THE SELECT INTERIM LEGISLATIVE TASK FORCE ON COMPREHENSIVE SCHOOL HEALTH REFORM

Final Report

December 2008

Members:

Rep. Glenn Andersen
Rep. Eileen Cody
Sen. Rosa Franklin
Sen. Chris Marr
Rep. Lynn Schindler
Rep. Shay Schual-Berke

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INTRODUCTION

In 2007 the Legislature passed Second Substitute Senate Bill 5093 which established the Select Interim Legislative Task Force on Comprehensive School Health Reform (Task Force). The Task Force was established to:

(1) review and make recommendations on policies, environmental changes, and programs needed to support healthy schools, including but not limited to food choice, physical activity, and childhood fitness; and

(2) review the delivery of health care services in the schools by school personnel providing health services.

There were six members of the Legislature appointed to the Task Force:

Rep. Glenn Andersen (replacing Rep. Buri)	Sen. Chris Marr
Rep. Eileen Cody	Rep. Lynn Schindler
Sen. Rosa Franklin	Rep. Shay Schual-Berke

The Task Force met six times during the 2007-08 interims. These meetings were held in Olympia, Seattle, and Spokane. Work sessions were held at each of these meetings with an opportunity for public comment. The work session topics discussed school health services delivery, coordinated school health, mental health services in schools, school environmental health, school-based health centers, nutrition and physical activity, and the availability of educational staff associates.

PREAMBLE

In 2007 the Legislature established the Select Interim Legislative Task Force on Comprehensive School Health Reform in an effort to create policy initiatives that would contribute to improving the health of the state's children. Nationally, obesity among children ages two to 19 has more than tripled since 1971, and nearly one-third of all kids today are overweight. Further, the number of children taking medication for Type-2 diabetes, closely linked to obesity, has more than doubled from 2002 to 2005, to a rate of six out of 10,000 children. Chronic disease in children including asthma, depression, attention deficit/hyperactivity disorder, allergies are all increasing -- as are use of medications to manage them. These health trends are true for Washington.

The Legislature recognized that it had to look beyond expanding health insurance to address the health of children. Through the work of this Task Force, schools have been identified as places where good practices and policies can make kids healthier. Children spend six or more hours a day at school, which makes this daily experience a primary opportunity to impact their health. Students eat two meals a day in school and eat snacks both during school hours and after school on the campuses. They come to school with chronic illnesses that must be managed, and some that are contagious. They interact with dozens of people daily, developing relationships and learning social skills. They occupy buildings for hours at a time, structures that must be maintained to remain clean and safe. They come to school to learn -- and many ask -- what is more critical for them to learn than how to manage and maintain good health throughout a lifetime?

The Task Force also used emerging evidence that shows the direct relationship between health and academic performance. Over the last decade, research has concluded that student health status and academic achievement are deeply connected. The Task Force learned from state epidemiologists that poor nutrition and physical inactivity puts students at increased academic risk. It is clear that meeting the basic developmental needs of students -- ensuring that they are safe, drug-free, healthy, and resilient -- is central to improving academic performance. Simply put, when kids are hungry, scared, in pain, sick, distracted, then they are unable to learn.

With this in mind, the Task Force took on health-related issues for children in schools from both perspectives -- in an effort to improve health for children overall and to advance the connection between healthy kids, healthy schools, and academic achievement. The Task Force recognized that there remain unmet medical needs in schools that could be addressed with adequate numbers of school health personnel. It found that school health clinics successfully act as medical homes for kids in a very limited number of schools in the state, and policies need to improve the opportunities for these clinics to continue and expand. It acknowledged that emerging psycho/social issues include children who have parents at war and that services and policies in schools need to respond to emotional and psychological issues with more sensitivity and resources. And overall, the Task Force was unsatisfied with the kind of fiscal information that is received from school districts on how much and where they spend health dollars on their students. Without adequate data on health care spending, the Task Force felt unable to make state level fiscal decisions about future state expenditures on health in schools.

The following recommendations reflect these concerns and provide a framework for future investment in school health. The Task Force believes that the health of students is within the purview of the education community in this state, and that recognizing the role of schools is critical to the longevity of current and future generations.

RECOMMENDATIONS

I. GENERAL STATEWIDE CONSIDERATIONS

Background

Beyond certain basic requirements, school districts have broad discretion to spend state funds. Although the state provides the majority of school district funding, there are few requirements that school districts report their spending on health-related activities. The lack of data regarding school district spending decisions pertaining to health-related activities provides challenges to understanding the status of school health and the effects of school health policies.

Administrative Recommendation

1. The Office of Superintendent of Public Instruction (OSPI) should prepare an inventory of the health-related data that the state currently collects from school districts, such as personnel providing health services to students, food services, physical activity, health education, and building maintenance (including improvements and maintenance personnel). The OSPI should evaluate the ability of the data to inform local and state policymakers of local school district efforts to address the health needs of students. The OSPI should determine which additional data must be collected to provide sufficient information about school district performance pertaining to health measures. A strategy should be developed to incorporate the additional data into existing information systems as well as future systems as they are developed. Outcome-based measures should accompany the data being collected. The Basic Education Task Force should consider incorporating this into its work on reporting.

II. COORDINATED SCHOOL HEALTH

Background

Coordinated School Health is a 10-year-old health improvement model identified by the Centers for Disease Control and many other public health entities as an approach that integrates important health practices in schools. The model basically addresses at least eight different health-related activities and suggests that these should be coordinated and supported in order for any one of them to make a difference. The Coordinated School Health model includes unifying and improving health services, nutrition, physical activity and education, mental health services, family and community involvement, health promotion for staff, and healthy school buildings and grounds.

Administrative Recommendation

2. The OSPI should convene an advisory group to identify the elements of school health, and to advise on the resources needed to implement that vision. The advisory group will provide guidance to a new, statewide School Health Advisory Council that will be established to permanently oversee and monitor the provision of school health in all school districts across Washington. The OSPI will use current information gathered through the Coordinated School Health grants, and use the feedback from schools involved in this project, to identify best practices in school health. The OSPI will also provide guidance on how to monitor, evaluate outcomes, and involve local communities in important school health initiatives.

III. HEALTH SERVICES

A. Personnel: School Nurses

Background

School nurses, assisted by other school health personnel, provide or coordinate the provision of certain health services, pursuant to a student's individual health plan or in emergency situations. By law, administration of some medications may be delegated, with supervision, to school staff other than nurses. There are also several health screenings and services mandated by law that school nurses must coordinate or provide directly. These various responsibilities include visual and auditory screening, scoliosis screening, emergency planning, medication management, and asthma and anaphylaxis management.

School nurses also spend a significant amount of time updating medical forms and completing health planning materials for students. Several factors limit a nurse's ability to accomplish the health care service, health care planning, and recordkeeping functions, including parental non-responsiveness and high volumes of activity at certain times of the year. And, despite the extensive record keeping that these functions require, there is little baseline data about student health that school health personnel or health investigators can use to establish a disease cluster or adverse impacts from changes to the environmental conditions of a facility.

While performing various mandatory screening services is valuable to student health, the cumulative effect of these requirements may burden the capacity of schools to provide other important health services. Legislation introduced in the 2008 legislative session would have discontinued mandatory scoliosis screening requirements.

The ratio of school nurses to students varies throughout the state. In 2000, a report from the OSPI and the Nursing Care Quality Assurance Commission recommended that school districts provide one nurse for every 1,500 regular education students. A 2006 report based on survey results from 79 of the state's 106 Class I school districts found that it would take an additional

1,113 registered nurse hours per week (28 FTEs) to achieve a ratio of 1:1,500 in those responding districts.

Following a 1997 Joint Legislative Audit and Review Committee report, the School Nurse Corps was established through an appropriation in the 1999-01 operating budget. This budget item has been continued at the same funding level each biennium since then. The School Nurse Corps operates in all nine educational service districts, providing nursing services to rural school districts that would not otherwise be able to hire nurses. The Task Force received testimony that the average salary of a School Nurse Corps nurse is $25 per hour compared to $40 for hospital nurses. This has resulted in challenges in recruiting and retaining nurses.

Legislative Recommendations

3. The Legislature should reevaluate mandatory screenings and services to determine whether the services should be eliminated, reduced in scope, or enhanced.

4. The Legislature should establish a minimum staffing level for the ratio of nurses to students in school districts of one professional school nurse for every 1,500 regular education students in Class I school districts and should review appropriate nurse to student staffing ratios in smaller districts, with consideration given to the contribution made by the School Nurse Corps.

Administrative Recommendations

5. The Department of Health should review the provision of health services in schools to determine if services are provided in compliance with current professional standards for health care providers and make recommendations to the Legislature if, in the interest of student health, statutory changes are warranted.

6. The OSPI and school districts should consider whether opportunities exist to ease paperwork burdens on school health personnel, such as making computerized electronic health records available between schools in the event of student transfers and allowing certain record updates to be renewed by a child's birthday.

B. Personnel: Other ESA Health Personnel

Background

Educational staff associates practice in a variety of fields where there is a high demand for their services. There are broad workforce shortages among many of the health care professions that serve schools as education staff associates, such as psychologists, occupational therapists, and physical therapists. While these shortages persist in all practice settings, they are particularly pronounced in school settings where pay tends to be lower than in private practice. In many cases the positions go unfilled or are filled through temporary agencies, which results in inconsistent care to students and significant financial cost to the district. Recent legislation to

encourage more of these professionals to seek employment with school districts provided recognition of up to two prior years of related service for educational staff associates on the salary allocation model.

Administrative Recommendation

7. The OSPI should establish a workgroup of school district and workforce training professionals to identify the extent and causes of the shortages of educational staff associates providing health services. The workgroup should develop prioritized policy options for attracting and retaining these professionals in school settings, including consideration of additional pay for those professionals who have achieved national certification and recognition of up to five years of prior related service on the salary allocation model.

C. School-Based Health Centers

Background

The concept of a health care home explores many of the elements associated with coordinating an individual's health care through a place where health care services are likely to be provided and health care information is likely to be collected. Schools have frequently been mentioned as one component of the health care home model. School-based health centers provide a structure for maximizing that role.

The Department of Health is coordinating 11 planning grants for communities to identify local needs, staff and equipment resources, and financial support. These grants help schools identify partners, resources, and strategies to encourage the community support necessary to establish and sustain school-based health centers.

School-based health centers frequently provide free services that would be eligible for reimbursement had they been delivered at a health care provider's office. Barriers to billing by school-based health centers include denial letters sent to students' homes, privacy concerns about identifying students' insurance and Medicaid eligibility status, and administrative burdens to establishing billing systems.

Legislative Recommendation

8. The Legislature should recognize that schools have become de facto health care homes for many students and school-based health centers represent a promising structure to help schools fulfill that role. It should further recognize that funding is a key impediment to both establishing school-based health centers and supporting their continued operation. In addition to continuing planning grants, the Legislature should encourage the resolution of billing obstacles to promote the establishment of more school-based health centers. The Legislature should encourage the OSPI to establish an interagency workgroup to identify barriers that prevent school-based health centers from billing for their services.

This group should recommend how the state can establish a central billing system for school-based health centers, require subcapitation by health plans for the students they cover, or require the inclusion of school-based health centers in health plan networks.

IV. ENVIRONMENTAL HEALTH

Background

The state requires students to attend school and pays the majority of the costs, but there is no clear entity in state government that is responsible for holding local school districts and local health jurisdictions accountable when schools do not meet health and safety standards and resolution cannot be found at the local level. Jurisdiction over standards for the construction, maintenance, and operation of school facilities is shared among several state and local authorities. Parents and other advocates for student health complain about being passed from agency to agency.

The number of state and local agencies with oversight of the safety and health of school facilities creates an administrative burden for schools and makes it difficult to build in efficiencies, such as a single statewide Web-based reporting system, and to ensure consistent enforcement and technical knowledge. The Department of Labor and Industries' jurisdiction covers only employees. The State Board of Health rules cover facilities, and they are enforced inconsistently by 35 different health jurisdictions. The OSPI has required submission of maintenance information and established the Washington Sustainable Schools Protocol.

The standards developed by these agencies frequently do not consider issues specific to school populations, which have unique issues due to children's heightened susceptibility to environmental factors. While a building might be in technical compliance with existing rules, it might not necessarily provide a healthy environment for school populations. Furthermore, without adequate maintenance by properly trained individuals, the buildings will not provide a healthy environment for students and faculty. Schools facing budget challenges often reduce staffing for custodial and maintenance personnel and defer maintenance.

Legislative Recommendations

9. The Legislature should recognize the nexus between the design and maintenance of school facilities and the health of students and faculty. The Legislature should encourage local public health jurisdictions and local school districts to develop and implement strategies to monitor environmental changes on school campuses. Agencies that establish standards for public buildings, including schools, should be required to consider standards that are appropriate to the unique environmental health and safety needs of school populations, and they should be given the authority to enforce their standards. Standards should be established to require local school districts to provide adequate resources to properly maintain school facilities by providing adequate staffing levels, sufficient maintenance funding, and training.

10. The Legislature should coordinate, and perhaps consolidate, resources and enforcement authority in a statewide or regional entity to provide broad accountability for the maintenance and safe and healthy operation of school facilities to promote adequate compliance at the local level.

V. MENTAL HEALTH

Background

An estimated 20 percent of the state's children suffer from a psychological disorder. However, many children who may have a diagnosable mental illness do not have access to the state's publicly funded mental health system. Medicaid payment restrictions severely limit youth from receiving mental health services. Further, an increasing number of children go to school each day in crisis. Studies show that these kids are experiencing powerful and dangerous events that cause them to constantly feel overwhelmed. These children miss school, cannot learn, and disrupt classes.

Formal systems meet only a portion of the identified need for psychological services for children. Schools use a different language and mechanisms for identifying and treating behavior than are used by the outside mental health community. Each system is directed by different funding mechanisms and constrained by exclusionary rules that govern access to service.

Traditionally, school counselors have provided psychological services to students, but with a focus on academic issues – graduation requirements, testing, etc. Often one counselor must travel between several schools in a district. The functions of school counselors, psychologists, social workers and others in the mental health professions are essential to identification, assessment, coordination, and follow through on behalf of the children and K-12 educational management of student needs.

Administration Recommendations

11. The OSPI should encourage promising collaborative efforts between mental health providers and school districts. One example of this collaboration is school-based health centers where schools have worked with political entities to develop comprehensive approaches to health services delivery to students. Both Medicaid and non-Medicaid resources should be used to coordinate delivery of mental health services in schools by community providers.

12. School districts should increase the use of school-based mental health providers, including psychologists, counselors, social workers and others, at all levels of the state's public schools. Schools should employ a mix of mental health providers who can address both academic success and overall mental health. Services should include early screening and diagnosis and treatment of mental illness and substance abuse. Trained mental health professionals should be encouraged to bridge the worlds of education and mental health

and to maintain strong and meaningful ties between students, educators, families, school nurses, and the mental health community.

13. The OSPI should develop consensus on the laws, policies, training opportunities, and funding mechanisms necessary for schools to intervene early on behalf of traumatized students. School districts should seek a better understanding of the problems associated with childhood trauma, and address current practices like changing discipline practices. Consideration should be given to include statewide training of mental health providers on ways to approach the K-12 system, and for educators in the K-12 system on ways to access mental health resources in the community. Special populations of children needing support, like those with parents in the military, should be considered. Specific training in mental health first aid for educational staff should also be considered.

VI. NUTRITION SERVICES

Background

The Task Force heard evidence of a correlation between nutritional inadequacy and academic risk. Research shows that students who do not eat breakfast may be at increased academic risk. Ideally, all students should have two nutritious meals by the end of the school day. In Washington, approximately 90,000 students in public schools meet the requirements for reduced price meal benefits. When the state eliminated the co-payment for reduced price breakfast, participation increased approximately 45 percent. In 2007 the Legislature fully funded free breakfast for all eligible students and provided funding for the 2007-2009 biennium to eliminate the copayment for lunch students in kindergarten through third grade. This was not done for students beyond third grade.

In 2008 the Legislature created the Washington Grown Fresh Fruit and Vegetable Grant Program. With $600,000 from the Legislature, the OSPI was authorized to solicit applications from rural and urban schools with 50 percent low-income students to provide free Washington grown fresh fruits and vegetables throughout the school day. These types of nutritious snacks are basic to good nutrition but are not available to many Washington youth.

Recent legislation requires all school districts in the state to establish wellness policies that address access to nutritious foods and adequate exercise for all students. While all school districts have complied with the mandate to produce a wellness policy, most middle and high school campuses continue to offer to students competitive foods that have little or no nutritional value. (Competitive foods are food or beverages sold outside the federally funded school meal programs in elementary, middle/junior, and high schools. These include snacks, side items, treats, and desserts offered for sale.) While the state provided a model wellness policy, it did not give school districts specific nutritional standards or guidance for competitive foods. Second Substitute Senate Bill 5093, enacted in 2007, outlined nutritional standards for competitive foods, but established the standards as goals for schools to meet by 2010.

Beverage contracts entered into by schools typically include requirements that company products be advertised to students. This includes such venues as Coke and Pepsi marquees at after school events, etc. The Task Force believes that schools should be role models on nutrition education and should be seeking ways to re-enforce good nutrition messages. This message is lost if schools are marketing unhealthy food and beverage items to students.

Legislative Recommendations

14. The Legislature should eliminate the co-payment for all students enrolled in the free and reduced price lunch program statewide.

15. The Legislature should expand the Washington Grown Fresh Fruit and Vegetable Grant Program to include more qualifying schools and fund the development of tracking measures to analyze health outcomes associated with this program. The program should report back to the Legislature in 2011 on the impact of providing free, nutritious, locally-grown snacks to at-risk students.

16. The Legislature should require that competitive foods sold and otherwise available on school campuses meet the following minimum nutritional standards by 2012:

(a) Not more than 35 percent of the food's total calories shall be from fat. This restriction does not apply to nuts, nut butters, seeds, eggs, fresh or dried fruits, vegetables that have not been deep fried, legumes, reduced-fat cheese, part-skim cheeses, or non-fat or low-fat dairy products.

(b) Not more than 10 percent of the food's total calories shall be from saturated fat. This restriction does not apply to same list as in paragraph (a).

(c) Not more than 35 percent of the food's total weight or fifteen grams per food item shall be composed of sugar, including naturally occurring and added sugar. This restriction does not apply to fresh or dried fruits and vegetables.

(d) Not more than 230 mgs of sodium per serving shall be allowed.

(e) Foods containing transfat are prohibited.

17. The Legislature should restrict food and beverage marketing by schools to those foods and beverages that meet specific nutritional guidelines and should consider supporting access to workshops and other programs that assist schools to develop curriculum to educate students about nutrition and/or revenue replacements for marketing food and beverages that do not meet the guidelines.

VII. PHYSICAL EDUCATION

Background

State law requires students in first through eighth grade to receive an average of 100 minutes of physical education per week. Adequate physical activity is essential to youth development and physical education is considered essential to establishing life-long exercise habits and an understanding of overall health. The decrease of physical activity in youth is associated with an

increase in juvenile obesity and related chronic disease. The Task Force heard evidence and is concerned that school districts around the state are not meeting current state requirements for physical education in schools.

School facilities are an essential element of a healthy community. In addition to their primary role in providing an environment conducive for education, schools provide opportunities for active recreation outside of school hours. Siting schools is a process that too often does not include participation from local government planners and, as a result, schools may be built on the cheapest land available, far away from the areas where students could walk or bike and where the community could make use of the campus for recreational purposes.

The Task Force heard that schools face challenges meeting current requirements for physical activity during the school day. There was discussion about the importance of expanding opportunities for students to walk and bike to schools by improving existing infrastructure and enlisting neighborhoods that currently bus kids to schools. The Task Force heard about school districts around the state that have reduced their transportation costs by increasing investments in sidewalks, crosswalks, signage and patrols.

In 2005 the Legislature passed the High Performance Public Buildings Act, finding that public buildings, including public schools, can be built and renovated in such a way that money is saved, school performance is improved, and worker productivity is increased. The law applies to all major construction projects of public school districts receiving any funding in a state capital budget and requires that they be designed and constructed to at least LEED silver standard or the Washington Sustainable Schools Protocol. It went into effect on July 1, 2007, for Class One districts and July 1, 2008, for Class Two districts. The Protocol and the OSPI's recently updated School Facilities Manual for the School Construction Assistance Program (5th Edition, 2008) emphasize the importance of, and award points for:

- Central location with existing infrastructure
- Potential for the joint use of facilities by community
- Ability to accommodate bicycle traffic
- Connectivity with the community which offers students and staff more transportation
- Choices such as biking and walking
- Availability of public transportation services

Legislative Recommendations

18. The Legislature should establish financial consequences for school districts that fail to comply with statutory requirements for physical education in schools. Financial consequences should commence no earlier than the 2011-12 school year and could include denying grants or other optional funding, but should not affect state funds for the basic education allocation.

Administrative Recommendations

19. Consistent with the Washington Sustainable Schools Protocol and the School Facilities Manual for the School Construction Assistance Program (5th Edition), the OSPI should

establish mechanisms that will encourage school districts, when evaluating and selecting new school sites, to consider and prioritize the availability of sidewalks and other safe walking and biking routes to school, as well as whether the land can be shared with other community facilities and organizations for recreational purposes.

STATE REPRESENTATIVE
5th DISTRICT
GLENN ANDERSON

State of
Washington
House of
Representatives

HIGHER EDUCATION
EDUCATION
APPROPRIATIONS

December 15, 2008

RE: Task Force on Comprehensive School Health Reform Recommendations

I would like to thank my fellow task force members and staff for all the work that went into this task force over the past year and a half. The research and testimony to-date has provided a significant foundation to evaluate the connection between both schools and children's health and, consequently, their academic performance.

While I support the good intentions of the recommendations contained in this report, I had hoped that the recommendations would be narrowed in number and prioritized during our final task force meeting, as referred to in my October 9, 2008 memo to task force members. I think the budget realities of this, and future years, imposes a compelling obligation to suggest succinct prioritization of any new proposals.

I am concerned that the sheer number and lack of prioritizations of recommendations will dilute the impact of the recommendations and attentiveness to the importance of the issues raised by the task force. I also think that some of the recommendations were made with limited data on the "problem" and more research and analysis is needed before new policies are put before the Legislature for consideration.

Since the recommendations were not prioritized, I would like to suggest the recommendations that I feel should be the highest priority for policy makers, OSPI, and school administrators to consider:

- Recommendation 1 related to the collection of health related data and reporting by schools;
- Recommendation 8 related to school-based health centers;
- Recommendations 15-17 related to Nutrition Services; and
- Recommendations 18-19 related to Physical Education.

I believe these recommendations provide the most fundamental building blocks to address childhood health issues related to school attendance and academic performance. Moving forward with these select recommendations will provide a firm foundation for further future action on these issues.

Sincerely,

Glenn Anderson
State Representative, 5th Legislative District

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CERTIFICATION OF ENROLLMENT

SECOND SUBSTITUTE SENATE BILL 5093

Chapter 5, Laws of 2007

60th Legislature
2007 Regular Session

CHILD HEALTH CARE

EFFECTIVE DATE: 07/22/07

Passed by the Senate February 14, 2007
YEAS 38 NAYS 9

BRAD OWEN

President of the Senate

Passed by the House March 6, 2007
YEAS 68 NAYS 28

FRANK CHOPP

Speaker of the House of Representatives

Approved March 13, 2007, 1:29 p.m.

CHRISTINE GREGOIRE

Governor of the State of Washington

CERTIFICATE

I, Thomas Hoemann, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SECOND SUBSTITUTE SENATE BILL 5093** as passed by the Senate and the House of Representatives on the dates hereon set forth.

THOMAS HOEMANN

Secretary

FILED

March 13, 2007

Secretary of State
State of Washington

SECOND SUBSTITUTE SENATE BILL 5093

Passed Legislature - 2007 Regular Session

State of Washington 60th Legislature 2007 Regular Session

By Senate Committee on Ways & Means (originally sponsored by Senators Marr, Keiser, Franklin, Shin, Fairley, Hobbs, Weinstein, Kauffman, Pridemore, Oemig, Eide, Brown, Tom, Kohl-Welles, Regala, McAuliffe, Spanel, Rockefeller and Rasmussen; by request of Governor Gregoire)

READ FIRST TIME 02/14/07.

AN ACT Relating to health care services for children; amending RCW 74.09.402; adding new sections to chapter 74.09 RCW; adding a new section to chapter 28A.210 RCW; adding a new section to chapter 48.43 RCW; creating a new section; and repealing RCW 74.09.405, 74.09.415, 74.09.425, 74.09.435, and 74.09.450.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 74.09.402 and 2005 c 279 s 1 are each amended to read as follows:

(1) The legislature finds that:

(a) Improving the health of children in Washington state is an investment in a productive and successful next generation. The health of ((~~the~~)) children ((~~of Washington state~~)) is critical to their success in school and throughout their lives((~~.~~));

(b) Healthy children are ready to learn. In order to provide students with the opportunity to become responsible citizens, to contribute to their own economic well-being and to that of their families and communities, and to enjoy productive and satisfying lives, the state recognizes the importance that access to appropriate health

services and improved health brings to the children of Washington state. In addition, fully immunized children are themselves protected, and in turn protect others, from contracting communicable diseases;

(c) Children with health insurance coverage have better health outcomes than those who lack coverage. Children without health insurance coverage are more likely to be in poor health and more likely to delay receiving, or go without, needed health care services;

((~~(b) Access to preventive and well-child health services for children is a cost-effective investment of both public and private dollars that improves the health of children and of our communities at large; and~~

~~(c)~~)) (d) Health care coverage for children in Washington state is the product of critical efforts in both the private and public sectors to help children succeed. Private health insurance coverage is complemented by public programs that meet needs of low-income children whose parents are not offered health insurance coverage through their employer or who cannot otherwise afford the costs of coverage. In ((~~2004~~)) 2006, thirty-five percent of children in Washington state had some form of public health coverage. Washington state is making progress in its efforts to increase the number of children with health care coverage. Yet, even with ((~~the~~)) these efforts of both ((~~the~~)) private and public sectors, ((~~too~~)) many children in Washington state continue to lack health insurance coverage. ((~~In 2004, almost one hundred~~)) In 2006, over seventy thousand children were uninsured. Almost two-thirds of these children are ((~~low income~~)) in families whose income is under two hundred fifty percent of the federal poverty level; and

(e) Improved health outcomes for the children of Washington state are the expected result of improved access to health care coverage. Linking children with a medical home that provides preventive and well child health services and referral to needed specialty services, linking children with needed behavioral health and dental services, more effectively managing childhood diseases, improving nutrition, and increasing physical activity are key to improving children's health. Care should be provided in appropriate settings by efficient providers, consistent with high quality care and at an appropriate stage, soon enough to avert the need for overly expensive treatment.

(2) It is therefore the intent of the legislature that:

(a) All children in the state of Washington have health care coverage by 2010. This should be accomplished by building upon and strengthening the successes of private health insurance coverage and publicly supported children's health insurance programs in Washington state. Access to coverage should be streamlined and efficient, with reductions in unnecessary administrative costs and mechanisms to expeditiously link children with a medical home;

(b) The state, in collaboration with parents, schools, communities, health plans, and providers, take steps to improve health outcomes for the children of Washington state by linking children with a medical home, identifying health improvement goals for children, and linking innovative purchasing strategies to those goals.

NEW SECTION. **Sec. 2.** A new section is added to chapter 74.09 RCW to read as follows:

(1) Consistent with the goals established in RCW 74.09.402, through the program authorized in this section, the department shall provide affordable health care coverage to children under the age of nineteen who reside in Washington state and whose family income at the time of enrollment is not greater than two hundred fifty percent of the federal poverty level as adjusted for family size and determined annually by the federal department of health and human services, and effective January 1, 2009, and only to the extent that funds are specifically appropriated therefor, to children whose family income is not greater than three hundred percent of the federal poverty level. In administering the program, the department shall take such actions as may be necessary to ensure the receipt of federal financial participation under the medical assistance program, as codified at Title XIX of the federal social security act, the state children's health insurance program, as codified at Title XXI of the federal social security act, and any other federal funding sources that are now available or may become available in the future. The department and the caseload forecast council shall estimate the anticipated caseload and costs of the program established in this section.

(2) The department shall accept applications for enrollment for children's health care coverage; establish appropriate minimum-enrollment periods, as may be necessary; and determine eligibility based on current family income. The department shall make eligibility

determinations within the time frames for establishing eligibility for children on medical assistance, as defined by RCW 74.09.510. The application and annual renewal processes shall be designed to minimize administrative barriers for applicants and enrolled clients, and to minimize gaps in eligibility for families who are eligible for coverage. If a change in family income results in a change in program eligibility, the department shall transfer the family members to the appropriate programs and notify the family with respect to any change in premium obligation, without a break in eligibility. The department shall use the same eligibility redetermination and appeals procedures as those provided for children on medical assistance programs. The department shall modify its eligibility renewal procedures to lower the percentage of children failing to annually renew. The department shall report to the appropriate committees of the legislature on its progress in this regard by December 2007.

(3) To ensure continuity of care and ease of understanding for families and health care providers, and to maximize the efficiency of the program, the amount, scope, and duration of health care services provided to children under this section shall be the same as that provided to children under medical assistance, as defined in RCW 74.09.520.

(4) The primary mechanism for purchasing health care coverage under this section shall be through contracts with managed health care systems as defined in RCW 74.09.522 except when utilization patterns suggest that fee-for-service purchasing could produce equally effective and cost-efficient care. However, the department shall make every effort within available resources to purchase health care coverage for uninsured children whose families have access to dependent coverage through an employer-sponsored health plan or another source when it is cost-effective for the state to do so, and the purchase is consistent with requirements of Title XIX and Title XXI of the federal social security act. To the extent allowable under federal law, the department shall require families to enroll in available employer-sponsored coverage, as a condition of participating in the program established under this act, when it is cost-effective for the state to do so. Families who enroll in available employer-sponsored coverage under this act shall be accounted for separately in the annual report required by RCW 74.09.053.

(5)(a) To reflect appropriate parental responsibility, the department shall develop and implement a schedule of premiums for children's health care coverage due to the department from families with income greater than two hundred percent of the federal poverty level. For families with income greater than two hundred fifty percent of the federal poverty level, the premiums shall be established in consultation with the senate majority and minority leaders and the speaker and minority leader of the house of representatives. Premiums shall be set at a reasonable level that does not pose a barrier to enrollment. The amount of the premium shall be based upon family income and shall not exceed the premium limitations in Title XXI of the federal social security act. Premiums shall not be imposed on children in households at or below two hundred percent of the federal poverty level as articulated in RCW 74.09.055.

(b) Beginning January 1, 2009, the department shall offer families whose income is greater than three hundred percent of the federal poverty level the opportunity to purchase health care coverage for their children through the programs administered under this section without a premium subsidy from the state. The amount paid by the family shall be in an amount equal to the rate paid by the state to the managed health care system for coverage of the child, including any associated and administrative costs to the state of providing coverage for the child.

(6) The department shall undertake a proactive, targeted outreach and education effort with the goal of enrolling children in health coverage and improving the health literacy of youth and parents. The department shall collaborate with the department of health, local public health jurisdictions, the office of superintendent of public instruction, the department of early learning, health educators, health care providers, health carriers, and parents in the design and development of this effort. The outreach and education effort shall include the following components:

(a) Broad dissemination of information about the availability of coverage, including media campaigns;

(b) Assistance with completing applications, and community-based outreach efforts to help people apply for coverage. Community-based outreach efforts should be targeted to the populations least likely to be covered;

(c) Use of existing systems, such as enrollment information from the free and reduced price lunch program, the department of early learning child care subsidy program, the department of health's women, infants, and children program, and the early childhood education and assistance program, to identify children who may be eligible but not enrolled in coverage;

(d) Contracting with community-based organizations and government entities to support community-based outreach efforts to help families apply for coverage. These efforts should be targeted to the populations least likely to be covered. The department shall provide informational materials for use by government entities and community-based organizations in their outreach activities, and should identify any available federal matching funds to support these efforts;

(e) Development and dissemination of materials to engage and inform parents and families statewide on issues such as: The benefits of health insurance coverage; the appropriate use of health services, including primary care provided by health care practitioners licensed under chapters 18.71, 18.57, 18.36A, and 18.79 RCW, and emergency services; the value of a medical home, well-child services and immunization, and other preventive health services with linkages to department of health child profile efforts; identifying and managing chronic conditions such as asthma and diabetes; and the value of good nutrition and physical activity;

(f) An evaluation of the outreach and education efforts, based upon clear outcome measures that are included in contracts with entities that undertake components of the outreach and education effort;

(g) A feasibility study and implementation plan to develop online application capability that is integrated with the department's automated client eligibility system, and to develop data linkages with the office of superintendent of public instruction for free and reduced price lunch enrollment information and the department of early learning for child care subsidy program enrollment information. The department shall submit a feasibility study on the implementation of the requirements in this subsection to the governor and legislature by July 2008.

(7) The department shall take action to increase the number of primary care physicians providing dental disease preventive services

including oral health screenings, risk assessment, family education, the application of fluoride varnish, and referral to a dentist as needed.

(8) The department shall monitor the rates of substitution between private-sector health care coverage and the coverage provided under this section and shall report to appropriate committees of the legislature by December 2010.

NEW SECTION. **Sec. 3.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The legislature finds that parents have a responsibility to:

(a) Enroll their children in affordable health coverage;

(b) Ensure that their children receive appropriate well-child preventive care;

(c) Link their child with a medical home; and

(d) Understand and act upon the health benefits of good nutrition and physical activity.

(2) The legislature intends that the programs and outreach and education efforts established in section 2(6) of this act, as well as partnerships with the public and private sectors, provide the support and information needed by parents to meet the responsibilities set forth in this section.

NEW SECTION. **Sec. 4.** A new section is added to chapter 74.09 RCW to read as follows:

(1) The department, in collaboration with the department of health, health carriers, local public health jurisdictions, children's health care providers including pediatricians, family practitioners, and pediatric subspecialists, parents, and other purchasers, shall identify explicit performance measures that indicate that a child has an established and effective medical home, such as:

(a) Childhood immunization rates;

(b) Well child care utilization rates, including the use of validated, structured developmental assessment tools that include behavioral and oral health screening;

(c) Care management for children with chronic illnesses;

(d) Emergency room utilization; and

(e) Preventive oral health service utilization.

Performance measures and targets for each performance measure must be reported to the appropriate committees of the senate and house of representatives by December 1, 2007.

(2) Beginning in calendar year 2009, targeted provider rate increases shall be linked to quality improvement measures established under this section. The department, in conjunction with those groups identified in subsection (1) of this section, shall develop parameters for determining criteria for increased payment or other incentives for those practices and health plans that incorporate evidence-based practice and improve and achieve sustained improvement with respect to the measures in both fee for service and managed care.

(3) The department shall provide an annual report to the governor and the legislature related to provider performance on these measures, beginning in September 2010 and annually thereafter.

NEW SECTION. **Sec. 5.** A new section is added to chapter 28A.210 RCW to read as follows:

It is the goal of Washington state to ensure that:

(1) By 2010, all K-12 districts have school health advisory committees that advise school administration and school board members on policies, environmental changes, and programs needed to support healthy food choice and physical activity and childhood fitness. Districts shall include school nurses or other school personnel as advisory committee members.

(2) By 2010, only healthy food and beverages provided by schools during school hours or for school-sponsored activities shall be available on school campuses. Minimum standards for available food and beverages, except food served as part of a United States department of agriculture meal program, are:

(a) Not more than thirty-five percent of its total calories shall be from fat. This restriction does not apply to nuts, nut butters, seeds, eggs, fresh or dried fruits, vegetables that have not been deep-fried, legumes, reduced-fat cheese, part-skim cheese, nonfat dairy products, or low-fat dairy products;

(b) Not more than ten percent of its total calories shall be from saturated fat. This restriction does not apply to eggs, reduced-fat cheese, part-skim cheese, nonfat dairy products, or low-fat dairy products;

(c) Not more than thirty-five percent of its total weight or fifteen grams per food item shall be composed of sugar, including naturally occurring and added sugar. This restriction does not apply to the availability of fresh or dried fruits and vegetables that have not been deep-fried; and

(d) The standards for food and beverages in this subsection do not apply to:

(i) Low-fat and nonfat flavored milk with up to thirty grams of sugar per serving;

(ii) Nonfat or low-fat rice or soy beverages; or

(iii) One hundred percent fruit or vegetable juice.

(3) By 2010, all students in grades one through eight should have at least one hundred fifty minutes of quality physical education every week.

(4) By 2010, all student health and fitness instruction shall be conducted by appropriately certified instructors.

(5) Beginning with the 2011-2012 school year, any district waiver or exemption policy from physical education requirements for high school students should be based upon meeting both health and fitness curricula concepts as well as alternative means of engaging in physical activity, but should acknowledge students' interest in pursuing their academic interests.

NEW SECTION. **Sec. 6.** (1) There is hereby established a select interim legislative task force on comprehensive school health reform. The task force shall consist of two members of each caucus of the senate, and two members of each caucus of the house of representatives. The task force shall review and make recommendations on policies, environmental changes, and programs needed to support healthy schools, including but not limited to food choice, physical activity, and childhood fitness. The task force shall also review the delivery of health care services in the schools by school personnel providing health services. The task force may establish technical advisory committees related to nutrition, fitness, and child health.

(2) The task force shall submit its findings and recommendations to the appropriate committees of the senate and house of representatives by October 1, 2008.

NEW SECTION. **Sec. 7.** A new section is added to chapter 48.43 RCW to read as follows:

When the department of social and health services has determined that it is cost-effective to enroll a child participating in a medical assistance program under chapter 74.09 RCW in an employer-sponsored health plan, the carrier shall permit the enrollment of the participant who is otherwise eligible for coverage in the health plan without regard to any open enrollment restrictions. The request for special enrollment shall be made by the department or participant within sixty days of the department's determination that the enrollment would be cost-effective.

NEW SECTION. **Sec. 8.** The following acts or parts of acts are each repealed:

(1) RCW 74.09.405 (Children's health program--Purpose) and 1990 c 296 s 1;

(2) RCW 74.09.415 (Children's health program established) and 2005 c 279 s 2, 2002 c 366 s 2, 1998 c 245 s 144, & 1990 c 296 s 2;

(3) RCW 74.09.425 (Children's health care accessibility--Community action) and 1990 c 296 s 4;

(4) RCW 74.09.435 (Children's health program--Biennial evaluation) and 1990 c 296 s 5; and

(5) RCW 74.09.450 (Children's health insurance program--Intent--Department duties) and 1999 c 370 s 1.

Passed by the Senate February 14, 2007.
Passed by the House March 6, 2007.
Approved by the Governor March 13, 2007.
Filed in Office of Secretary of State March 13, 2007.

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AGENDA

Comprehensive School Health Reform Task Force

Monday
October 15, 2007
2:00 PM Highline CC

I. Introductions and Committee Governance Decisions.

II. An Introduction to School Health in Washington State.
- Rhoda Donkin, Senate Committee Services
- Christopher Blake, Office of Program Research

III. An Introduction to School Health Services in Washington State.
- Gayle Thronson, RN, MEd, Health Services Program Supervisor, Office of the Superintendent of Public Instruction
- Paula R. Myer, MSN, RN, Executive Director, Health Professions Quality Assurance Section 6, Washington State Department of Health
- Donna Burr, RN, BSN, President, School Nurse Organization of Washington; School Nurse, Evergreen School District 114
- Julie Schultz, RN, BSN, School Nurse Corps Director, Educational Service District 101

IV. Coordinated School Health in Washington.
- Pam Tollefsen, RN, MEd, School Health Programs Coordinator, Office of the Superintendent of Public Instruction
- Leslie Sturdivant, Health and Fitness Teacher, Spokane Public Schools
- Debra Gary, Principal, Pioneer Elementary School, Auburn

V. Overview of Survey Responses.

VI. Public Comment on the School Health Needs in Washington.

VII. Next Actions and Work Plan.

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AGENDA

Comprehensive School Health Reform, Interim Leg. Task Force

Friday
January 11, 2008
9:00 a.m. HHR B

Agenda:

1. How the K-12 Public Schools Budget Funds School Health Services.
    a. Bryon Moore, Senate Committee Services (Ways and Means).
    b. Ben Rarick, Office of Program Research (Appropriations).

2. Coordinated School Health: The School Health System - Panel Discussion.
    a. Moderator:
        Lori Stern, Alliance for a Healthier Generation.
    b. Panel:
        Dr. Jane Gutting, Education Service District 105.
        Mike Merino, Evergreen School District.
        Racie McKee, Omak School District.
        Jerry Warren, Federal Way High School.

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AGENDA

Comprehensive School Health Reform, Interim Leg. Task Force Committee

Tuesday
March 4, 2008
8:30 a.m. RUL

Agenda:

1. Governance Issues.
    - Member Discussion.

2. Future Meeting Planning.
    - Member Discussion.

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AGENDA

Comprehensive School Health Reform, Interim Leg. Task Force

Friday
May 2, 2008
9:30 a.m.
Administrative Building Boardroom
200 North Bernard
Spokane WA

Agenda:

9:30-11:30 a.m. **I. Work Session: School Environmental Health Issues**

30 Min Panel One: What environmental considerations related to school facilities affect health of students and faculty and how do they impact learning?

- Patricia Butterfield, Ph.D, RN, Washington State University Intercollegiate College of Nursing
- Kathy O'Toole, Washington Education Association
- Vicky Gardner, Mead Education Association

40 Min Panel Two: What programs and standards have state agencies developed to promote a healthy school environment and how have they impacted school facilities?

- Craig McLaughlin, Washington State Board of Health
- Nancy Napolilli, Washington State Department of Health
- Gordon Beck, Martin Mueller, Office of the Superintendent of Public Instruction

45 Min Panel Three: How do different local authorities promote healthy school environments?

- John Mannix, Spokane Public Schools
- Steve Main, Spokane Regional Health District
- Eric Dickson, Educational Service District 101
- Jason Conley, Spokane Public Schools

11:30 a.m.-
1:00 p.m. **II. Facility Tour (Members & Staff only)**

1:00 – 4:00 p.m. **III. Work Session: Programs Addressing Psychosocial Issues Facing Students**

40 Min What are the social and emotional issues facing school age kids today and how are Washington public schools responding?

- Martin Mueller, Assistant Superintendent, Student Support, Office of the Superintendent of Public Instruction

50 Min Why the magnitude of psychosocial health issues affecting kids requires a public health solution.

- Natalie Turner, MS, Area Health Education Center of Eastern Washington, WSU Extension

30 Min How Spokane Public School District works with Regional Support Networks to provide mental health services to school age children.

- David Crump, Ph.D, Spokane Public Schools

30 Min How one educational school district is implementing prevention programs in Spokane.

- Astri Zidack, Director, Center of Prevention Programs, ESD 101

30 Min **IV. Public Comment**

V. Adjourn

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AGENDA

Comprehensive School Health Reform, Interim Leg. Task Force Committee

Wednesday
June 11, 2008
2:30 p.m.

1:30 PM Tour of Rainier Beach Teen Health Center.

2:30 PM Work Session: Roundtable Discussion of Issues Involving School-Based Health Centers.

Molly Belozer, Community Health Networks of Washington.
David Brenna, Mental Health Transformation Project.
Candy Cardinal, Kitsap County Public Health.
T.J. Cosgrove, Seattle-King County Public Health.
Dr. Benjamin Danielson, Odessa Brown Children's Clinic.
Kristine Hildebrandt, Group Health Cooperative.
Jill Lewis, Seattle Public Schools.
MaryAnne Lindeblad, Department of Social and Health Services.
Kate Mills, Washington State Smile Partners.
Judy Schoder, Washington State Department of Health.
Mark Secord, Puget Sound Neighborhood Health Clinics.
Gayle Thronson, Office of the Superintendent of Public Instruction.
Peggy Wanta, Molina Health Care.

4:00 PM Public Hearing: Opportunity for Public Comment on Discussions Covered During the Work Session.

4:15 PM Staff Update on Future Meetings and Recommendations.

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AGENDA

Comprehensive School Health Reform, Interim Leg. Task Force

Tuesday
September 9, 2008
9:00 a.m.
Senate Hearing Room 2
John A. Cherberg Building
Olympia, WA

Work Session:

I. Introductions 9:00- 9:10 am

II. The connection between physical activity and nutrition and academic performance 9:10- 9:30 am

- Julia Dilley, Senior Research Scientist

III. Current school policies and programs related to physical activity/education and nutrition 9:30- 10:15 am

- George Sneller, OSPI
- Lisa Rakoz, OSPI
- Sophia Aragon, Department of Health

IV. Schools Can't Do it alone 10:15 – 11:15 am

- Lori Stern, Alliance for a Healthier Generation
- Larry Cohen , Prevention Institute
- Jon Gould, Children's Alliance
- Jen Cole, Feet First
- Sandi Swarthout ,Washington Health Foundation

V. Educational Staff Associates 11:15- 11:45 am

- Lucinda Young, Washington Education Association.
- John MacDonald, Washington State Association of School Psychologists.
- Elise Dalke Petosa, Washington Association of School Social Workers.

- Leslie Power, Washington Speech and Hearing Association.
- Jan Galvin, Physical Therapy Association of Washington.
- Yvonne Swinth, Washington Occupational Therapy Association.
- Jenny Morgan, Washington School Counselor Association.

VI.	Recommendation Format Discussion	11:45 am- 12:00 pm
VII.	Public Comment & Close	12:00 pm

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AGENDA

Comprehensive School Health Reform, Interim Leg. Task Force Committee

Wednesday
October 29, 2008
9:00 a.m. HHR A

Discussion of Final Recommendations.