SCHOOL NURSE STUDY

REPORT ON HEALTH SERVICES IN WASHINGTON STATE CLASS I DISTRICTS

Washington State Department of Health

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ASSESSING SCHOOL NURSING SERVICES

Dr. Terry Bergeson
State Superintendent of
Public Instruction

June 2006

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A special tribute goes to the SNSWG for their valuable knowledge and input in developing this report. The dedication and commitment of this group was apparent as they worked together towards the goal of creating a healthier environment for the school age child as a means of increasing academic potential of children.

We would like to acknowledge the contributions of those who efficiently coordinated and arranged the meetings and enhanced communication among the group through typing, editing, and assisting with organizing this report.

A list of the SNSWG members may be found in Appendix B.

REPORT ON HEALTH SERVICES IN WASHINGTON STATE CLASS I DISTRICTS

“Many of the things we need can wait. The children cannot……To him we cannot say tomorrow, his name is today.

Gabriela Mistral

DIGEST

OVERVIEW

The Legislature appropriated $45,000 for the fiscal year 2005 to study school health services provided in Class I School Districts (more than 2000 students) in Washington State. The 2005 Omnibus Supplemental Appropriations Act directs the Office of Superintendent of Public Instruction (OSPI) and the Department of Health (DOH) to collaborate and develop a work group to assess school nursing services. The work group was charged to:

- Study the need for additional nurse services.
- Assess the demand for nurse services by acuity levels.
- Recommend best practices in school nursing.
- Recommend a dedicated, sustainable funding model, including assessing whether funding for school nurses should continue as a part of basic education.
- Identify opportunities to improve coordination of and access to health services for low-income children through school nurse services.
- Evaluate the feasibility of pooling school district and managed care plan funding to finance school nurse positions.

OSPI was required to report the work group's findings and plans for implementation to the Legislature by February 1, 2006.

See Appendix A for the legislative directive as included in the 2005 Omnibus Supplemental Appropriations Act.

To meet the requirements set by the Legislature, a contractor was hired in August 2005. The contractor facilitated and coordinated the activities of the School Nurse Study Work Group (SNSWG), and conducted a comprehensive review of school health services in Washington State Class I school districts. Refer to Appendix B for a complete list of the SNSWG members.

BACKGROUND

There are approximately 1,021,500 students in Washington's public schools. Of Washington's 296 public school districts, 106 are categorized as Class I (those districts with more than 2000 students), serving approximately 896,200 of these students. In general, these districts individually determine the amount of health care and medical personnel they wish to provide. Staffing decisions may be based on student needs within the districts, funding availability, and health services provided in the local

community. The level of health services provided by schools is determined at the local level; as a result, a wide range of nurse staffing possibilities exists.

One consequence of the individual, local nature of district decision-making regarding school nursing is that little information has been available about student health needs and nursing practices in these districts. To address this, beginning with the 2002–03 school year, OSPI invited Class I schools to voluntarily submit health services data using the *Assessment of District Student Health Services – Class I Districts.* The purpose of gathering data from Class I districts is to assist OSPI in assessing students' access to registered nurse (RN) services and estimating the incidence of children with complex health concerns in our schools (asthma, severe allergies, etc.). The information also assists with moving toward evaluating the impact of school nurse services (Office of Superintendent of Public Instruction, 2001).

In 1997, a Joint Legislative Audit Review Committee (JLARC) *Survey of School Nurses Report* (Joint Legislative Audit Review Committee,1997) identified 44 Class II districts (less than 2000 students) that reported no on-staff nursing. The Legislature responded to this significant gap in services by funding the School Nurse Corps (SNC) to address student health needs in schools, primarily Class II districts, where there had previously been scarce or no registered nurse (RN) services. These nurses provide bare minimum direct care to students, health education, training, and supervision for school staff. Additionally, the funding provides for a SNC supervisor at each educational service district (ESD) to administer the program, provide consultation to all districts, and direct nursing services as time permits. The SNC furnishes the infrastructure for current school heath services data collection.

Prior to establishing the SNSWG, OSPI's Health Services program sponsored a two day work session on June 14–15, 2005. The work session provided an opportunity for a cross section of school nurse leaders (26 attendees) to consider what next steps might be taken to better meet the health needs of students in all Washington public schools. The focus question for the session was, "Presuming that in Washington State, we know some things about the health needs of students and the gaps in services preventing us from meeting these demands: *what essential steps must we take to improve and strengthen the school health services system?*" The report of this work session was used as a resource by the SNSWG, and informed OSPI and DOH in determining the findings, conclusions, and implementation plan that are central to this study.

STUDY METHOD

The contractor conducted an extensive review of the literature (Appendix H), and identified and analyzed several existing data sources regarding school heath services, including OSPI's *Assessment of District Student Health Services – Class I Districts*. The SNSWG met five times between August and December of 2005 to complete their work. By dividing into three sub-groups, the SNSWG members considered in-depth information and data related to; (1) ratios, best practices, and access to care; (2) health services data analysis; and (3) health services funding. The SNSWG then developed recommendations for each of the study's directives.

The contractor submitted a preliminary report of the SNSWG to OSPI and DOH on November 1, 2005. After feedback from the state agencies and a final meeting of the SNSWG, a revised draft report was submitted on December 1, 2005. Using the contractor's report and the SNSWG findings and recommendations as a foundation, OSPI and DOH formulated conclusions and an implementation plan.

STUDY FINDINGS

The following overview of the study findings is aligned to the general study requirements described in the budget proviso (see appendix A).

Finding 1: Need for additional school nurse services in Class I districts.

The SNSWG primarily reviewed the 2004–05 *Assessment of District Student Health Services – Class I Districts* summary report. The voluntarily submitted data from this report represents 75 percent of the 106 Class I districts and 74 percent of students served in Class I districts. The 79 districts reported a need for a total of 1,113 additional RN hours per week (28 Full-time Equivalence [FTE]) to meet the recommendation of one nurse for every 1500 students according to the *Staff Model for Delivery of School Health Services (Staff Model)*. The total of 1,113 hours does not reflect the range of need (See Appendix F and G). Districts reported a range from needing an additional 285 hours per week of RN service to meet the 1:1500 ratio, to an existing RN staff model of 1 nurse for every 830 students.

Finding 2: Demand for nurse services by acuity levels.

The *Staff Model* (Washington State Nursing Care Quality Assurance Commission and Washington State Office of Superintendent of Public Instruction, 2000) describes a way to predict the nursing care and staff needs of individual schools and school districts. The *Staff Model* is used as a means of determining acuity level of student needs in the 2004–05 *Assessment of District Student Health Services – Class I Districts* summary report. The summary indicates that, for those districts reporting, a total of 10,496 additional hours per week of RN service (262 FTEs) are needed to meet the needs of students identified as Level A–nursing dependent, Level B–medically fragile, Level C–medically complex, or Level D–health concerns. Districts reported a wide range of need for RN service to meet these levels of care. The variability in reported need, in conjunction with the very large total number of reported hours, raises questions about varying interpretations of the severity coding by those who completed the report; and thus, questions about the reliability of the data collected via the *Assessment of District Student Health Services – Class I Districts.*

Finding 3: Best Practices in school nursing.

An analysis of best practices in school nursing reveals that within the state of Washington, the *Staff Model* is the baseline for best practices in school nursing (Appendix C). The SNSWG highlighted Educational Staff Associate (ESA) Certification standards for school nurses as an additional component of best practices in our state. Additionally, toward improving school nurse practice, the OSPI School Nurse Research

Task Force (SNRTF) developed a tool and process for school nurses to begin to measure the outcomes of nursing interventions.

Finding 4: A dedicated, sustainable funding model.

To explore the issue of funding, the legal definition of basic education was analyzed to determine if it included the provision of school health services. The SNSWG found that the definition, related statutes, and recent court decisions are silent on the inclusion of school health services in basic education. Additionally, nursing services are not a separate, specific element of the basic education funding formula. Districts may choose to hire nurses under Certificated Instructional Staff (CIS), classified, or administrative categories. The funding model provides for a number of CIS that encompasses teachers as well a group of staff labeled Educational Staff Associates (ESAs) which includes nurses and other health care professionals. As there is no breakdown within the funding formula of how many ESAs are included in the funded staff units, there is also no requirement that districts actually hire any specific number of ESA staff with the funding. Staffing decisions for nurses at the district level are therefore based completely upon local districts' judgment and historical practices. The SNSWG found that sources of payment for school health services vary widely among school districts. Still, basic education funding was determined to be the primary source of funding for school health services in most (87 percent of reporting districts) Class I districts.

Finding 5: Opportunities to improve coordination of and access to health services for low-income children; the feasibility of pooling school district and managed care plan funding.

After consulting with Department of Social and Health Services (DSHS) personnel, the SNSWG found that there are significant, ongoing challenges to collaboration between schools and the various Medicaid programs. Further, the dialogue with DSHS staff revealed that, based on current requirements and priorities, Medicaid and managed care funds are not a source of funding for school nurse services.

SNSWG RECOMMENDATIONS

After considering their review of the literature, the outcomes of the sub-group work, and the legislative directives, the SNSWG offered recommendations:

Regarding the need for additional nurse services and assessing the demand for nurse services by acuity levels:

- Health services data collection.
- Training for school nurses on effective data collection practices.

Regarding best practices in school nursing:

- Reviewing and updating the *Staff Model for the Delivery of School Health Services (Staff Model)* See Appendix C.
- Professional standards for school nurses.

Regarding a dedicated, sustainable funding model, including assessing whether funding for school nurses should continue as a part of basic education:

- Providing for school nurse services.

Regarding identifying opportunities to improve coordination of and access to health services for low-income children through school nurse services, and evaluating the feasibility of pooling school district and managed care plan funding to finance school nurse positions:

- The role of school nurses in contributing to improved services for children living in poverty.

A complete listing of the SNSWG recommendations, and corresponding legislative directives, may be found in Appendix D.

OSPI/DOH RECOMMENDED IMPLEMENTATION PLAN

The findings and recommendations of the SNSWG add to a growing body of professional literature and anecdotal evidence suggesting that the school health service demands of many Class I school districts exceed the capacity of these districts to provide such services. Further, the study makes clear that there are no easy solutions to establishing a dedicated, sustainable funding model to meet the current and future health services needs of these districts. Importantly, the study also highlights the absence of a consistently applied staffing model that is based on the varying health services needs of all students, and the absence of accurate data that measures over time both the health services needs of students and the capacity of school districts to meet these needs.

In consideration of these findings and recommendations, OSPI and DOH suggest a 4-step implementation plan that:

- Validates a standard of practice and staffing model for school heath services that is based on the health services needs of students.
- Establishes a data collection system for ALL school districts that identifies current health services needs and health services capacity.
- Provides ongoing training and technical assistance for school nurses to ensure accurate, timely submission of health services data.
- Utilizes the *Staff Model* and data collection as the foundation for examining a dedicated, sustainable funding model that best meets the current and future needs of Washington's schools contributing to greater academic success of all students.

The implementation plan assumes that sufficient resources will be allocated by the Washington State Legislature to accomplish these tasks.

The implementation plan takes into consideration such issues as:

- Recognizing the dynamics around school financing.
- Developing a system that encompasses the needs of all schools.

- Taking incremental steps toward an intentional service model.
- Defining minimal school nurse services.

A further consideration is the potential coordination of the implementation plan and SNSWG recommendations with the work of the Governor's Healthy Washington Work Group. The charter for Healthy Washington states: "Improving people's health in Washington is one of Governor Gregoire's top priorities. She focuses on three related and mutually supportive areas: Prevention, Cost Containment in Health Care, and Covering all Kids (with health insurance.)" A natural tie between the work of the Healthy Washington Work Group and the SNSWG recommendations may occur.

Appendix E presents the OSPI/DOH action plan with the SNSWG recommendations and study findings.

Step 1: Update and validate the *Staff Model for Delivery of School Health Services.*

To accomplish this step, OSPI and DOH suggest replicating the original process used to develop the *Staff Model* to update the content of the document. The original process included representation from DOH, the Nursing Care Quality Assurance Commission, and OSPI. It included substantial stakeholder input, a review of compliance with existing statutes and rules, and high level ownership by all involved state agencies.

The *Staff Model* was first published in 2000. This document outlines recommended guidelines for delivering health services based on the nursing care needed by the student population. Severity coding, a key component of the *Staff Model*, establishes the nursing staff needed by the students within a school building. In addition to the nursing staff required by the severity coding, the *Staff Model* recommends a 1:1500 ratio of school nurses to students to provide, for example, emergency services, health education, and health assessments as a part of the evaluation of students referred for special education. A copy of the *Staff Model* is included in Appendix C.

Since 2000 numerous federal and state laws have changed or been added that impact the delivery of health services to students. School nurses and school districts are encouraged to utilize the *Staff Model* to predict and plan for individual student and school health services needs. Prior to, and in support of the SNSWG recommendation, the OSPI Health Services School Nurse Issues Committee, the June 2005 health services work session participants, and the SNC Supervisors all stated the need to update the *Staff Model*. The document needs to be revised to reflect "lessons learned," changes in the educational setting, changes in regulatory requirements, and changes in nursing practice.

Accomplishing this step will require approximately 12 months to complete, and will necessitate dedicated staff time from both OSPI and DOH.

Step 2: Establish a school health services data collection system for all public school districts.

Currently, OSPI annually requests, but does not require, all Class I (for the past three years) and Class II (for the past six years) school districts to submit school health services data. The result is a lack of consistent, objective, and accurate data to understand current student and school health services needs and practices. Establishing systematic statewide health services data collection will dramatically improve the quality and completeness of these data.

An expert work group representing both Class I and Class II districts, as well as the SNC, should establish a minimum set of school health services data to be collected annually from all Washington public schools and school districts. The minimum data set should include information on frequency, intensity, and duration of nursing services for various levels of severity, as identified in the *Staff Model*. The data system will thus inform intermittent revisions to the *Staff Model*. The work group should annually review and update this data set. In order to better assure accurate data, the SNC program should provide regional support to all school districts for collecting data.

Accomplishing this step will require approximately six months to complete the development of the minimum data set; 3 to 6 months to develop an electronic reporting system; ongoing staff time at OSPI to manage the data collection system, including analysis and reporting; and ongoing staff time in local school districts to collect and report health services data.

Step 3: Develop and implement a training plan for nurses to collect and submit school health services data in a standardized manner to improve the reliability and validity of the data.

The training plan should be developed in consultation with an expert work group representing Class I and Class II districts and the SNC. The training medium should provide a way for school nurses to discuss questions or concerns. The SNC should be utilized as a regional vehicle for implementing the training plan.

Accomplishing this step will require 1 to 3 months, after the data system is established, to develop the specific training program, and will require dedicated staff time to deliver training and technical assistance to school nurses on an ongoing basis.

Step 4: Utilize updated *Staff Model* and accurate health services data to examine a dedicated, sustainable funding model for school health services.

Maintaining the validity of the *Staff Model*, and having reliable data gathered over time provides the framework for future steps. Without current, consistent standards of care and an accurate accounting of the need for that care, critical information is missing to develop a substantiated plan for funding to address the health needs of students and schools.

The timeline and resources needed for examining funding for school health services should be determined after successfully accomplishing the first three steps in the implementation plan.

CHAPTER ONE: INTRODUCTION

One national source estimated 40 percent of children with a chronic health problem experience school related problems (Thies and McAllister, 2001). With the increasingly complex health care needs of students, and an increase in the number of students needing health care, the demand for well prepared school nurses has multiplied. As a next step in the Legislature's longstanding recognition of the need to improve school health services, the 2005 OSPI school nurse study budget proviso was adopted.

The 2005 Omnibus Supplemental Appropriations Act directed OSPI and DOH to collaborate and develop a work group to assess school nursing services in Class I districts (districts with more than 2000 students). The work group was charged to:

- Study the need for additional nurse services.
- Assess the demand for nurse services by acuity levels.
- Recommend best practices in school nursing.
- Recommend a dedicated, sustainable funding model, including assessing whether funding for school nurses should continue as a part of basic education.
- Identify opportunities to improve coordination of and access to health services for low-income children through school nurse services.
- Evaluate the feasibility of pooling school district and managed care plan funding to finance school nurse positions.

See Appendix A for the legislative mandate to study school nurse services in Class I districts.

APPROACH AND METHODOLOGY

To meet the requirements set by the Legislature, a contractor was hired through OSPI in August 2005. The contractor facilitated and coordinated the activities of the School Nurse Study Work Group (SNSWG), and conducted a comprehensive review of the school health services in Washington State Class I school districts.

The SNSWG included statewide representation of school nurses from Class I school districts, the President of the School Nurse Organization of Washington (SNOW), the Parent Teacher Association (PTA), the Washington Education Association, administrators, the Legislature, the Washington State School Directors' Association (WSSDA), OSPI, DOH/Washington State Nursing Care Quality Assurance Commission (NCQAC), and the Department of Social and Health Services (DSHS). Refer to Appendix B for a complete list of the SNSWG members.

The work group met five times between August and December of 2005, to complete their work. Occasionally guests attended these meetings as observers. In addition, a group of interested parties, including parents and various educational and health care professionals reviewed meeting agendas and minutes providing input and tracking the progress of the SNSWG. Information and opinions were sought from all members and interested parties.

To support the work of the SNSWG, a review of current literature was completed (Appendix H). The literature was studied by members of the SNSWG and research was found supporting the conceptual categories. In addition, the following data sources were reviewed and analyzed:

- The *Assessment of District Student Health Services* 2004–05. The assessment was given to Class I School Districts. Seventy-five percent of the forms were returned (Appendix F).
- Data from the School Nurse Survey of Teacher Satisfaction Questionnaire; 119 responses out of 220 were received. This was a small sampling conducted in one school building by one school nurse (Appendix I).
- Data from DOH related to children and youth with special health care needs (Washington State Department of Health, 2005).
- Data from a nationwide telephone survey of 1,101 parents (Center for Health and Health Services).

The legislative mandate served as the framework guiding the SNSWG. These experts proved to be a highly energized group of thoughtful professionals. Dividing into three small groups, the SNSWG members considered in-depth information and data related to (1) ratios/best practices and access to care, (2) data analysis, and (3) funding.

As funding was explored, the legal definition of basic education was sought, and analyzed to determine if it included the provision of school health services. Further study of methods of payment for school health services was then conducted.

In order to investigate the potential for managed care and Medicare funding for the provision of school nurse services, representatives from DSHS were consulted. A series of meetings with the representatives included:

- Review of the budget proviso language.
- Review of the intent of the SNSWG.
- Describing the coordination of services.
- Describing managed care and Medicare funding mechanisms.
- Exploring potential application of these funds for school nursing services.

The SNSWG then further examined the mandate and drafted recommendations for each directive of the study. Next, the recommendations were discussed and refined. Upon considering their review of the literature, the outcomes of the subgroup work, and the legislative directives, the SNSWG adopted recommendations.

The contractor submitted a preliminary report of the SNSWG to OSPI on November 1, 2005. After feedback from the state agencies, and the final meeting of the SNSWG, a revised draft report was submitted on December 1, 2005. Once the recommendations were documented, analysis for implementation occurred with OSPI and DOH. Conclusions and a plan of action were then developed. The conclusions and implementation plan were categorized into four main groups: confirmation of the *Staff Model,* reliable data collection, training, and further exploring a funding model.

CHAPTER TWO: STUDY'S FINDINGS

OVERVIEW

The primary data sources are briefly described to set the context for reporting the findings of the SNSWG. The balance of the chapter is organized to address, in order, each section of the legislative directive.

OSPI has gathered data related to health services in Class I school districts for the past three school years. OSPI utilizes the SNC Supervisors to collect data relevant to school heath programs evaluating services offered, number of children being served, and the number of health professionals required to maintain a safe and quality health services program.

Appendix F contains the Assessment of District Student Health Services – Class I Districts 2004–05.

A Washington State report, the *Children and Youth with Special Health Care Needs Washington State Report* (Washington State Department of Health, 2005) includes data that describes the prevalence of children with special health care needs and indicators affecting health. The data from four sources includes a comparison of Washington State with national statistics.

A limited survey of teachers' attitudes toward health services was conducted in one school district. A survey with seven questions was sent to 220 teachers. A three-point Likert scale was used for the responses: Agree, Disagree, or No Opinion. Out of 220 surveys, 119 were returned. Additionally, teachers wrote many comments related to their feelings about school health services (Appendix G).

A nationwide telephone survey was conducted by the Center for Health and Health Care in Schools February 25–March 10, 2003. A total of 1,101 parents of school age children were polled. Included in the survey was an over-sample of parents in households earning less than $35,000 per year (Center for Health and Health Care in Schools).

NEED FOR ADDITIONAL SCHOOL NURSE SERVICES

Class I School Health Services Data

As described in the JLARC Survey of School Nurses Report (1997), health care staffing decisions are made by the local school districts. The Class I Assessment of District Student Health Services data reveals that Class I districts report a need for additional school nurse services.

In the 2004–05 school year, Class I districts were invited to complete an *Assessment of District Student Health Services – Class I Districts* report. Districts submitted the data through the SNC Supervisor at their Educational Service District (ESD). The SNC Supervisors reviewed the data, clarified data with districts (as time allowed), and then forwarded the district assessments to OSPI. Seventy-nine out of 106 Class I districts responded voluntarily. These districts serve 663,509 students. The data reported here

represent 75 percent of Class I districts and 74 percent of students served in Class I districts.

The question was asked, “How many total hours per week of RN service did districts have during this year?” This data does not include 1:1 time assigned specific to student(s) or classroom(s). Districts reported a total of 16,562 hours per week of nursing service as follows:

RN Classification	Hours
Certificated RN	11,506
Classified RN	4,750
RN	270
School Nurse Corps (RN)	36
Total	**16,562**

Districts were asked, based on a 40 hour week, how many hours per week of RN service would be needed to meet the recommendation of one nurse for every 1500 students according to the *Staff Model*. The seventy-nine school districts reported a combined need of an additional 1,131 RN hours per week (28 FTEs). The total of 1,131 hours does not reflect the range of need. One district reports needing an additional 285 hours per week of RN service to meet the 1:1500 ratio. Another district reports an RN staff model of 1 nurse for every 830 students. Refer to Appendix J for a summary table of ratio findings.

School Nurse Survey of Teachers

Overall, the SNSWG found the responses to the School Nurse Survey of Teachers were very positive with many comments related to the need for consistent school health nurses and services. Examples of comments are as follows:

- *“It is too hard to use the nurse as a resource when she/he isn’t here everyday. His/her schedule is pulled in so many directions that it is difficult for him/her to be consistent.”*
- *“School nurses should be placed in school on a full time basis.”*
- *“The school nurse is a **VERY** important member of the staff. The health needs of the students are best met when a trained health care professional is on site.”*

A tally of the School Nurse Survey of Teachers responses and additional anecdotal stories may be found in Appendix G.

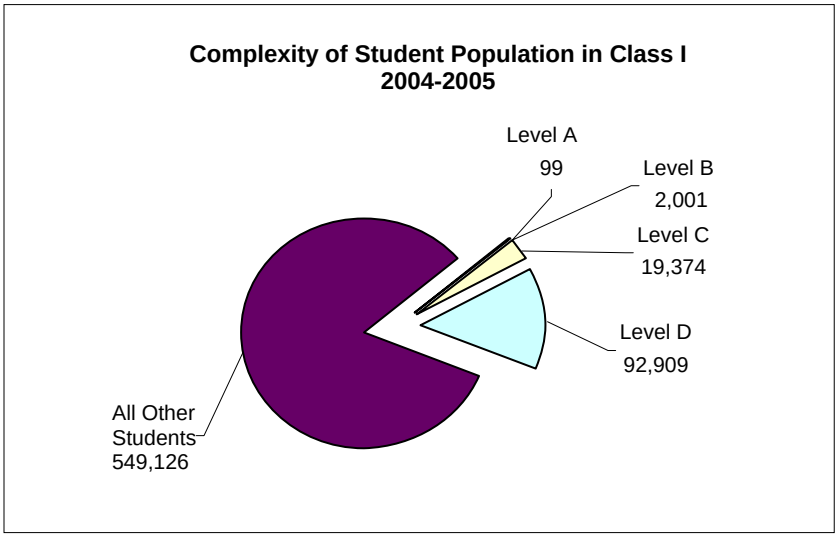
DEMAND FOR SCHOOL NURSE SERVICES: ACUITY LEVELS

Class I School Health Services Data

The *Staff Model* severity coding establishes the nursing staff needs of the students within a school building, according to acuity level. The *Staff Model* is included in Appendix C and is available online at www.k12.wa.us/HealthServices/publications.

The numbers reported here in the 2004–05 school year reflect the severity of students' health care needs in the school. The 79 school districts identified the following total number of students per category:

- Level A: Nursing Dependent— 99 Students.
- Level B: Medically Fragile—2,001 Students.
- Level C: Medically Complex—19,374 Students.
- Level D: Health Concerns— 92,909 Students.

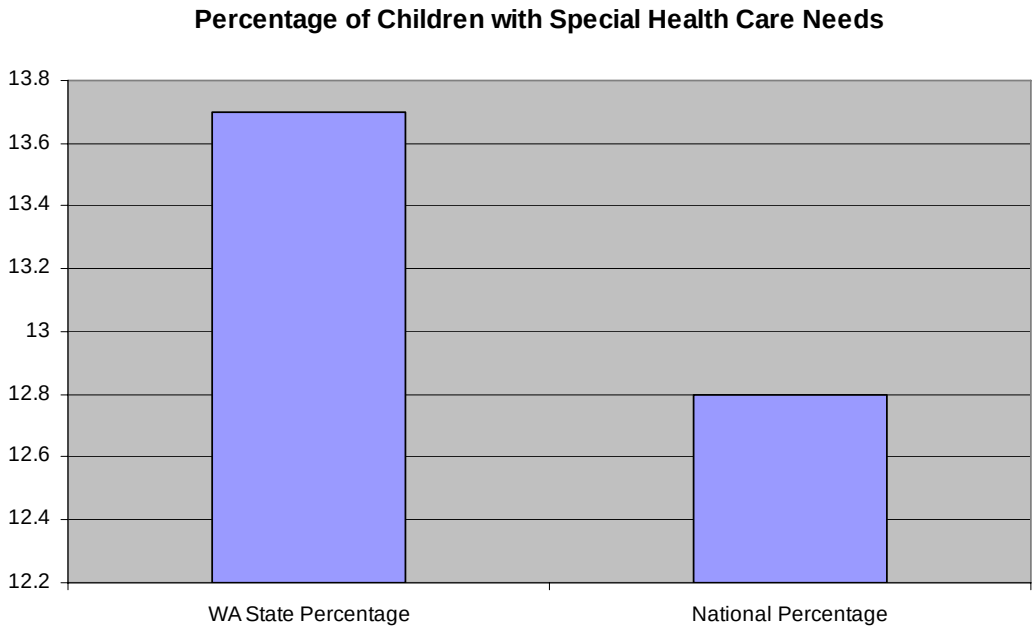


Districts were asked, "Based on the severity levels and a 40 hour week, how many hours per week are needed to meet the OSPI staffing model?" Only 66 districts answered this question. These districts determined the need for an additional 10,496 hours per week of RN service (262 FTEs) to meet the staffing needs of students identified as Level A–nursing dependent, Level B–medically fragile, Level C–medically complex, or Level D–health concerns. Again, districts reported a wide range of need for RN service to meet these levels of care. The variability in reported need, in conjunction with the very large total number of reported hours, raises questions about varying interpretations of the severity coding by those who completed the report; and thus, questions about the reliability of the data collected via the *Assessment of District Student Health Services – Class I Districts.*

Washington State Department of Health Data

The *Children and Youth with Special Health Care Needs Washington State Report* (DOH, 2005) shows that overall Washington State has a higher prevalence of children with special health care needs than the national norm. This data also reveals that more of those children's daily activities are affected by their special health care need than the national norm. The 2005 Washington State report reflects data that was collected nationally in 2001.

Percentage of Children/Youth with Special Health Care Needs 0–17 years



Prevalence	WA State Percentage	National Percentage
Prevalence by Age:		
0–5 years of age	8.6	7.8
6–11 years of age	15.4	14.6
12–17 years of age	16.7	15.8

Indicator		
Number of CYSHCN Whose Health Condition Affects Their Daily Activities	27.2	23.2

There are more children in the state of Washington whose health problems interfere with activities of daily living than the national norm. This factor poses a safety concern in planning school activities for these children. This finding supports the need for a higher number of school nurses than the recommended norm. Students with disabilities and special needs require a tremendous amount of individual attention which often includes nursing related services such as intensive care plan development and documentation, and multiple nursing procedures on a daily basis.

BEST PRACTICES IN SCHOOL NURSING SERVICES

Washington State Standards

An analysis of best practices in school nursing reveals within the state of Washington, the *Staff Model* is the baseline for best practices in school nursing. The *Staff Model* was

first published in 2000. The SNSWG found that since 2000, numerous federal and state laws have changed or been added that impact the delivery of health services to students.

Further, the SNSWG determined that having standards of practice and accountability for school nurses is significantly important due to the nature of the independent practice. The SNSWG study highlighted Educational Staff Associate (ESA) Certification standards as an additional component of best practices in our state.

The SNSWG discovered that the OSPI School Nurse Research Task Force (SNRTF) developed a tool and process for school nurses to begin to measure the outcomes of nursing interventions. The tool kit, *Improving Practice through Measuring Outcomes* was finalized and distributed through a "Train-the-Trainer In-Service Program," January 2005. The tool kit is a step-by-step guide to teach school nurses to do outcome-based evaluations. Outcome evaluations are a systematic method of assessing the extent which a school nurse intervention or school health program achieves its intended results (See Appendix K). Two hundred and twenty school nurses across the state are trained in the use of this kit. As a result, 90 nurses each submitted a plan to OSPI for a research project focusing in data gathering to better evaluate the outcomes of specific nursing interventions.

Additionally, the SNSWG found that the NCQAC recently restructured their subcommittee structure to reflect their legislative mandate that includes "to establish, monitor and enforce consistent standards of practice…." (RCW 18.79.010). The NCQAC recognizes that there are many standards of care used across our state, but minimum standards need to be expected for the delivery of school health services. The NCQAC will be developing action plans in order to establish consistent standards of practice.

National Standards

The SNSWG review shows national standards of practice are currently the gold standard for school nursing best practices. The scope and standards of practice developed by the National Association of School Nurses (NASN) describe the professional expectations of school nurses. The standards serve as a definitive guide for role implementation, interpretation, and evaluation. They are used in conjunction with the state nurse practice act and other relevant laws or regulations to determine the adequacy of a given school nursing practice (American Nurses Association, 2005). To meet the challenges associated with the ongoing and changing health problems of students, NASN has developed seven specific roles to guide the school nurse in the school setting, the school nurse:

- Provides direct health care to students and staff.
- Provides leadership for the provision of health services.
- Provides screening and referral for health conditions.
- Promotes a healthy school environment.

- Promotes good health.
- Serves in a leadership role for health policies and programs.
- Serves as a liaison between school personnel, family, community, and health care providers.

A description and list of the Standards of Practice and Standards of Professional Performance developed by NASN may be found in Appendix L.

Standards of practice also assist school administrators to understand the complexity of the nurse's role; it is not simply performing tasks. Many nurse responsibilities require a license to perform.

The SNSWG recognized that nurses often are the first to see children who have been maltreated, victims of violence, bullying, depression, drug abuse, and other psychosocial problems. Many of these problems lead to increased absences contributing to higher dropout rates or decreased academic achievement. Nurses are able to identify and refer these children to proper resources and to follow up. However, they need time and funding to provide the standard of care dictated by the Washington State Nurse Practice Act and their national school nursing organization (American Nurses Association, 2005). It is recognized that a multiplicity of factors contribute to academic failure and improving school nursing services is only one entry point for a positive intervention. However, the bottom line is that improved health status can contribute to improved student academic performance.

The group dialogue further revealed that school nurses, functioning in a nonmedical facility, require additional knowledge and skills including laws pertaining to the educational system and nursing practice. These nurses must be knowledgeable about delegation policies, communication and collaboration with families, community agencies, and health care providers to plan effective care for students. A professional development plan must be available to ensure school nurses are adequately trained to provide safe and quality health services.

The SNSWG determined that education beyond a bachelor's degree prepares school nurses to address specific health problems in the school setting, as well as issues related to safety and psychosocial concerns, health education, health promotion, and illness prevention. Advanced education focuses on the relationship between health and academic performance, school nurse standards of practice, and ethical and legal issues related to the school setting. In addition, communication skills assist the school nurse to work within an educational setting to coordinate with parents, families, and primary care givers as a representative of the school (Center for Mental Health in Schools, 2005). With the complex health needs of children in schools, school nursing requires ongoing and advanced educational preparation and skills commensurate with the complex needs of students.

National Parent Attitude Data

The SNSWG found that survey data of parents' attitude towards school health services for Class I school districts is not available at this time. However, a nationwide telephone

survey was conducted by the Center for Health and Health Care in Schools February 25–March 10, 2003 (Center for Health and Health Care in Schools). A total of 1,101 parents of school age children were polled. Included in the survey was an over-sample of parents in households earning less than $35,000 per year. Following are the results of that survey:

Question One: How important is it for health services to be provided in school?

- Prevention and education about drug and alcohol abuse - 83 percent Very Important, 13 percent Somewhat Important (96 percent total response).

- Educating students about health issues like eating right - 77 percent Very Important, 19 percent Somewhat Important**.**

- Providing age appropriate sex education - 56 percent Very Important, 28 percent Somewhat Important.

Question Two: Parents attitude toward health care in schools:

- 83 percent of parents say they support health care in the schools. Over half (56 percent) are strong supporters. Only one in ten (11 percent) oppose health care in the schools.
- 56 percent strongly support school health services.
- 26 percent somewhat support.
- 6 percent somewhat oppose.
- 5 percent strongly oppose.

Question Three: Is health care in schools most important at the Elementary, Middle School or High School level?

- Elementary 75 percent.
- Middle School 7 percent.
- High School 6 percent.
- Don't know 12 percent.

Since parents are a partner in planning and implementing health services, the SNSWG determined that it is imperative to seek their input. They further determined that parental surveys may be a future health services tool for Class I districts.

DEDICATED SUSTAINABLE FUNDING MODEL

School Nurses Continue as a Part of Basic Education

To explore the issue of funding, the legal definition of basic education was analyzed to determine if it included the provision of school health services. The SNSWG found that the definition, related statutes, and recent court decisions are silent on the inclusion of school health services in basic education. Additionally, nursing services are not a separate, specific element of the basic education funding formula. Districts may choose

to hire nurses under Certificated Instructional Staff (CIS), classified, or administrative categories. The funding model provides for a number of CIS that encompasses teachers as well as a group of staff labeled Educational Staff Associates (ESAs) which includes nurses and other health care professionals. As there is no breakdown within the funding formula of how many ESAs are included in the funded staff units, there is also no requirement that districts actually hire any specific number of ESA staff with the funding. Staffing decisions for nurses at the district level are therefore based completely upon local districts' judgment and historical practices. The SNSWG found that sources of payment for school health services vary widely among school districts. Still, basic education funding was determined to be the primary source of funding for school health services in most (87 percent of reporting districts) Class I districts.

The data reveals that methods of payment for school health services vary widely from school district to school district. Districts reported the following categories for funding school health services:

Funding Source	Number of Districts Reporting
Basic Education	69
Special Education	34
Levy	25
Medicaid Administrative Match	9
SNC	5
Grants	7
Other	8

The "Other" category for funding included: general funds, local funds, and two districts partnering with local hospitals for funding. Basic education funding is the primary source of funding for school nurse services.

There have been at least three statutory changes in Washington State with an increased expectation in the provision of nursing resources in the schools: children with diabetes, life-threatening conditions, and asthma. The SNSWG determined there appears to be an assumption that schools will provide for nursing services in their education program funding resources. However, Class I school districts have not received any direct increase in funding proportionate with the increased expectations.

OPPORTUNITIES TO IMPROVE COORDINATION OF AND ACCESS TO HEALTH SERVICES FOR LOW-INCOME CHILDREN; THE FEASIBILITY OF POOLING SCHOOL DISTRICT AND MANAGED CARE PLAN FUNDING

Opportunities to Improve Coordination of and Access to Health Services for Low-Income Children Through the Use of School Nurse Services

The SNSWG dialogue with DSHS staff revealed that there are significant and ongoing challenges to collaboration between schools and the various Medicaid programs. To meet the mission of education, schools find themselves delivering many services that help ensure that students come to school as healthy learners. Understanding and complying with the stringent requirements of the programs, especially when seeking reimbursements, places an increased burden on school administrators who are

unaccustomed to the complexities of operating in a medical services world (Center for Medicare and Medicaid Services, 2003).

The meetings with the Medicaid personnel resulted in positive outcomes including:

- School nurses were recognized as an important component of the health care delivery system.
- Communication between the two groups on how to best work with children enrolled in the Medicaid program to ensure they receive the services they are entitled.
- Willingness to accept feedback and suggestions on the current model being used for receiving reimbursements.

Feasibility of Pooling School District and Managed Care Plan Funding to Finance School Nurse Positions

DSHS staff described for the SNSWG that there is reimbursement or partial reimbursement for some nurse time activities under the following programs:

- Medicaid Special Education.
- Medicaid Administration Match.

Any Medicaid school nurse reimbursement program must comply with regulations from the Federal Medicaid Agency, which is the Centers for Medicare and Medicaid Services (CMS) as well as state regulations.

However, DSHS staff clarified that there are no current funds available to specifically pay for school nurse positions and, as mentioned earlier, the reimbursement funds received for children under the Medicaid system often go to school programs other than health services. **Further, the dialogue with DSHS staff revealed that based on current requirements and priorities, Medicaid and managed care funds are not a source for funding school nurse services.**

ADDITIONAL SUPPORTING INFORMATION, RESOURCES, AND REFERENCES

Additional supporting information, resources, and references may be found in the following Appendices:

Appendix M	The Need for School Health Services: Rationale.
Appendix N	Access to Health Care.
Appendix O	References.

APPENDICES

“Coming together is a beginning. Keeping together is progress. Working together is success.”

Henry Ford

APPENDIX A

SCHOOL NURSE STUDY
2005 OSPI BUDGET PROVISO

(f)(i) $45,000 of the general fund—state appropriation for fiscal year 2006 is provided solely for the office of the superintendent of public instruction and the department of health to collaborate and develop a work group to assess school nursing services in class I school districts. The work group shall consult with representatives from the following groups: School Nurses, schools, students, parents, teachers, health officials, and administrators. The work group shall: (A) Study the need for additional school nursing services by gathering data about current school nurse-to-student ratios in each class I school district and assessing the demand for school nursing services by acuity levels and the necessary skills to meet those demands. The work group also shall recommend to the legislature best practices in school nursing services, including a dedicated, sustainable funding model that would best meet the current and future needs of Washington's schools and contribute to greater academic success of all students. The work group shall make recommendations for school nursing services, and may examine school nursing services by grade level. The work group shall assess whether funding for school nurses should continue as part of basic education; and (B) In collaboration with managed care plans that contract with the department of social and health services medical assistance administration to provide health services to children participating in the Medicaid and state children's health insurance program, identify opportunities to improve coordination of and access to health services for low-income children through the use of school nurse services. The work group shall evaluate the feasibility of pooling school district and managed care plan funding to finance school nurse positions in school districts with high numbers of low-income children.
(ii) The office of superintendent of public instruction shall report the work group's findings and plans for implementation to the legislature by February 1, 2006.

APPENDIX B

SCHOOL NURSE STUDY WORK GROUP MEMBERS

Anderson, Mark – Disability Coordinator, WEA

Doyle, Janice – SNOW, President

Justin, Brenda – Board Member WSPTA

Meyer, Paula – Executive Director, NCQAC, DOH

Representative Morrell, Dawn – WA State House of Representatives

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Myers, Mary K. – School Nurse, SNOW

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VanSweringen, Colleen – School Nurse, Vancouver School District

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DSHS Subcommittee:

Bess, Christine – Program Manager, DSHS, Family Services Section

Himsl, Alan – Section Manager, DSHS, Health and Recovery Services Administration

Reddick, Sharon – Program Manager, DSHS, Office of Managed Care

Wilson, Margaret – Nurse Consultant Advisor, DSHS, Division of Program Support

Wilson, Peggy – Section Manager, DSHS, Office of Managed Care

APPENDIX C

STAFF MODEL FOR THE DELIVERY OF

SCHOOL HEALTH SERVICES

WASHINGTON STATE NURSING CARE
QUALITY ASSURANCE COMMISSION

WASHINGTON STATE OFFICE OF SUPERINTENDENT
OF PUBLIC INSTRUCTION

April 2000

STAFF MODEL FOR THE DELIVERY OF SCHOOL HEALTH SERVICES

Acknowledgements

This staff model was developed from a series of public meetings. The public meetings were attended by representatives of hospitals, university schools of nursing, state and local health and education agencies and organizations, student advocacy organizations, parents, and professional organizations representing school staff. These stakeholders provided valuable input and support in the development of this document.

We would also like to thank the following for their contributions to this model and recognize their continuous contributions to the students of the state of Washington. Their professionalism and dedication make it possible for all children in kindergarten through Grade 12 to have their health care needs assessed and addressed while their educational needs are met.

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STAFF MODEL FOR THE DELIVERY OF SCHOOL HEALTH SERVICES

Introduction

This document is divided into three sections. The first is a general discussion of nursing care in schools and the different levels of staff who may provide health services in terms of their training, education, licensure, certification, and responsibility. The staff model is two parts as described in the summary below.

SUMMARY: The staff model consists of a nursing assessment to determine levels of care needed for individual students in a school and an overall school district model with staffing level recommendations. The staff model is two parts: (1) "Levels of Nursing Care for Student Diseases and Conditions: Severity Coding," a nursing assessment to determine levels of care needed for individual students in a school, and (2) "School District Model for the Delivery of Health Services," an overall school district model with staffing level recommendations. The staff model is to be used to predict the nursing care and staff needs of individual schools and school districts.

In the school setting, it is essential to aggressively manage any health problems that are likely to compromise daily learning readiness. For this reason, school health care providers may prioritize concerns and assign health services staff somewhat differently from the traditional medical community.

I. Nursing Care in Schools

The school nurse's primary responsibility is to the students. Each school nurse is responsible for each component of the nursing process with children in school: assessing, planning, implementing, and evaluating the nursing care. This is a continuous process. The registered nurse is responsible for the initiation of the care plan. In order to complete the initial care plans, the registered nurse(s) must be alerted to the needs of the child(ren) who will attend school. Optimally, these needs would be identified and communicated prior to attendance at the school to allow for adequate planning and training of school personnel. Administrators (including special education) in each school must establish a procedure that identifies and communicates the student's actual or potential need(s) for nursing care to the registered nurse. The identification of these needs, at the port of entry, can be communicated through health forms, parents' messages to school administrative personnel, or the health room personnel. Time to assess the needs of children and develop the plans must be considered as additional to the time needed to provide the actual care.

Components of a nursing assessment are:

- Patient interview.
- Review of physical systems.
- Family history.
- Physical examination.
- Psychosocial nursing assessment (review of support systems, mental health assessment, etc.).
- Patient's compliance history.

- Understanding of procedures and outcomes.
- Physical environmental assessment.
- Functional assessment.
- Review of current medical diagnoses.
- Developmental assessment.
- Review of medications, interpretation of side effects, identification of effects on patient outcome (pharmacological assessment).
- Identification and interpretation of deviations from physiological norms.
- Interpretation of the impact of patient's medical history and treatment modalities on the patient's current condition.
- Evaluation of effectiveness of current treatment modalities.

From the information obtained in this nursing assessment, the nurse develops nursing diagnoses, a plan of care specific to the student, and provides for the implementation of the plan of care and ongoing evaluation. The plan of nursing care, often referred to as an individual health care plan (IHP), is a component of the interdisciplinary plan of care for a patient. The registered nurse is responsible for the "plan of nursing care" component of the interdisciplinary plan. (Excerpt from Washington State Board of Nursing, *Unlicensed Practice Task Force Recommendation,* March 1991).

L.P.N./R.N. Preparation

Licensed practical nurses (L.P.N.) use specialized knowledge, skill, and judgment to carry out selected aspects of the designated nursing regimen under the direction and supervision of a licensed physician and surgeon, dentist, osteopathic physician and surgeon, physician assistant, osteopathic physician assistant, podiatric physician and surgeon, advanced registered nurse practitioner, or registered nurse (RCW 18.79.060). L.P.N.s are fully licensed health professionals and are accountable for their own actions at all times. L.P.N.s may give medications in school settings, including injections, with indirect registered nurse (R.N.) supervision.

WAC 246-840-705 describes the functions of a licensed practical nurse. In summary, a licensed practical nurse recognizes and meets basic client needs in routine nursing situations, which are defined as situations that are relatively free of scientific complexity, involving stable and predictable client conditions. L.P.N.s also function in more complex nursing care situations, and in these cases an L.P.N. would function as an assistant to the registered nurse or physician. Licensed practical nurses can revise the care plan and deliver the care according to the plan.

As stated above, indirect supervision by an R.N. who is not on school premises is within the standards of care, as long as the L.P.N. is providing care for students in routine, noncomplex situations and as long as the supervisory role of the R.N. has been established. Periodic review of the plan and R.N. availability for questions are recommended components of school health services.

A registered nurse has the knowledge, skills, and license to provide nursing care. The registered nurse may have either a bachelor's of science in nursing (BSN), an associate degree in nursing (ADN), or a diploma from a hospital school of nursing. Registered nurses with a BSN possess the knowledge and skills to function independently in a

community or school setting and to coordinate family and community services in managing students with significant health problems.

The Certificated School Nurse Employed by a School District
The registered nurse with educational staff associate (ESA) certification as a school nurse has the preparation to develop and administer a comprehensive school health program, contribute to the development and teaching of the health education program, and is familiar with school law and the implications for school nursing practice. The certificated school nurse has the knowledge and skills to perform and supervise nursing care of students. The knowledge and skills acquired through the certification process (WAC 180-79A-223[1]) are over and above the knowledge and skills required for licensure as a R.N. and that generally obtained in a BSN program. Persons serving as school nurses in first class districts must hold an ESA certificate (WAC 180-86-011). WAC 180-87-050, Misrepresentation or Falsification in the Course of Professional Practice, addresses professional misconduct by a person (such as a school nurse) acting as a nurse without the valid, appropriate certification.

For an employer (such as a school administrator), WAC 180-87-070(1) defines an act of unprofessional practice as the intentional employment of a person to serve as an employee in a position for which certification is required by rules of the State Board of Education when such person does not possess a valid certificate to hold the position for which such person is employed.

WAC 180-87-070(2) further defines an act of unprofessional practice as "The assignment or delegation in a school setting of any responsibility within the scope of the authorized practice of nursing, physical therapy, or occupational therapy to a person not licensed to practice such profession unless such assignment or delegation is otherwise authorized by law, including the rules of the appropriate licensing board." Nursing care can only be delegated by the R.N. within the regulations and guidance of the Nursing Care Quality Assurance Commission.

Other certificates are available within certain restrictions if an R.N. has no BSN. See WAC 180-79A-231(1)(c)(iii).

Delegation of Nursing Care
Properly credentialed health care professionals, including R.N.s and L.P.N.s, are able to work in the school settings, but must act within the scope of their respective practice acts. Licensed health care professionals must also comply with any specific laws that apply to the provision of health care in the school setting, laws that may be more or less restrictive than in other settings. For instance, registered nurses may delegate certain limited health care tasks to uncredentialed school employees so long as the registered nurse and the employee comply with delegation, training, and supervision requirements addressed in RCW 28A.210.260 and 28A.210.280. Under these laws, uncredentialed school employees may administer oral medications and perform clean intermittent catheterizations as delegated tasks, tasks that in other settings could not be lawfully performed by uncredentialed individuals. Registered or certified nursing assistants (and health care assistants) are not authorized to practice in the school setting, but they may

function in the role of uncredentialed school employees who may receive the delegated tasks of administering oral medications or performing clean intermittent catheterizations. Therefore, nursing assistants (and health care assistants) would be limited to the performance of only those tasks they could complete as uncredentialed school employees under RCW 28A.210.260 and 28A.210.280.

If the nursing assistant or licensed practical nurse completes other tasks, he or she would then need to comply with all of the regulations that govern their practice. Schools are not included in the list of health care facilities as determined by the Washington State Nursing Care Quality Assurance Commission. Therefore, a nursing assistant's practice would be limited to the tasks he or she could complete as a school employee.

In the process of determining the appropriateness of nurse delegation in schools, the registered nurse uses his/her judgment to determine the competency of the individual accepting the training to complete a delegated task. The person to whom the R.N. delegates care must be trained, willing, and competent to accept the delegation of a nursing task or care. In every instance, the nurse retains responsibility to the student for the quality of nursing care provided by the delegatee. If, in the judgment of the registered nurse, the caregiver is not able or willing to complete the task, the caregiver is not considered competent and must not provide the care. Delegation and supervision are both part of the assessment phase in nurse delegation. The registered nurse evaluates the competency of the caregiver on a regular basis and therefore assesses the safety and efficacy of the caregiver providing the care. References to this are in RCW 18.79.040(1)(c) and RCW 18.79.260(2).

IDEA/Section 504 Staffing Accommodations

For students who have qualified for special education, the requirements of the Individual with Disabilities Education Act (IDEA) and state law for development of the individualized education program (IEP) and for the provision of health and education services in the least restrictive environment must be met.

For students who do not require special education, Section 504 of the Rehabilitation Act of 1973 requires students with a disability to have full access to all activities, services, or benefits provided by public schools. Any school receiving federal funds must accommodate the special health care needs of its students with disabilities in order to provide them with a "free appropriate public education." Such accommodations should be documented in an appropriately developed Section 504 plan or, if the child also needs special education or related services, in an IEP. These accommodations must be developed with parental input and cannot be implemented without parental consent. The school district has a legal obligation to ensure that these accommodations are provided as described in the Section 504 plan.

Confidentiality of Health Care Information

All unlicensed health care providers, such as health room aides or pupil transportation staff who assist the health care provider in the delivery of health care to students, must be informed of the confidentiality requirements of the federal Family Education Rights and Privacy Act (FERPA) and state requirements under chapter 70.02 RCW, Medical

Records—Health Care Information Access and Disclosure. Health care information about a student cannot be disclosed without signed consent of parent, guardian, or student except in selected situations identified by the licensed health care provider (such as the school nurse). See *Guidelines for Handling Health Care Information in School Records*, State of Washington, Superintendent of Public Instruction, September 1995.

II. Levels of Nursing Care for Student Diseases and Conditions: Severity Coding

Students attend school with a broad range of health conditions, from potentially life-threatening acute and chronic conditions to correctable vision problems and everything in between which could impede the student's ability to fully participate in the educational process. Severity coding is a method for planning adequate staffing to meet the varying needs of students.

Severity of condition does not always translate directly into nursing time with the students. Many students with significant chronic conditions **predictably** require daily nursing time. For example, a student with spina bifida who is not yet independent with urinary bladder management requires 40 minutes every day of the nurse's time for catheterizations at the same time every school day. Other students such as those with severe asthma may experience an acute asthma attack and require nursing assessment and care **at any time** during a school day.

Examples of treatments/intervention that may be performed in schools at all levels of severity are (these are only a few examples and not meant to be an exclusive list):

Blood glucose test
Continuous oxygen administration
Dressing change
Gastric tube feeding
Intermittent oxygen administration
Laboratory tests
Medication management
Monitor blood pressure
Monitor disability
Monitor illness
Monitor weight
Nebulizer treatments
Peak flow monitoring
Sterile bladder catheterization
Suctioning
Toileting
Tracheostomy care
Unsterile bladder catheterization

In order to plan, care for, and monitor the students with special health care needs, the school nurse will assign each qualifying student to a level of care based on the following categories: nursing dependent, medically fragile, medically complex, and health concerns. In addition to children being considered for assignment to these levels of severity, there are many other students not requiring care on a daily basis. Therefore, the School District Model for the Delivery of Health Services (pages 12-14) has been recommended for this larger population of students. This model is to be used in conjunction with severity coding which establishes the nursing staff needs of students within a school building.

Level A: Nursing Dependent
Nursing dependent students require 24 hours/day, frequently one-to-one, skilled nursing care for survival. Many are dependent on technological devices for breathing, for example, a child on a respirator, and/or for continuous nursing assessment and intervention. Without effective use of medical technology and availability of nursing care, the student will experience irreversible damage or death. Before a student enters school, a registered nurse will complete a nursing assessment of the student and determine an appropriate plan of care/individual health care plan.

Staffing requirements: Immediate availability of the nurse (registered nurse or licensed practical nurse as determined by the R.N.) "on the premises and is within audible and visual range of the patient [student] and the patient [student] has been assessed by the registered nurse prior to the delegation of duties to any care giver" (WAC 246-840-010[11][d]).

Statutory Authority
- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of a licensed practical nurse.
- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

Level B: Medically Fragile
Students with complex health care needs in this category face daily the possibility of a life-threatening emergency requiring the skill and judgment of a professional nurse. An individual health care plan or plan of nursing care developed by a registered nurse must be complete, current, and available at all times to personnel in contact with these children. This includes bus drivers for daily transportation and special events, sports coaches, and school personnel assigned to extracurricular activities. Every child in this category requires a full-time nurse in the building. Children in this category may be transported to school. Someone must be trained and available on the bus to provide care during transport to the school. This training must include the primary bus driver, the child, and back-up personnel. The registered nurse makes the decision of who will be trained and what level of preparation is required, and uses the nurse delegation principles described on pages 4–5.

Examples may include, but are not limited to:
- Severe seizure disorder, requiring medications that can be administered only by a nurse.
- Severe asthma with potential for status asthmaticus.
- Sterile procedures.

- Tracheostomy with frequent and/or unpredictable suctioning.
- Unstable and/or newly diagnosed diabetic with unscheduled blood sugar monitoring and insulin injections.

Staffing requirements: Every child in the medically fragile category requires a full-time nurse in the building. The nurse "is on the premises, is quickly and easily available and the patient [student] has been assessed by the licensed registered nurse prior to the delegation of the duties to any caregiver" (WAC 246-840-010[11][c]).

The child may need to transfer to a school where full-time nursing staff is provided if not available at the local school. If the child needs a high level of nursing service, but is not willing to move or the parents object to the move to the school where the service is provided, the parents, school administrators, and school nurse should meet and discuss options. Options **may** include a waiver signed by the parent in compliance with school district policy for the student to remain in the local school. In these cases, a move toward students attending their neighborhood schools works against the provision of adequate care if there is not a full-time nurse in the neighborhood school. Parents need to be fully aware of the services that are offered by a school. Placement of their children in schools where services are not available to the degree required, could present undue stress on the child, the nursing staff, parents, and school staff. If a waiver has been signed, the professional registered nurse in the school the child is attending must be aware of the child's condition and needs and develop emergency care plans for these children. Reasonable accommodation and provision of education and health services under Section 504 or under IDEA must be considered and addressed in each child's individual health care plan.

Statutory Authority
- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of a licensed practical nurse.
- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

Level C: Medically Complex
The medically complex student has a complex and/or unstable physical and/or social-emotional condition that requires daily treatments and close monitoring by a professional registered nurse. Life-threatening events are unpredictable. Treatments, medications, and reporting of current signs and symptoms can be delegated, but delegation requires a trained, willing, and competent staff person and close supervision of that staff person by a registered nurse. The level of supervision required is determined by the R.N. but must be adequate to maintain safety and ensure competence of the direct caregiver. Adaptations of the medically complex student to the educational system must be negotiated and maintained with the student, family, school staff (classroom and administrative), and community health care provider(s).

Examples include, but are not limited to:

ADHD and on medications
Anaphylactic event
Cancer
Complex mental or emotional disorders
Immune disorders
Moderate to severe asthma; inhaler at school and peak flow meter
Oxygen, continuous or intermittent
Preteen or teenage pregnancy
Taking carefully timed medications
Taking medications with major side effects
Unstable metabolic conditions

Emotional disorders and homicidal and/or suicidal behaviors may be assessed and categorized at this level. These conditions require collaboration with school counselors. The registered nurse's role must be identified and defined and mutually agreed to in these cases. Pregnancy may also be classified at this level. Pregnancy issues must be assessed and may require weekly evaluation.

Staffing requirements: Children placed in this category require a professional registered nurse in the building a full day a week who is available on a daily basis when not in the school building. The registered nurse prioritizes issues weekly and provides a face-to-face assessment of these children at least one day a week. If children in this category become more fragile and meet the definition of Level A or Level B care, they may need to transfer to a school that meets the staffing requirements of the higher categories. This is dependent on the registered nurse's judgment and district policy. At Level C, the registered nurse "is not on the premises but has given either written or oral instructions for the care and treatment of the patient [student] and the patient [student] has been assessed by the registered nurse prior to the delegation of duties to any caregiver" (WAC 246-840-010[11][e]). If any alteration of the written care plan is required, it must be done by the registered nurse and must be documented. Licensed practical nurses can revise the care plans and consult with the registered nurse.

Statutory Authority

- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of a licensed practical nurse.
- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

Level D: Health Concerns

The student's physical and/or social-emotional condition is currently uncomplicated and predictable. Occasional monitoring is required. Required monitoring varies from biweekly to annually. Examples include, but are not limited to:

Dental disease
Diabetes self-managed by the student
Dietary restrictions
Eating disorders
Encopresis
Headaches, migraines
Sensory impairments
Orthopaedic conditions requiring accommodations
Uncomplicated Pregnancy

Staffing Requirements: Children placed in this category should have their health needs assessed at least once a school year by the registered nurse at the beginning of the school year or at the time of diagnosis. Reassessment occurs as the condition requires and the nurse's judgment determines.

Statutory Authority

- RCW 18.79.260 Registered nurse—Activities allowed.
- RCW 18.79.270 Licensed practical nurse—Activities allowed.
- RCW 18.79.280 Medication, tests, treatments allowed.
- RCW 18.79.290 Catheterization of students—Rules.
- WAC 246-840-010 Definitions.
- WAC 246-840-700 Standards of nursing conduct or practice.
- WAC 246-840-705 Functions of a licensed practical nurse.
- WAC 246-840-710 Violations of standards on nursing conduct or practice.
- WAC 246-840-715 Standards/competencies.

Social/Emotional Factors, Comorbidity

Classification of students by the severity of their condition(s) remains the responsibility of the registered nurse. The registered nurse may factor into his/her decision any of the following or other significant factors that increase health care need:

Chronic illness stressors
Drug/alcohol stressors
English-as-second language
High mobility/turnover
Homeless
Poverty/low income
Reentry
Special education, enrolled

The student's diagnosis may place him or her at Level D, but if the student has more than one diagnosis (comorbidity) or any of the above risk factors, the nurse may place the student in a higher level of severity and increase monitoring, at least initially.

Transportation

A student may need transportation as a related service, as determined under procedures provided under IDEA and chapter 392-172 WAC, because of student characteristics which could require nursing care, or intervention, or require the use of adaptive or assistive equipment. In these situations, the pupil transportation staff should be invited to participate in the nursing assessment and care planning process as a resource person and potential provider of care.

Time allotted for training by the registered nurse and for the pupil transportation personnel needs to be considered in the staffing model. Informing and training

transportation staff prior to the first transport is essential to ensure safe transport. The degree of ongoing nursing supervision must also be addressed and provided. Appropriate substitutes for the transportation personnel must be trained as well. Liability questions associated with the provision of nursing care and supervision need to be addressed. The registered nurse will assess the student and secure answers to the following questions prior to transportation arrangements being made:

1. Can the student be safely transported?
2. Can the student's medical equipment be transported?
3. What inservice training is necessary to safely transport this student, e.g., use of medical equipment, signs and symptoms of illness or disease progression, universal precautions, etc.?
4. Is an additional staff person necessary in the vehicle to observe and care for the student during transport?
5. What level and degree of nursing supervision is required by the transportation staff for the student?

Level C or D students may require some adaptations but not require nursing staff to be on the bus. If a student in Level C or D experiences deterioration in condition or an acute episode requiring increased nursing care, the nurse will reassess the student. If the student is then categorized as Level A or B, the student may be transported to a school with full-time nursing services depending on district policy and/or additional or licensed personnel resources may be added to the bus.

III. School District Model for the Delivery of Health Services

In this section we will discuss the second part of the staff model which describes a districtwide staffing model. "Levels of Nursing Care for Student Diseases and Conditions: Severity Coding" determines health services staffing for students within a school building based on the student's condition and the nursing services the student requires during the school day [pages 31-35]. The following "School District Model for the Delivery of Health Services" provides recommendations for districtwide staffing for health services.

The recommended model for districtwide staffing for health services consists of:

- One professional school nurse for every 1500 regular education students, including those on the health concerns level (Level D).
- A health room paraeducator to student ratio based on the grade level within a building.
- Additional assigned professional registered nurses, L.P.N.s, and unlicensed school staff to whom the care of students on Levels A, B, and C have been delegated based on individual student need as determined by the registered nurse's assessment.

Certificated School Nurses
The certificated school nurse could be expected to have the abilities because of her/his educational preparation [see page 29] for the activities described here. The school nurse with educational staff associate (ESA) certification has responsibility for assessing the health care needs of all 1500 students in his/her caseload; assigning students to an appropriate level (A–D); delegating the care to R.N.s, L.P.N.s, and unlicensed school staff; and providing appropriate training and supervision of the caregiving staff. The school nurse participates as a member of each student's evaluation group, which includes parent(s), participates in the development of the student's IEP, and ensures the implementation of the health care aspects of the IEP. For students not receiving special education, the nurse develops an IHP. The nurse participates in the development of health education curricula and teaches classes when appropriate. The nurse evaluates and monitors the school environment for health and safety hazards and works with the local health department in the control of communicable disease and the monitoring of student immunization against vaccine-preventable disease.

The school nurse recommends or designs accommodations (Section 504 Plan) that permit the student to participate fully in learning and communicates to school staff to ensure understanding and compliance with the student's educational program goals. The school nurse ensures that each student in his/her caseload is well enough to learn each school day and that any student and family health issues that may increase absences or negatively affect the student's ability to learn are identified and addressed.

The school nurse provides case management for students in his/her caseload and interacts with parents, primary health care providers, community and school resources to provide a school environment that is safe, healthy, and conducive to learning.

The school nurse in this role should have current ESA certification in order to meet the basic requirements for managing the health care of 1500 students within the educational system and culture.

Non-ESA Certificated Nurses/L.P.N.s
As previously discussed on pages 3–5, other registered nurses and licensed practical nurses can work in the school settings without the ESA certificates. Licensed practical nurses work under the supervision of R.N.s, physicians, and other authorized health care providers.

Health Room Assistants
The health room assistant (HRA) is specially trained to staff the health room and provide care to students based on protocols developed and supervised by the registered nurse. The HRA has completed the Office of Superintendent of Public Instruction (OSPI) "Orientation-Level Training for Paraeducators Working with Students with Special Health Care Needs" course. The HRA may be a registered or certified health care provider which would require the HRA to act within her/his scope of practice with the exception of clean intermittent catheterization and oral medication administration [see pages 29-30] and comply with the Uniform Disciplinary Act.

The health room assistant is in the building daily at least during the high use times such as 11 a.m.–1 p.m. when most medications are given. The recommended ratio is:
1. Elementary schools—at least 0.1 FTE/100 students.
2. Middle and high schools—at least 0.1 FTE/200 students.

Up to a limit of one HRA per building is recommended. The HRA may be in the school at times the school nurse is not, but there must be provision for at least weekly face-to-face communication with the school nurse on a routine, scheduled basis. The R.N. has responsibility for selection, training, and supervision of the HRA and for the development of health room protocols. The hiring and performance evaluation of the HRA remains with the school administration with weighted comments from the supervising R.N. in health care provision by the HRA. As indicated in the introduction, however, registered/certified nursing assistants and certified health care assistants are not authorized to practice in the school setting; they may function in the role of uncredentialed school employees who may receive the delegated tasks of administering oral medications or performing clean intermittent catheterizations under RCW 28A.210.260 and 28A.210.280.

Clerical Staff
For the nursing staff to complete nursing responsibilities, clerical staff are needed as support for filing the individual health plans, data entry, and ensuring that the health forms and immunization records are completed.

Summary
This paper provides a discussion of an approach to the hiring and assignment of staff for the provision of school health services that considers the individual student nursing care needs during the school day, plus the need for school nurse services by all students within a district.

APPENDIX D

SCHOOL NURSE STUDY WORK GROUP RECOMMENDATIONS ON HEALTH SERVICES IN WASHINGTON STATE CLASS I DISTRICTS

RECOMMENDATIONS

This Appendix repeats the language from the 2005 budget proviso and states the SNSWG recommendations directly related to the language.

PROVISO EXCERPT: Study the need for additional school nurse services by gathering data about current school nurse-to-student ratios in each Class I school district... and

PROVISO EXCERPT: Assessing the demand for school nursing services by acuity levels and the necessary skills to meet those demands...

RECOMMENDATION: Mandate the district assessment for Class I school districts starting with 2006–07 school year. Data gathered on an annual basis can identify trends, needs, and strengths of school health services. Revision of the district assessment form needs to have input from the nurses serving in Class I School.

Revision of the *Assessment of District Student Health Services – Class I Districts* is to include:

- Duties related to special education, i.e., assessments and re-evaluation to capture both numbers of assessments and time needed to complete these tasks.
- Data that would reflect range of time it takes to write out and monitor care plans including individualized care plans, emergency care plans, and 504 accommodation plans. To assist with determining the school nurse to student ratio, it is imperative that data be gathered on how much time nurses are spending on these tasks.
- Questions that focus on key risk factors to health and learning. Identify current health problems, i.e., obesity which has shown to increase absences as well as leading to many health problems.

RECOMMENDATION: The Superintendent of Public Instruction (OSPI), with input from school nurses in Class I School Districts, will develop a training tool for nurses to complete the assessment forms in a consistent and reliable manner. The training medium will provide a way for school nurses to discuss questions or concerns. Training shall take place from September through December 2007.

OSPI would be primary in training nurses in how to fill out the assessment form. A training tool such as a video, online tutorial, and/or CD would be developed that would standardize teaching of the tool(s).

PROVISO EXCERPT: The work group also shall recommend to the legislature best practices in school nursing services.

RECOMMENDATION: Implementation of the *Staff Model for Delivery of School Health Services* developed by DOH, NCQAC, and OSPI (Washington State Nursing Care Quality Assurance Commission and Washington State Office of Superintendent of Public Instruction, 2000) as a minimum standard. This model will serve as an infrastructure to provide a more consistent delivery of health services.

As indicated in the *Staff Model*, additional nursing staff may be indicated in order to ensure health and safety of students based upon community population characteristics and demographics. Examples include, but are not limited to, the following:

- Low socio-economic status.
- Mobile populations, i.e., military, migrant, and homeless.
- Before and after school programs.
- Geographical location of schools.
- Uninsured/underinsured.

The *Staff Model* shall include a prevention/health promotion component. The *Staff Model* is to be revised and updated by February 2008 by OSPI, DOH, and OSPI designated committees.

RECOMMENDATION: That every Class I school district in the state of Washington be required to have a school nurse.

RECOMMENDATION: Provide a funding mechanism which would allow nurses additional paid time at the beginning of the school year to complete assessments of special needs children who will require an Individual Health Plan (IHP) and Emergency Care Plan (ECP) prior to attending school in accordance with current state law. In the 2004–05 district assessments, 80 Class I school districts reported that a total of 16,381 IHPs were written.

RECOMMENDATION: To better ensure positive, safe, and healthy outcomes for all students, an Education Staff Associate (ESA) certificated nurse evaluates the clinical practice of licensed school health services staff.

RECOMMENDATION: Nurses utilize National Association of School Nurses (NASN) scope and standards and the nurse practice act to establish a minimum standard of school nursing services.

RECOMMENDATION: Require the State Board of Education (SBE) to assign at least one member to represent school health programs by collaborating with: the SNOW, OSPI Health Service, NCQAC, and school administrators.

RECOMMENDATION: Each school district needs to consider forming a school health advisory board to provide input into a comprehensive school health and safety program. Members are to include, but are not limited to, representation from the following areas:

- Nutrition.
- Health education.
- Physical education.
- Parent and community involvement.
- Counseling.
- Psycho-social health.
- Healthy school environment.
- Health promotion.
- Health services.

RECOMMENDATION: Nurses working in the school setting shall make a concerted effort to identify clinical, ethical, and competency practice issues and actively seek education in these areas.

School nurses shall support NCQAC in the adoption of continued competency requirements.

PROVISO EXCERPT: ...including a dedicated, sustainable funding model that would best meet the current and future needs of Washington's schools and contribute to greater academic success of all students.

The work group shall assess whether funding for school nurses should continue as part of basic education…

RECOMMENDATION: A sustainable funding source from the legislature be enacted as a budget line item to be sent directly to school districts for the sole purpose of funding school nursing services in accordance with the *Staff Model for the Delivery of School Health Services*.

Staffing is to be determined and adjusted based on the severity codes established in the *Staff Model* which addresses the needs of students with complex needs. In addition, a minimum of one ESA certificated school nurse should be assigned to each Class I school for every 1500 students without significant health conditions.

RECOMMENDATION: Revised Code of Washington (RCW) be developed mandating minimum health services. This would then provide a baseline for funding.

PROVISO EXCERPT: In collaboration with managed care plans that contract with the department of social and health services medical assistance administration to provide health services to children participating in the Medicaid and state children's health insurance program, identify opportunities to improve coordination of and access to health services for low-income children through the use of school nurse services.

RECOMMENDATION: School nurses will collaborate with social agencies, i.e., DSHS, DOH, and other community resources providing linkage and outreach assistance with specific intent to assist families in enrolling children in health insurance programs.

PROVISO EXCERPT: The work group shall evaluate the feasibility of pooling school district and managed care plan funding to finance school nurse positions in school districts with high numbers of low-income children.

RECOMMENDATION: NONE.

> **NOTE:** ***Through the meeting process, the Department of Social and Health Services staff clarified that pooling managed care funding was not an option.***

APPENDIX E

OSPI/DOH IMPLEMENTATION PLAN, SNSWG RECOMMENDATIONS, AND FINDINGS

OSPI/DOH IMPLEMENTATION PLAN	Corresponding SNSWG Recommendations	Findings
1. Update and validate the *Staff Model for the Delivery of School Health Services (Staff Model).*	Implement the *Staff Model.*	The *Staff Model* was published in 2000. Since 2000 numerous federal and state laws have changed or been added that impact the delivery of health services to students.
2. Establish a school health services data collection system for all public school districts.	Mandate health services data collection in Class I districts with particular attention to special needs children and emergency care plans.	There is a lack of consistent, objective, and accurate data to understand current student and school health services needs and practices.
3. Develop and implement a training plan for nurses to collect and submit school health services data in a standardized manner to improve the reliability and validity of the data.	Train Class I school district nurses to complete assessment forms to ensure accuracy and completeness of data.	Questions were raised about varying interpretations of how individuals completed the *Assessment of District Student Health Services – Class I Districts*; and thus raised questions about the reliability of the data collected.

APPENDIX F

ASSESSMENT OF DISTRICT STUDENT HEALTH SERVICES CLASS I DISTRICTS, 2004–05

In the 2004–05 school year, Class I districts (enrollment of over 2000 students) were invited to complete an *Assessment of District Student Health Services* report. Districts submitted the report through the School Nurse Corps (SNC) supervisor at their Educational Service District (ESD) to the Office of Superintendent of Public Instruction (OSPI). Seventy-nine out of 106 Class I districts responded. These districts served 663,509 students. The data reported here represent 75 percent of Class I districts and 74 percent of students served by Class I districts.

(See pages 57-58: Assessment of District Student Health Services – Class I)

Registered Nurse Services

This data does not include 1:1 time assigned to specific student(s) or classroom(s). Districts reported a total of 16,562 hours per week of nursing service as follows:

- 11,506 hours certificated registered nurse (R.N.).
- 4,750 hours classified R.N.
- 270 hours R.N. (not identified as certificated or classified).
- 36 hours R.N. (provided by the SNC to five districts).

Districts were asked, based upon a 40 hour week, how many hours per week of R.N. service would be needed to meet the OSPI recommended staffing model of one nurse for every 1500 students. The seventy-nine school districts reported a combined need of an additional 1,131 R.N. hours per week (28 FTEs). The total of 1,131 hours does not reflect the range of need. One district reported needing an additional 285 hours per week of R.N. service to meet the 1:1500 ratio. Another district reported a R.N. staff model of 1 nurse for every 830 students.

Complexity of Student Population Served

The *Staff Model for the Delivery of School Health* Services, available online at www.k12.wa.us/HealthServices/publications, was developed by the Washington State Nursing Care Quality Assurance Commission and OSPI. This document outlines recommended guidelines for delivering health services based on the nursing care needed by the student population. Severity coding, a key component of the model, establishes the nursing staff needs of the students within a school building. *Please note: many districts did not complete or only partially answered this question. Some answers appeared to be incorrect. Numbers were all used as reported.*

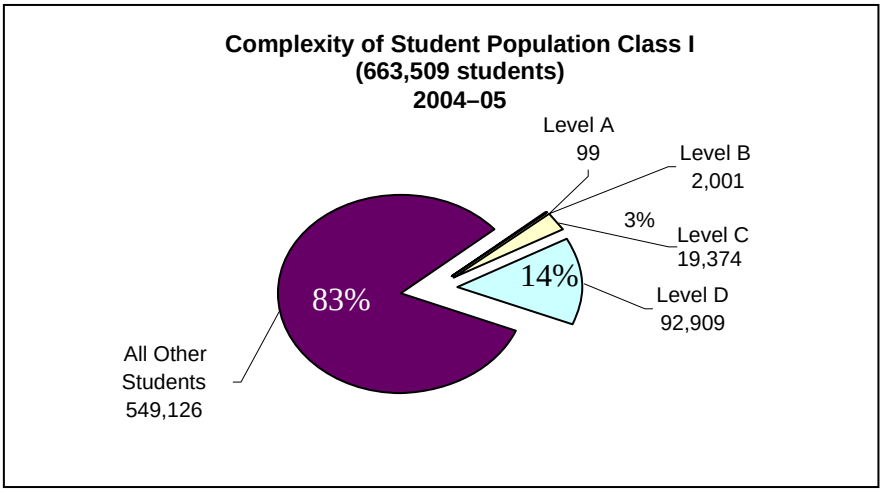
The numbers reported here reflect the severity of students' health care needs in the school. The 79 school districts identified the following total number of students per category:

- **Level A: Nursing Dependent—99 Students.** These students require 24 hours a day, skilled nursing care for survival.

- **Level B: Medically Fragile—2,001 Students.** These students have complex health care needs and face the daily possibility of a life-threatening emergency requiring the skill and judgment of a professional nurse. Some examples are severe seizure disorder, severe asthma, and students newly diagnosed with diabetes. Students with a Level B health condition require a nurse in the building full time.

- **Level C: Medically Complex—19,374 Students.** These students have a complex and/or unstable physical and/or social-emotional condition that requires daily treatments and close monitoring by a professional R.N. Some examples are students with attention deficit hyperactivity disorder (ADHD) requiring medication, cancer, and moderate to severe asthma. These students require a professional R.N. in the building one full day a week, and who is available on a daily basis when not in the school building.

- **Level D: Health Concerns—92,909 Students.** These students have an uncomplicated physical and/or social-emotional condition such as dental disease, eating disorder, headaches, or sensory impairments that require an assessment by the nurse at least once a school year with reassessment and change in severity status as needed.



Districts were asked, “Based on the severity levels and a 40 hour week, how many hours per week are needed to meet the OSPI staffing model?” Only 66 districts answered this question. These districts determined the need for an additional 10,496 hours per week of R.N. service (262 FTEs) to meet the staffing needs of students identified as Level A–nursing dependent, Level B–medically fragile, Level C–medically complex, or Level D–health concerns. Again, districts reported a wide range of need for R.N. service to meet these levels of care.

Disease Conditions Diagnosed and Disease Conditions Considered Life-Threatening

The 79 Class I districts have indicated the number of identified cases of specific health conditions. Additionally, these districts reported the number of each specific health condition considered life-threatening per RCW 28A.210.320. This information is another data source that illustrates the number and severity of health conditions present in school districts across the state. The 79 Class I districts reported the following data:

Disease/Condition	Number of Diagnosed Cases	Percentage of Student Population	Number of Life-Threatening Cases	Percentage of Diagnosed Cases Reported as Life-Threatening
Asthma	41,853	6.3	3128	13%
Diabetes	1801	.3	1498	83%
Severe Allergies	10,109	1.5	5491	54%
Heart Conditions	2984	.4	402	13%
Seizures	4266	.5	997	23%
ADHD/ADD	23,571	6.4	95	.06%
Neuropsychological Disorders	7082	1.0	48	4%
Others	16,329	2.4	998	6%
Total	102,559	15.0	9386	9.1%

Health Room Coverage/Medication Administration

Districts were asked, "Who staffs your health room and administers regularly scheduled medication in your district (not including the R.N.)?" Districts reported the number of hours per week for each job category. All of these staff members require training and supervision by the R.N. in medication administration. The results were as follows, starting with the job category reporting the most hours:

Job Category	Hours per week
School Office Personnel	10,926
Health Room Assistant	8,966
LPN	2,727
Paraprofessionals	1,718
Other	247
Volunteer	121

Funding for School Health Services

Districts reported the following categories for funding school health services:

Funding Source	Number of Districts Reporting
Basic Education	69
Special Education	34
Levy	25
Medicaid Administrative Match	9
SNC	5
Other	8
Grants	7

The "Other" category for funding included: general funds, local funds, and two districts partnering with local hospitals for funding.

School Nurse Corps Supervisor Services
School Nurse Corps supervisors provide services to both Class I and Class II districts. The numbers reported here represent data reported by the 79 Class I districts and additional data provided by the SNC supervisors. Class I districts received the following services from SNC supervisors:

- Program management and supervision to five districts.
- Consultation and training to 75 districts.
- Resources to 74 districts.

Medication/Medical Treatment Training and Supervision
Ninety-seven percent of the 79 school districts reported formal medication training and ongoing supervision provided by an R.N. The number of daily, as needed and emergency medications administered was 30,327. All districts, except two, reported medical treatment training and supervision provided by an R.N.. The reporting districts recounted 2,351 daily medical treatments being performed.

Student Health Information
Districts were asked how often they collect student health information.

- Zero districts reported “never.”
- Twenty-two districts reported “enrollment only.”
- Sixty-three districts reported “annually.”

Note: Some districts responded more than once.

Emergency Care Plans (ECPs), Individual Health Care Plans (IHPs), and Plans for Children with Life-Threatening Conditions
ECPs or IHPs are developed by R.N.s for students with serious health conditions. These plans of care are also known as nursing care plans. According to state law, R.N.s working as school nurses are responsible for each component of the nursing process with children in school: assessing, planning, implementing, and evaluating the nursing care.

ECPs are developed to enable school staff to know what specific actions are to be taken to respond to a student’s critical health needs. ECPs were created for students with a variety of serious health issues including: asthma; anaphylactic reactions to bee stings, food, and latex allergies; diabetes; seizures; and more. There was a total of 16,095 ECPs reported in place in the 79 Class I districts.

IHPs are developed for students with chronic or temporary health conditions that require accommodations, staff knowledge, involvement, provision of treatment, medications, and/or health care procedures by school staff. IHPs were developed for students with a variety of health conditions including: kidney disease, heart disease, visual and hearing impairments, ADHD, autism, cerebral palsy, leukemia, hypertension, obesity, and others. A total of 16,376 IHPs were reported as being in place in the 79 reporting Class I districts.

Students have a safer learning environment if ECPs and IHPs are in place. This is a significant outcome of providing R.N. services in schools. Additionally, having plans in place contributes to staff feeling more confident and better equipped to deal with emergencies, parents having increased confidence in the staff, and students having a better understanding of their own health condition. Any of these outcomes may also result in fewer days that students are absent from school.

Data Collection
Sixty-four districts reported current use of a software program to collect health data. Some of the software systems included WISPC, Skyward, Student Health Manager, and School Master.

Districts were asked if they were currently analyzing collected data to identify the impact of school nurse interventions on student health and educational outcomes.

- Seven districts reported yes.
- Sixty-Seven districts reported no.
- Five districts did not respond to the question.

Summary
The completion of the Assessment *of Student Health Services* by 75 percent of Class I districts provides valuable information. A primary purpose of collecting this data is to take a “next step” in assessing students’ access to R.N. services across the state. This information also serves as groundwork for further building of the infrastructure necessary to measure the impact of school nursing services on student health and educational outcomes.

Other worthwhile uses for the data reported here include:

- Estimating the incidence of children with complex health concerns in our schools.
- Documenting the additional need for nursing services, based on the *Staff Model for the Delivery of School Health Services.*
- Collaborating with other agencies and organizations.
- Assisting district nurses in documenting and planning for health service needs.

The authors of this report extend their appreciation to the SNC supervisors for facilitating the collection of this data and to the Class I school nursing leaders for their partnership in helping students to achieve academic success by working together to improve school health services and student health outcomes.

APPENDIX G

SAMPLE OF 2004–05 CLASS I DISTRICT ASSESSMENT NARRATIVES—ANECDOTAL STORIES

- Second grade student was a newly diagnosed diabetic when she started school in the fall. In the beginning, she needed School Nurse supervision 5 days per week; giving her insulin, figuring out amount of insulin, etc. Now she uses an Insulin Scale, ***administers her own insulin*** with an insulin pen and figures the insulin amount with only the school secretary or school nurse monitoring her.

- An asthmatic student was using the health room a lot to access his rescue inhaler. The nurse worked with student's primary care provider to determine need for inhaler according to numbers on peak flow meter. Using this information, the asthma emergency care plan was tailored to meet the student's needs. The result has been better asthma management and ***less missed class time.***

- Student with a nut allergy transferred from another school. Collaboration between the two school nurses, parents, and school staff resulted in a current care plan and an easy transition for the student. Parents also felt confident their child was safe in the new school.

- Teachers verbalized relief when informed that the ***school secretaries were trained*** to give the EpiPen.

- Students with severe food allergies report they feel safer in the school lunchroom with the implementation of a nut-free table.

- An autistic student with diabetes has fulfilled many of his learning goals and he is learning at a faster pace this year because he has closer control of his blood sugar.

- Severe asthmatic student was missing a lot of class and school. Peak flow meters were placed in each classroom and an inhaler and nebulizer in the office. ***He is now missing less class and school.***

- Through medical training of staff and development of a centralized Care Plan book, the advisors have an envelope of medical ***information available*** to them each time they go on ***field trips***. The teachers are aware of the health needs of the students and are prepared to leave the building safely.

- Nurses were very instrumental in compiling medication orders, health care plans, and 24-hour supervision for all the fifth graders in the district who participated in an overnight field trip. The process took several months and many hours of collecting information.

- A student requiring nursing assistance with catheterization twice a day was reassessed mid-year by the school nurse. Barriers influencing student independence were identified (wheelchair accessible lock for the staff bathroom, wheelchair accessible power button at school entrance and a minor change in catheterization schedule to minimize disruption of time in class). This student was frequently missing instruction waiting for contracted nursing services to arrive. It was determined that this student was now able to demonstrate adequate self-catheterization skills and required minimal nonlicensed assistance to continue independence in a safe manner at school.

- A student with a severe peanut allergy ingested a peanut product but delayed telling anyone she was having symptoms. When office staff became aware of the emergency, they called 9-1-1 but hesitated to administer the emergency medication (EpiPen). The student was transported and successfully treated in the hospital emergency room. When meeting with staff after this incident, the school nurse helped to assess the school's response and provided additional training and guidance. The nurse contacted the student's parents and met with the student as well to discuss issues that delayed prompt treatment. Due to the awareness that this student was not confident about using the emergency medication herself or addressing serious symptoms, the nurse provided the student with EpiPen training and a review of the care plan. As a result, the nurse and assistant principal met with every student who had emergency medications at school for severe allergies. It was determined that over 90 percent of the students with emergency medication were not clear as to how or when to self-inject their medication. Training for these students was provided by the nurse in a group setting. The assistant principal and school nurse will now assess these needs early each year and provide a group training session.

- Due to a power outage, the cafeteria made peanut butter and jelly sandwiches to serve for lunch that day. The assistant principal quickly referred to the *"Care Plan Notebook"* kept in the office and made sure students with severe peanut allergies were given an alternative meal.

- A fourth grade student with multiple severe food allergies was missing instructional time due to nausea whenever fish was served in the cafeteria (1–2 episodes per month). The care plan was modified to include an accommodation of eating lunch outside the cafeteria when fish products were served. This resulted in a decrease in missed class time on these days.

- A student was diagnosed with Type I diabetes in the fourth grade. The family has been involved and available for school staff. This family has changed their diet and lifestyle to meet the needs of their child. When first developing the individualized health care plan, it was obvious that it would be difficult for the parents to completely trust the school regarding the care of their child. By writing the initial care plan so that the parent was contacted regarding all concerns, the parents gradually developed trust and released more control to the school. Less than a year after diagnosis, the student has an insulin pump, independently monitors her blood sugars, and calls mom to verify insulin doses. This student is now rarely absent, very healthy, and involved in numerous activities at school.

- A student with frequent migraine headaches has missed less school since a health care plan was developed and early recognition of symptoms and treatment at school is available.

- A student who has attended the same elementary school for three years has severe encopresis and bladder spasms. Over the years, the school staff has modified accommodations as the student's needs have changed. This student is now completely independent with changing her clothing and addressing hygiene needs. Her attendance has remarkably improved and her parent has been able to return to work. The benefit of having a care plan for this student was to identify that this youngster had a physical problem versus a behavioral problem early on, and addressed the issues appropriately.

- A part-time high school student had a defibrillator implanted after a severe cardiac arrest. There were great concerns among the staff as to what to do if the defibrillator fired. The school nurse wrote a care plan outlining the need to call 9-1-1 immediately if this occurred. The nurse met with staff to answer their questions and was able to allay their fears of receiving an electrical shock if they touched the student during an episode. The care plan encouraged staff to protect the student from injury and to provide comfort measures while waiting for emergency services to arrive. The staff was relieved and the family felt welcomed into the school setting.

APPENDIX H

REVIEW OF THE LITERATURE AND RELEVANT WEB SITES

Summary of Findings from Reviewing the Literature that Support the SNSWG Project

A detailed search of current literature related to the issues set forth in the study was conducted through the guidance of the Washington State University Intercollegiate College of Nursing library staff. The review included selected Web sites and articles from educational and nursing journals and other related fields. Key words used in the search included terms from the study language, i.e., school nurse health funding, school nurse skills, school nurse practice, school nurse to student ratios, school nurse standards, access to health care, health and educational outcomes, funding, and data analysis of school health programs.

Overall, the literature search revealed that:

- Research linking student health to academic achievement is abundant in both educational and nursing journals.
- Schools remain an important context for youth to learn socialization and health promotion.
- School districts are challenged to meet the health and educational needs of the many children attending with special needs. However, they are charged to provide adequate services that will facilitate the child's educational needs in a safe environment.
- The role of the school nurse becomes increasingly important in light of the multiple and overlapping health and social needs presented by students who lack access to adequate health care providers.
- The need for a coordinated school health program is an important concept if health care services are to meet the needs of today's students.
- Staffing and ratio of nurses to students is a complex process considering the many variables such as student acuity level and nursing shortages that interfere with quality and well prepared nursing personnel.
- Advocating and marketing school health services with the school board, legislators, and community is a must for school nurses, if a sustainable funding program is to be realized.
- Collaborative partnerships can be a viable option to funding school health programs such as mental health programs teaming up with a community mental health agency.
- Community and school partnerships vary and are most notable between school-based clinics and community agencies.
- Enrolling children in a health insurance plan in the school setting has been successful in other states.

- There is no uniform or standard manner in which schools deliver health services. However, school nurses need to adhere to the Standards of Practice as noted by NASN and the Washington State Law Relating to Nursing Care.
- Many models of school health services have been proposed, but the most frequently mentioned is the one by Allensworth and Kolbe (8 components).
- Emphasis on services is often regarding children in crisis or with special health care needs, leaving very little time and resources directed towards prevention.

Literature

Health is Academic: A Guide to Coordinated School Health Programs
Eva Marx, Susan Wooley, Frelick Northrup, Daphne Boyer, Ernest L. (ed). 1998.

The National School Board Association reaffirms that school health programs offer the opportunity to provide services and knowledge necessary to enable children to be productive learners and to develop the skills to make health decisions for the rest of their lives (1995).

The concept that health, education, and human service programs must be integrated and that school health programs support the educational process….and that children who are disadvantaged or have a disability must be included is supported by the following groups:

- U.S. Department of Education and U.S. Department of Health and Human Services (1994).
- Carnegie Council on Adolescent.
- National Council on the Role of the School and the Community in Improving Adolescent Health–Boyer (1983).
- Council of Chief State School Officers (1991).

This book focuses on integrative models of health care and funding–focusing on communication, cooperation, coordination and collaboration.

Articles
BEST PRACTICES

American Academy of Pediatrics Committee on School Health Pediatrics
Volume 108, No. 5, November 2001, pp. 1231–1232.

This article describes the crucial role of the school nurse in the provision of health services. The article describes the school nurse as a member of the school health service team and its relation to children with special health care needs. Recommendations and education for preparation of the school nurses are also included. Major goals discussed include:

- Ensure access to primary health care (medical home).

- Provide a system for dealing with crisis medical situations.
- Provide a mandated immunization and screening monitoring program.
- Provide a process for identification and resolution of students' health care needs that affect educational achievement.

Special Day Class: Teachers' Perceptions of the Role of the School Nurse
Janice L. Leie, Virginia Young Cureton, Daryl L. Canham.

Abstract: School nurses are on the front lines of health care in public schools. The integration of student's health care needs as components of educational programs has become increasingly important as medically fragile children rely on school nurses to deliver and coordinate their health care. This research article focuses on those services teachers perceive to be important, very important, somewhat important, or not at all important.

Two concepts in addition to the research findings that were mentioned were:

- School nurses must continue to advocate for the services they provide by demonstrating their level of health care knowledge and the advanced practice skills necessary to keep special education students in the classroom ready to participate and learn.
- School nurses must learn how to market themselves and promote better visibility among those with whom they interact.

The Journal of School Nursing- Effect of Full-Time versus Part-Time School Nurses on Attendance of Elementary Students with Asthma. Telljohann, Joseph A. Dake, James H. Price, Vol. 20, No. 6, December 2004, pp. 331–335.

This article noted that poor African American students with asthma missed significantly fewer school days with full-time school nurses as compared to those schools with part-time nurses. Possible reasons cited for this finding included more time for patient education and the establishment of better communication with the child.

The Health and Education Leadership Project: A School Initiative for Children and Adolescents with Chronic Health Conditions Journal of School Health. Kathleen M. Thies and Jeanne W. McAllister, Vol. 71, No. 5, May 2001, (pp. 167–172).

An estimated 40 percent of children with a chronic health problem experience school related problems. Although many of these children may not qualify for special educational programs, they may have unmet learning needs associated with chronic absenteeism, disease complications, or side effects from medication and treatment modalities. This article focuses on family centered schools, a coalition of schools, families, health care providers, and nurses working together to help the child with a chronic health problem succeed. This article describes an ongoing initiative designed to support schools in their efforts to meet the health and education of students with chronic health problems.

Developing a Strategic Plan for School Health Services in Massachusetts - Journal of School Health. A.H. Sheetz, Vol. 72., No. 7, September 2000.

This paper describes a redevelopment of School Health Services in Massachusetts as a result of:

1. Increased number of students with special needs.
2. Increased stress and time pressure .
3. Rapid changes in the health care system.

Seven components of a plan to restructure nursing services including:

1. Setting standards.
2. Reviewing and revising statutes and regulations.
3. Promoting credentialing of school health personnel.
4. Providing continuing education on subjects pertinent to school health.
5. Exploring reimbursement systems and new funding sources, including funds from the tobacco claim settlements.
6. Exploring new models of care.
7. Implementing data systems.

The focus is on developing school nurse managed school health services within a public health system.

Ethical Problems Experienced by School Nurses - Journal Of School Nursing
Linda L. and Marjorie A. Schaffer, Vol. 19, No. 6, December 2003, pp. 330–335.

This research article focuses on ethical conflicts school nurses encounter and the methods they use to solve ethical dilemmas. The major ethical conflicts that emerged from this study were:

1. Conflicts in professional relationships (parents, principals, administrators, supervisor).
2. Delegation and supervision.
3. Child protection reporting.
4. Maintaining confidentiality.
5. Do Not Resuscitate policy.
6. Pressure to work outside of nursing practice standards.

The United Kingdom National Healthy School Standard: A Framework for Strengthening the School Nurse Role - The Journal of School Nursing. Molly K. Wicklander, Vol. 21, No. 3, June 2005, pp. 132–138.

This article provides a framework for developing a foundational role for strengthening the school nurse role and school health services around the globe. The article provides a model for nurses to effectively partner, manage, and work with schools and to collaborate with local health and education authorities that remain unconnected entities.

The School Health Portfolio System: A New Tool For Planning and Evaluating Coordinated School Health Programs - Journal of School Health. Robert M. Weiler, R. Morgan Pigg, Jr., Vol. 74, No. 9, November 2004, pp. 359–364.

This article offers a new innovative system for planning and evaluating a coordinated school health program at the individual school level. The article details an easy to follow system that enables schools to create new programs or to modify existing programs. By using this system, schools can develop program goals, plan activities to achieve the goals, set future goals, and assess progress towards meeting goals and document accomplishments.

Community Health Indicators Predicting Adolescent Achievement - NF Journal. Spencer R. Baker and Bertha Lane Davis, Vol. 12, No. 4, July/August 2001, pp. 83–88.

A research article looking at contextual variables as indicators of community health and academic achievement.

School Nurse Perceptions of Barriers and Supports for Children with Diabetes - Journal of School Health. Laura Nabors, Amanda Troillett; Tiffany Nash, Barbara Masiulis, Vol. 75, No. 4, April 2005, pp. 119–124.

A research article looking at ways to support adolescents with diabetes. Several supportive themes were identified including communication, support, education, and parental involvement. Barriers to successful disease management at school included school issues, communication, food issues, and education. Suggestions for meeting after school needs were identified.

Sec. 504 of the Rehabilitation Act - Determining Eligibility and Implications for School Districts - The Journal of School Nursing. Marsha Moses, Cynthia Gilchres, Nadine C. Schwab, Vol. 21, No. 1, February 2005, pp. 48–58.

This is an excellent article on the many facets of the “504 Act” reviewing the mandate and its regulations, case law, implications for school district practice, program components, and a form to assess eligibility criteria and determination.

The Effects of Budget, Delegation, and Other Variables on the Future of School Nursing - Journal of School Nursing. Theresa M. Tetuan, Cynthia G. Akagi, Vol. 20, No. 6, December 2004, pp. 352–358.

> At a time of dramatic shifts in the financing and delivery of health care services, school health care providers face many challenges. The school nurse gains importance in light of the many and overlapping health and social needs presented by students who lack adequate access to health resources.

A Community Collaborative Partnership for the Chicago Public Schools - Journal of School Health. Kimberly M. Glow, Arlene M. Sperhac, Vol. 73, No. 10, December 2003, pp. 395–398.

> A collaborative teaching learning program with Rush University and the public schools is described noting benefit to the school children, the university, and the nursing students.

School Nurses: What It Was and What It Is - Pediatric Nursing. Linda C. Wolfe and Janice Selekman, Vol. 28, No. 4, July/August 2002, pp. 403–407.

> The changes in the responsibilities of today's school nurses are directly related to the changes in the school setting. While the specific needs of students, families, and communities have changed, the role of the school nurse remains essentially the same.

RATIO

Does the School Nurse to Student Ratio Make a Difference? - Journal of School Health Martha Guttu, Martha Keehner-Engelke, Melvin Swanson, Vol. 74, No. 1, January 2004, pp. 6–9.

> Legislators and school administrators need concrete evidence that increases in funding for school nurses lead to better services and better outcomes for students. This article focuses on a study of school nurse to student ratios, noting correlations between lower student ratios to school nurse services. Although there were several limitations to this study, the bottom line was that school nurses do make a difference.

Rising Student Health Needs Require a School Safety Net - North Carolina Medical Journal. Leah M. Devlin and Marilyn Assay, Vol. 66, No. 2, March/April 2005.

> This article, written by two North Carolina nurses, describe what can happen when the ratio of nurse to student is inadequate and the need for a "Safety Net."

Where Oh Where Are the School Nurses? Staffing in School Health Service Programs - NASN Newsletter. Vicki Taliaferro, July, 2005, pp. 17–21.

> School nurse programs are not immune to staff reductions, budget limitations, or shortage of nurses. School health service programs struggle every budget cycle to

adequately provide school health services to children. This article focuses on staffing issues, legislative mandates, ratios, and nursing shortages.

ACCESS TO HEALTH CARE

Archive Feature: Health Disparities and Access to Care – Health in Education Initiative http://ascd.org/health_in_education/082001/feature

This resource focuses on the Healthy People Goal 2010 that the U.S. will eliminate health disparities that occur among different racial and ethnic populations. Although some progress has been made, minority groups have more health problems and lack access to needed health care. Research shows that access to quality health care is related to income level and possession of health insurance. Children without access are more likely to go without medical care, dental care, and needed medications. The article gives some suggestions on eliminating this disparity through school based clinics.

Access to Health Care Part 1: Children Series 10-196. Gloria Simpson, Barbara Bloom, Robin A. Cohen, Ellen Parsons, pp. 1–30.

This report presents national estimates of access to health care looking at the unmet needs of children through age 17. Variables considered include sex, age, race, and/or ethnicity, family income, family structure, place of residence, and health status. The impact of children's health insurance on access to care is described.

Children's Lack of Access to Health Care as a Barrier to Academic Performance: A Brief Summary of Issues - American Journal of Health Education. Sue J. Fletcher, Vol. 35, No.4, July/August 2004, pp. 234–236.

Discusses the use of Allensworth and Kolbe's identified model of comprehensive school health (eight components) as one way health educators could influence health insurance among children. A power point presentation "Making the Connection: Health and Student" is available on the Web.

FUNDING

Integrating School Based Health Centers into Managed Care in Massachusetts - Journal of School Health. Karen Hacker, Vol. 66, No. 9, November 1996, pp. 319–321.

School based health centers are facing many funding issues and are forced to look at alternative sources of revenue. This article explores collaborating with managed care as a way to increase revenue.

The Link Between School Performance and Health Insurance: Current Research Consumers Union, West Coast Regional Office. Carolyn Schwartz, Earl Lui, October 2000, pp. 1–9.

This paper reviews published articles related to the link between health insurance and school performance including a list of citations on related articles. Although studies showing a direct cause of academic problems and no insurance enrollment are not available, there are many studies and indicators demonstrating a correlation.

The two concepts covered include:

1. Good health is connected with improved school performance.
2. Having health insurance is linked to better health.

Contextual Influences on School Provision of Health Services - Journal of Adolescent Health. John O.G. Billy, William R. Grady, Audra T. Wenzlow, Nancy D. Brener, Janet L. Collins, Laura Kann, Vol. 27, 2000, pp. 12–24.

A research article.

"Express Lane Eligibility" The Future of Children. Dawn Horner, Wendy Lazarus, Beth Morrow, Vol. 13, No. 1, Spring 2003, pp. 224–229.

This article describes some states' creative strategies to increase children's enrollment in health insurance programs by connecting Medicaid and State Children's Health Insurance Program (SCHIP) with other public programs for low income children and families. These strategies are referred to as "Express Lane Eligibility" (ELE) and have the potential to significantly increase the number of low income children with health insurance.

Assessment of a School Based Mental Health Screening and Treatment Program in New York City Mental Health Services Research. Pinka Chatterji, Christine M. Caffrey, Maura Crowe, Linda Freeman, and Peter Jensen Cost, Vol. 6, No. 3, September 2004.

Providing mental health programs in the schools affords youth who otherwise may go without needed treatment access to a needed service. This article analyzes the cost and evaluation of such services and discusses further research that needs to be done.

Advocacy to Action; Addressing Coordinated School Health Program Issues with School Boards - Journal of School Health. David C. Wiley, Elissa M. Howard-Barr, Vol. 75, No. 1, January 2005, pp. 6–9.

As the need for coordinated School Health Programs (CSHP) increases, so does the recognition of the importance for advocating with local school boards for their support. This article presents strategies to consider and steps to take before, during, and after addressing the local school board members for their support to implement a program.

Funding a Full Continuum of Mental Health Promotion and Intervention Program in the Schools - Journal of Adolescent Health. Mark D. Weist, Julie Goldstein, Steven W. Evans, Nancy A. Lever, Jennifer Axelrod, Robert Schreters, and David Pruitt, Vol. 325, 2003, pp. 70–78.

The purpose of this article was to assess the availability of public and private financing sources to support comprehensive school mental health programs.

The Impact of School Enrollment Based Health Insurance on the State Children Health Insurance Program (SCHIP) - Journal of School Health. Camilla M. Romund and Frank L. Farmer, Vol. 70, No. 9, November 2000, pp. 381–384.

This paper describes the current status of the SCHIP programs nationwide and summarizes lessons learned from enrolling youngsters through the school system.

Assessing the Cost of School Based Mental Health Services - Journal of School Health. Laura A. Nabors, Stephen S. Leff, Jennifer E. Mettrick, Vol. 71, No. 5, May 2001, pp. 199–200.

Evaluations reviewing cost effectiveness of mental health programs in the school are presented. Additional reports describing ways to finance school health programs are included.

Fee For Service Revenue for School Mental Health Through a Partnership with an Outpatient Mental Health Center - Journal of School Health. Nancy L. Lever, Sharon Hoover-Stephan, Jennifer Axelrod, Vol. 74, No. 3, March 2004, pp. 91–94.

School mental health programs are increasingly prominent throughout the country. However, funding remains tentative. This article describes a partnership between a school based program and community mental health agency as a means of providing sustainability and increasing revenue.

Incorporating Expanded School Mental Health Programs in State Children's Health Insurance Plans - Journal of School Health. Laura A. Nabors and Jennifer E. Mettrick, Vol. 71, No. 2, February 2001, pp. 73–76.

Several ideas presented on incorporating mental health programs into SCHIP plans.

Web sites

American School Health Association – http://www.ashaweb.org/
Resources for practicing school health professionals (Health in Action), and policy resolutions of many school health and safety issues.

Centers for Disease Control and Prevention (CDC) – http://www.cdc.gov/

Centers for Medicare and Medicaid Services – http://cms.hhs.gov/

Coalition for Community Schools – http://www.communityschools.org/
Information on school partnerships with community agencies, parents, and volunteers.

Family Educational Rights and Privacy Act (FERPA) –
http://www.ed.gov/offices/OM/fpco/ferpa/
A U.S. Department of Education Web site that describes a federal law that protects the privacy of student health records.

Maternal and Child Health Bureau: Health Resources and Services Administration –
http://www.mchb.hrsa.gov/
Includes programs, data, and resources on health and safety issues for school children.

National Association of School Nurses – http://www.nasn.org

National Maternal and Child Health Oral Health Resource Center –
http://www.mchoralhealth.org/
Information on current and emerging public oral health issues.

National School Boards Association – http://www.nsba.org/
Includes sample school policies (including health-related), resources for school attorneys, school governance, and advocacy.

Office of School Health, University of Colorado – http://www.uchsc.edu/schoolhealth/
Includes a School Health Evaluation Services (SHES) site that assists schools with school health quality assurance issues.

U.S. Department of Education – http://www.ed.gov/

U.S. Department of Education-Individuals with Disabilities Education Act (IDEA) –
http://www.ed.gov/offices/OSERS/Policy/IDEA/

U.S. Department of Education-Office of Civil Rights –
http://www.ed.gov/offices/OCR/504faq.html
Provides information of Section 504 of the Rehabilitation Act of 1973.

American Academy of Pediatrics-School Health – http://www.schoolhealth.org/

Healthy People 2010 - http://www.healthypeople.gov/
National health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats.

Centers for Disease Control and Prevention (CDC)-Guidelines for School Health Programs - http://www.cdc.gov/nccdphp/dash/healthtopics/guidelines.htm

Case Management Society of America – http://www.cmsa.org/
Site includes information on continuing education in fields of case management, nursing, social work, disease management, and rehabilitation.

Center for Health Services Financing and Managed Care (DHHS/HRSA) – http://www.hrsa.gov/financeMC/

Center for Mental Health in Schools – http://smhp.psych.ucla.edu/
Resources, technical assistance, and continuing education on topics related to mental health in schools, with a focus on barriers to learning and promotion of healthy development.

Center for Health and Health Care in Schools – http://www.healthinschools.org/

Massachusetts Department of Education, Department of Public Health: School Health Unit – http://www.state.ma.us/dph/fch/schoolhealth/index.htm
Example of a state resource that provides technical assistance to school health service systems.

U Mass-Simmons School Health Institute – http://www.umass.edu/umsshi/

APPENDIX I

SCHOOL NURSE SURVEY OF TEACHERS

Question	Agree	Disagree	No Opinion/NA
1. I have received training this school year from my school nurse in dealing with school emergencies and/or students with health care needs.	107	7	5
2. As a result of this training I believe that my skill level and confidence in dealing with school emergencies and/or students with health care needs has improved.	97	5	17
3. I believe having a school nurse in the district has resulted in improved health and/or safety for students/staff.	118	0	1
4. I believe having a school nurse in the district has resulted in improved communication about students with health care needs.	116	0	1
5. I believe student learning has improved as a result of the school nurse's interventions and referrals.	98	0	21
6. I have utilized the nurse as a resource for obtaining health information for my students or myself.	107	1	11
7. The nurse has contributed to health education through classroom presentations or resource material.	82	6	31

Comments:

- It is too hard to use the nurse as a resource when she/he isn't here everyday. His/her schedule is pulled in so many directions that it is difficult for him/her to be consistent.
- Teachers who are part-time in a building may not be aware of training that may have taken place. Also, a standard form indicating certain problems/information on a student in emergency situations should not be considered "training." Actual training would be helpful.
- Our nurse is invaluable!
- I am an art teacher – my answers of N/A are due to the fact that I don't have a "regular" classroom. I appreciate the information the school nurse gets to me to keep on hand as I see every student in the school!
- I have been able to go to her with my concerns for my students' health and always know that she will find the appropriate resources and take my concerns seriously. I don't know what we'd do without her!

- Our school nurse is so important as a health resource…. She even lets us know (via email) when many…are showing similar symptoms.
- Beginning of the year – hard to answer most of these questions.
- A competent school nurse is critical to the safety and welfare of our needy school community.
- I feel as a parent of a student and as an employee it would benefit our students to have a nurse in the school every day.
- Having a nurse at our school full-time would be a great benefit to our students and staff.
- School nurses should be placed in school on a full-time basis.
- [Name] does a fantastic job both in practice and application of the health profession.
- I am always sending my students to the nurse for care. She is needed everyday!
- Having a school nurse is vital to our school. We have students that do not receive the kind of attention and nurturing supplied by our nurse. A school nurse is a must!
- Thank you for your support! The nurse's assistance in special education evaluations is also vital.
- It would be a great benefit to have a full-time nurse at each building. The office staff is trained in CPR and first aid, however, many situations arise on a daily basis in which a nurse can intervene, communicate, and problem solve because of her medical expertise.
- I cannot imagine not having the school nurse in the building. They provide such a valuable piece to the educational team.
- The school nurse is a **VERY** important member of the staff. The health needs of the students are best met when a trained health care professional is on site!
- Schools have populations that are in great need of a school nurse. Their knowledge and help is very important for the health and safety of our children. Our school could utilize a nurse full-time with health concerns K–5 and life skill (self-contain) students.
- The school nurse also acts as a liaison between teacher and parent. Sometimes parents feel more comfortable sharing information (with the nurse).
- There needs to be a nurse full-time on every school staff–today there are just too many students with health concerns (diabetes, asthma, severe allergies, etc.). A full-time, medically trained professional is a must!
- The nurse has been quite helpful with student issues. She is an invaluable member of the school team. Thanks!
- We continue to be given new, updated information on student health care concerns that we must be on top of (nut allergies, etc.). Our school nurse brings a definite measure of safety and calm to our building.
- Nurses play an integral role in the educational process.
- I cannot stress enough the importance of having a nurse in the building. Our nurse is part-time but I wish she were here every day. Our nurse also helps train volunteers who work in the health room. In addition she trains the office staff who administer medications.
- [Name] is doing a great job with the kids and educating the staff. She also has helped with situations that occurred at (my) home! Thanks, [Name].

- Our school nurse is in our building two days a week. We need her five days a week. The need is that great. She is a vital part of our students health care, and staff as well.
- Our school nurse goes above and beyond to meet the needs of students. Example: (our nurse) spent two hours of an evening meeting with Russian and Spanish speaking parents.
- We need her at our school all week long, not just three days a week.
- We need nurses full-time in our buildings. We are not medically trained to have to deal with all the medical conditions students seem to have nowadays.
- Our school nurse is an integral part of a successful classroom.
- I have worked in districts without a school nurse. Our school nurse's contributions to staffing and parent conferences is immeasurable.
- Our nurse sheds light on students' conditions, leading to a better school environment.
- Although here only one day per week, (our nurse) has been very helpful to staff and students. Students will wait for Wednesdays to ask for her advice. Even though she is very busy with paperwork, she is never too busy to talk to staff regarding student concerns.
- I don't know what we would do without our nurse. She is so much more than all of the things listed above.
- I have worked with some outstanding school nurses here in Vancouver.
- We love our school nurse!
- Though a bit lengthy, I believe this note is the voice of many who are in a position to speak out on behalf of daily skilled care for our family that is _____ School District. I believe a school nurse is necessary at each school every day. Though not realistic, it is as necessary as having a teacher in each room, and the office fully staffed and functioning. I speak for parents, having experienced the anxiety of being called for split lips and broken arm injuries. Knowing a competent nurse on staff had diagnosed, cleaned up, and calmed my children, I could then complete my responsibilities of getting them stitched and casted. I speak for the schools. As an employee of _____ School District I am aware of the void left when our nurse is at her other school. Our office staff is called upon to fill in and do their best to soothe, calm, and even triage, minor to major complaints when necessary. She has done her best to train us in her absence, but reality rears its ugly head and provides us inadequate substitutes. Let's not forget to mention neglecting the phones, the frequent flow of parents, payroll, office machines jammed, and the countless other duties we rely on office staff to perform as they undertake simulated nurse's duties. I speak for taxpayers. … I am positive that our children are our future, our hope. Our concern over their care away from home will not go away, nor will the need for daily skilled nurses to attend them.

APPENDIX J

SUMMARY TABLE OF REGISTERED NURSING SERVICES—CLASS I DISTRICTS 2004–05

District Type	Total Number of Districts / Total Number of Students	Number of Districts Reporting / Percentage of Districts Reporting	Number of Students	Available RN Hours (Certificated and Classified)	FTEs Based on 37.5 Hour Week / Nurse to Student Ratio	FTES Based on 40 Hour Week / Nurse to Student Ratio
Class I (Over 2000 students)	106 / 896,206	79 / 75%	663,509	16,562	442 / 1:1501	414 / 1:1603

NOTE:

- These are the numbers reported to OSPI per *Assessment of Student Health Services – Class I*, 2004–05.
- 25 percent of Class I districts **did not** report.
- These ratios do not reflect the range of differing staffing patterns in individual school districts.
- Ratios in general do not account for proximity between buildings and number of school buildings served.
- The national recommendation (the federal government and nationally recognized associations of pediatricians and school nurses) is one nurse for every 750 students.
- Does not consider staffing needs based on the severity of individual student's health concerns.
- Does not include nurses hired for one-on-one services to students.

APPENDIX K

OUTCOME MEASURES/EVALUATION

The OSPI School Nurse Research Task Force (Washington State Office of Superintendent of Public Instruction, 2004) encourages school nursing research that demonstrates the impact of nursing interventions on student health and educational outcomes.

The goal of data gathering is to document the outcomes of student interventions showing their relationship to educational achievements.

One concern in documenting outcomes is that interventions for the same diagnosis vary from district to district. However, progress has been made with the development of technical assistance such as for children with diabetes that provides guidelines for interventions for all health personnel to follow.

Outcome evaluation is a systematic method of assessing the extent to which a school nurse intervention or school health program achieves its intended results (Washington State Office of Superintendent of Public Instruction, 2004).

With funding from DOH in 2004, OSPI contracted with a doctorally prepared nurse to work closely with the School Nurse Research Task Force. Together they developed a tool kit designed to assist school nurses in using research and data gathering tools to improve their practice and student health and education outcomes. The tool kit, *Improving Practice through Measuring Outcomes* was finalized and distributed through a "Train-the-Trainer In-Service Program," January 2005. Two hundred and twenty school nurses across the state have been trained in the use of this kit. As a result, ninety nurses each submitted a plan for a research project that focuses on data gathering.

The tool kit for School Nurses, *Improving Practice through Measuring Outcomes* (Washington State Office of Superintendent of Public Instruction, 2004), is a step-by-step guide to teach school nurses to do outcome based evaluations. Outcome evaluations are a systematic method of assessing the extent which a school nurse intervention or school health program achieves its intended results. This type of evaluation can answer the following questions:

- What has changed in the lives of students and/or their families as a result of the interventions provided at school?
- How have the lives of students in the program differed as a result of the interventions?
- What effect did the interventions have on the students' academic achievement?

Following are examples of some of the questions the nurses will try to answer in their projects:

- Do asthma IHP's implemented by school nurses decrease absenteeism?
- Does teaching about hand-washing and posting reminders resulting in increased knowledge produce more frequent hand-washing and improved attendance for diseases related absences?
- Does a program of identifying children with high absenteeism and sending a letter to their parents with follow-up counseling and support result in improved school attendance and grade reports?

As noted by these examples, ***school nurses are focused on children achieving their full academic potential through better health and decreased absenteeism.*** Encouraging this type of research by school nurses will improve the services being provided to students.

APPENDIX L

STANDARDS OF PRACTICE AND PROFESSIONAL PERFORMANCE FOR SCHOOL NURSING

Source: American Nurses Association and National Association of School Nurses *School Nursing: Scope and Standards of Practice*, 2005 Silver Spring, MD.

Standards of Practice for School Nursing:

Standard 1. *Assessment*. The school nurse collects comprehensive data pertinent to the client's health or the situation.

Standard 2. *Diagnosis*. The school nurse analyzes the assessment data to determine the diagnosis or issues.

Standard 3. *Outcomes Identification*. The school nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

Standard 4. *Planning*. The school nurse develops a plan that prescribes strategies and alternatives to attain expected outcomes.

Standard 5. *Implementation.* The school nurse implements the identified plan.

Standard 5a. *Coordination of Care*. The school nurse coordinates care delivery.

Standard 5b. *Health Teaching and Health Promotion*. The school nurse provides health education and employs strategies to promote health and safe environment.

Standard 5c. *Consultation*. The school nurse provides consultation to influence the identified plan, enhance the abilities of others, and effect change.

Standard 5d. *Prescriptive Authority and Treatment*. The advanced practice registered nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.

Standard 6. *Evaluation*. The school nurse evaluates progress towards attainment of outcomes.

Standard 7. *Quality of Practice*. The school nurse systematically enhances the quality and effectiveness of nursing practice.

Standard 8. *Education*. The school nurse attains knowledge and competency that reflects current school nursing practice.

Standard 9. *Professional Practice Evaluation*. The school nurse evaluates one's own nursing practice in relation to professional practice standards and guidelines, relevant statutes, rules and regulations.

Standard 10. *Collegiality.* The school nurse interacts with, and contributes to, the professional development of peers and school personnel as colleagues.

Standard 11. *Collaboration*. The school nurse collaborates with the client, the family, school staff, and others in the conduct of school nursing practice.

Standard 12. *Ethics*. The school nurse integrates ethical provisions in all areas of practice.

Standard 13. *Research*. The school nurse integrates research findings into practice.

Standard 14. *Resource Utilization*. The school nurse considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of school nursing services.

Standard 15. *Leadership*. The school nurse provides leadership in the professional practice setting and the profession.

Standard 16. *Program Management*. The school nurse manages school health services.

APPENDIX M

THE NEED FOR SCHOOL HEALTH SERVICES: RATIONALE

One Definition of Health Services: The purpose of an integrated health service program is to maximize student's physical, intellectual, social, and emotional health. The goal is to identify, prevent, or remedy student health problems and to enhance the educational potential of all students by promoting wellness and facilitating the resolution of health concerns that create barriers to learning (Colleen VanSweringen, 2005).

Education and health care intersect on many levels. In order for children to learn, it is essential they are healthy and have access to quality health care. Just as improving education can improve health care, conversely improving health services can improve educational attainment. It is imperative that legislators and policy makers acknowledge the relationship between health status and academic achievement. With the increased emphasis placed on standardized testing and meeting the expectations of the "No Child Left Behind Act" (U.S. Department of Education, 2002), both staff and students are placed under a great deal of pressure. School board members need to be informed about how a coordinated school health program can benefit this goal. Knowing that strong links have been found between poor school performance and poor physical health, schools must deal with children's health by design, or they will have to deal with it by default. (Marx, et al., 1998).

An integrated approach acknowledges that school health programs support the educational process and recognizes that children who are disadvantaged or have a disability must be included. The following groups support this model (Marx, et al., 1998):

- U.S. Department of Education and U.S. Department of Health and Human Services.
- Carnegie Council on Adolescent Development.
- National Council on the Role of the School and the Community in Improving Adolescent Health, B. Boyer.
- Council of Chief State School Officers.

Ultimately, schools are society's vehicle for providing young people with the tools for successful adulthood. Perhaps no tool is more essential than good health (Council of Chief State School Officers, 1991). Without good health, young people cannot become productive adults in today's world. Considering that a child spends much of his day in school, the chance of needing services offered by a school health program and directed by a nurse is very high.

Reasons for promoting quality school health services are numerous, including:

- Children spend the majority of their day in a school setting where acute, chronic, and/or emergency health problems arise daily.
- School nurses are able to decrease absenteeism and time away from the classroom through planned interventions and education such as helping the asthmatic child control asthmatic episodes.
- Immediate access to primary health care is often delayed, as parents are inaccessible.
- School nurses are educated to triage emergency care and provide services including assessment, interventions, referrals, consultation, and follow-up.
- School nurses are able to identify both physical and psychosocial health problems that interfere with academic achievement and refer children to appropriate health care providers and/or agencies.
- Through classroom observation, nurses are able to identify changes in children with special needs and provide the teacher with suggestions.
- Well planned health services provide a link between community health agencies, parents, and the school in providing a safe healthy environment for the special needs child.
- With the increased number of children without health insurance, a well defined school health services program affords all children a chance for health care.
- School nurses can assist children and their families in locating affordable quality health services.
- With early diagnosis and intervention, students with identified health problems are less likely to progress to a more severe stage.
- With the number of health problems seen in the school on a daily basis, school staff and administrators would be overwhelmed if they had to provide health services in addition to their teaching and administrative duties.
- Without a school nurse, teachers, administrators, and other school staff may inappropriately and unsafely provide care that should be provided by a licensed professional.

Over time, the type of health services offered changes in accordance with new policies and the demographics of children. Consideration must be given to an ever-increasing number of low income children, often from single-parent homes, and the increased number of children needing specialized care. The lack of access to health care, the number of children who are uninsured, changing family structures, and changing technology all affect morbidity and mortality rates. All have a direct effect on a child's well being. Therefore, health services must be continuously evaluated to determine what services are needed and which services are most effective to support a child's ability to learn.

Two federal laws require the provision of health services to students:

1. National Activities to Improve Education of Children with Disabilities Act, Part D, of 2004.
2. Section 504 of the Rehabilitation Act of 1973 (Moses et al., 2005).

Children impacted by these regulations may enter the school system at age three and stay until age 21. In addition, these children may require daily performance in a variety of nursing skills in the school setting including, but not limited to, tracheal suctioning and management, catheterization, and seizure management. These activities require oversight and often direct services of individuals with professional licensure and advanced nursing education.

The National School Boards Association reaffirms that school health programs offer the opportunity to provide services and knowledge necessary to enable children to be productive learners and to develop the skills to make health decisions for the rest of their lives (Marx, et al., 1998).

Requiring a fully qualified health professional to supervise health services protects the safety of students as well as protecting school districts and staff from potential liability suits. Qualified, licensed school nurses must be the leaders in providing school health services.

In order to meet the health needs of all children, nurses may delegate some nursing procedures to less qualified individuals. However, without adequate supervision these individuals risk the safety of the students they serve. School health services should be supported by a sufficient number of qualified school nurses in order to be available throughout the day to health room assistants, students, teachers, and parents.

The following is an anecdote from a school nurse who correctly assessed and initiated actions for a child at school, based on astute observations:

"A teacher stopped me in the hall and mentioned that I might want to check a child for scoliosis because the child was always holding her head to one side. With assessment I learned that the child was having frequent headaches when she held her head straight which were more severe at night. They had been to a physician who prescribed Ibuprofen. I recommended that they return to the doctor and faxed a letter to him regarding my concerns. The next day I received a phone call from the doctor stating that… because of my observations and assessments he examined her further and discovered that she had a tumor ... and was at that moment in surgery. They were able to remove it [the tumor]. The doctor stated that if it had not been diagnosed it would have grown much larger and impacted her basic functions."

School Nurses are in one of the most challenging nursing specialties, caring for many children with a broad range of health problems. Increasingly, the school nurse is used as both an access point to a primary health care and liaison to community health resources. School nurse services directly support the national education goals by providing both direct and indirect services to children of all ages (Doyle, 1999).

As a team member in an academic setting, the school nurse's primary goal is to enhance the academic potential of each child whose health may be compromised by physical, social, or emotional concerns or problems. The school nurse continually struggles to maximize resources while maintaining a quality school health program by collaborating with educational personnel, community agencies, students and families (National Association of School Nurses, 2005).

School nurses practice in an interdisciplinary setting that integrates many differing views from various stakeholders. Wide ranging views of administrators, parents, students, and school nurses can lead to conflict when making decisions related to a student's safety or other health issues. At times an area of law, federal health care mandates, and/or education law may produce conflict as to the right thing to do. Often there are no clear answers in the law and the question then arises—Who makes the final decision regarding the best assistance for a child? (Solum, 2003)

The composition of today's student population continues to change, particularly in relation to the number, complexity, and acuity of medical and psychiatric problems with which students come to school. Students come to school with a variety of physical and mental health conditions, disabilities, and treatment modalities. Additionally, much of today's school population is rife with poverty, homelessness, single-parent households, working parents, drug and alcohol abuse, eating disorders, teenage pregnancies, suicide, and violence. American student have:

- A one-in-five chance of not having health insurance.
- A one-in-twelve chance of suffering from asthma.
- The greatest chance to die in adolescence from medical or social causes (in one of the ten most industrialized nations in the world).

An article in *The Spokesman Review* (McDonald, 2005) reported a record number of homeless students have passed through the Spokane Public Schools so far this year. In the first year of the district's homeless program six years ago, 340 students were served. This year, the numbers are approaching 600 students. The director of the program states that many of these children don't know where their parents are. Of the high school students, 70 students are homeless and 35 are without any guardians. These students often go without proper medical care except on an emergency only basis.

Recognizing that learning can only occur if a child is healthy, the school nurse is able to promote academic success and facilitate positive student outcomes through:

- Assessing.
- Promoting health and safety.
- Intervening with actual and potential problems.
- Collaborate with others to build student and family capacity for adaptation, self-management, self-advocacy, and learning.

School Nurse Ratio: Rationale

School health service programs face staff reductions, budget limitations, or shortage of nurses. Each year school health service programs and school nurses struggle to provide the needed services to the children they serve. Additionally, the number of legislative mandates at the federal and state level requiring skills of a well prepared health professional to care for special needs children has increased, adding to the complexity of determining adequate staffing for each district and building.

Current staffing in many schools does not allow for most school nurses to work on health promotion and prevention. This is a critical need given many lifestyle choices such as poor dietary habits and lack of proper exercise leading to health problems by the time a child is an adolescent. An example of this is the epidemic of obese children leading to a myriad of health problems including diabetes with related complications.

The appropriateness of an established school nurse to student ratio is dependent on the complexity of health problems and needs of each school. Many variables need to be considered to determine adequate staffing patterns.

Although the overall school nurse/student ratio for Class I Districts appears to be within the recommended 1:1500 (Refer to Appendix F for graph “Complexity of Student Population Class I,” many factors besides numbers need to be considered to ensure safety. Barriers to using a ratio of 1:1500 includes nurses who must travel several miles between schools thereby decreasing their time at a school and not having enough time to educate staff on children with special needs. As an example, many questions arise regarding children going on field trips. Teachers and coaches express concern about potential problems, especially for children with diabetes, asthma, and allergies. Nurses also express concern for before and after school activities where staff needs to be trained to recognize problems and provide adequate care.

Identifying Factors to Determine Ratio

Factors that need to be considered when establishing a nurse to student ratio include:

- The number of medically fragile children requiring complex skills and monitoring.
- The number of buildings to which a school nurse is assigned. Often nurses are assigned to several buildings each day at variable distances from each other decreasing the amount of time to provide care to individual students needing special care. The location of children with special needs must be considered.
- The amount of time required to teach staff, bus drivers, coaches, volunteers, and other personnel safety precautions related to a child’s health problems. For example, sending a diabetic child who is having a reaction to the office without a “buddy”.
- Having enough time to discuss and train personnel on how to handle emergencies such as allergies, seizures, insulin reactions, asthmatic episodes, etc. while students are on a field trip or participating in athletic events.
- Assisting students in learning self-care activities including learning how to communicate their needs adequately while at school.

- Supervising non-nursing personnel delegated to perform nursing tasks (Devlin and Assay, 2005), (Talioferro, 2005).

The day-to-day ability of schools without adequate school nurse coverage particularly in low income areas to handle emergencies, administer medications, and provide needed resources for health care is questionable, particularly in light of other school based priorities, limited financial resources, and inadequate staffing. With inadequate school nurse coverage, the ability for schools to provide daily health care services is compromised: emergency situations, medication administration, and resources for health care. Currently, health services compete for limited resources due to the many other demands placed on our schools.

APPENDIX N

ACCESS TO HEALTH CARE

With adequate school nurse staffing, school nurses will be able to maximize their role of assisting students and families to access health care and enrolling in appropriate health coverage. National Association of School Nurses (NASN) supports the opinion that students and their families must have a health care home.

Barriers to Accessing Health Care
Many barriers exist that prevent families from enrolling their children in an insurance program including:

- Geographic location may limit the options available.
- Lack of financial resources if medical premiums do not fully cover.
- Transportation to medical facility.
- Availability of needed services.
- Socio-cultural factors such as migrant, immigrant, or English as a second language (ESL) families.

Healthy People 2010 set a goal that the U.S. will eliminate health disparities that occur among different racial and ethnic populations by the end of the decade (U.S. Department of Health and Human Services, 2000). Unfortunately, differences in access to health care and the health status of these populations continue to be problematic, particularly for African Americans, Asian, Pacific Islanders, and Native Americans.

Children's Health Outreach has suggested the following strategies for school nurses to encourage families to enroll in an insurance plan:

- Send home information about health coverage with sick children.
- Add health insurance questions to mandatory health forms.
- Coordinate special health coverage sign-up events such as health fairs, sporting events, PTA conferences where parents could ask questions, and seek assistance in understanding the forms. This is particularly important with ESL families.
- Directly enroll children in children's health coverage programs using the Presumptive Eligibility Option Children's Health Coverage (Ross and Booth, 2001).

Enrolling individuals in an insurance plan is a relatively new role for nurses and one that requires partnering with the educational system and community organizations. It is

imperative that educators realize the long term affect of a child having access to health care benefits decreases absences and increases learning capabilities. However, it must be recognized that without adequate nurse staffing, implementing this role will be impossible.

Often the school nurse is the first and only consistent source of health service for the uninsured child. Fortunately, a qualified school nurse can triage students identifying problems requiring immediate care and referring to agencies for appropriate treatment. Because the school nurse is often assigned to many buildings, contact with these needy children is limited and cannot support the medical care needed to keep the child healthy and in school.

These factors influence the need for school nurse services to address barriers to accessing health care:

- Minority groups have more health problems and lack access to needed health care more than any other group.
- Research shows that access to health care is related to income level and insurance coverage.
- Changes in family economics, structure, and mobility have placed many children in need of health services.
- Children from low income families face nutritional deficiencies, inadequate housing, violence, and abuse which increases their need for multiple types of health services.
- Health insurance is now available in most states but many children are not enrolled because families do not understand the form and feel it is too difficult to complete.
- Often the school nurse is the first and only consistent source of health services for many of these uninsured children.

APPENDIX O

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