



Health and Health Care in Schools

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In this issue:

Pediatric Oral Health—New Attention to an Old Problem

A Medicaid-insured child's death from tooth infection spurs debate on the availability of dental care for many children.

The School as Drug Mart

It's easy, students say, to trade prescription drugs at school.

Beverage Makers Promise Progress on School Drinks

A progress report on changes in beverages sold in schools is due in August from the American Beverage Association.

SCHIP—The Second-Hottest Item on Congress' Agenda

Congress and the President seem at odds on the most popular federally supported health insurance program for children.

WORTH NOTING

- Public Health Week Focuses on Public Health Threats
- What's in a Name—Is It Drug Abuse or Addiction?
- March News Alerts

Pediatric Oral Health—New Attention to an Old Problem

When a 12-year-old Medicaid-insured child living in a suburb of Washington, D.C., died of a brain infection caused by an untreated abscessed tooth, it was hard for Congress to ignore the questions raised by the tragedy.

In a hearing called March 27, just a month after Deamonte Driver's death, the chairman and ranking minority members of the House Subcommittee on Health called it "shocking" that in the U.S. today, oral disease is the most prevalent chronic disease of children, and 80 percent of the decay occurs in 25 percent of children—"primarily low-income and minority children."

The president of the American Dental Association (ADA), who said she is herself a Medicaid provider, echoed the committee's concern that dental care is not available to uninsured children or in many cases to children who are covered by Medicaid, as was the case with Deamonte. The boy's death "underscores the significant chronic deficiencies in our country's dental Medicaid program," said ADA president Kathleen Roth.

Barriers that make it difficult to supply care, Roth said, include the geographic distribution of providers, who are often located far from neighborhoods of children who are covered by Medicaid. She conceded that Medicaid payment rates are also a problem, with analyses showing that Medicaid reimbursements are lower than Medicare or private insurance. "In short, the vast majority of the dental Medicaid programs in the United States are woefully under funded and the reimbursement rates simply cannot attract enough dentists," particularly young people who are graduating from dental school with indebtedness often exceeding \$150,000, she said. "This level of debt puts a great deal of

pressure on young dentists to set up private practices in relatively affluent areas to the exclusion of underserved areas."

"To truly address the oral health access problems faced by underserved populations, we need to get more private sector dentists participating in Medicaid," she said. "Over 90 percent of practitioners are in the private sector, and with over 30 million children estimated to be Medicaid-eligible, there is simply no other way to adequately serve such a large segment of our nation."

The Problems

Calling the death of 12-year-old Deamonte Driver "a result of the passive complicity of a failed system," Dr. Stephen Corbin, an official of Special Olympics International, described Deamonte's condition as "heart failure, precipitated after an infection of the brain, arising out of a blood-borne infection that moved from an infected pulp of a tooth, that had been preceded by a deep carious lesion of the dentin of the tooth, that was preceded by an extensive carious lesion of the enamel, that was preceded by a minimally invasive carious lesion of the enamel, that was preceded by a barely detectable lesion of the enamel."

"Was this some exotic new invader unknown to medical science? Was this a clinical condition for which there was no known treatment? Sadly, the answers to these questions are 'no, no, and no!'" Instead, he said, Deamonte died "from a disease that we have known how to prevent and treat for more than a hundred years."

Speaking for the American Academy of Pediatrics, Dr. David Krol of the University of Toledo College of Medicine noted

Continued on page 2

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Continued from page 1

the need for providing information about the importance of dental care to low-income families, whose children are most likely to have serious dental and other health problems. The board chair of The Children's Dental Health Project in Washington, D.C., Dr. Burton Edelstein, agreed, pointing out that research sponsored by the National Institutes of Health (NIH) over the past 40 years "has well established that tooth decay is an infectious disease that is typically transmitted from mothers to children during a child's first year of life."

Citing a recent upswing in tooth decay in the youngest children, the Centers for Disease Control and Prevention (CDC) reported in August 2005 that more than a quarter (28 percent) of 2-5-year-olds already have cavities in their baby teeth and half (49 percent) of children ages 6-11 have cavities in their adult teeth.

Currently, Edelstein noted, only 30 percent of children enrolled in Medicaid at any time during the year had at least one dental visit and only 25 percent had at least one preventive dental visit—less than half the rate of services obtained by commercially insured children. State-by-state performance varies greatly, ranging from as low as 13 percent in one state to as high as 47 percent in another. Those figures are for Medicaid; Edelstein said we know far less about the effectiveness of the State Children's Health Insurance Program (SCHIP) in covering dental care, because Congress has not to date required systematic dental performance reporting in SCHIP.

What To Do?

Since they were testifying before congressional committees with jurisdiction over federal health programs, including Medicaid and SCHIP, witnesses at last month's hearing stressed the need for more federal oversight of the dental care that is supposed to be provided to Medicaid-eligible children under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, and they urged new requirements for dental coverage in Medicaid and SCHIP, along with increased federal funding of those two programs. They also cited need for federal support of community health centers, many of which provide dental services.

Said one witness, "On behalf of America's children, I urge you and your Committee to continue attending to pediatric oral health, to maximize opportunities for cost-effective cavity protection and to integrate oral health into every federal program that addresses the health and welfare of our nation's children."

Also see:

"Dental Health Services in Schools," at www.healthinschools.org/dentalhealth.asp.

The School as Drug Mart

Adolescents in U.S. public high schools have little trouble trading, selling, or giving away prescription medications, including stimulants, sedatives, and sleeping and pain relief drugs, according to a survey of 7th- to-12th grade students in an ethnically and racially balanced high school in southeast Michigan.

Conceding that their survey relied upon self-reports of drug swapping by students, where there may have been some exaggeration about the ease or frequency of the transactions, researchers said it appears there are still good reasons for concern about the problem, especially since the Substance Abuse and Mental Health Services Administration (SAMHSA) is pointing to misuse of prescription medications as the fastest-growing category of drug abuse.

In the survey, students were asked to respond to computerized questions about their medical and nonmedical use of sleeping, sedative, or anxiety, stimulant, and pain medications, and were asked if they had been solicited to divert their prescription drugs to other persons—and if so, who had asked for the drug, and who had received it.

Their data, while preliminary, show a number of things, the researchers said.

- In the study of 1,086 public school students, almost half had received a prescription for a scheduled medication (one described as Schedule I, II, or III by the Food and Drug Administration in terms of its potential for addiction or abuse) in their lifetimes, and one in three had had a prescription in the previous year. Opioid analgesics were the most widely prescribed and the most widely abused. Stimulant and sedative or anxiety medications had the highest illicit-medical use ratios.
- Diversion was common: between 29 percent and 62 percent of 390 students with legal prescriptions had been approached to divert their medications within the previous year.
- Students reported "trading" medications, and those who diverted them to others were more likely to have given them away than to have sold them. A relatively small number of students reported having had their prescription drugs taken from them by force. Girls appear to be slightly more likely than boys to divert medications, primarily to their female friends.

It appears from the numbers that physicians are quick to write prescriptions for Schedule II and III medications, which the FDA identifies as subject to addiction and abuse, though physicians rarely report talking to young patients about potential medication abuse. "Our data," said the researchers, "indicate that physicians, nurses, and dentists must discuss the proper use of abusable medications; it appears that many middle school and high school students engage in exchanges that challenge traditional ways of

Continued on page 3

Continued from page 2

educating about drug abuse.” And it appears from the numbers that “availability is high.” A 16-year-old student speaking to one of the researchers said, “Pills are so easy to get; I can get Viocodin, Adderall, or Ritalin anytime I want at school.”

The Michigan researchers defined the terms they used in their study in describing the school drug diversion scene.

“Nonmedical use, prescription drug abuse, and illegal use of prescription medications (drugs) refer to the same phenomenon and are defined as the use of prescription medications to ‘get high,’ to create an altered state, or for reasons (or by routes) other than what the prescribing clinician intended. The use of someone else’s prescription is illegal. Diversion of prescription medications (drugs) is defined as the exchange of prescription medications that lead to the use of these drugs by people other than for whom the prescribing clinician intended or under conditions associated with ‘doctor shopping,’ misrepresentation of medical problems, or theft.”

In the computerized survey, students were asked if “based on a health professional’s prescription,” they had used the following types of prescription drugs in their lifetimes or during the previous year:

- Sleeping medication (e.g., Ambien, Halcion, Restoril, etc.);
- Sedative or anxiety medication (e.g., Ativan, Xanax, Valium, Klonopin, etc);
- Stimulant medication for attention deficit/hyperactivity disorder (e.g., Ritalin, Adderall, Concerta, etc.), and
- Pain medication (e.g., Viocodin, OxyContin, Tylenol 3 with codeine, etc.).

What the study strongly suggests, the researchers concluded, is that secondary school students, physicians, nurses, and parents should be educated and should closely monitor the medical use, illicit use, and diversion of abusable prescription medications. “School administrators must enforce policies that require centralized medication monitoring. Too often, parents and students fail to report the medications they have been prescribed.”

The research report on which this article is based, “Prescription Drug Abuse and Diversion Among Adolescents in a Southeast Michigan School District,” was published in the March 2007 issue of Archives of Pediatrics and Adolescent Medicine.

Beverage Makers Promise Progress on School Drinks

August of this year is the date for a first progress report on implementation of guidelines for improving the calorie content and nutrition of bottled drinks offered for sale in schools, according to the American Beverage Association (ABA), the trade association for all major bottlers in the United States.

The association offered guidelines for elementary, middle, and high school beverage options last year, as it became clear that legislation limiting such sales was moving to possible enactment in Congress. Since then, says ABA president and CEO Susan Neely, beverage companies have “spent hundreds of hours training their marketing and sales teams about the guidelines. These teams have reached out to school contract partners to educate them.”

“Our companies are reformulating products. They are creating new package sizes to meet the smaller portion sizes required in the guidelines. And they are retrofitting vending machines to accommodate the changes in product sizes.”

With full implementation of the ABA guidelines more than two years away—August 2009—the beverage makers say they expect the August 2007 report to show “a continued decline in the sale of full-calorie soft drinks in our schools.” Sales volume and contract data are currently being gathered from bottlers and schools across the country, the ABA says.

The following are the guidelines proposed by the beverage association for bottled drinks sold in schools:

Elementary School

- Bottled water;
- Up to 8-ounce serving of milk and 100% juice (low fat regular and flavored milk and USDA nutritionally equivalent milk alternatives with up to 150 calories/8 ounces; and 100% juice with no added sweeteners, up to 120 calories/8 ounces, and with at least 10% daily value of three or more vitamins and minerals.

Middle School

- Same as elementary school, except juice and milk can be sold in 10-ounce servings;
- As a practical matter, if middle school and high school students have shared access to areas on a common campus or in common buildings, then the school community has the option to adopt the high school standards.

High School

- Bottled water;
- No- or low-calorie beverages with up to 10 calories/8 ounces (e.g., diet soft drinks, diet and unsweetened teas, fitness waters, low-calorie sports drinks, flavored waters, seltzers);
- Up to 12-ounce servings of milk, light juice, 100% juice and certain other drinks such as: low-fat and no-fat regular and flavored milk and USDA nutritionally equivalent milk alternatives with up to 150 calories/8 ounces; and 100% juice with no added sweeteners, up to 120 calories/8 ounces and at least 10% daily value of three or more vitamins or minerals; and other drink with no more than 66 calories/8 ounces (e.g., light juices and sports drinks);
- At least 50 percent of beverages must be water and no- or low-calorie options.

Continued from page 3

The beverage association emphasizes that under its proposed guidelines, no full-calorie soft drink products will be offered in any grade.

The American Beverage Association says its guidelines were designed “using nutrition science,” including the Dietary Guidelines for Americans, 2005 and the American Heart Association’s Dietary Guidelines for Healthy Children and 2006 Diet and Lifestyle Recommendations, “in order to balance children’s nutritional needs with the requirement to manage calorie consumption.”

Also see:

“Bottlers Agree to Limit Soft Drinks in Schools” at www.healthinschools.org/2006/may4a_alert.asp.

SCHIP—The Second-Hottest Item on Congress’ Agenda

It has already made headlines—a \$750 million appropriation meant to ease state SCHIP funding shortfalls is at risk because Congress put the money into a war spending bill that President Bush has vowed to veto. But there is more controversy to come for SCHIP (the State Children’s Health Insurance Program) because the program, beloved of state governors and reviled as an opening wedge to socialized medicine by its critics, is due to expire on September 30.

That has produced a rash of bills in the House and Senate, most of them proposing to expand the popular program, and a lot of congressional hearings have been held or are scheduled. Meanwhile, the Bush administration is expressing strong opposition to any SCHIP expansion and has proposed instead to give families tax deductions to buy private health insurance.

Whether all of this will produce a compromise both sides can live with remains to be seen, but here are some of the issues involved:

- According to the U.S. Government Accountability Office (GAO), SCHIP enrollment increased rapidly during the program’s earliest years, but has stabilized over the past several years;
- As of fiscal 2005, the latest year for which data are available, SCHIP covered approximately 6 million enrollees, including about 639,000 adults;
- State SCHIP programs reflect the flexibility federal law allows in structuring approaches to health care coverage. As of July 2006, 18 states had opted for a separate SCHIP child health program, 11 states had expanded their existing Medicaid programs to include more children, and 21 states had gone for a program that included both expanded Medicaid and a separate child health program.
- Forty-one states cover children whose family incomes are at 200 percent of the federal poverty level or higher; seven of

those states insure children whose family incomes are 300 percent or higher of the federal poverty level.

- Thirty-nine states require families to contribute to the cost of their children’s SCHIP coverage, through premiums or co-payments;
- As of February 2007, SCHIP identified 14 states that had received waivers from the Department of Health and Human Services allowing them to cover adults in their SCHIP programs; covered adults include caretaker relatives of Medicaid and SCHIP children, pregnant women, and childless adults.

Unlike Medicaid, SCHIP payments are capped, at levels depending on states’ populations of eligible children, overall fiscal circumstances, and health care needs. SCHIP spending was initially low but now threatens to exceed available funding; some states consistently spend more than their federal contribution.

SCHIP is more popular than Medicaid with state governments because the federal government contributes a larger proportion of revenues, even though the total may be capped. State governors testifying at congressional hearings on reauthorization generally strongly support SCHIP.

With the Bush administration insisting on “refocusing the SCHIP program on low-income uninsured children” and congressional Democrats vowing to triple spending on the program by adding \$50 billion, for a total of \$75 billion over the next five years, the GAO cautions that “SCHIP reauthorization occurs in the context of debate on broader national health care reform and competing budgetary priorities, highlighting the tension between the desire to provide affordable health insurance to uninsured individuals, including low-income children, and recognition of the growing strain of health care coverage on state and federal budgets.”

A GAO report, “Children’s Health Insurance: State Experiences in Implementing SCHIP and Considerations for Reauthorization,” is available online at www.gao.gov.

To view all SCHIP-related bills that have been introduced in this session of the United States Congress, go to <http://thomas.loc.gov> and enter “SCHIP reauthorization.”

WORTH NOTING

Public Health Week Focuses on Public Health Threats

April 2-8 is National Public Health Week, and the American Public Health Association is taking the opportunity to describe “first steps to address the needs of the nation’s vulnerable populations” in public health emergencies, including the “unique needs of schools K-12.” The APHA is urging schools to take the first

Continued on page 5

Continued from page 4

step toward developing a comprehensive plan for their students and employees to be prepared for a public health threat, and the organization is offering to provide school administrators customized tools, recommendations, and strategies to prepare for public health threats they may face. More information is available at www.apha.org/NPHW.

What's In a Name—Is It Drug Abuse or Addiction?

A United States Senator who says he has been working for 35 years to address the health and safety issues associated with drug and alcohol addiction now wants to change the names of two institutes in the National Institutes of Health to recognize that addiction is a disease that can be treated. In legislation introduced March 28, Senator Joseph Biden (D-DE) proposes renaming the National Institute on Drug Abuse as the National Institute on Diseases of Addiction and the National Institute on Alcohol Abuse and Alcoholism as the National Institute on Alcohol Disorders and Health. The changes would remove the pejorative term “abuse” and would “more clearly link the concepts of addiction and disease,” Biden said. “Identifying addiction as a neurobiological disease will diminish the social stigma, discrimination, and the personal shame that is often a barrier to seeking treatment, and it will further a common understanding of the diseases of addiction.” Biden cited the fact that 1 in 10 Americans over the age of 12 suffers some form of substance dependency and said the economic costs of dependency and addiction are estimated to exceed half a trillion dollars annually in the United States, due to health care expenditures, lost productivity, and crime. Biden called his bill, S. 1011, Recognizing Addiction as a Disease Act of 2007, “a small but important stride towards helping those struggling with diseases of addiction.”

March News Alerts

The following information appeared during the month of March 2007 in the News Alerts section of the website of the Center for Health and Health Care in Schools, at www.healthinschools.org.

March 1, 2007 RWJF Announces New School-Connected Mental Health Services

The Robert Wood Johnson Foundation (RWJF) announced today that it is making grants to programs in 15 communities to address the mental health challenges facing growing numbers of immigrant and refugee children. “These are special populations of children with mental health needs that are both unique and substantial,” said Foundation program officer Wendy Yallowitz. The new program, called Caring Across Communities, will aim to improve the mental health of new residents by addressing the effects

of social factors such as language skills, cultural differences, poor education, and poverty on the more than 30 million immigrant and refugee children currently living in this country, the Foundation said. Each of the 15 projects has been funded for three years for a maximum grant of \$300,000. Information about project sites and the Caring Across Communities program is available from the national program office at the Center for Health and Health Care in Schools, www.healthinschools.org.

March 7, 2004 Bills Would Update School Nutrition Rules

Bills introduced with broad bipartisan support in both the House and Senate yesterday would require the Secretary of Agriculture to initiate a rulemaking process to update nutritional standards for foods sold in schools, including the federally subsidized school lunch and breakfast programs. The Senate bill’s primary sponsor, Senator Tom Harkin (D-IA) pointed out that the Agriculture Department, which has responsibility for those programs, “Currently relies upon a very narrow nutritional standard that is more than 30 years old. Since that definition was formulated, children’s diets and dietary risk have changed dramatically. It is time for public policy to catch up with the science.” The House and Senate bills also call for the Secretary of Agriculture to apply the revised nutrition standards not only to the federal school lunch and breakfast programs but also “everywhere on school grounds and throughout the school day.” Harkin noted that currently the Agriculture Department can only issue rules limiting “a very narrow class of foods” and can only stop even those sales “in the actual school cafeteria during the meal period.” As a result, the senator said, “a child only needs to walk into the hall outside the cafeteria to buy a lunch consisting of soda, a bag of chips, and a candy bar.” Calling this “a loophole that is big enough to drive a soft drink delivery truck through, literally,” Harkin said his bill will not, by itself, solve the problem of poor diet and rising rates of chronic disease among children, “But it is a start.” The Senate bill, S. 771, and the House bill, H.R. 1363, can be read and followed at <http://thomas.loc.gov>.

March 19, 2007 Court Says Company Can Refuse to Pay for Birth Control

In a ruling that Planned Parenthood called “shocking” and “a significant setback to women’s health,” a panel of the U.S. Court of Appeals for the Eighth Circuit ruled March 15 that health insurance plans available to employees of the Union Pacific railroad can deny payment for prescription and non-prescription products for women that are “used for the sole purpose of contraception.” The ruling by three judges can now be appealed to the full appeals court, but for the present is binding on courts in the Eighth Circuit, which includes Arkansas, Iowa, Minnesota,

Continued on page 6

Continued from page 5

Missouri, Nebraska, and North and South Dakota. The judges held that the railroad's health coverage is not sex discrimination, since the policy also does not pay for contraception employed by men, such as condoms and vasectomy. The case was brought by two women representing approximately 1,500 female employees of the Union Pacific who are of child-bearing age. The current health policies cover contraception only when "medically necessary for a non-contraceptive purpose such as regulating menstrual cycles, treating skin problems or avoiding serious health risks associated with pregnancy."

March 23, 2007 **TB Still Low in U.S., but Drug Resistance Increases**

World TB Day is observed on March 24 each year in commemoration of the date in 1882 when Dr. Robert Koch announced the discovery of *Mycobacterium tuberculosis*, the bacterium that causes tuberculosis. Worldwide, TB remains one of the leading causes of deaths from infectious disease. In the United States, although the 2006 TB rate is the lowest recorded since national reporting began in 1953, the average annual decline in number of cases has slowed, and drug-resistant TB has become a major threat, according to the Centers for Disease Control and Prevention (CDC). Foreign-born persons and racial/ethnic minority populations continue to be affected disproportionately, with TB rates 8.4 times higher for blacks than for whites, 21.2 times higher for Asians, and 7.6 times higher for Hispanics. Multi-drug-resistant tuberculosis—TB that is resistant to first-line therapies such as isoniazid and rifampin and to second-line therapies such as fluoroquinolone—is difficult and costly to treat and can be fatal. Although the United States has made progress in treating drug-resistant TB, "Recently, our success against MDR TB has slowed," said Dr. Kevin Fenton, director of the CDC's National Center for HIV, STD, and TB Prevention. Reports on tuberculosis in the United States and worldwide appear in the March 23 edition of Morbidity and Mortality Weekly Report, at www.cdc.gov/mmwr.

March 26, 2007 **Report on School Food Delayed Again**

After two days of a tightly closed meeting, a committee of the Institute of Medicine that is charged with setting nutrition standards for food served in schools postponed the release date for a final report to April or May of this year. That's the third time the report has been postponed, possibly reflecting controversy over its recommendations, which involve industries that sell alternative foods to schools as well as school nutritionists and administrators. Not known at this time is whether the report will challenge standards set by the Department of Agriculture for the federally subsidized school lunch and breakfast programs, though the re-

port is expected to make recommendations concerning soft drinks and other minimally nutritious foods offered in vending machines in schools. Progress of the report can be tracked at www.iom.edu, click on "Reports."

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