



## ***TEXAS GUIDE TO SCHOOL HEALTH PROGRAMS***

Texas Department of State Health Services  
Child Health and Safety Branch - School Health Program  
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# Module 1

## INTRODUCTION TO SCHOOL HEALTH PROGRAMS

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History of School Health

Describing the Components of a School Health Program

Assumptions for School Health Services

Developing a School Health Program

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## Module 1: Introduction to School Health Programs

### Table of Contents:

History of School Health.....	3
History of School Health Activities in Texas.....	3
Describing the Components of a School Health Program.....	4
Assumptions for School Health Services.....	6
The Health Needs of School-Aged Children.....	6
The Health Status of Children in Texas Schools.....	9
Types of Health Services Available in Texas.....	9
Health Services for Special Needs Children.....	11
The Legal Environment for School Health Services.....	13
Conclusions and Recommendations from <i>Report of the School Health Task Force</i> ....	16
Developing a School Health Program.....	17
Planning.....	18
Infrastructure.....	19
Infrastructure at the State Level.....	21
Infrastructure at the District or Community Level.....	22
Infrastructure at the School Level.....	25
Needs Assessment.....	25
Identification of a Model.....	26
Financing a School Health Program.....	27
Federal Funding.....	27
Fiscal Issues in Texas.....	28
Collaboration Within the School System.....	31
Collaborative Partnerships Outside the School.....	32
Evaluation.....	33
References.....	36

## History of School Health

School nursing is a specialized practice of professional nursing that advances the well-being, academic success and lifelong 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.

This definition was adopted at the National Association of School Nurses (NASN) Board of Directors meeting in Providence, Rhode Island, in June 1999.

### History of School Health Activities in Texas<sup>1</sup>

Like school health services in the rest of the United States, school health in Texas has evolved from a simple system of visiting nurses to a complex network of multifaceted school health programs and full-service school-based health centers.

Prior to 1991, the Texas Education Agency (TEA) played a large role in school health services. In 1976 the State Board of Education (SBOE) adopted 19 Texas Administrative Code §85.41, which stated that TEA would consider school health services a “part of the educational program of the school children of Texas.” Local school districts developed policies to address school health issues such as planning, development and evaluation, prevention and control of communicable diseases, health counseling and coordination with community health resources.

TEA currently supports school health services, which are “(1) locally determined based on the needs of the local community; (2) disclosed fully through local discussions involving parents and community members; and (3) implemented in a manner that allows parents the option of declining any health services for their child.”<sup>2</sup> The Texas Education Code [\(TEC\) §38.012](#) outlines requirements for school boards to follow to implement or expand school health services.

Currently, there is no legal mandate in Texas that school districts provide school health services except for individually required health-related services for students with

disabilities and state mandated screenings. School boards have discretion over which health services are provided in their district and how those services are provided. Other state agencies have some involvement in the provision and structure of school health services.

The Department of State Health Services (DSHS) School Health Program provides consultant services to public schools and information and resources to school personnel. In addition, through a competitive bid process, DSHS makes available Maternal and Child Health grant money to communities interested in establishing a school-based health center.

## **Describing the Components of a School Health Program**

### **Definition**

There are a variety of definitions used to explain school health programs. The following definition of a comprehensive school health program was established by the Institute of Medicine Committee on Comprehensive School Health Programs in Grades K-12.

*A comprehensive school health program is an integrated set of planned, sequential, school-affiliated strategies, activities and services designed to promote the optimal physical, emotional, social and educational development of students. The program involves and is supportive of families and is determined by the local community based on community needs, resources, standards and requirements. It is coordinated by a multidisciplinary team and accountable to the community for program quality and effectiveness.<sup>3</sup>*

Currently the term “coordinated school health program” (CSHP) is utilized to describe the process of implementing comprehensive school health in a district.

### **Essential CSHP Elements.**

A successful CSHP not only strives to prevent illness but also provides the opportunity for students to enhance their ability to learn by promoting physical and mental health and social well-being. While there is no universally accepted model for CSHPs, the Centers for Disease Control and Prevention’s (CDC) eight-component model is widely

used and is enhanced by integration and overlap between the components. The following elements are essential:<sup>4</sup>

**Comprehensive School Health Education:** Classroom instruction that addresses the physical, mental, emotional and social dimensions of health; develops knowledge, attitudes and skills; and is tailored to each age level. Designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors.

**Physical Education:** Planned, sequential instruction that promotes lifelong physical activity. Quality physical education programs are designed to develop basic movement skills, sports skills and physical fitness as well as to enhance mental, social and emotional abilities.

**School Health Services:** Preventive services, education, emergency care, referral and management of acute and chronic health conditions. Designed to promote the health of students, identify and prevent health problems and injuries and ensure care for students.

**School Nutrition Services:** Integration of nutritious, affordable and appealing meals; nutrition education; and an environment that promotes healthy eating behaviors for all children. Designed to maximize each child's education and health potential for a lifetime.

**School Counseling and Mental Health Services:** Activities that focus on cognitive, emotional, behavioral and social needs of individuals, groups and families. Designed to provide a safe physical plant as well as a healthy and supportive environment that fosters learning.

**Healthy and Safe School Environment:** The physical, emotional and social climate of the school. Designed to provide a safe physical plant as well as a healthy and supportive environment that fosters learning.

**Staff Wellness Promotion:** Assessment, education and fitness activities for school faculty and staff. Designed to maintain and improve the health and well-being of school staff, who serve as role models for students.

**Parent and Community Involvement in Schools:** Partnerships among schools, families, community groups and individuals. Designed to share and maximize resources and expertise in addressing the healthy development of children, youth and their families.

## **Assumptions for School Health Services**

### **The Health Needs of School-Aged Children**

School nurses have effectively delivered school health services for many years. Recent social and economic changes have increased the need for health services delivered at school, straining the traditional role of the school nurse. Nearly 13 million children, or 17.6 percent of children, live in poverty in the United States.<sup>5</sup> The child poverty rate in the United States is two to three times higher than any other industrialized nation. These children are typically uninsured or underinsured and lack access to adequate health care. Children living in poverty are more prone to chronic and acute illnesses, poor nutrition, developmental delays and learning disabilities than children from more affluent homes.<sup>6</sup> Poverty is also a risk factor for psychological distress in school-aged children.<sup>7</sup>

Parents who work in low wage jobs must often choose between losing badly needed income and staying home with a sick child, or sending their sick children to school to avoid missing a day of work and lost wages. The increase in single parent families also impacts the ability of families to care for their sick child at home. Families frequently rely on the school nurse to provide primary health care services for their child in the school setting. Not only is it stressful for children to attend school when they don't feel well, but other children are exposed to the child's illness. Frequent illnesses ultimately affect the ability of children to learn and grow into thriving adults.<sup>8</sup>

Parker (2000) conducted a study examining student, parent and teacher perceptions of health needs of school-aged children.<sup>9</sup> The top three health problems identified by students included:

1. headaches,
2. stomachaches/cramps, and
3. leg cramps.

The top three health problems identified by parents were:

1. head lice,
2. colds, and
3. eye problems.

Teachers identified the top three problems as:

1. head lice,
2. lack of routine health care, and
3. recurrent skin infections.

It is significant that children, teachers and parents identify different problems and suggests that the incidence of health problems experienced by school-aged children is greater than expected. Parker (2000) suggests a wide range of services to address these health problems in the school setting.<sup>10</sup>

The health of adolescents is critically linked to their health behaviors. The major causes of morbidity and mortality in this age group are the result of unhealthy behaviors learned during early adolescence.<sup>11</sup> These include:

- Unhealthy dietary behaviors;
- Inadequate physical activity;
- Alcohol and other drug use; and

- Sexual behaviors that can result in HIV infection, other sexually transmitted diseases and unintended pregnancies.

A survey in Texas revealed the most common health problems of school-aged children encountered by school nurses are:

- obesity,
- Type II diabetes,
- headaches,
- stomachaches,
- sore throats,
- conjunctivitis,
- stress,
- dental caries,
- upper respiratory infections,
- asthma,
- drug and alcohol abuse,
- ear infections, and
- seizure disorders.<sup>12</sup>

The challenge of school nursing is to promote and maintain the health of children so they are optimally prepared to learn at school.

### **The Health Status of Children in Texas Schools<sup>13</sup>**

“...Children growing up in poor communities today face tough odds. Research predicts that they are at greater risk of being sick and having inadequate health care; of being parents before they complete school; of being users of easily available drugs; of being exposed to violence; and of being incarcerated before they are old enough to vote.”<sup>14</sup>

According to recent statistics, over 1.3 million children in Texas were living in poverty.<sup>15</sup>

In addition, many school-aged children have chronic illnesses. “Asthma affects one in 12 school-age children in the United States and is the most common cause of absences nationally.”<sup>16</sup> The number of Texas children under the age of 21 who suffered from arthritis increased from 13,378 in 1993 to 13,900 in 1997. It is estimated that the number of school aged children that are overweight or at risk for overweight has increased to 35 percent in the last few years.

## **Types of Health Services Available in Texas<sup>17</sup>**

### **Basic School Health Services**

Many providers of school health services as well as parents and teachers feel that there are certain primary functions of basic school health services. One definition of the essential functions of school health services includes:

1. Screening, diagnostic, treatment and health counseling services;
2. Referrals and linkages with other community providers; and
3. Health promotion and injury and disease prevention education<sup>18</sup>.

Texas statutes do not require that health services be provided to the general student population in the school setting. However, the law does require all schools to conduct and to keep records of the following health screenings on all school-aged children:

- Vision
- Hearing
- Spinal
- Dyslexia
- Acanthosis nigricans.

Providers of basic school health services include registered nurses, licensed vocational nurses, unlicensed health personnel and other school personnel.

Other basic health services provided in schools throughout Texas are the administration of first aid, the monitoring and care for chronically ill students, and the distribution of medication to students. According to a 1992 study conducted by the Texas Association

of School Nurses (TASN) in the 328 school districts responding to the survey, 111,128 medications were given out daily to students.<sup>19</sup> There is no statewide data regarding the number of medications administered at school, the number of children with chronic conditions attending school, or the types of special health procedures provided by school staff.

### **Extended School Health Services**

Some extended health services delivery models used in Texas school districts include:

#### **School-Based Health Centers**

A school-based health center (SBHC), also known as a school-based clinic, "...consists of one or more rooms within a school building or on the property of the school that are designed as a place where students can go to receive primary health services. A SBHC is more than a school nursing station; students can receive on-site diagnosis and treatment services from one or more members of an interdisciplinary team of clinicians that may include physicians, nurse practitioners, nurses, social workers, health aides and similar professionals."<sup>20</sup> The Texas Association of School Based Health Centers (TASBHC) reported that in 2006 there were approximately 96 SBHCs in operation in Texas.<sup>21</sup>

#### **Mental Health Centers**

According to the pre-publication copy of the Institute of Medicine's report on schools and health, "one of the most important unmet needs of young people is mental health counseling."<sup>22</sup> Anecdotal reports indicate this is true for children in Texas.<sup>23</sup>

#### **School-Based Youth Service Centers**

"School-based youth service centers provide a wide range of activities—including health services, counseling, recreation and education remediation—to needy adolescent students."<sup>24</sup> Communities in Schools (CIS) are one example of a school-based youth service in Texas. CIS is a statewide, year-round dropout prevention program administered by the Texas Department of Family and Protective Services (DFPS), which "...attempts to improve participants' academic, vocational, social and personal skills to enable them to graduate from high school and to continue their education, enter vocational training, or obtain employment after graduation."<sup>25</sup>

### **Family Resource Centers**

“Family Resource Centers deliver, either at the school site or by referral to community providers, a set of comprehensive services—including parent education, child care, counseling, health services, home visiting and career training—to students of all ages and their families.”<sup>26</sup> These centers may be based either on the school campus or at some other community setting.

### **Comprehensive Multicomponent Programs, Full-Service Schools**

Although the definition of “full-service” varies from place to place, a full-service school most commonly calls for “...restructured academic programs integrated with parent involvement and a wide range of services for students and families—health centers, family resource rooms, after-school activities, cultural and community activities and extended operating hours.”<sup>27</sup> The full-service school model attempts to create an easily navigated network of school and community resources for parents and students,<sup>28</sup> including but not limited to health services.

### **Health Services for Special Needs Children**

“Prior to 1975, children with disabilities were either not served in local school systems or placed in segregated, often inadequate settings.”<sup>29</sup> “In 1975 Congress enacted the landmark Education of the Handicapped Act (P.L. 94-142), which in 1990 was renamed the Individuals with Disabilities Education Act (IDEA).”<sup>30</sup> The act was passed to ensure a “...free and appropriate education for all children with disabilities, including those with physical or mental disorders, in the least restrictive setting from birth through age 21.”<sup>31</sup> IDEA requires school districts to provide special education and related services to eligible children free of charge.

Students with “...mental retardation, hearing impairments including deafness, speech or language impairments, visual impairments including blindness, serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities” are eligible for special education and related services under IDEA.<sup>32</sup> Each student identified for services under IDEA is served through an Individual Education Plan (IEP). The IEP details the specific component of specially designed instruction to meet the student’s individual needs.

Related services may include:

- Speech-language pathology and audiology services
- Psychological services
- Physical and occupational therapy
- Recreation, including therapeutic recreation
- Social work services
- Counseling services, including rehabilitation counseling
- Orientation and mobility services
- School health, school nursing and medical services<sup>33</sup>

About 494,302 children, representing approximately 11 percent of the students in Texas public schools currently receive special education services.<sup>34</sup> The federal government contributed about 12 percent of the funding, while the majority of the funds came from state and local sources.<sup>35</sup>

**Table 1:**

**Most Common Special Needs Conditions among Texas School-Aged Children.**

Condition	3-5 Years	6-21 Years
Learning Disability	479	231,900
Speech Impairment	30,068	68,986
Emotional Disturbance	162	35,277
Mental Retardation	1,175	27,209
Other Health Impairments	2,607	55,547
Orthopedic Impairment	622	4,251
Auditory Impairment	763	6,262
Visual Impairment	569	2,660
Autism	2,443	16,801
Traumatic Brain Injury	68	1,273
Deaf and Blind	16	82
All Students	38,972	450,248

*Data from TEA Special Education Data, 2006-2007*

[www.tea.state.tx.us/special.ed/data/childcount.html](http://www.tea.state.tx.us/special.ed/data/childcount.html)

### **The Legal Environment for School Health Services<sup>36</sup>**

The main recipients of school health services are minors. A brief summary of pertinent Texas laws is presented below along with a summary of state and federal statutes that were determined to be relevant by the Texas Department of Health (TDH) School Health Task Force.<sup>37</sup>

Multiple laws govern the delivery of school health services, but most of these laws pertain to practice regulations for licensed health professionals and the development of voluntary or recommended guidelines for services, for example:

*Licensed health professionals involved in the delivery of basic school health services must comply with laws and regulations governing their practice in the school setting to the same extent as in other practice settings. Failure to do so will subject them to possible disciplinary action against their licenses.*

The TDH School Health Task Force legal subcommittee responded to several legal questions relating to school health services. The following is one of several questions answered by the committee. The reader is asked to consult the School Health Task Force's Report<sup>38</sup> for other pertinent questions and answers. For a copy of the report contact the School Health Program Information Specialist at [schoolhealth@dshs.state.tx.us](mailto:schoolhealth@dshs.state.tx.us).

Question: What are the legal (statutory and nonstatutory) responsibilities of public school districts to provide health services (nursing services) for their student populations? Please provide summaries of any federal and/or state statutory language or case law which addresses and/or mandates health services for public school children in the school setting.

ISSUE: The task force wants to ensure that children in the public schools of Texas have access to quality health care delivery in schools.

Response: We have found no statutory or case law imposing a general mandate on school districts to provide basic school health services. Nor have we found any statute that would impose such a mandate on any other state or local governmental agency or entity. There are a number of state and federal statutes that impose specific health-related responsibilities on school districts. The following are the most significant statutes:

The federal IDEA and [Chapter 29, TEC](#), require districts to provide health related services to students with special needs.

Chapter 38 of the TEC addresses health and safety issues including:

- Requiring immunizations, which DSHS must provide if otherwise unavailable ([§38.001](#)-[§38.002](#)).
- Dissemination of Bacterial Meningitis information ([§38.0025](#)).
- Testing for dyslexia for which TEA is to adopt standards ([§38.003](#)).
- Child abuse reporting ([§38.004](#)).
- Tobacco on school property ([§38.006](#)).
- Posting of steroid notice ([§38.008](#)).
- Access to medical records ([§38.009](#)) and parental access to medical records ([§38.0095](#)).
- Parental notification if referred to outside counselor ([§38.010](#)).
- Dietary supplement promotion or use ([§38.011](#)).
- Notice required concerning health care services ([§38.012](#)).
- Coordinated school health (CSH) for elementary and middle/junior high school students. ([§38.013](#))
- Self-administration of prescription asthma or anaphylaxis medication by students ([§38.015](#)).
- Psychotropic drugs and psychiatric evaluations or examinations ([§38.016](#)).

The Health and Safety Code includes several provisions relating to school health services including:

- Hearing and vision screening ([§36.001 et seq.](#)).
- Spinal curvature screening ([§37.001 et seq.](#)).
- Risk Assessment for Type 2 Diabetes ([§95.001](#))
- Unlicensed Diabetes Care Assistants (UDCA) ([§168.000](#))
- Automated External Defibrillators ([§779.001](#))

The health professional licensing laws require licensed health care professionals involved in the provision of school health services to comply with their respective practice acts.

While not imposing any specific responsibilities on school districts, [§281.0465](#), Health and Safety Code, authorizes hospital districts covering counties of at least 190,000 to contract with school districts included in the district to provide “nursing service and assistance to employees or students of the school districts.” It should be noted that the phrase “nursing services and assistance” is used and not “health care services.”

### **Conclusions and Recommendations of A Report of the School Health Task Force to the Texas Board of Health (March 1998)**<sup>39</sup>

The Texas Board of Health (BOH) met with the Board of Nursing (BON) because of calls from school nurses about delegation issues and general concern about the oversight and delivery of school health services. As a result of that meeting, the BOH established the School Health Task Force consisting of representatives from public and private entities including TDH, BON, TEA, Board of Vocational Nurse Examiners, Texas Pediatric Society, Texas Conservative Coalition, Texas Association of School Administrators (TASA), Texas Association of School Boards (TASB), TASN, and the Texas Nurses Association (TNA).

In light of BOH and TDH statutory responsibility to “protect and promote the health of the people of this state” the Task Force decided that BOH and TDH should assume leadership roles in developing voluntary standards for school health services, and

provide guidance and technical assistance to schools electing to provide school health services. Decisions about the types of health services provided in individual school districts are ultimately the right and responsibility of the parents and community served by the schools.

The School Health Task Force made the following recommendations to the BOH:

- Establish a leadership role for the TDH in the support for and delivery of school health services;
- Develop and implement a data collection model to compile basic information about school health services in the state; and
- Establish a state-level interagency school health council (of representatives from public and private sector agencies) to consider relevant issues based on data collected to coordinate and improve school health services including health promotion.

In 2005, the legislature passed Senate Bill 42 which instructed the DSHS to establish a state level school health advisory committee. The text of the statute, now codified in the Health and Safety Code, can be found at <http://tlo2.tlc.state.tx.us/statutes/hs.toc.htm>, Title 12 of Chapter 1001, Subchapter D, §1001.0711: SCHOOL HEALTH ADVISORY COMMITTEE.

The Texas School Health Advisory Committee (TSHAC) began meeting in October, 2006. The purpose of the TSHAC is to provide assistance to the State Health Services Council in establishing a leadership role for the DSHS in the support for and delivery of CSHPs and school health services. For more information on the TSHAC, go to [www.dshs.state.tx.us/schoolhealth/shadvice](http://www.dshs.state.tx.us/schoolhealth/shadvice).

## **Developing a School Health Program**

“School health services contribute to goals of both the education system and the health care system...Because most children older than five years attend school, schools are particularly ideal places to provide preventive services...”<sup>40</sup> School health offices are

busy facilities that perform a variety of services both for the students and faculty of the school in the community where they are located.

The purpose of this section is to provide an introductory discussion of the necessary infrastructure needed to build and support a CSHP. In addition, the basic steps necessary for planning the establishment or enhancement of a school health program will be outlined.

## Planning

[§38.012](#), TEC, Notice Concerning Health Care Services<sup>41</sup>, states:

- (a) Before a school district or school may expand or change the health care services available at a school in the district from those that were available on January 1, 1999, the board of trustees must:
  - (1) hold a public hearing at which the board discloses all information on the proposed health care services including:
    - all health care services to be provided;
    - whether federal law permits or requires any health care service provided to be kept confidential from parents;
    - whether a child's medical records will be accessible to the child's parent;
    - information concerning grant funds to be used;
    - the titles of persons who will have access to the medical records of a student; and
    - the security measures that will be used to protect the privacy of students' medical records; and
    - approve the expansion or change by a record vote.
- (b) A hearing under Subsection (a) must include an opportunity for public comment on the proposal.

An organized, planned, approach is necessary for the successful establishment or enhancement of a CSHP. The six key steps<sup>42</sup> in the planning process are listed below:

1. Establish the planning team
2. Assess health problems and service needs
3. Set goals and objectives
4. Develop an action plan
5. Implement the plan
6. Evaluate effectiveness of the planning process and program.

The following characteristics of a plan for the establishment or enhancement of a CSHP contribute to successful implementation<sup>43</sup>:

- Underlying purpose and potential outcomes
- Perceived value in addressing identified needs
- Clarity of purpose
- Adaptability
- Replicability
- Consistency with the school's mission and vision
- Ease of implementation (for example, requirements for additional training and resources)
- Credibility with school staff and the community
- Capacity for broadening the knowledge base of the students or staff
- Potential to enhance, supplement, or support existing programs

The following sections will discuss each step of the process.

#### Infrastructure<sup>44</sup>

The infrastructure refers to the basic system that supports the CSHP. When fully implemented, the CSHP infrastructure will enable each state and community to establish a collaborative organizational pattern. The infrastructure facilitates community-wide planning, implementation, and evaluation of activities to help schools implement CSHPs that are consistent with community values and needs.<sup>45</sup>

The four main supports that make up the CSHP infrastructure include:

1. authorization and funding,
2. personnel and organizational placement,
3. resources, and
4. communication and linkages.

These four supports overlap in order to form a coordinated organizational pattern. According to the CDC, these are the functions and subcategories of each of the four elements of CSHP infrastructure:

### **Authorization and Funding**

Functions to establish the purpose, structure and function of the infrastructure and the commitment to infrastructure development. Important subcategories include:

- Directives (laws, statutes, codes, policies, regulations, mandates, operating procedures and written agreements at multiple levels).
- Financial Resources (federal, state, county, city, local, and private sources).

### **Personnel and Organizational Placement**

Functions to provide access to decision makers at the highest level, effective management and operation of the infrastructure, accountability for the completion of tasks, authority for making decisions, and commitment to the CSHP. Important subcategories include:

- People (key decision makers, people with responsibility and people with appropriate preparation, experience and maturity).
- Positions (CDC-funded infrastructure leadership positions, responsibilities and parameters within agencies; position descriptions; and position requirements).
- Hierarchical and Organizational Placement (location in educational agency, health agency, and other agency structures; lines of

responsibility; lines of authority and decision making; and team membership).

- Physical Placement (office space, proximity to others, meeting space, location and quality of space).

## **Resources**

Function to provide for development, continued functioning and administration of the CSHP infrastructure. Important subcategories include:

- Human Resources (support staff, consultants and contractors)
- Technological Resources (hardware and software)
- Data and Data Systems and Sources (health risk and epidemiologic data, epidemiologic data systems, libraries and information centers)
- Inservice Support (training systems, resource centers and statewide networks)
- External Supports (volunteer, professional and philanthropic agencies; institutions of higher education; and parent and community groups)

## **Communication and Linkages**

Function to build capacity, establish or strengthen linkages and collaboration, facilitate advocacy efforts and constituency recruitment, promote broad-based decision-making and allow effective resolution of disagreements. Important subcategories include:

- Communication and Collaboration (informal, formal and technical networks and social marketing campaigns).
- External Communication and Collaboration between Stakeholders in Child and Adolescent Health (informal, formal and technical networks and social marketing campaigns).

“To successfully establish and perpetuate a CSHP infrastructure, the CSHP leadership must be aware of the location, status, functional level and quality of these four supports, as well as how to influence the supports over time<sup>46</sup>.”

## **Infrastructure at the State Level**

The federal Interagency Committee on School Health recommends that:

*...an official state interagency coordinating council for school health be established in each state to integrate health education, physical education, health services, physical and social environment policies and practices, mental health, and other related efforts for children and families. Further, an advisory committee of representatives from relevant public and private sector agencies, including representatives from managed care organizations and indemnity insurers should be added.<sup>47</sup>*

Some elements of state level school-health supporting infrastructure in existence in Texas include:

- DSHS Texas School Health Advisory Committee
- Texas Department of Agriculture (TDA)
- Texas Education Agency
- Texas School Nurse Organization (TSNO)
- Partnership for a Healthy Texas
- Texas Action for Healthy Kids Alliance (TAHKA)
- Texas Health and Human Services Commission (HHSC)
- Texas Medical Association (TMA)
- Parent Teachers Association (PTA)
- Texas Nurses Association
- Texas School Health Network (TSHN)

## **Infrastructure at the District or Community Level**

It is mandated that all Texas school districts form school health advisory councils (SHACs) to support the infrastructure at the school and community level. The function of the SHAC includes but is not limited to overseeing the district's CSHP. Specific duties should include: assessing resources, planning strategies for program execution, evaluation and quality assurance, educating key school personnel on standards of practice and emerging legislation, and coordinating programs and resources with other agencies and organizations in the community.<sup>48</sup>

### School Health Advisory Council (SHAC) <sup>49</sup>

A district-wide SHAC is an essential component of a successful CSHP. The advisory committee reviews the needs assessment, monitors program effectiveness and provides recommendations for program development and improvement. Sample responsibilities include the following:

- Assist in the development of a school and community needs assessment to identify student health needs
- Guide the school health services program
- Review state and federal requirements related to school health services and programs
- Review and develop program guidelines in such areas as environmental health, health appraisal, communicable disease control, emergency health care, and comprehensive health education curriculum
- Review and develop guidelines for the implementation of program goals, health services, program objectives, policies, and procedures regarding personnel, facilities, and supplies
- Make recommendations to the school board or designee on school health issues
- Serve as an advocacy group for improved health status in the community
- Develop resources for the school health program
- Participate in evaluating the outcomes and effectiveness of the school health program.

Membership of the committee should be broad and must *include*:

- a majority of parents that are not employees of the school district.

May also include:

- medical professionals;
- school nurses; administrators, classroom, health and P.E. teachers, nutrition services managers and counseling staff;

- public service agency representatives;
- civic and service organizations members;
- media;
- public and government officials; and,
- students.

A workable committee is broadly representative of the community and should have no more than 20 people.

The committee should promote and encourage links between the school and the community. It should strive for a diverse and sizable representation to allow for participation by a greater number of people and enable new voices to be heard. The membership should be open to volunteers that:

- Show interest in school health issues;
- present an interest in youth;
- have knowledge of the community profile;
- demonstrate professional ability;
- can give a commitment of time;
- are representative of the population; and
- present credible membership.

The whole committee should meet as necessary, but at a minimum on a quarterly basis at a time of day or evening and at a location that is most convenient for committee members. Meeting agendas should be planned and distributed in advance. It may be important to prepare participants ahead of time in order for them to feel comfortable and encourage their participation during meetings. Parents who have not had experience serving on committees or whose first language is other than English may wish to be contacted and briefed by the school prior to attending their first SHAC meeting.

The committee may organize small work groups that are project-specific or establish standing subcommittees in such areas as violence prevention, health policies or health curriculum. For example, a working group including a school nurse, a teacher and an

administrator may work on projects in consultation with a larger committee. A committee's collective knowledge, expertise and influence can be a powerful force on behalf of the comprehensive school health program; it can identify health and social problems related to the community's youth, develop viable solutions and identify key resources.

DSHS has developed the *School Health Advisory Council: A Guide for Texas School Districts* to help in the establishment of a SHAC. It can be downloaded from the following Web address: [www.dshs.state.tx.us/schoolhealth/sdhac.shtm](http://www.dshs.state.tx.us/schoolhealth/sdhac.shtm).

### **Infrastructure at the School Level**

In addition to state, district and community level infrastructure, each individual school should establish a CSH Leadership Team to oversee the CSHP in that school. The CSH team functions would be similar to those of the district SHAC. The CSH team would coordinate school health programs within the school including nutrition, physical and health education, counseling and mental health, staff wellness promotion and maintenance of a healthy and safe school environment.<sup>50</sup>

### **Needs Assessment**

Once the infrastructure has been identified and a planning team is in place, an assessment of the status of school health in the community and a determination of needs should be completed. The availability of resources should also be assessed.<sup>51</sup> A needs assessment may be conducted by communicating with representatives of the school and the community through surveys, face-to-face interviews and focus groups and by reviewing health statistics from state and local sources. It may also include reviewing existing research or instrumentation and consulting with experts on the content and the method proposed. An assessment should answer questions such as:

- What are the demographics (cultural, linguistic, economic, social) of the school population?
- What data on health statistics (e.g., teen pregnancy, school drop-out, communicable disease rates) are already available from local and statewide sources?

- Are there health disparities in the student population?
- What health issues and problems (e.g., peer violence, suicide, anorexia) are identified by students, parents, faculty, and administration?

An additional assessment tool that schools find helpful is the School Health Index. This is based on the eight component model and includes questions related to coordination of health programs and services, policy and procedures, and infrastructure. This can be completed online or downloaded from the CDC at the following link.

<http://apps.nccd.cdc.gov/shi/default.aspx>.

### **Identification of a Model**

Based on the needs assessment, a model for the delivery of school health programs should be adopted. There are several different models commonly used including the traditional model of basic health services and the more comprehensive models of expanded health programs. Information on school health program models can be found in the CDC's *Promising Practices in Chronic Disease Prevention and Control: A Public Health Framework for Action* at [www.cdc.gov/healthyyouth/publications/pdf/PP-Ch9.pdf](http://www.cdc.gov/healthyyouth/publications/pdf/PP-Ch9.pdf) and other school health program resources available from the CDC at [www.cdc.gov/healthyyouth/publications/school-pubs.htm](http://www.cdc.gov/healthyyouth/publications/school-pubs.htm).

### **Financing a School Health Program**

The first step in financing a CSHP is to identify existing sources of funding. In seeking new funding to expand a school health program the SHAC or planning committee should determine whether:

- the district already receives funds that could support new or expanded initiatives;
- the district is eligible for such funds;
- the district makes allocations to schools; and
- the school is free to pursue additional funding independently<sup>52</sup>.

## Federal Funding

Some potential sources of federal funding are listed below and may serve as a starting point for a CSHP's fund-raising efforts:<sup>53</sup>

- **Improving America's Schools Act** (previously the Elementary and Secondary Education Act) provides support for schools in low-income communities.
- **Title I (Services for Disadvantaged Children)** makes available funding for schools to provide additional health and social services to selected students and their families.
- **Title II (Professional Development)** supports staff training that fosters school reform efforts.
- **Title IV (Safe and Drug Free Schools and Communities)** supports safe, violence-free and drug-free environments for teaching and learning.
- **Title XI (Coordinated Services)** allows school districts to use up to 5% of funds received under the act to develop, implement, or expand a coordinated services project.
- **The Individuals with Disabilities Education Act** provides funds for special education programs for children aged 0-22 years with disabilities.

### Others:

The U.S. Department of Education: [www.ed.gov](http://www.ed.gov)

The National Institutes of Health: [www.nih.gov](http://www.nih.gov)

The Centers for Disease Control and Prevention: [www.cdc.gov](http://www.cdc.gov)

## Fiscal Issues in Texas<sup>54</sup>

There is no dedicated money for health programs in schools in Texas. Most funding for school health services comes from local property tax revenue or reimbursement from

state and federal programs. The lack of consistent funding has been an impediment to establishing and maintaining health programs for students in Texas schools. When state and federal funding sources are available for school health these funds are not always readily accessible.

### **Changes in Fiscal Environment.**

“The onset of managed care systems has significantly changed the delivery of health care in the United States.”<sup>55</sup> The resulting changes brought on by managed care reforms have opened the doors of opportunity for new partnerships and collaborations among those involved with children and those providing health services. Collaborators may be private health care and/or managed care providers or public entities (such as city or county government), community health service agencies and school nursing services provided by local boards of education. Across the United States, collaborations are occurring with greater frequency in school-based health settings. These new relationships are generally created at the community level. However, “in a few states, health planners and policy makers are recognizing the need to integrate the two as part of their statewide efforts to expand support for school-based health services and increase access to care for school-aged children.”<sup>56</sup>

One of the first collaborative efforts in Texas was developed in Galveston.

*The Department of Pediatrics of the University of Texas Health Sciences Center at Galveston has formed a non-profit corporation to address the problems of the city’s low-income, high-risk children, youth, and families, which is funded by contractual arrangements with school systems, Medicaid and other health insurance claims*<sup>57</sup>.

This effort has brought together “private practitioners, the health district, the school district, the State Department of Human Services, and a consultant from the University Health Sciences Center.”<sup>58</sup>

Although patient revenues historically have contributed relatively little to school-based health service finances, they are being looked to with greater frequency as a means to continue providing quality health services to school-aged children. Recovering funds from patient revenues is not an easy undertaking. The billing process for Medicaid is tedious and many schools are not equipped to manage the time-consuming process. In addition, negotiating with managed care providers can be challenging and burdensome,

sometimes concluding with unsatisfactory results. One result of particular concern to school health personnel is the loss of certain services that are not considered necessary or billable by the contracted organization or Medicaid but are considered essential by most health center employees

There are several factors that need to be considered when schools explore contractual agreements for the provision of health services. For example, how would a student choose a primary care physician and how would the role of “gatekeeper” function at the school level? If there is more than one managed care organization operating within a state, how will contracts be worked out to ensure that access and quality concerns are answered? No evaluations have yet been conducted to measure the success of these collaborative efforts. Therefore, it is too early to report on what works. However, it is safe to say that such collaborative efforts will continue, again redefining the shape and scope of school health services.

**Table 2:**

**Currently Available Federal Funding Sources.<sup>59</sup>**

Government Programs Providing Funding or Reimbursement	Types of Care Provided
Title XIX - Medicaid and Early Periodic Screening, Detection and Treatment	Health care for eligible children living in poverty
Title V	Maternal and child health services
Title I -Elementary and Secondary Education	Health care of educationally disadvantaged children
I.D.E.A.	Specialized health services for some students with disabilities are mandated but only partially funded
Cooperative agreements with the CDC of the U.S. Department of Health and Human Services	Services to prevent HIV and hepatitis B infections
Safe and Drug Free Schools and Communities Act	Addresses drug use among school-aged children
U.S. Department of Education	Model comprehensive school health programs that may include health services

**Collaboration Within the School System<sup>63</sup>**

Interdisciplinary collaboration and coordination, in the context of CSH and human services, involves personnel from all areas of the school working together cooperatively to deliver health education and services. Interdisciplinary collaboration and coordination provides many advantages and opportunities:

- Participants bring a variety of expertise, skill, experience and creativity to the project.
- When interdisciplinary teams focus on a particular student, at-risk students are more likely to be tracked for referral and support and less likely to be lost to follow-up. Collaboration reduces the incidence of duplication of efforts and services as well.
- Members of interdisciplinary groups enjoy opportunities to share their roles, responsibilities, skills and special interests with members of the school community, families and the broader community.
- Participants share decision making, promoting consensus building essential to caring for children with special health care needs in the school setting.

Alternate Sources of Funding	Types of Care Provided
Medicaid School Health and Related Services (SHARS)	Reimburses for health services provided to children in special education, if services are on the IEP and if the student is Medicaid eligible. <sup>60</sup>
Medicaid Managed Care	Services may be reimbursed upon agreement with the Managed Care Organization (MCO). In CA, school nurses are reimbursed for checking and treating head lice, immunizations, well child exams and case management for children with chronic conditions. <sup>61</sup>
Private Foundations and Grants	Upon individual application short-term funding may be provided to schools for the provision of school health services. Funding could pay for basic and extended services. <sup>62</sup>

Involvement of parents, students, and other members of the community ensures that key resources and concerns from the community are brought to the school's attention. Collaboration provides a mechanism for identifying resources and individuals with expertise on particular topics and skills. There are both formal and informal mechanisms for interdisciplinary collaboration in a school and within a community.

### **Formal Collaboration.**

Formal collaboration typically can occur in three ways:

1. An organized team meets regularly to identify and address issues;
2. An "ad hoc" team is formed to address a specific health or behavioral problem and disbands when the issue is addressed or problem resolved; or
3. Two or three people in the school meet formally on a regular basis to share information and discuss common issues, concerns and problems.

### **Informal Collaboration**

Informal collaboration occurs on a temporary, as-needed basis for information exchange, as when the school nurse informs the physical education teacher that a particular student may not participate in gym because of a recent injury.

## **Collaborative Partnerships Outside the School**

"Successful school health programs have a common denominator—collaborative partnerships... Collaboration is defined as an integrated, skill-based, shared decision-making model based upon mutual respect and effective communication."<sup>64</sup>

"Schools by themselves cannot, and should not, be expected to address the nation's most serious health and social problems. Families, health care workers, the media, religious organizations, community organizations that serve youth and young people themselves also must be systematically involved."<sup>65</sup> It is also important for schools to partner with professional and volunteer organizations, health experts and universities for the purpose of information sharing.<sup>66</sup>

The following are some collaborative efforts currently occurring throughout the nation. These efforts represent an attempt to provide coordinated school health services in order to prevent the fragmentation of care and reduce the likelihood that some health issues may be overlooked.<sup>67</sup>

- The Council on Collegiate Education for Nursing, an affiliate of the Southern Regional Education Board, actively supports school health by encouraging partnerships between nursing education programs and public school health.
- The National Association of Pediatric Nurse Associates and Practitioners developed a school health special interest group composed of 135 NAPNAP members. This group has developed a position statement and has influenced school health legislation throughout the nation.
- The National PTA encourages integrated services and accepts the responsibility of coordinating community resources.
- The National Assembly on School-Based Health Care is a national organization dedicated to promoting accessible, quality school-based primary health and mental health care for children and youth through interdisciplinary and collaborative efforts.
- CIS is a national service committed to the welfare of children with a network of almost 200 local and 27 state CIS offices serving 3,400 schools across the country. CIS forges partnerships with technology innovators, government agencies, institutions of higher learning and health care agencies.

### **Evaluation<sup>68</sup>**

In order to determine how effectively schools meet the health needs of students and staff, it is essential to conduct evaluations of the school health program. The purpose of program evaluation is to assess whether goals and objectives have been met. Health laws and regulations change, professional standards change and the needs of students change. Program goals are adapted accordingly. Ongoing data collection and evaluation are key to promoting responsiveness in programs, staffing, funding and resources. Results and recommendations developed during the evaluation process become input for subsequent planning. This feedback loop allows plans to be revised

as needed in order to keep programs appropriate, realistic and effective. It also provides the health team with measures of accountability.

### **Process Evaluation**

Also called formative evaluation, this is an ongoing process, occurring during the formative stage of a program. The goal of this evaluation is improve the program or materials being designed. Process or formative evaluation begins with initial program design and continues through implementation, observation and revisions.

The first phase is a needs assessment, which establishes baseline data on the need for a service, program, curriculum or materials. It should occur before embarking on a project. During design development and planning, developers should test instruments with knowledgeable practitioners and potential users for comprehensibility, persuasiveness, user friendliness, appeal and other factors.

During field testing, the program or materials are tested for effectiveness. Data collected will help fine-tune materials, pinpoint any problems, aid in the revision process, and assist in the development of new materials. Developers should use different situations or settings to try out the program (reflective of the target audience), whether it be students, faculty, and/or parents.

Once the program is implemented evaluation will be used to answer questions such as: Is the program being used? How? Is what we're assessing the same as what was planned? Are we reaching our intended targets? What should we be monitoring in our program? This type of evaluation tool should be used as an ongoing self-assessment management tool.

### **Outcome Evaluation**

In contrast, outcome evaluation (also called summative evaluation) examines the success of the program in meeting specific objectives, such as whether there were changes in health behavior or in the health status of students and/or staff. Did the program make a difference? For instance, as a result of a program to improve food in vending machines, did students eat less junk food? Should the program be continued?

Outcome evaluations are designed to answer questions about the immediate changes that occur as a result of the program. Participant satisfaction, numbers served, and objective measures of change are common data collected for outcome evaluations. Impact evaluation looks at longer-term changes that can help answer the question of overall program effectiveness. Some examples may include reducing costs, improvement in student health or productivity, or lower rates of school violence over an extended period of time.

It may be helpful to consult a skilled external evaluator for outcome and impact evaluations; someone who is experienced in conducting evaluations, has some medical knowledge, and understands the mechanics behind day-to-day triage in a health office. The basis of any good outcome evaluation is a good management information system for all children in the program.

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