Proposal Summary

Healthy kids learn better. Research shows that schools with adequate nursing coverage have fewer absences, decreased dropout rates, and higher academic success. Research also makes clear the relationship between heath disparities and the academic achievement gap among racial and ethnic minorities, and children living in poverty [1]. Many schools in Washington, however, do not have adequate nursing services available to their students. As delineated above, districts have faced an increase of students with chronic conditions, new mandates on how those conditions should be managed in schools, and steadily growing statewide nursing shortage.

A comprehensive funding system includes resources for adequate staffing, professional development, and systems for monitoring student progress. The proposed funding level for school nurse staffing includes funding of a composite ratio of 1 school nurse per 750 students in all schools. Typically, this would provide 1 school nurse per 500-student elementary school, 1 nurse per 750-student middle school, and 1 nurse per 1,000-student high school. Resources for professional development for school nurses are included in the proposed professional development model, and resources for monitoring systems is included in proposed operating costs model (non-employee related costs).

As with other certificated instructional staff, the allocation would be embedded in a single CIS staffing allocation from the state to school districts and delineated for school nurses in a legislative document (typically a LEAP document). Districts could continue to hire a range of employee skill sets, based on the unique needs of their district and community. The recommendations are in the context of additional staffing for pupil support and additional resources for guidance counseling at the secondary level.

Resources must be available in the Educational Service Districts for a regional delivery model similar to the School Nurse Corps to assist small and rural school districts with the provision of school health services, and to provide ongoing professional development and technical assistance to all schools.

Coordinated School Health is a ten-year-old model of health improvement identified by the Centers for Disease Control and many other public health entities as a successful model to improve health, not just respond to health deficits. The model includes family and community involvement; counseling, psychological and social services; nutrition improvement; health services; physical education; health education; health promotion for staff; and a healthy school environment. The proposal for small grants

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[1] See, for instance:
http://www.cdc.gov/HealthyYouth/health_and_academics/index.htm;http://www.gettingresults.org/ ;
http://www.activelivingresearch.org/alr/alr/files/Active_Ed.pdf;
Telljohann, S. ; Drake, J. A.; and Price, J. H. (2004). *Effect of full-time versus part-time school nurses on attendance of elementary students with asthma*, The Journal of School Nursing, 20,331-334.
Currie, Janet. 2005. “Health Disparities and Gaps in School Readiness.” *The Future of Children* 15(1): 117-138.

to schools, based on a per student amount of $6, will provide the resources to start up and coordinate a school health improvement plan. Schools would combine this resource with resources in other components of the Superintendent's recommendations, as follows:

Health Improvement Plan Development and Implementation	Coordinated School Health Grant
Family & community involvement	Coordinated School Health Grant
Counseling, psychological, an social services	Pupil Support allocation of 1:1000 students and 1:500 students in poverty
Nutrition Services	Current Resources
Health Services	Nursing ratio of 1:750
Physical Education	Current Resources
Health Education	Current class schedules plus recommendation for Instructional Materials (Non-Employee Related Costs-NERC)
Health Promotion for Staff	Coordinated School Health Grant
Healthy School Environment	Recommendation for Facilities Maintenance (NERC/Classified Staff)

Schools would be required to submit a health improvement plan in order to receive the grants.

Background and Historical Funding in Washington

The practice of school nursing dates back to the early 1900's, when nurses functioned primarily to reduce absenteeism by intervening with students and families regarding health care needs related to communicable diseases. Over the years the school nurse role has expanded so that today school nurses support student success by providing health care assessment, intervention, and follow-up for all children in the school setting.

The National Association of School Nurses (NASN) defines a school nurse in the following way:

> *A specialized practice of professional nursing that advances the well-being, academic success, and life-long achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self management, self advocacy, and learning.* (See NASN Issue Brief: School Health Nursing Services Role in Health Care)

While this definition is consistent with the current training, credentialing and practice of school nurses in Washington State, there are also specific requirements related to school nursing that are unique to our state. Under rules of the State Professional Educator Standards Board (WAC 181-79A), anyone holding the title of 'school nurse' must be a Registered Nurse and possess an Educational Staff Associate

certificate. However, Washington State law allows Class II districts (those districts with enrollment under 2000 students) to employ a regularly licensed physician or a licensed public health nurse to provide school health services.

A survey of districts conducted in 1979 identified that about 50% of Washington school districts had nurses on staff, about 38% utilized local public health nurses to provide school health services, and about 12% had no nursing services at all. During this time, state and federal rules and laws related to school health were limited to addressing communicable diseases, and providing visual and auditory screening and scoliosis screening. And, in 1979, the State Legislature required that children provide proof of immunization as a condition of attending school. Thus, in the late 1970's school nurses typically provided required vision and auditory screenings, conducted scoliosis screening, ensured appropriate immunization status of school children—including documenting and monitoring immunization status and actually providing immunizations—and provided first aid and other emergency services as needed.

As identified in the 1979 survey, during the late 1970's and through the 1980's, public health nursing was an important health service resource for local school districts. The provision of direct public health services such as immunizations and certain screenings was an important aspect of the local public health delivery system. However, over the past 30 years the there has been a substantial reduction in direct public health nursing services in most Washington communities. In 2008, it is rare for schools to receive direct public health nursing services like those provided in 1979.

In 1996, the Washington State Legislature required the Joint Legislative Audit and Review Committee (JLARC) to conduct a survey of school nurses and other health workers providing health services in Washington's public schools, and their funding sources. The resulting JLARC report (Survey of School Nurses Report 97-5) provides an excellent overview of the provision of school health services at that point in time. The JLARC survey also identified significant concerns regarding the provision of health services in Washington public schools. At least 45 districts reported not having any nursing services on staff (18 of these districts contracted out for health services), and that many districts used non-nursing personnel to provide health services to their students. In addition, the survey identified that some advanced medical procedures were being performed in the school setting by non-medical personnel. Because of how school districts track and report expenditures, JLARC was unable to identify the discrete funding sources and relative percentages of funding for school nurses.

One result of the JLARC survey was the establishment by the 1999 State Legislature of the Washington School Nurse Corps funding proviso. The School Nurse Corps is a regional delivery system of school nursing services (managed via the nine Educational Service Districts) that places nurses in primarily rural districts and schools that lack local school health services and have demonstrated health services need. The program was never designed to provide services to all students, but rather provide services where districts could not. The original funding proviso in 1999 was $2.5 Million, and after a 3% reduction in 2001, that amount has remained the same while costs have increased each year since. The program can no longer cover the students originally intended; direct School Nurse Corps service hours have declined

by 25% since 2002-2003; 17 school districts have been dropped from program coverage. The scope of the program—the number of students enrolled in served schools—covers 82,836 students (8% of all students).

Over the past 30 years, the need for school health services has been influenced by fairly dramatic changes in the health status of school-aged youth, and by a significant expansion in school health mandates.

Generally speaking, school-aged youth are less healthy today than they were 30 years ago across several key dimensions. According to national data gathered by the Federal Centers for Disease Control (CDC), the youth obesity rate in 1980 was approximately 6%. Today the rate is 15%. Asthma shows a similar trend. In the early 1980's about 3% of youth were diagnosed with asthma. Today the asthma rate is 8.5%. The asthma prevalence among African-American students is 38% higher than the prevalence among white students. Diabetes is another chronic health condition that has seen dramatic increases in prevalence in recent years. According to the CDC, diabetes prevalence increased from 25 per 1000 in 1975 to 55 per 1000 in 2005. Type 2 diabetes, which accounts for 90% to 95% of all diagnosed cases of diabetes, involves insulin resistance – the body's inability to properly use its own insulin. Type 2 used to occur mainly in adults who were overweight and ages 40 and older. Now, as more children and adolescents in the United States become overweight and inactive, Type 2 diabetes is occurring more often in young people. And, diabetes prevalence is increasing disproportionally faster among African-American, Latino, and Pacific Islander populations.

Advances in health care practice and medical technology also play a role in determining the need for school health services. Children with severe and/or chronic illness or special health care needs have benefited from these advancements so that, in many of these cases, children who would not have been able to attend school 30 years ago because of the nature of their conditions can and are fully engaged in their education. However, many of these children need ongoing specialized health services over the course of a school day or week, such as GI tube feeding, catheterization, and breathing treatments.

As indicated earlier, school health requirements 30 years ago dealt primarily with management of communicable diseases, immunizations, and certain health screenings. The school health regulatory landscape is substantially different today. The following table displays these changes:

School mandates requiring Professional Registered Nurse (RN)	1978	1990s	Today
Contagious Diseases	RCW 28A.210.010—Contagious diseases, Limiting contact—Rules and regulations.	Continuing requirement.	Continuing requirement.

Vision and Auditory Screening	RCW 28A.210.020 through .040—Visual and auditory screening of pupils.	Continuing requirement.	Continuing requirement.
Scoliosis Screening	28A.210.220 through .250—Screening program for scoliosis.	Continuing requirement.	Continuing requirement.
Medication Administration	Minimal monitoring or guidance. Informal and non-regulated.	1982 RCW allowing RN delegation of oral medications. RCW 28A.210.260 Public and private schools — Administration of oral medication by — Conditions.	Majority of districts have Medication Policies and Procedures. RN may not authorize (delegate) unlicensed individuals to administer non-oral medications, such as Diastat (commonly prescribed rectal medication used for life-threatening seizures).
Nurse Delegation RN transfers and supervises performance of selected nursing tasks to competent individuals in selected situations. References: RCW 18.79—Nursing Care RCW 18.130—Uniform Disciplinary Act WAC 246-840-705—Functions of a Registered Nurse and a Licensed Practical Nurse.	Rarely addressed in WA schools.	Washington State Board of Nursing recommendations informed nurse delegation in all settings. Also heightened awareness of providing nursing services in schools and how, what, and when nursing tasks are delegated. See Washington State Board of Nursing Unlicensed Practice Task Force (UPTF), Recommendations Guideline Sheet, 1991.	Initial guidance to districts on nursing delegation in the schools by OSPI and the Nursing Care Quality Assurance Commission. The School Nurse Corps provides technical assistance to all school districts. Oral medication and CIC statutes allow for limited exception for nurses to delegate tasks in schools which may not be delegated in typical clinical care settings.

School mandates requiring Professional Registered Nurse (RN)	1978	1990s	Today
Immunizations	School Immunization Program effective April 5, 1974. Immunizations required for school attendance includes 6 vaccines: diphtheria, tetanus, pertussis, measles, rubella, mumps, and poliomyelitis. References: WAC 248-100-162 Immunization of school children.	Increased requirement. School Immunization Program effective Sept 1, 1979 RCW 28A.210.040 through 07—Immunization Program. Immunizations required for school attendance includes 7 vaccines: diphtheria, tetanus, pertussis, measles, rubella, mumps, and poliomyelitis Reference WAC 248-100-166—Immunization of day care and school children	Increased requirement. 9 vaccines (15 doses): hepatitis, diphtheria, tetanus, pertussis, polio, measles, mumps rubella, & varicella. State Board of Health preparing to add pneumococcal vaccine for attendance. References: RCW 28A.210.060 through 170—Immunizations required for school attendance. WAC 246-100-166 Immunization of child care and school children against certain vaccine-preventable diseases.
Section 504 of the Federal Rehabilitation Act of 1973	Not yet implemented in schools.	Cedar Rapids Court case heightened parents and schools recognition of expected accommodations for students with health conditions. Reference: http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=US&vol=000&invol=96-1793	Accommodations must be provided for students with a health condition that impacts a major life function. Reference: A Parent & Educator Guide to Free Appropriate Public Education (Puget Sound ESD) (under section 504 of the Rehabilitation Act of 1973)

School mandates requiring Professional Registered Nurse (RN)	1978	1990s	Today
Emergency Care Planning/Life Threatening Conditions	Plans rarely developed.	Schools beginning to develop plans in response to the Section 504 obligations.	In addition to the 2002 life-threatening Conditions (LTC) statute, see diabetes, asthma and anaphylaxis. Reference: RCW 28A.210.320 Children with life-threatening health conditions -- Medication or treatment orders -- Rules.
Diabetes	No requirements and rare interventions.	Schools beginning to address diabetes in light of Section 504 obligations.	Statutes established requiring individual health plans, emergency care plans and all staff training about diabetes. References: RCW 28A.210.330— Students with diabetes -- Individual health plans -- Designation of professional to consult and coordinate with parents and health care provider -- Training and supervision of school district personnel. RCW 28A.210.340 Students with diabetes -- Adoption of policy for inservice training for school staff.
Asthma	No requirements and rare interventions.	Schools beginning to address asthma in light of Section 504 obligations.	Statutes established requiring individual health plans, emergency care plans and all staff training about asthma. References: RCW 28A.210.370— Students with asthma.
Anaphylaxis	No requirements	No requirements	SSB 6556: School Districts must develop policies to prevent Anaphylaxis, by Sept 1, 2009.

School mandates requiring Professional Registered Nurse (RN)	1978	1990s	Today
Clean, Intermittent Bladder Catheterization (CIC)	No requirements	RCW 28A. 210.280—Catheterization of Public School Students. Requires schools to provide clean, intermittent bladder catheterization to students who need it.	RCW 28A.210.280 and 290 modified in 2003; changes address delegation issues; requires specific training.
Nursing dependent students These students require 24 hours/day, frequently one-to-one, skilled nursing care for survival. Without effective use of medical technology and availability of nursing care, the student will experience irreversible damage or death. **Medically fragile students** These students require a full time nurse in the building. Students face daily the possibility of a life threatening emergency requiring the skill and judgment of a professional nurse	Nursing dependent students were not typically served in schools: often did not survive or were in other settings e.g. home or institutions. Section 504 of the Federal Rehabilitation Act of 1973 was not yet implemented in schools for medically fragile students.	Cedar Rapids Court case heightened parents and schools recognition of expected accommodations for students with health conditions. Reference: http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=US&vol=000&invol=96-1793	Based on recent survey, in 06-07 roughly 160 students were classified as nursing dependent and roughly 4100 students were classified as medically fragile http://www.k12.wa.us/HealthServices/pubdocs/SchHealth.pdf Accommodations must be provided for students with a health condition that impacts a major life function. Reference: A Parent & Educator Guide to Free Appropriate Public Education (Puget Sound ESD) (under section 504 of the Rehabilitation Act of 1973)

Historically Washington basic education funding formulas have provided funds for schools to employ health services staff through the Certificated Instructional Staff and Classified Staff funding ratios. Although these funding formulas do not specifically delineate funding for school nurses, we can identify state funding at about 1 certificated school nurse per 2,660 students. At this allocation level, most school districts do not have high enough enrollment to generate even part of a school nurse FTE.

We know that the number of school nurses that districts feel compelled to deploy has increased. However, at the state level we do not collect adequate data to see the full picture of school health services staffing, as we do not separately identify other categories of health services providers such as non-ESA registered nurses, licensed practical nurses and other health practitioners.

What we do know is that districts are under significant pressure to utilize resources from these funding ratios to meet instructional needs rather than health services needs. Thus, districts often have limited health services which are being funded in other ways, using local levy funds, local, state, and federal competitive grants, and collaborative partnerships with community-based health service providers. This results in an ever-changing patchwork quilt of health services funding across the state, which leads to health service inequities and likely contributes to disparities in academic achievement.

As indicated earlier, funding for the School Nurse Corps (SNC) has remained static since its inception in 1999, at $2.5 Million. Due primarily to inflation, the purchasing power of this program has declined significantly over this period of time. Over just the past five years, direct nursing hours purchased through the SNC have declined by 25%. While student enrollment in schools served by SNC has decreased by 15%, the number of student health conditions increased by 16%. As a result, the scope of this program has shrunk significantly, severely impairing its mission.

Estimates of Necessary Resource Levels

Changes in student characteristics and school health mandates over the past 30 years make clear that our current funding levels do not adequately resource school health requirements, and that we need to draw from other researchers and district practice to identify an appropriate resource level for a new funding system. The table below summarizes resource level recommendations and experience:

	Summary
School Finance Researchers	
Picus/Odden for Wa Learns	Grouped across all support categories (nurse/counselor/social worker/etc): 1 FTE for 100 poverty students, with a minimum of 1.0 for a prototypical school; provides enough funding for 1 nurse per 750 students plus adequate social supports.
Conley, 2007	1 school nurse FTE at every school.