

School Nursing Services and Why We need an Integrated Approach beyond Task Forces

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Introduction

The surge of complex conditions among school children in the past decades is reshaping the roles and responsibilities of school nurses. In addition to performing health assessments to promote wellness and disease prevention, increasingly, school nurses are called to provide health care services to students with chronic conditions, such as asthma, allergies and diabetes, children that don't have adequate health care or are uninsured, and children with mental health needs^[1]. However, budget constraints for education and for health care services in schools have long undermined the efforts of school nurses^[2]. In response to these old and new challenges, states and municipalities have proposed policies and localized action that have not yet been widely reported nor translated into scalable policies for the whole country. Upon considering a selection of those initiatives across the U.S., we contend that an integrated approach combining legislation, advocacy work and consistent and uniform data collection is key to successfully implementing and sustaining school nursing services in public schools.

Persistent old challenges

The main challenges to improving school nursing services are not new problems. They are related to the increase of complex health care needs among children, changes in socio-economic and racial/ethnic demographics, budget constraints and ambiguous legislation, a lack of uniform data sets and privacy and data sharing concerns.

Increasing complex health care needs among children

The number of children with complex health care needs has been increasing in the U.S. for at least two decades. As of 2015, as many as 19.8% of children aged 0 - 17 had spe-

cial or complex health care needs^[3]. Complex health care needs and chronic conditions affect students' performance with health episodes that can be frequent, difficult to prevent, disruptive and sometimes fatal. While these circumstances are not new, the current situation is aggravated by the persistence of childhood health disparities directly linked to socio-economic, ethnicity, and immigration status, length of time since immigration, as well as political changes affecting families^[4]. Complex health care needs, including some chronic conditions such as diabetes or asthma, disproportionately affect children who live in poor households^[5] or minority populations^[6]. For example, from 2001 to 2009, asthma rates increased 50% among African American children^[7] and hospitalization rates due to asthma were highest among minority populations^[8]. In addition, complex and chronic health conditions are more pressing among children with no health insurance, a reality for approximately 5.9 million children under 19 years of age in the U.S. in 2014^[9], and 4.5 million in 2015^[10]. Refusal to expanding Medicaid in some states and uncertainties about the future of the Affordable Care Act (ACA) may further limit access to health care for the poorest and those without coverage. It is unclear how many children might be affected, but experts estimate that if the ACA is repealed the number of uninsured could double and a large number of American children with special health needs in immigrant families could face additional hurdles and barriers to accessing health coverage through federal or state plans^[11]. Even when children with special health needs have insurance, they are more likely than other children to report care that did not meet their needs^[12]. In addition, children in immigrant families with no health insurance are more likely to report language as health care access barriers and delays in medical care^[13].

Budget restraints and ambiguous legislation

Many factors influence and affect the implementation of school health care services and school nursing^[14,15,16,17,18]. Among them, budget constraints are an important challenge to providing adequate and sustainable nursing services in public schools. Budgetary restrictions may limit the capability of school districts to hire full-time nurses as well as to afford other health provision such as mental health services^[1]. Apart from the Individuals with Disabilities Education Act (IDEA), a federal law that requires schools to provide nursing services for students with disabilities, funding for preemptive or preventive health care services in schools is generally determined at state level where requirement, resources and legislation vary widely.

In general, states have adopted *ad hoc* legislation to respond to the need for health care services in schools and mitigate imminent health crises. For example, in 2014, many states adopted legislation promoting school-based mental health training and services as well as enacted anti-bullying legislation^[19]. In our research, we have observed that what has been most effective, however, is state specific legislation that guarantees budgetary allocation for health care services in schools and school nurses. Some states, such as Vermont and Tennessee, have legislation that guarantees funding for physical facilities and basic conditions for health care services in schools^[20]. Delaware, New Jersey and Rhode Island have innovated adopting legislation that mandates employment of school nurses per district or facility and not per number of students^[21].

Lack of uniform data and privacy concerns

Along with budgetary restrictions, a lack of uniform school health care services data is among the most serious barriers to advancing school health services. Data sets are necessary to describe current student needs, activities and interventions implemented. They are fundamental in advocacy efforts and cost-benefit analysis because they help us understand the situation in the state, evaluate health disparities and monitor developments based on facts and accurate information. However, often, data are collected based on district self-reporting with no uniform collection protocol in the state, much less at national level. School districts are not required to collect information the same way with some districts being able to complete comprehensive reporting while others are not. There must be a greater effort in integrating data collection among districts and reporting with other school health providers. This would enable analysis and monitoring using other public health data and academic performance data thus, better aligning school health services with community needs.

Task Forces

One popular measure in states seeking to improve health services in schools has been the creation of task forces to analyze their situation and address student health needs. A task force that includes a variety of experts including administrators, nurses, politicians, families and health economists can provide analysis in an objective and scientific form. Task forces in Michigan, Oregon and Idaho have discussed the rationale for policy decisions by identifying the outcomes to be delivered to children in schools including how to measure and evaluate performance^[22,23,24]. Sometimes, task forces may create a wider support for CDC's collaborative approach to learning and health, known

as the Whole School, Whole Community, Whole Child (WSCC) model. The WSCC model calls for communities, educators and key decision makers to work together to address the physical and emotional needs of students^[25]. Yet, in our own work evaluating a pilot effort to implement a Coordinated School Health program in the San Jose Unified School District, we saw how merely having a positive and integrated program was not sufficient to ensure continued funding for these activities^[26]. Although there seems to be a positive relation between school nurse or school health task forces and improvements in the student-to-school nurse ratio, assessments and analysis of its contributions are still limited. Task forces will be ineffective if their recommendations are not implemented *de facto*. In addition, there are other important aspects that are not necessarily captured by task forces. Task forces promote the notion that school health services go beyond the scope of health professionals and that their work needs to be carried out in collaboration with networks of care and other interested parties. This new focus empowers community-based organizations, partnering with health and educational professionals to advocate for passing of legislation that guarantees designated funds for health services in schools including new systems of health data collection. Advocacy training and partnerships are critical to the success of policies to advance health care services in schools. Some initiatives provide systematic advocacy training for health professionals, educators, and parents to improve health services for all students^[27]. These trainings include skills on how to assess specific needs of children in their school district as well as how to propose policy to local and state governments, and how to implement programs and evaluate results. Still, these initiatives alone and if not well coordinated may not produce the desired effect of implementation and evaluation of health care services programs in schools or support school nursing.

Conclusion

An integrated approach to supporting children at school has the potential positively to both impact child health and well-being, and improve educational attainment, contributing to better health over the course of their lives and future generations^[28,29]. The most successful initiatives to promote school nursing services are those in which cross-disciplinary engagement takes place at the local and state levels fostering the necessary political will to implement legislation designating budget allocations and an organized system to pay for health services in schools. Efforts from task forces to multi-level collaborations of health professionals, educators, families and legislators have a positive impact on supporting and passing legislation that could maintain and improve health services in school^[30]. The mobilization that task forces, expert advisers, and children advocates produce is necessary also for designing and implementing policies to accompany legislation such as mandates for a school-level health administrator, delegation of care, health recording and reporting, and care in the event of a medical or public emergency. In addition, much awareness and mobilization is needed to implement systems for consistent data collection that allow for effectively monitoring the implementation of laws and policies ensuring accountability and evaluation.

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