain access for every child.

Likely Impact Of Recent Changes

The 1998 rate change was small and had little effect, and it is too soon to measure the impact of the rate increase from July 2000. However, based on four other states that have made similar payment changes, we expect to see four things happen sequentially in Georgia. At first, these changes could raise concerns, because spending will increase before access increases.

1. The same volume of services will cost more, as price per procedure has increased.

2. The volume of procedures for children already accessing care will increase as their needs are more comprehensively and appropriately met.

3. The number of children obtaining care will increase as participating dentists increase their volume of Medicaid and PeachCare patients.

4. The volume of dentists who participate in Medicaid and PeachCare will increase as the dental community becomes more involved, particularly through peer communication that "the program works".

Other steps taken by the Division of Medical Assistance (DMA) will help speed Georgia along this path. In July 2000, DMA simplified administrative procedures for dentists and began working with the Georgia Dental Association to publicize the changes to dentists and recruit more dentists to participate. While these changes can be expected to increase access significantly, we estimate a third or more of Medicaid and PeachCare children will still not have access to dental care because of capacity ("supply side") limitations relative to need and demand for care.

What Else Can Georgia Do?

A recent survey of other states showed significant legislative activity to address dental access problems across the country. Some of the ideas suggest improvements Georgia could try.

- After low reimbursement, dentists report "broken appointments" as the top problem in providing effective care to low- and moderate-income families. Alabama began a program to address this issue in October, 2000. They use caseworkers paid with Medicaid and/or Title V funding (Maternal and Child Block Grant) to assist families who have missed an appointment. Dentists can refer a family to the caseworkers who will then reschedule the appointment and help families keep it. It is too soon to know if the program is working, but it is popular among dentists.

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Dental Care

- Provide scholarships to dental school or loan repayment programs for dentists to work in underserved areas if they see Medicaid and PeachCare kids (Maine and Maryland).

- Locate satellite clinics of dental schools in underserved areas and have dental faculty and students staff them (New York and Connecticut).

- Enhance provider relations by strengthening provider service and outreach, and instituting programs that complement dentists' needs. The state could create a purchasing cooperative only available to participating dentists or offer free continuing education to Medicaid dentists on topics highly relevant to the Medicaid population, such as cultural competence, children with special needs, treating patients with language barriers, etc.

Other experiments are underway to tap into existing capacity. Vermont's oral health program is partnering with underused private offices to let public practice dentists deliver services there at off times. Though critics have opposed large public dental systems because it is hard to recruit dentists and the duplicate infrastructure is inefficient, there are situations, as in Vermont, where they may work.

Finally, a frequently mentioned idea is to use independent dental hygienists to substitute for dentists. However, hygienists are trained to provide only preventive care, and would not be able to treat cavities or gum disease, which are the biggest needs in Georgia.

A Georgia summit on improving oral health access for children is being planned by the Division of Public Health for Spring 2001. A Georgia Oral Health Initiative Advisory Partnership is being formed including key executive and legislative branch officials, provider associations, and the Medical College of Georgia, School of Dentistry. The goal of the summit is to discuss collaborative approaches that can increase access to dental care.

Conclusion

Georgia' dental system, both private and public, does not have sufficient capacity to assure dental access to all low-income children. If the state is going to succeed in helping all children be ready for and productive in school, dental access is an essential problem to address. There is a need for leadership and coordination between the two primary programs providing dental services for low-income children, as well as ongoing monitoring and evaluation to examine the impact of recent and future changes. Piloting new activities in different parts of the state may make it easier to determine the most successful approaches.

For more information, please contact Jennifer Edwards, Andrew Young School of Policy Studies, 404-651-1540.

Georgia's Dental Capacity

Georgia has 3,900 private practice dentists. 18 counties and parts of 10 others are designated by the Federal government as Dental Health Professional Shortage Areas.

The Georgia Oral Health Prevention Program, run by the Department of Public Health, funds school-based dental prevention services in the areas of the state with the most low-income children. Other dental public health resources include 43 public health department dental clinics, serving 64 counties, and six community health centers with dental facilities. Fulton County funds mobile dental vans to serve hard to reach populations.

Dental shortages for low-income families tend to be most acute when the economy is strong, as higher income people choose to buy dental care. When the economy slows down, low-income families find it easier to get appointments, unless public programs make cutbacks in provider payments.

State Expenditures for Children's Dental Services

	Medicaid and PeachCare		Division of Public Health	
	$ million	Children	$ million	Children*
FY98	27.5	200,397	1.4	129,175
FY99	35.9	195,117	1.4	60,974
FY00	38.4	204,047	1.4	81,676
FY01 (bud.)	59.9	Unavailable	2.4	Unavailable

*Combined state and local oral health initiatives.

Child Policy Brief

Issue

Quality child care is critically important to preparing young children for school and work, especially disadvantaged children who are at-risk for academic and social problems. Georgia's policies lag behind most other states' in assuring quality care or making it available to all at-risk children.

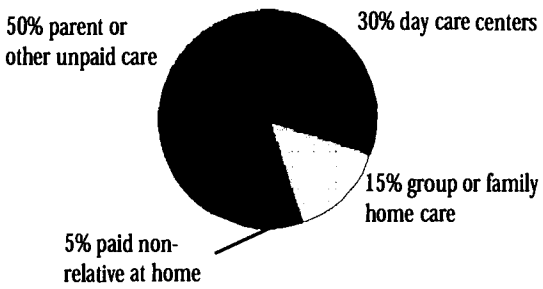
Recommendation

Implement strategies for quality improvement such as those recommended by the Georgia Early Learning Initiative (GELI) and others, and use federal and state subsidies so that all low-income children have access to affordable, quality care.

Background

Half of all preschool age children in Georgia, 285,000 of the state's 570,000 children under age 5, are cared for by paid child care providers.

Care Arrangements of Preschoolers in Georgia



Georgia regulates the safety of centers and some home-based child care providers, and subsidizes care to enable many parents in poor families to work or attend school. However, Georgia has not made a financial commitment to address the quality of child care — despite strong research showing that high quality child care has a large, positive impact on children and families, with long term education and employment benefits accruing to the state. Quality child care contributes to children's intellectual, physical, and emotional development, with children at highest risk receiving the greatest benefits. For this reason, many states are working to assure their child care options meet the criteria for high quality care. Recent findings from the Georgia Early Learning Initiative (GELI) have encouraged Georgia to move in that direction, too.

Quality improvement alone can price child care beyond the reach of low-income families. 170,000 of Georgia's preschoolers live in poor or near poor families where any present parents work. Public subsidies currently are directed to families leaving welfare, with occasional surplus funds available for other low-income families. Almost two-thirds of low-income families are without any assistance. Further, subsidy levels are not adequate to purchase the higher quality care available. Lastly, families in some parts of the state have the additional barrier of no high quality care nearby.

This paper describes the magnitude of effort needed to assure quality, affordable care. A later paper will address after-school care needs of families with school-age children.

What is Quality Child Care?

Many interpersonal and environmental factors contribute to a child's experience in paid child care. Methods exist to measure quality, but they are expensive to implement because they require observation by trained scorers. Often proxies are used to estimate the likelihood that quality care is being delivered. Because child-teacher interaction is the most important factor in child care quality, one common indicator is the teacher to child ratio. Fewer children per teacher result in higher levels of individual attention and better cognitive outcomes for children of all ages. Teacher to child ratios are substandard in Georgia. For example, Georgia regulations allow 1:15 rather than the more commonly used ratio of 1:10 for 3 year olds. The recommended classroom size is 20 children, but Georgia allows 30.

Teacher education is also important. Teachers with at least a bachelor's degree, and teachers with specific training in child development, are important contributors in elevating children's language skills and performance on intelligence tests. Again, Georgia lags behind the nation in training requirements for its child care teachers.

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Availability of Quality Child Care

The availability of quality child care in Georgia is frighteningly low. Just 172 centers and 16 home day cares are accredited by one of three national accrediting organizations, providing spaces for approximately 21,000 children. This only meets the needs of 7% of preschoolers using paid child care. Seven percent is a slight undercount because centers and family day care homes do not have to be accredited to assure quality. However, even in a national study based on classroom observation, just 14% of centers and 9 percent of home day care settings had acceptable quality care. Thirty-five to 40% of the settings studied actually had such poor quality as to inhibit children's development.

Raising Georgia's child care to the desired level of quality would increase the cost considerably, primarily because more teachers with more training would need to be hired. To reduce the tremendous amount of turnover in the field, salaries would also have to be raised to be more competitive with other industries. GELI estimates the cost of providing quality child care to all preschoolers currently served in out-of-home settings in Georgia would be $185 million.

Affordability of Quality Child Care

The Federal government has determined that a reasonable family contribution to the cost of child care is up to ten percent of household income. For a family of four at 185% of the poverty threshold, the guideline would suggest they could afford $60 per week for child care, or $30 per child. Accredited child care in Georgia costs on average $100-$125 per child per week, far exceeding a reasonable share of income for these families. The figure at right shows the enormous gap low-income families face in being able to afford quality child care.

The Department of Human Resources provides subsidies to families leaving welfare and, when there are extra funds, they also provide subsidies to other low-income families. In 1999, 56,400 families received subsidies out of 105,000 low-income families that needed them. 21,000 families receive federal assistance by enrolling in the Head Start and Early Head Start programs.

An estimated $199 million would be needed to subsidize quality care for all low-income families where any parents in the household work. A policy of paying for greater subsidies for high quality care would have to be linked with higher standards and accountability.

Access to Affordable, Quality Child Care

The geographic accessibility of care throughout the state is a third critical issue for families. The 4% of spaces that are accredited are mostly located in the Atlanta metropolitan area. If quality and affordability are addressed, geographic access would be the next most pressing concern for Georgia families and bears future study. Parents seeking care for a child with a disability or other special health care needs face shortages as well.

Conclusions

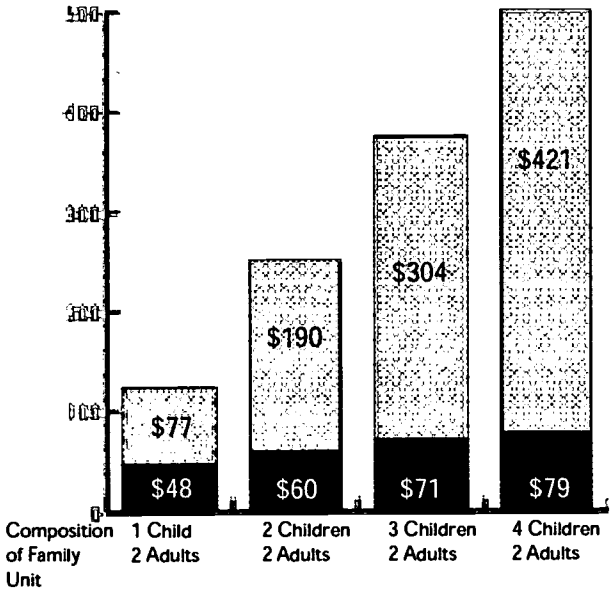
Assuring quality child care to Georgia's preschoolers is an expensive proposition. Federal child care subsidies are helpful, but a major state and private sector commitment is still needed. Some states have found that improvements in child care reap immediate benefits in lower education costs and higher tax revenue, and longer term benefits in lower juvenile justice, education, social, and health care costs.

The work already done by the Georgia Early Learning Initiative and others lays out a credible, responsible blueprint for the state. It would raise the quality of care in Georgia significantly but may not help all low-income families in the short term. An alternative or complementary strategy targeting low-income families may have more benefits for the state.

Acknowledgements: We would like to thank the Georgia Child Care Council, BROC, and GELI for providing background information for this paper. However, the authors take responsibility for any errors or omissions.

For more information, please contact Jennifer Edwards, Andrew Young School of Policy Studies, 404-651-1540.

The Affordability Gap
Example of Families at 185% of Federal Poverty Level



Child Policy Brief

Special Health Care Needs

Issue

Children with special health care needs incur enormous health costs and use services from many state agencies in an environment with minimal coordination or accountability.

Recommendations

The state has a responsibility to monitor and report on access and quality of care, as well as a financial incentive to use funds efficiently. Critical activities are:

- Assuring the availability of services that meet children's needs
- Appropriately financing benefits, including maximizing the use of federal funds, reducing duplication of services, and coordinating payment strategies
- Convening payer, provider, and family representatives to develop a coherent strategy for care
- Developing an accessible, user-friendly guide for families and providers to navigate the existing system, and
- Establishing a statewide data collection and reporting system that measures cost, needs, services, and quality.

Children with special health care needs are:
Those who have or are at increased risk of chronic physical, developmental, behavioral, or emotional conditions and who require health and related services beyond that required by children generally.
Maternal and Child Health (MCH) Bureau, 1998

Changing Federal and State Expectations

In Georgia, children with special health care needs (CSHCN) rely on a wide range of state and federally funded services to maintain or improve their health and well being. In recent years, advocates, providers, parents, and agency staff have met to attempt care coordination and to simplify administrative processes. These efforts have borne little fruit, in part because of the lack of good information on which to base sound policy and lack of clear direction.

Three recent changes suggest an opportunity may exist for addressing these children's needs. First, Georgia has strengthened its commitment to children. Pre-Kindergarten programs, education reforms, Hope Scholarships, Family Connection, Medicaid expansions and PeachCare for Kids are just a few of the major initiatives that are preparing children for school and productive lives after school. Second, the Federal government has increased expectations about states' provision of services for children with special needs. The Department of Health and Human Services through maternal and child health programs, Medicaid, and CHIP, has begun asking states to demonstrate that CSHCN have access to appropriate services. The Department of Education requires states to provide special education and related services to enable all students to participate in the education system. Third, research has begun to document that access problems do exist.

Who Are Children With Special Health Care Needs?

Almost a fifth of U.S. children have at least one special health care need that may be interfering with their success in school and beyond. CSHCN miss, on average, 17 school days a year; fall behind in their school work; and at the high school level, 35% have failing grades.

Based on national estimates, over 370,000 children in Georgia can be expected to have a special health care need. Among Medicaid children, the most frequent diagnoses are mental illness, asthma, perinatal complications, and congenital disorders. Some have substantial health care needs, and cost the state over $70,000 per year for health care needs alone.

CSHCN are served by over twenty agencies and programs. (See table next page.)

How Are CSHCN Faring In Georgia?

Federal regulations and state initiatives create a complex system of public services. In 1999, the Georgia Health Policy Center conducted interviews with providers, state personnel, families, and advocates to understand how children were faring. Our main findings were:

- Families, providers, and state personnel have difficulty identifying the services CSHCN are eligible for and how to enroll them. Once enrolled, confusion exists about benefit limits and continued eligibility.

Special Needs

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Special Health Care Needs

Georgia's Largest Public Programs Serving Children with Special Needs

Agency/Program	Estimated CSHCN Served Per Year	Annual Expenditure
Department of Community Health		$510,780,245
TANF, RSM, and Foster Care	105,000	$304,040,680
SSI	20,080	$141,005,365
PeachCare for Kids	18,900	$ 65,734,200
Department of Human Resources		$147,102,764
DPH, Children's Medical Services	16,000	$ 30,686,580
DPH, Babies Can't Wait (DoE funds)	6,000	$ 18,590,928
MH/SA, Community Services	Not Available	$ 50,825,256
MH/SA, Match Program	1,100	$ 47,000,000
Department of Education	150,000	$741,000,000
Special Education (all costs)		
Department of Juvenile Justice	59,000	$ 19,200,000
Youth Development Campuses		$ 9,400,000
Regional Youth Detention Centers		$ 9,800,000
Total Annual Expenditures in the Largest Programs		**$1,418,083,009**

Note: Children receive services in multiple places so a sum of the children in these programs would overcount the total children served.

- Substantial numbers of CSHCN access multiple agencies with minimal coordination among the agencies. Duplication of services; inefficient use of federal, state, and local tax dollars; and a lack of accountability arise from this fragmentation.

- Providers seek higher reimbursement for care of medically complex children.

- Monitoring the quality of services and management of care are essential for improvement and increased accountability.

- Some children are going without needed services, especially specialty physician services (18%) and dental care (51%).

What Have Other States Done?

Like Georgia, most states have fragmented delivery systems and funding streams, and can provide little or no information about quality or adequacy of care. A few states have begun to identify and enroll CSHCN in special programs.

- Florida diverts CSHCN from the Medicaid and CHIP programs to the Title V program, which is a complete and separate delivery system.

- California has a specialty-care carve out. Children with special needs are simultaneously enrolled in managed care plans for primary care and in the Children's Services program (Title V) for specialty care.

- Connecticut and North Carolina established wrap-around services for children who exceed the basic benefits of public insurance programs. CSHCN receive services through the mainstream system and are eligible for an additional package of clinical and support services.

A growing number of states are attempting to blend funding from different agencies. Their efforts have emphasized strong leadership and inter-agency collaboration to overcome problems experienced in the past.

Conclusion

Assuring comprehensive access to needed care for children with special health care needs is a major undertaking. We believe this can happen best if the State will:

- Support agencies to work together to coordinate eligibility, funding, and service delivery
- Facilitate family participation in planning and monitoring their child's care
- Assure the availability of benefits that meet children's needs
- Measure and improve the cost, delivery, and quality of services
- Coordinate financing benefits, including maximizing the use of federal funds
- Developing an accessible, user-friendly guide for families and providers to navigate the existing system.

The challenges are enormous and a strong commitment by all parties is needed. The Federal push for accountability will make it increasingly evident that our current system is inadequate. The evidence is mounting that changes must be made, and some models exist for building a more integrated system.

For more information, please contact Jennifer Edwards, Andrew Young School of Policy Studies, 404-651-1540.

Child Policy Brief

Improving School Health in Georgia

Last year the Georgia legislature allocated $30 million in House Bill 1187, the "A+ Education Reform Act of 2000" (A+), to augment funding for school health personnel. Prior to implementation of this Act, Georgia lagged behind the rest of the country as one of very few states that did not directly fund school nurses or require health personnel in schools.

Lack of school health resources has placed enormous pressure on schools. Children in Georgia are sicker than in most of the country, and so come to school with greater healthcare needs. High rates of chronic diseases require daytime monitoring and treatment. Increasingly, medically fragile children are attending school as a result of federal law. In addition, many rural communities lack healthcare providers, including pediatricians, dentists, or medical specialists. For all these reasons, school health funding was a timely policy change with the potential for significantly improving child health in Georgia. Healthy children are better learners.

The Georgia Health Policy Center surveyed school superintendents to measure the impact of A+ funding and determine additional unmet needs.

The survey was conducted in January and February 2001. Of 180 school districts in Georgia, 113 superintendents responded (63%). The responding districts serve over 80% of the state's students.

School-based Health Services in Georgia Prior to A+

Historically, schools have been important, but varied, in meeting the healthcare needs of children. In schools with the fewest services, school employees untrained in healthcare dispensed medicine, cared for children with special needs, and provided emergency first aid. Controlled substances including Ritalin were stored in desk drawers and distributed by teachers or school secretaries. Classroom teachers administered nebulizer treatments for asthma. Clerical staff and paraprofessionals assisted children with special needs by clearing tracheotomy tubes, tube feeding, and providing an array of other specialized services.

In the best school health programs, comprehensive health services were provided by full-time registered nurses (RNs). Nurses developed close contacts with physicians, hospitals, the local health department, DFCS, and community Family Connection staff to identify problems early and make appropriate referrals. Nurses acquired training specific to school nursing. The school system was reimbursed by Medicaid for significant amounts of primary care.

In the year prior to A+, each school nurse was serving over 3,000 children on average. When LPNs are also counted, each nurse was still caring for over 2,300 students. Funding for nurse salaries and supplies came from state and local government sources ($14 million in our survey), and local hospitals, businesses, and charitable donations ($1.4 million).

Impact of A+ School Health Funding

A+ funding, made possible by the tobacco settlement, has made a tremendous contribution to the expansion of school-based health services in Georgia. Each school system was allotted $20,000 plus $18.89 per student. No programmatic guidance was included, though funding was restricted to be used for personnel.

According to the survey, total spending on school health services more than doubled from FY00 to FY01, and the number of nurses increased 150%. While it is too soon to measure the impact on children's health outcomes or school performance, such measurement could be possible in the next year.

Additional funding is needed for Georgia to achieve either the state's goal of a nurse in every school, or the national standard of a nurse for every 750 students. Medical supplies, training, guidance, and coordination are additional priorities named by the school superintendents surveyed.

While many schools currently utilize their local health departments and the Medicaid program, some superintendents believe they need assistance to develop these relationships further to coordinate available resources. A statewide strategy to make the most efficient use of state and federal funds should be developed. Model school districts can be identified and invited to lead such an effort.

Key Findings of the Survey

Personnel

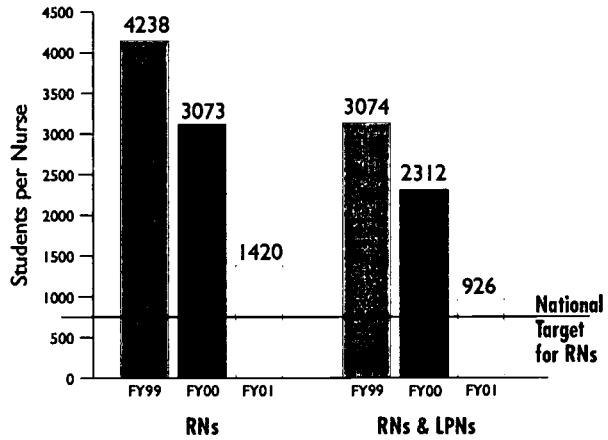
The ratio of school nurses (RNs and LPNs) to students has improved from 2,300:1 in FY00 to 926:1 in FY01 (see Figure on reverse side). However, nearly half of the schools surveyed have no nurses and many others share a nurse among two or more schools. We estimate that an additional 700 RNs or LPNs are needed to have a nurse in every school.

Many school districts are filling the nurse gap by relying on unlicensed health personnel, such as paraprofessionals, clinic monitors and other unlicensed assistive personnel. In FY00, these

Georgia State University ANDREW YOUNG SCHOOL OF POLICY STUDIES

School Health

Improved Ratio of Students to Nurses in Georgia



employees made up 96 health positions among our survey respondents. In FY01, the number increased to 244 (a 150% increase). By comparison, the number of RNs grew from 238 to 499 in the same period, and LPNs grew from 64 to 222.

Other Needs

Nurses need other supports to make a school health program. Many programs lack infrastructure such as phones, clinic space, running water, or computers to maintain records and retrieve medical information. Others lack the most basic supplies, such as thermometers, band-aids, stethoscopes, and blood pressure cuffs.

Needs most frequently mentioned in the survey were:

- Guidelines to help school administrators set health priorities and best utilize new personnel; and training in school health issues for clinical staff (45%)
- Medical supplies, such as band-aids, blood pressure cuffs, and stethoscopes (38%)
- Expanded services, including dental, mental health, and teen services that are either unavailable in the community or especially difficult to coordinate with children's and parents' schedules (37%)
- Ability to get reimbursement for services they provide to Medicaid children (18%)

Other Sources of Funding

Funding from A+ is by far the largest school health resource in most Georgia districts. Other significant sources of support come from Medicaid, local boards of education, county boards of health, area hospitals and private providers. Some federal funding from the Department of Education is channeled to each school district, but it is not possible to identify how much of that is spent on school health. Based on survey responses, we estimate the federal spending on school health is less than one-tenth of A+ spending.

According to our survey, the primary source of state funding other than A+ is Medicaid. Medicaid pays for care for poor and low-income children with special health care needs to receive services in the school through the Children's Intervention School Services (CISS) program. A small number of districts additionally have been able to bill Medicaid for primary care services Medicaid children receive.

County funding streams include the local board of education, county board of health, and county commission. Survey respondents reported that Medicaid reimbursement, together with those county funds, totaled almost $15 million (about two-thirds as much as A+ funds in 2001).

Partnerships

In addition to financial support, many school health programs get professional and technical assistance from community partners, especially the health department and local hospitals. Seventy-seven percent of districts collaborate with the local health department. Most often, collaboration consists of health department personnel providing screening. One out of six districts has a more involved relationship with their health department. For example, the health department supervises the nurses, helps hire nurses, and provides consultations.

Other partners in delivering health care services include local hospitals (27%) and area health care providers (23%). Respondents also reported collaborating with Family Connection (32%) and DFCS (32%).

Shortages of Health Services in the Community

One important role school health programs play is identifying health needs of school children and referring them to providers in the community. However, when providers are not available in the community, school health personnel struggle to meet students' needs. The most commonly reported local shortages for children were: dental care (34%); mental health services (14%); transportation services (13%); vision care, especially eyeglasses (12%); and services for children with special health care needs (12%). Policymakers may want to consider expanding school health programs in underserved communities to fill these gaps.

Conclusion

A+ funding is helping to make school health programs possible for the first time for many schools in Georgia. Based on experiences in other states, improvements in children's health and their ability to stay in school and learn will result.

More support is needed, however, to provide basic health services to all school children. Superintendents report they need more funding, policy and programmatic guidance, collaborative partners, and coordination with key agencies.

Some school districts are resourcefully using federal and state revenue to fund more expansive programs. This and other innovations are reported in a longer paper available from the Georgia Health Policy Center.

For more information, please contact Jennifer Edwards, Georgia Health Policy Center, Andrew Young School of Policy Studies, 404-651-1540.

Acknowledgements: We would like to thank the Governor's Office of Planning and Budget, the Georgia School Superintendents' Association, and all the school personnel who completed the survey.

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EFF-089 (1/2003)