

THE ESSENTIAL SCHOOL HEALTH SERVICES PROGRAM DATA REPORT

2008 – 2009 School Year

Deval L. Patrick, Governor
Timothy P. Murray, Lieutenant Governor
JudyAnn Bigby, MD, Secretary of Health and Human Services
John Auerbach, Commissioner of Public Health
Jewel Mullen, MD, Director, Bureau of Community Health Access and Promotion

Massachusetts Department of Public Health
Bureau of Community Health Access and Promotion
Office of Statistics and Evaluation

Spring, 2010

**This and other Massachusetts Department of Public Health publications
can be accessed on the Internet at:**

<http://www.state.ma.us/dph/pubstats.htm>

For additional copies of this report, please contact Robert Leibowitz at:

Massachusetts Department of Public Health
Bureau of Community Health Access and Promotion
Office of Statistics and Evaluation
250 Washington Street, 5th Floor
Boston, MA 02108-4619

TDD/TTY: (617) 624-5992 (Division for Special Health Needs)

or

TDD/TTY: (617) 624-6001

To obtain other Department of Public Health data:

Register for the Department's free and internet-accessible data warehouse, MassCHIP:
masschip.state.ma.us/beuser.htm or call 1-888-MAS-CHIP (MA only) or (617) 624-5541.

Acknowledgments

This report was prepared by Robert Leibowitz of the Office of Statistics and Evaluation, Bureau of Community Health Access and Promotion. Anne Sheetz, Director of School Health Services, wrote the introduction, providing the history of the Essential School Health Services model. The authors also acknowledge the contributions of Jewel Mullen, MD, Director, Bureau of Community Health Access and Promotion; and Donna Johnson, Director, Division of Primary Care and Health Access. In addition, the authors would also like to thank all those who authored or contributed to earlier editions of this report. Further, we extend our appreciation to Anne Sheetz, Diane Gorak, Thomas Comerford, Mary Ann Gapinski, Barbara Mackey, and Janet Burke of the School Health Unit, and to Paola Gilsanz, CDC/CSTE Applied Epidemiology Fellow, for their work with the Essential School Health Services program. At the school district level, we thank the nurse leaders and school nurses for providing their time, clinical expertise, and cooperation.

Table of Contents

Introduction.....	1
Executive Summary	5
Findings.....	7
School Nurse Staffing	7
Student Demographics	7
School Health Services Activity	8
1. Health Encounters	8
2. Injury Reports, Early Dismissals and Referrals for Emergency Health Services.....	10
3. Medication Management	12
4. Health Screenings	15
5. Medical Procedures.....	18
6. Linkages to health care and insurance providers	22
7. Oral Health.....	24
8. Health Education, Tobacco Prevention, and Support Groups	24
9. Nursing Case Management	28
Program Development	29
Students With Special Health Care Needs.....	30
1. Types of Special Health Care Needs.....	30
2. Students With Do Not Resuscitate (DNR) Orders.....	32
3. Cardiovascular Health and Automated Electronic Defibrillators (AEDs).....	32
Client Satisfaction.....	33
Actions to Promote Healthy Weight.....	34
References.....	39
APPENDIX A.....	41
School Districts and Student Enrollment.....	41
APPENDIX B	44
Scope of Service	44

APPENDIX C	45
Data Collection Methods	45
Data Analysis Methods	46
Data Limitations	47

Introduction

In recent years, major societal, legal, and medical technological changes have dramatically affected the demand for school health services. These influences include: (1) research relating health to educational achievement; (2) improvement in medical technology; (3) increase in the number of students with special health care needs combined with an increase in condition severity in these students; (4) rapid restructuring of the health care delivery system; (5) laws requiring inclusion; (6) changes in family structure and patterns of parental employment; (7) rise in social morbidities such as substance abuse, depression, and violence among children; and (8) impact of diverse cultural and linguistic groups .

- Attendance in the early grades is correlated with school achievement and dropout rates. School nurses support attendance by providing needed health services in school. They also provide assessments of illness and injuries. School nurses are significantly less likely to dismiss a student than an unlicensed counterpart (Pennington & Delaney, 2008), and in one study 57% less likely (Wyman, 2005).
- As neonatal intensive care unit survivors enter early intervention services and kindergarten, the need for school health services increases (Clement, Barfield, Ayadi & Wilber, 2007). Data show that the students in the Commonwealth's schools require increasingly complex health care during the school day. The current (FY09) Essential School Health Data Report indicates that 28% of the ESHS students have at least one special health care need. Nationally, the incidence of diabetes among adults 18 - 79 has almost doubled in the last 10 years (CDC, 2008), and diabetes is increasingly being diagnosed in children and adolescents (Hannon, Rao, and Arslanian, 2005). In Massachusetts the percentage of children prescribed epinephrine for life threatening anaphylaxis more than doubled between 2001 and 2008, rising from .72% to 1.88%. In addition, the Cedar Rapids v. Garret Supreme Court decision of 1999 clarified the extent to which school districts are required to provide school nursing services for medically fragile children.
- Children assisted with medical technology, e.g. catheterizations, tracheostomies, ventilators, etc., are now attending school. Likewise terminally ill children are in the Commonwealth's classrooms, necessitating end of life planning.
- The rapid restructuring of the health care delivery system has dramatically impacted school health service programs. With reduced hospitalizations and/or reduced lengths of stay, school nurses are now often responsible for supervising the care of children who have illnesses such as acute asthma and diabetes, formerly managed in a hospital setting (Chabra et al., 2000; Coffman et al., 2008; Leslie et al., 1998; Schutte et al., 1997).
- Social attitudes that promote inclusion, as well as state and national laws, such as the Individuals with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 specify disability rights and access to education, resulting in more children requiring nursing care and other health-related services in school (Palfrey et al., 1992; Raymond, 2009; Small et al., 1995).

- With more working parents, children who are sick with mild or chronic conditions are less likely to be monitored at home on school days, and more likely to be sent to the school nurse for assessment and a determination as to whether they need to see a physician (Smolensky and Gootman, 2003; Thurber et al., 1991; Uphold & Graham, 1993; U.S. Census Bureau, 2000; Wold, 2001).
- Students spend a large part of their day at school; therefore, the school has become an important site where health and education risks, e.g. depression, absenteeism, substance use, may be identified and timely interventions initiated. One in five young people between that ages of 9 and 17 experiences symptoms of mental health problems, and one in ten children and adolescents has a mental illness severe enough to cause some level of impairment; yet in any given year, only about one-fifth of children in need of mental health services actually receive them. (US Surgeon General's Conference on Children's Mental Health, 2000). This disproportion can result in increased demands for professional health services in the schools (Thurber et al., 1991).
- Massachusetts schools have many “newcomer” groups, both immigrants and refugees, as well as those families who move between different communities. Often such families rely on the school for information about what services or providers are available in the community. They may not know how to obtain care elsewhere because of language or cultural barriers and, therefore, look to the school health service for assistance.

The Massachusetts Department of Public Health (MDPH) recognizes the need for quality school health services and provides consultation to all of the Commonwealth’s school districts. Since 1993, the Department of Public Health has extended to a number of school systems the opportunity to expand on the basic school health services model by establishing the Essential School Health Service Program (ESHS). (The Essential School Health Services Program was originally entitled the Enhanced School Health Service Program.)

In 1993, thirty-six school districts were funded for three and half years to: (a) strengthen the infrastructure of school health services in the areas of personnel and policy development, programming, and interdisciplinary collaboration; (b) incorporate health education programs, including tobacco prevention and cessation programs, into the existing school health programs; and (c) develop linkages between school health service programs and community health care providers.

In October 1997, the Department funded 19 school districts under the Essential model (Essential School Health Services, ESHS) and 8 school districts with experience in developing the Essential model to provide consultation to approximately 42 additional school districts (“recipient schools”) across the Commonwealth (Essential School Health Services with Consultation, ESHSC). These recipient school districts were interested in developing similar school health service programs.

In November, 1999, the Massachusetts legislature allocated additional funding to the Essential School Health Service Programs (ESHS and ESHSC). School systems for both models were

selected for participation through a competitive bid process based on a Request for Response (RFR) developed by MDPH. As a result of the 1999 RFR process, a total of 77 school districts (or affiliated school systems)¹ received awards in 2000: 11 Essential School Health Services with Consultation and 66 basic Essential Programs. An added component of the 1999 RFR was that each applicant public school district was required to provide some elements of basic school health services (vision/hearing screening, immunization review, etc.) to all non-public and charter schools within the community (77 award recipients in 2000 served 253 non-public and charter schools)². An additional 32 school districts received awards in 2001; all of these were basic Essential Programs (Sheetz, 2003).

In February 2003, midyear budget reductions eliminated most funding for the ESHS programs for the remainder of the fiscal year. Because of this, three programs decided to withdraw from the ESHS grant, thus reducing the number of participants to 106 school districts in the spring of 2003. Three more schools withdrew from the grant in 2004, and one additional school withdrew in 2006, leaving 102 districts in the ESHS program.

In 2009 a new funding cycle started and 80 school districts were funded (see **Appendix A**). Of these 80 funded districts, 68 (85%) had been funded during the previous cycle. Thirty-four districts in the previous funding cycle (33% of the 102 districts included in the earlier funding cycle) were not included in the new funding cycle. The number of funded districts was reduced because some funds were freed to establish an extension of the ESHS programs, namely mentored/partnered schools. Each of the 68 experienced programs (with the exception of the large cities) was required to mentor or partner with two other school districts in order to increase adoption of the standards established in the ESHS program initiative. Therefore 146 additional mentored/partnered school districts,³ each with a limited amount of funding, were added to the model. These school districts were required to meet a specified scope of service. Of note is that in the FY10 school year, these mentored/partnered school districts will begin to submit some data, consistent with ESHS requirements.

In addition to the Mentor/Partner School Program component of the 2009 grant cycle, a Regional Consultation program was also included in the funding. These six regional ESHS programs (based on the EOHHS defined regions) were selected to provide consultation to ESHS programs within their general geographical area. Regional consultation school districts must have been previously awarded the Essential School Health Service (ESHS) or Essential School Health Service with Consultation programs (ESHSC). The general goal of the ESHS Regional Consultation grant is to maximize the existing school nursing expertise, leadership and infrastructure to provide additional consultation to ESHS programs (including their mentored/partnered school districts and community public schools as appropriate) within a general region.

Throughout this report, comparison data from previous years are presented. Because the mix of school districts included in the program has changed over the years, caution should be exercised

¹ ESHS funding was awarded to local public school systems, regional academic school systems, independent vocational systems, vocational-technical regional systems, and school unions.

² 223 non-public (private and parochial) schools, 30 charter schools.

³ All public school districts were invited to join this program. . A number of vocational schools, educational collaboratives and charter schools were also invited to participate in this program when an opening in a geographic area was available.

when interpreting these data, as differences may be the result of the changing composition of school districts in the program.

The staff of the School Health Unit, Division of Primary Care and Health Access in the MDPH Bureau of Community Health Access and Promotion administers the programs.

Executive Summary

The information collected by the Essential School Health Services Program provides a valuable snapshot of school nursing practice in a diverse cohort of Massachusetts public schools. The data reveal that school nurses perform a wide array of duties -- direct care, health education, administrative case management, and policy/program development and oversight -- on behalf of students whose health needs range from routine to serious and complex. In addition, some school nurses provide services to school staff.

Analysis of the ESHS program data for the school year beginning September, 2008 and ending June, 2009 showed the following:

- 946 schools in 80 ESHS school districts reported a total of 4,384,071 student health encounters, and 84,640 staff encounters.
- In a typical district, students visited the school nurse an average of 1.1 times per month.⁴ There was substantial variability among school districts, with the encounter rate ranging from 0.7 to 2.0 visits per month.
- After assessment and/or treatment by a school nurse, the majority (91.5%) of the students visiting the nurse's office with an illness or injury complaint were returned to the classroom to continue their studies.
- 10.6% of the more serious injuries to students were classified as intentional. These include injuries resulting from assaults (e.g. physical fighting) and those that were self-inflicted (e.g. intentional drug overdose, suicide attempts).
- School nurses in ESHS districts referred students to urgent health care services a total of 10,184 times, 1,926 of which involved 9-1-1 ambulance calls. In the remaining cases, parents or others were called to transport the student to health services.
- The majority (91.5%) of the prescriptions managed by the school nurse were for medications dispensed on a PRN, or "as needed" basis.⁵
 - Among students taking PRN medications, asthma medications were the most common (35.3 prescriptions per 1,000 enrolled students).
 - Among students on scheduled prescription medications, psychotropic medications (drugs affecting perception, emotion or behavior) were by far the most common (5.1 per 1,000 enrolled students).
- In the ESHS districts, school nurses administered an average of 115,172 doses of prescription medication to students per month. Fifty-seven percent of the scheduled doses were for psychotropic medication, and 53% of the PRN prescription doses were for asthma medication.
- School nurses in 76 districts conducted Body Mass Index screenings on 109,674 students in grades 1, 4, 7 and 10. In each of the 4 grade levels, at least 28% of the students screened were overweight or obese.

⁴ "Typical" is defined in this report as the median district. It is the district lying in the middle of the group, with half the districts having higher values and half having lower values.

⁵ PRN is an abbreviation for "pro re nada," a Latin term meaning "as needed." PRN medications are not scheduled for set times, but given as needed.

- Blood glucose testing was the most common medical procedure (56.6 procedures per 1,000 students each month, a slight decline from 58.5 the prior year). While the proportion of students requiring glucose testing may be relatively small, the number of daily tests on those students requires considerable nursing time and assessment, as each child usually requires glucose monitoring several times a day.
- 15,018 students received an oral health screening from a school nurse, and 25,547 were screened by a dentist or hygienist.
- Tobacco prevention and cessation programs reached substantial numbers of individuals, although activity levels varied widely across districts.
 - 1,675 students participated in individual tobacco cessation counseling, while 507 participated in group cessation counseling.
 - 13,387 students participated in group tobacco prevention activities.
- A total of 134,729 students with special health care needs were reported to school nurses.
 - The most common physical/developmental condition reported to school nurses was asthma (116.2 per 1,000 enrolled students).
 - The most commonly reported behavioral/emotional condition was Attention-Deficit/Hyperactivity Disorder (51.8 per 1,000 enrolled students).
- Parent satisfaction with school health services was measured through a survey mailed to a sample of parents with a child who received nursing services. The response rate was 38.5% (1,193 questionnaires were returned out of 3,100 distributed). Satisfaction rates on the 6 measured criteria ranged from 93 to 97 percent.

Continued refinements in data collection and analysis will more accurately capture school nursing and school health activity, improve our ability to monitor the health needs and status of the school age population, and identify areas for improvements in services and quality of care. Identifying trends in school health encounters and student health indicators may assist school nursing staff in improving the delivery of prevention, education, and intervention services to the school community. Future data collection efforts will seek to increase our knowledge of health needs in the school setting and in the school age population, explore the relationship between student health status and educational outcomes, and investigate ways in which health services and prevention activities in schools can help children live healthier lives.

Findings

School Nurse Staffing

In the ESHS program, 1,180 full-time school nurses (or full time equivalents) provided health care services to students and staff in 80 public school districts. The student population in ESHS districts was 477,243 students, resulting in a student-to-nurse ratio of 404 students per nurse. This ratio is similar to that which existed in ESHS districts the previous year (422 students per nurse).⁶

Student Demographics

In 2008-2009, 49.8 percent of Massachusetts public school students were enrolled in an ESHS-funded school district. The racial and ethnic composition of the ESHS student population is different than that found in the Massachusetts public school population, however. There is a higher percentage of Black and Hispanic students in ESHS-funded districts (Table 1). In addition, a higher percentage of students in ESHS-funded districts are low income, have limited English proficiency, and have a first language that is not English (Table 2).

<i>TABLE 1. Race/Ethnicity of Students in ESHS Districts and Massachusetts Public Schools (2008-2009)</i>		
Race/Ethnicity	ESHS Schools	State Public Schools
	Percent	Percent
Black	12.3	8.2
Asian	6.6	5.1
Hispanic	21.8	14.3
Native American	0.3	0.3
White	56.7	69.9
Native Hawaiian, Pacific Islander	0.1	0.1
Multi-Race, Non Hispanic	2.2	2.0

Source: Massachusetts Department of Elementary and Secondary Education.

<i>TABLE 2. Selected Characteristics of Students in ESHS Districts and Massachusetts Public Schools (2008-2009)</i>				
Characteristic	ESHS Schools		State Public Schools	
	Number	Percent	Number	Percent
First Language Not English	110,354	23.1	147,672	15.4
Limited English Proficient	46,780	9.8	56,576	5.9
Low Income	201,591	42.2	294,385	30.7
Total Population	477,243		958,910	

Source: Massachusetts Department of Elementary and Secondary Education.

⁶ These statistics include data from the ESHS districts, but do not include data from any associated districts. The count of "School Nurses" includes only Registered Nurses (RNs) and nurse leaders, but excludes other health support staff which may have been funded by the ESHS contract.

School Health Services Activity

The primary goal of the Essential School Health Services Program is to improve the delivery of health services to students by reinforcing the school health service infrastructure. Toward that end, program participants were required to report throughout the year the type and scope of school nursing activity in their districts. These activities were divided into nine categories of data:

- 1) Health encounters, including dispositions following assessment**
- 2) Injury reports, early dismissals, and referrals for emergency health services**
- 3) Medication management**
- 4) Screenings**
- 5) Medical procedures**
- 6) Linkages to health care and insurance providers**
- 7) Oral health**
- 8) Health education, tobacco prevention, and support groups**
- 9) Nursing case management**

1. Health Encounters

Each month, districts reported the total number of student health encounters. An “encounter” was defined as *any contact with a student during which the school nurse provided counseling, treatment, or aid of any kind*. Casual conversations fall outside this definition and were not counted. In addition, mandatory screenings (such as vision, hearing and postural) were not counted as encounters because these are routine population-based activities. Screenings were tracked separately, however.

During FY2006, the ESHS Evaluation Committee refined the monthly and annual data collection tools. As a result, the FY07, FY08, and FY09 encounter categories are not comparable to those used in previous years. In addition to changes in encounter categories, districts no longer report secondary reasons for an encounter.⁷ The major impact of that change is that the multifaceted nature of the health encounter, which often includes health education and mental health counseling components, is not fully reflected in these data: The following rules are used to help define encounter categories:

- *Every* encounter includes nursing assessment and health education. An encounter is recorded as an Individual Health Education encounter only when the primary issue is health education and there is no illness or injury involved. Individual Health Education encounters previously made up a large percentage of the reported secondary issues.

⁷ While the goal of recording secondary reasons for an encounter was to capture the mental health services being provided, this goal was not achieved. Nurses frequently categorize the encounter with the presenting symptom, e.g., headache, when, upon further assessment, the underlying cause relates to behavioral health. An exploratory study by the Massachusetts School Nurse Research Network is underway to address this issue.

- An illness encounter may include illness assessment, acute illness, chronic health condition, etc. It excludes scheduled medication administrations (e.g. daily medication administration for ADHD) and scheduled procedures (ostomy care, scheduled glucose testing).
- Mental/Behavioral Health Support includes any encounter requiring active listening, anticipatory guidance, stress management, behavior modification/program support or evaluation of altered mental status. The primary reason for the encounter is related to a mental/behavioral health need. Mental/behavioral health services tend to be under-reported as nurses will often categorize an encounter according to the presenting complaint (e.g., headache) even if it is determined that the complaint has an underlying mental/behavioral health origin.

Between September 1, 2008 and June 30, 2009, 80 school districts reported a combined total of 4,384,071 student health encounters. “Illness assessment,” “Injury/first aid,” and “Scheduled medication administration” were the most common reasons for visits to the school nurse (Table 3). The number of encounters reported per district varied widely, with individual districts averaging between 167.2 and 42,108.7 encounters per month. These differences were largely due to district size. In a typical district, each student visited the school nurse an average of 1.1 times per month, although the encounter rate varied across the 80 districts from 0.7 to 2.0 visits per month. While some students are seen several times each month, many others are never seen. The school nurse workload, measured by the number of encounters a full time nurse logs each month, varied greatly across the districts, with the typical district workload being 419.9 encounters per month⁸.

Health services were also provided to school staff (i.e., teachers and administrators). School nurses in 80 districts reported a total of 84,640 staff health encounters. Across the 80 districts, monthly averages ranged from 0.2 to 1,208 staff health encounters per month.

TABLE 3. Number of Student and Staff Health Encounters
September 1, 2008 - June 30, 2009

Type of Encounter	Students		Staff	
	Number	Percent	Number	Percent
Illness Assessment	1,592,049	36.3	31,309	37.0
Injury/First Aid	976,721	22.3	14,254	16.8
Scheduled Medication Administration	607,853	13.9	1,127	1.3
Scheduled Medical Procedures*	507,369	11.6	8,958	10.6
Individual Health Education	162,633	3.7	10,758	12.7
Mental/Behavioral Health Support	59,534	1.4	4,022	4.8
Other	477,912	10.9	14,212	16.8
TOTAL	4,384,071	100.0	84,640	100.0

Scheduled Medical Procedures are those performed for preexisting conditions, which usually require an MD order.
Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program.

⁸ For these calculations, "school nurses" includes only RNs. The "typical" district workload was the workload that fell in the middle of the group (Half the ESHS districts had a higher workload, and half a lower workload).

2. Injury Reports, Early Dismissals and Referrals for Emergency Health Services

An important function of school nursing practice is to provide on-site health services to students who are sick, injured, or experiencing a serious health emergency. Each month, districts tallied the number of on-campus injury reports, early dismissals due to illness, and referrals for emergency health services. After assessment and/or treatment by a school nurse, the majority (91.5%) of students visiting the nurse’s office with an illness or injury complaint returned to the classroom to continue their studies (Table 4 and Figure 1). These on-site services provide major benefits. Students who are treated on-site can be returned to the classroom with minimal interruption of their educational activities; working parents do not have to take time off from work to provide care; and the high cost of treatment in a doctor’s office is avoided.

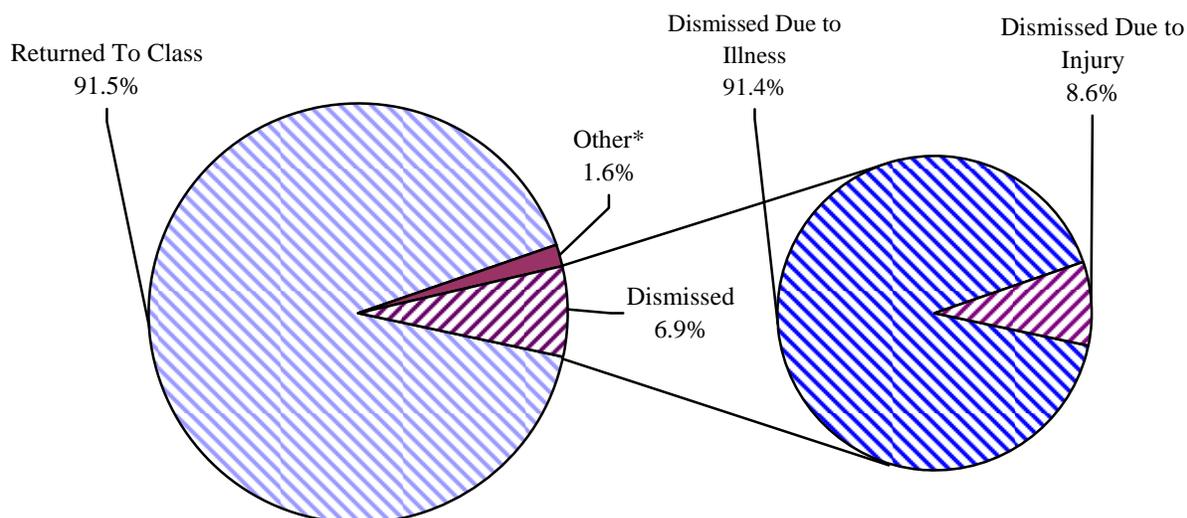
Disposition	Students		Staff	
	Number	Percent	Number	Percent
Returned to Class	3,705,845	91.5	62,052	78.6
Dismissals	279,309	6.9	14,659	18.5
Other*	66,544	1.6	2,262	2.9
Total	4,051,698		78,973	

* Includes “Stayed in health office” and “Referred to counselor’s office”.

Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program.

When students had to be dismissed, it was usually the result of illness (91.4%) rather than injury (8.6%).

**FIGURE 1. Disposition After Nursing Assessment
Student Health Encounters
September 1, 2008- June 30, 2009**



* Includes "Stayed in health office" and "Referred to counselor's office".

Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program.

For injuries of a more serious nature, school nurses filed *injury reports* according to state and local policy. For the 2008-2009 School Year, districts reported a total of 23,391 student injury reports and 2,806 staff injury reports (Table 5):

Intent	Student		Staff	
	Number	Percent	Number	Percent
Unintentional	17,730	75.8	1,827	65.1
Intentional	2,468	10.6	399	14.2
Unknown intent	3,193	13.7	580	20.7
Total	23,391		2,806	

Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program.

Of the student injury reports filed by school nurses, 10.6% involved the intentional infliction of injury (Table 5). These include injuries resulting from assaults (e.g. physical fighting) and those that were self-inflicted (e.g. intentional drug overdose, suicide attempts).

In addition, school nurses in the 80 districts referred students to *urgent health care services* a total of 10,184 times.

- In 1,926 (18.9%) of these events, 9-1-1 or ambulance services were called.
- In the remaining 8,258 (81.1%) events, parents or others were called to transport the student to health services.

3. Medication Management

In 1993, the Massachusetts Department of Public Health promulgated regulations governing the administration of medications in public and private schools. The purpose of these regulations (105 CMR 210.000) is to provide minimum safety standards for the administration of prescription medications to students during the school day.

The school nurse's role in managing the medication administration program for the district is broad in scope. In addition to developing district-wide medication policies in collaboration with the school committee, school administration, and school physician, the school nurse:

- administers medications to students (including monitoring students' response to medications);
- delegates the administration of selected medications to appropriately trained school staff (if the district is registered with the MDPH to do so);
- ensures the proper training and supervision of these designated staff; and
- establishes a formal record-keeping system for the district's medication administration program.

Implicit in the description of medication administration is the nurse's responsibility for the following: development of the medication administration plan; assessment of the child prior to administering each medication; follow-up evaluation of medication efficacy and side effects; and ongoing communication with parents and providers.

ESHS districts tracked the number of *prescriptions* that had been ordered for their students. Throughout the year, the total number of prescriptions reported to school nurses averaged 74,177.5 per month for the 80 districts (Table 6). Note that because some students had more than one prescription, the number of prescriptions is larger than the number of students with prescriptions. Among prescriptions taken on a scheduled basis, psychotropic medications were the most common, while among prescriptions taken on an "as-needed" (PRN) basis, asthma medications were the most common.

TABLE 6. Number of Student Prescriptions Reported to School Nurses (Monthly Average) September 1, 2008 - June 30, 2009			
Medication Class	Medication Schedule		
	Scheduled (All Districts)	PRN (As needed) (All Districts)	Total (Daily & PRN) Medications
Analgesics	33.1	22,738.2	22,771.3
Antibiotics	305.8	1,010.6	1,316.4
Anticonvulsants	152.3	588.3	740.6
Antihypertensive	88.9	57.0	145.9
Antihistamines	22.0	5,680.2	5,702.2
Asthma Medications	410.6	16,777.4	17,188.0
Epinephrine	0.0	8,191.9	8,191.9
Insulin	847.7	747.7	1,595.4
Psychotropic	3,078.9	540.5	3,619.4
Other Prescription/OTC Meds	1,335.6	11,570.8	12,906.4
Total	6,274.9	67,902.6	74,177.5
Row Percent	8.5%	91.5%	100.0%

Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program.

Tables 7a and 7b show the *at-school* prescription rates reported by the ESHS districts. The *at-school* prescription rate reflects the medications that are to be administered at school, during school hours, by the school nurse (or under the supervision of the school nurse). These rates *understate* the actual number of students taking prescription medications, however. There are two reasons for this. First, students who self-administer at school without the knowledge of the nurse are not counted in the nurse's data reports.⁹ This type of "counting error" may disproportionately lower reported prescription rates for certain categories of students. Middle and high school students, for example, might be more likely to self-administer than elementary school students, and, therefore, would be less likely to be counted in the numbers reported by the school nurse. Second, medications taken only at home, as some types of *daily* medications are, are unlikely to be reported to school nurses. For example, the decrease in the *at-school* psychotropic prescription rate over the last few years (from 21.0 per 1,000 students in 2001 to 5.1 per 1,000 students in 2009) may be due to the use of new one-dose slow-release psychostimulant drugs, which are administered at home and are not reported to school nurses. On the other hand, PRN medications (medications prescribed for administration on an 'as needed' basis) such as medications taken to treat asthma attacks or allergic reactions, are more likely to be reported to the school nurse because of the potential need for administration during the school day. As a result, prescription rates for these medications may be better estimates of the true overall prescription rate for the school age population.

⁹ Regulations require that students inform nurses about self-administered medications. If students do not comply with regulations, these medications may not come to the attention of school nurses.

School Year	Psychotropic	Asthma Medications	Antibiotics	Insulin	Anti-Convulsants	Others
2000-2001	21.0	1.5	1.4	0.2	--	1.9
2001-2002	13.2	1.0	1.2	0.3	--	2.0
2002-2003*	7.0	0.5	0.8	0.3	0.2	0.9
2003-2004	7.3	0.9	0.8	0.6	0.5	1.3
2004-2005	5.6	0.4	0.8	0.6	0.3	1.1
2005-2006	5.8	0.3	0.7	0.8	0.3	1.2
2006-2007	5.5	0.6	0.8	1.0	0.3	1.4
2007-2008	5.0	0.5	0.8	1.3	0.2	1.5
2008-2009	5.1	0.6	0.6	1.5	0.2	1.6

While the scheduled medication rate for insulin increased (from 0.2 per 1,000 students in 2001 to 1.5 in 2009), rates for most other classes of scheduled medications decreased from 2000-2001 levels, including psychotropic medications, asthma medications, and antibiotics (Table 7a). In contrast, for "as needed" medications, rates for a number of medication classes have increased. For example, the epinephrine prescription rate increased from 7.2 per 1,000 students in 2001 to 18.8 per 1,000 in 2009 (Table 7b). Similarly, "as needed" prescription rates increased for insulin and anti-convulsants.

School Year	Asthma Medications	Epi-nephrine	Anal-gesic	Anti-hista-mines	Insulin	Psycho-tropic	Anti-Convul-sants	Anti-biotics	Others
2000-2001	25.2	7.2	--	--	0.5	0.5	--	0.1	10.1
2001-2002	26.3	8.3	--	--	0.7	0.4	--	0.1	9.3
2002-2003*	22.7	8.1	4.5	--	1.0	0.2	0.1	0.1	12.6
2003-2004	30.2	9.8	15.6	--	1.2	1.4	0.4	0.2	3.7
2004-2005	28.0	12.1	4.2	--	1.3	1.2	0.3	0.1	3.5
2005-2006	30.9	12.8	4.4	--	1.4	1.1	0.4	0.1	3.3
2006-2007	32.2	15.3	5.7	4.8	1.5	0.8	0.7	0.0	6.4
2007-2008	33.4	16.9	6.7	5.7	1.6	1.1	0.7	0.0	6.4
2008-2009	35.3	18.8	6.2	8.1	1.5	1.0	1.1	0.0	6.3

* The 2002-2003 school year report only included data for 4 of the 10 months of the school year. The 2000-2001 school year had 74 districts reporting as compared to 103 districts in 2003-2004, and 80 districts in 2008-2009.

Rates shown are those reported by the typical (median) district in the ESHS program.

Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program

School nurses in the 80 ESHS districts administered an average of 115,172 doses of medication to students per month. Psychotropic medication was the most commonly administered type of

scheduled prescription medication, and asthma medication was the most commonly administered type of PRN prescription medication. Among medications administered per school protocol, analgesic medication was the most common. (Table 8).¹⁰

Medication Class	Medication Schedule					
	Scheduled Doses		PRN Doses per Prescription		PRN Doses per Protocol**	
	N	%	N	%	N	%
Analgesic	160.9	0.2	2,902.8	16.2	15,491.1	53.2
Antibiotic	1,114.8	1.6	46.5	0.3	641.1	2.2
Anticonvulsant	1,801.0	2.6	24.8	0.1	1.2	0.0
Antihypertensive	1,112.0	1.6	10.7	0.1	0.8	0.0
Antihistamine	204.7	0.3	316.1	1.8	482.7	1.7
Asthma	2,170.0	3.2	9,499.0	52.9	231.6	0.8
Epinephrine	0.0	0.0	27.1	0.2	14.9	0.1
Insulin	11,588.4	17.0	2,812.8	15.7	29.1	0.1
Psychotropic	38,918.4	57.1	318.9	1.8	80.7	0.3
Other	11,043.9	16.2	2,003.6	11.2	12,122.7	41.7
TOTAL	68,114.1	100.0	17,962.3	100.0	29,095.9	100.0

* Includes supervised self-administration ** These are protocols for non-prescription medications written by school physicians. Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program.

School also administered an average of 2,824 doses of medication to school staff per month, including 2,691 monthly doses of OTC/PRN medications, and 132 monthly doses of other prescription medications.

4. Health Screenings

Public schools in Massachusetts are required by law to conduct postural, hearing, vision, and height/weight screening on all students.¹¹ Some school systems conduct additional health screenings based on the particular health needs of their students. School nurses are responsible for screening students and making referrals for follow-up care when needed. Parents are responsible for making appointments for the follow up care specified in the referral, and for ensuring that students keep the appointments. During the school year, school nurses at 79

¹⁰ "PRN doses administered per protocol" refers to medication orders, signed by the school physician, which permit school nurses to administer over-the-counter (non-prescription) medications to students, according to guidelines provided by the Board of Registration in Nursing. "PRN doses per prescription" refers to medication orders written for prescription medications, which are to be administered to specific students.

¹¹ The law permits waivers of these screening requirements in certain circumstances. Postural screenings of students in grades 5 through 9 may not be waived, however.

districts conducted the following number of required and voluntary student health screenings (Table 9). These numbers represent *initial* screenings, and do not include *re-screenings*.

Type of Screening	Screenings		Referrals		Completed Referrals*	
	Number	% of All Students	Number	% of Screened Students	Number	% of Referred Students
Hearing	262,713	55.0	5,317	2.0	1,802	33.9
Height/Weight	279,552	58.6	10,776	3.9	4,099	38.0
Postural	141,181	29.6	4,752	3.4	1,643	34.6
Vision	293,337	61.5	33,133	11.3	12,216	36.9

Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program.

* A "completed" referral is one in which an appointment for follow-up care has been made and kept.

Body Mass Index (BMI) Screenings

The Centers for Disease Control and Prevention recommends the use of Body Mass Index (BMI) measurement to screen for obesity in children. BMI is a number calculated from height and weight, and is considered a reliable indicator of body fat in most people. For children and teens, BMI is age and sex specific. The measure is plotted on BMI growth charts to reveal the child's percentile ranking, which indicates the relative position of the child's BMI among children of the same age and sex. The BMI percentile can then be used as a screen for overweight or underweight. BMI percentiles derived from direct measurements done by school nurses should be more accurate than those derived from self-reported heights and weights obtained from student surveys. In FY10 an ESHS program requirement was to conduct BMI screenings in grades 1, 4, 7 and 10. In order to ensure the results would be representative of the students in their district, nurses were asked to complete BMI screenings on at least 70% of the student enrollment at each of the four grade levels. School nurses in 76 districts met the screening criteria (70% of enrollment) for 1 or more of the designated grade levels, with a total of 109,674 students screened (see Table 10). Nurses in 60 districts (75% of ESHS districts) met the screening criteria for all 4 of the designated grade levels.

Grade	Districts		Students Screened
	n	%	n
1	73	91.3	31,842
4	74	92.5	31,999
7	69	86.3	27,596
10	60	75.0	18,237
All reported grades	76	95.0	109,674

Notes: Any data that did not pass data quality tests or did not meet the reporting criteria (that 70% of students in a grade level should be screened) were excluded from the analysis.

Although these results are not necessarily representative of the entire state, they do provide information about a large number of students in ESHS districts. In each of the 4 grade levels, at least 28% of the students screened were overweight or obese, with males in all 4 grades more likely to be overweight or obese than females (Table 11). School nurses may send BMI screening results back to a student's physician or parents, depending on district policy.

TABLE 11. Percentage of Under- and Overweight Students in Grades 1, 4, 7, and 10 in ESHS Districts as Reported by School Nurses Conducting Universal BMI Screenings (80 Massachusetts Public School Districts, 2008-2009 School Year)

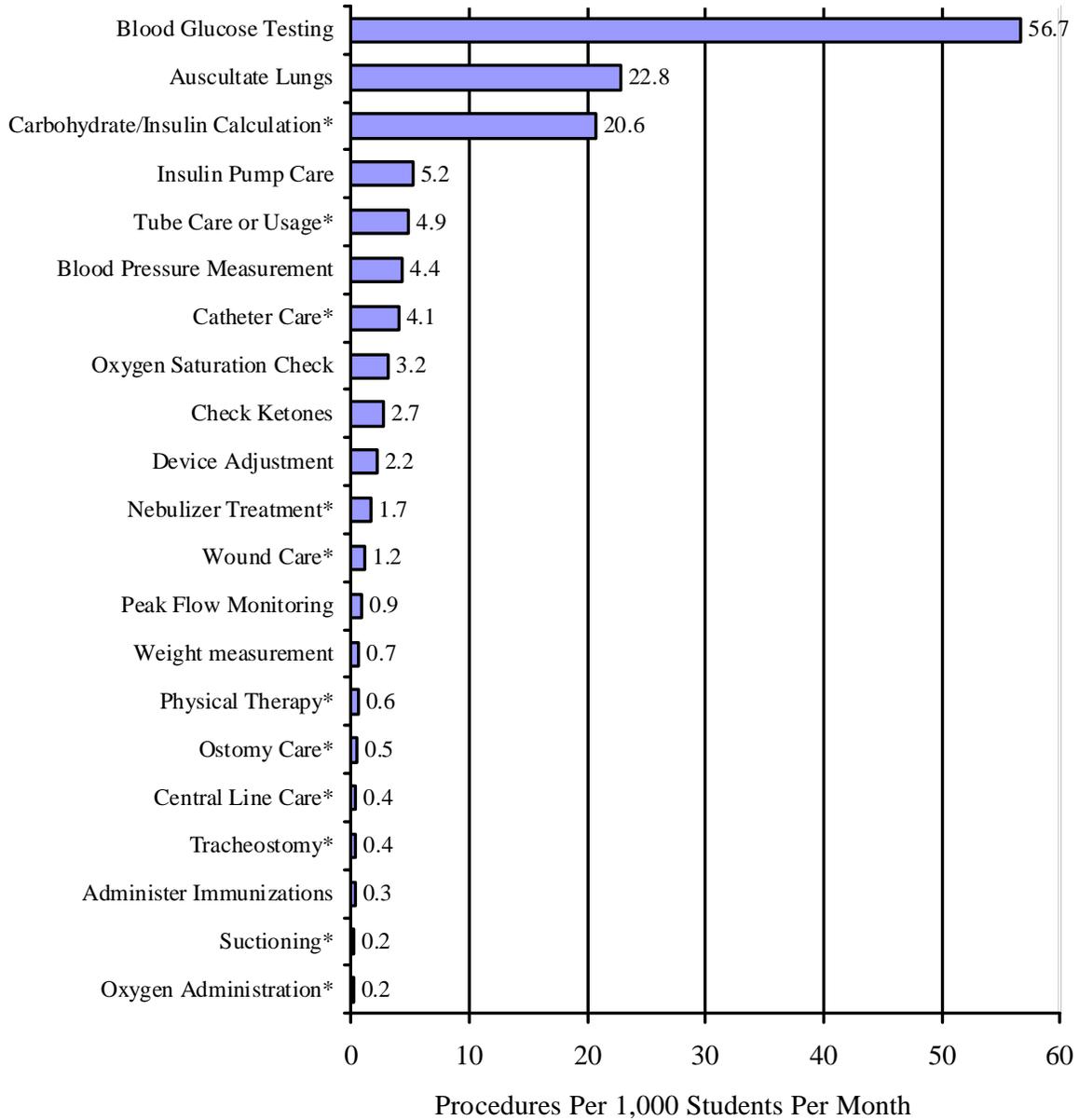
		Grade 1		Grade 4		Grade 7		Grade 10	
		Male	Female	Male	Female	Male	Female	Male	Female
<i>Total students screened:</i>		16,414	15,428	16,315	15,684	14,163	13,433	9,290	8,947
Weight category*	BMI Percentile Range	%							
Underweight	Less than the 5th percentile	3.4	3.6	2.6	3.1	3.6	3.8	2.4	2.1
Healthy Weight	5th percentile to less than the 85th	63.7	65.5	57.7	61.4	58.7	62.7	65.4	69.3
Overweight	85th to less than the 95th percentile	16.4	15.9	18.1	17.5	17.2	17.2	16.3	16.7
Obese	Equal to or greater than the 95th	16.5	15.0	21.6	18.0	20.4	16.3	16.0	11.9
Total		100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Subtotal: Overweight or Obese		32.9	31.0	39.7	35.5	37.7	33.5	32.3	28.6

* For children and adolescents, the CDC uses the term "overweight" instead of "obese" and the term "at risk of overweight" instead of "overweight." We have chosen to use the same labels that are used with adults to avoid confusion over the terminology in line with recommendations recently released by a committee of experts representing 15 medical and health organizations (Expert Committee, 2007).

5. Medical Procedures

School enrollment of children assisted by medical technology has increased in recent years. This phenomenon presents multiple challenges for school administrators, parents and guardians, school health services personnel, teachers, and students. ESHS school districts collected information on the number and type of procedures that involved medical technology, as well as other medical procedures performed by school nurses. Consistent trends in the school health data may be associated with emergent public health issues. For example, the increase in Blood Glucose Testing and Insulin Pump Care over the past 5 years may be a consequence increasing diabetes prevalence in face of the current obesity/diabetes epidemic. Monthly medical procedure rates per 1,000 enrolled students are shown in Figures 2 and 3.

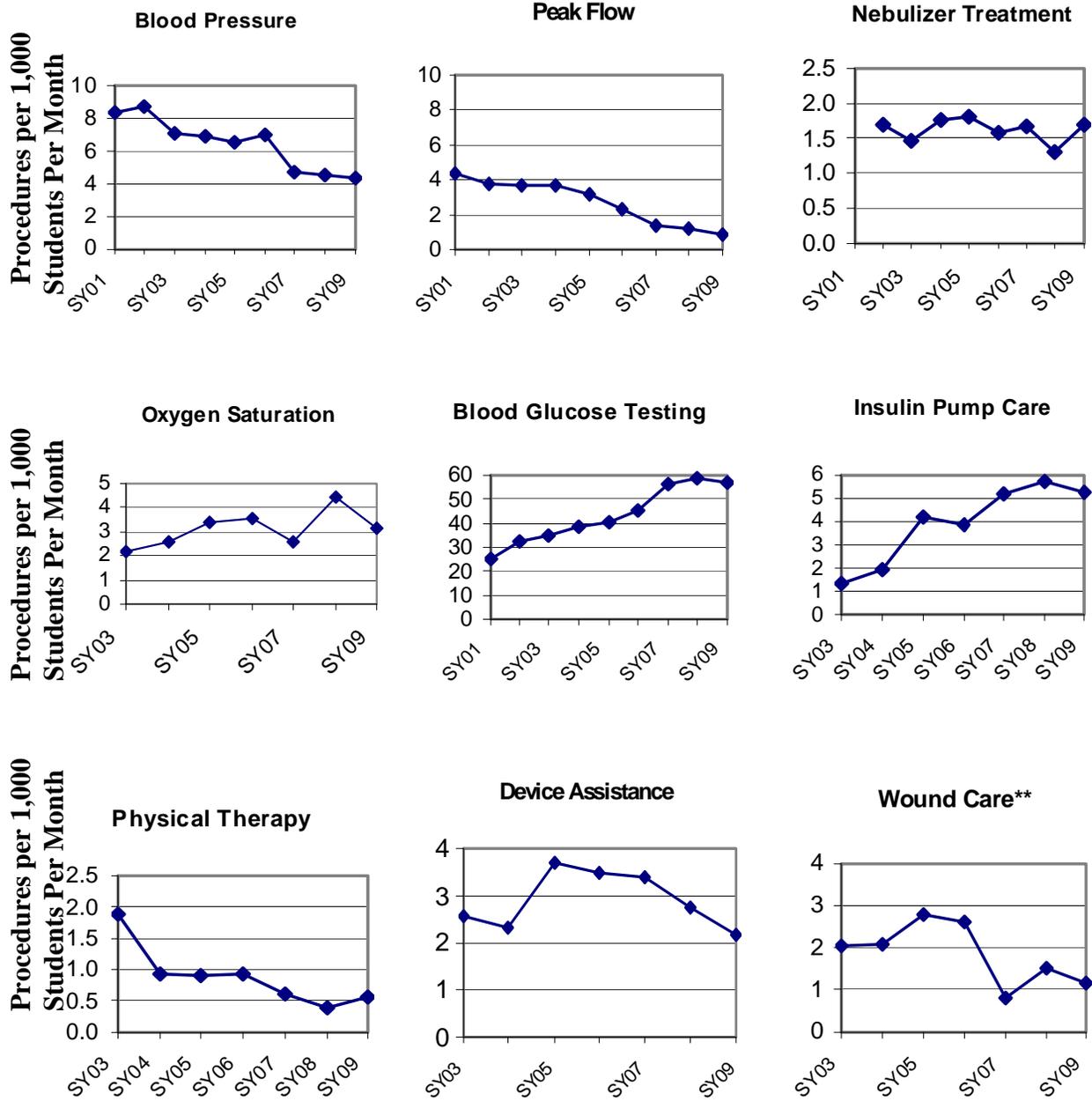
FIGURE 2. Medical Procedure Rates (Students)
September 1, 2008 - June 30, 2009



Source: *Monthly Activities Reports* submitted by 80 districts in the Essential School Health Services program.
 Note: Rates were calculated from those districts performing the procedure at least once.

The procedures listed in Figure 2 required differing amounts of nursing time. Those procedures identified with an asterisk (*) require significant amounts of professional nursing care, health education and monitoring. Many of these procedures were formerly performed in a hospital setting.

**FIGURE 3. Procedure Rates per 1,000 Students per Month*
School Years 2000-2001 through 2008-2009**



*Among those districts performing the procedure at least once.

** The definition of Wound Care was changed in 2007, so that dressing changes are no longer counted.

Note that in 2002-2003, data was available for only 4 out of 10 months. If there are no data points then data was not available for that year. Rates shown are those reported by the typical (median) district in the ESHS program.

Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program

While some procedure rates have declined (blood pressure monitoring, wound care), procedures related to diabetes management (blood glucose monitoring and insulin pump care) have increased.

Monthly medical procedure totals are summarized in Table 12:

TABLE 12. Medical Procedure Types and Totals		
<i>September 1, 2008- June 30, 2009</i>		
Type of Procedure	Number of Procedures Per Month	
	Students	Staff
Administer Immunizations	451	346
Auscultate Lungs	15,942	313
Blood Glucose Testing	28,150	100
Blood Pressure Monitoring	2,974	1,789
Carbohydrate/Insulin Calculation	10,372	18
Catheter Care	2,167	5
Central Line Care (a)	203	1
Check Ketones	1,430	7
Device Adjustment (e)	2,322	23
Insulin Pump Care	4,048	7
IV Infusion Care	155	2
Nebulizer Treatment	1,104	10
Ostomy Care (c)	451	4
Oxygen Administration	142	2
Oxygen Saturation Check	3,323	100
Peak Flow Monitoring	1,506	12
Physical Therapy	1,065	3
Suctioning	126	0
Tracheostomy Care	98	2
Tube Care or Usage (b)	3,466	15
Weight measurement (d)	462	153
Wound Care	3,057	79

a) Central Line Care: Monitor infusion or administration, Pump monitoring, IV Bag Change, dressing change.

b) Naso-Gastric, Gastronomy or Other Feeding Tube Care or Usage

c) Ostomy Care- Colostomy/Ileostomy/Urostomy

d) Weight management for medical conditions not related to screening

e) Includes orthotic or prosthetic device adjustment, wheelchair assistance, and crutch walking instructions.

In addition to medical procedures, school nurses performed head checks for pediculosis at a rate of 15.2 per 1,000 students per month.

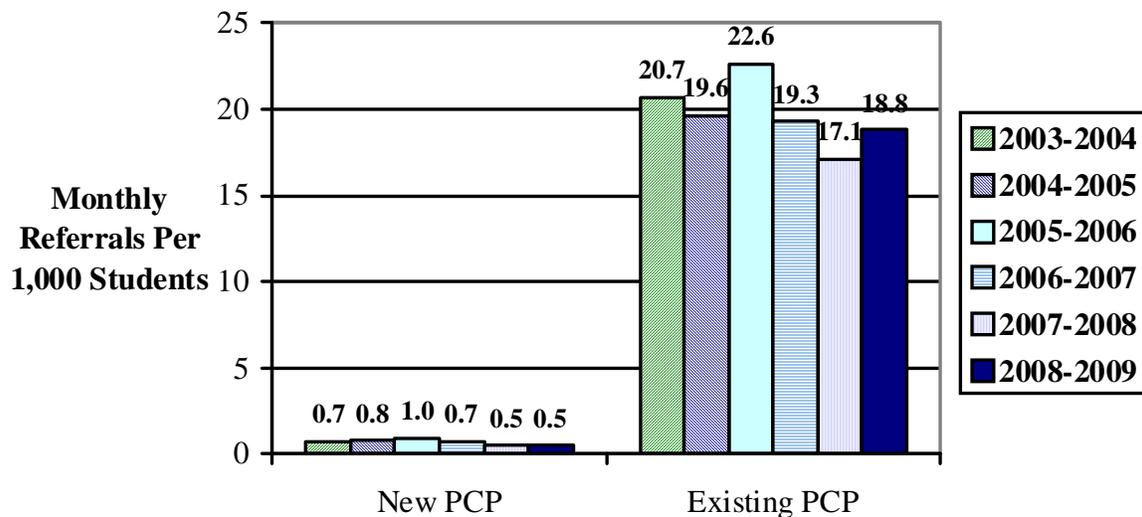
Source: *Monthly Activities Reports* submitted by 80 districts in the Essential School Health Services program.

6. Linkages to health care and insurance providers

ESHS school systems identified students without a primary care provider and, in consultation with their families, referred them to appropriate health care services. A referral is reported whenever an actual appointment has been set up with a provider or agency.¹² School systems also referred many students to their existing primary care providers. During the 2008-2009 school year, participating districts reported the following:

- A total of 102,167 students requiring primary care services were identified and referred to primary care providers. Those students without primary care providers were referred to new providers. Referrals included:
 - 7,784 referrals to new primary care providers (7.6% of total primary care referrals). In a typical district, monthly referrals to new primary care providers averaged 1.3 students, a rate of 0.5 referrals per 1,000 enrolled students per month.
 - 94,383 referrals to existing primary care providers (92.4% of total primary care referrals). In a typical district, monthly referrals to existing primary care providers averaged 69.7 students, a rate of 18.8 referrals per 1,000 enrolled students per month.

**FIGURE 4. Primary Care Provider Referrals
Median Monthly Rate Per 1,000 Students
School Years 2003-2004 to 2008-2009**



Source: *Monthly Activities Reports* submitted by 80 districts in the Essential School Health Services program.

¹² Prior to 2006-2007, a referral was counted whenever the student was advised to follow-up with a provider.

In addition, districts in the ESHS program provided the following referrals for students during 2008-2009:

- 6,832 referrals to insurance providers.
- 9,727 referrals for mental/behavioral health services.

Each month, school nurses receive Massachusetts Asthma Action Plans (MAAPs) from health care providers.¹³ These written plans provide individualized instructions for managing asthma episodes and administering asthma medications. During the school year, 79 districts reported receiving MAAPs for 4,709 students. Individual districts received between 0 and 1,343 action plans.

¹³ This section refers only to Standard Triplicate Form Massachusetts Asthma Action Plans.

7. Oral Health

School nurses are increasingly performing oral health related activities. Table 13 summarizes these activities for the 2008-2009 school year.

The typical district participating in oral health screening activities screened students at an annual rate of 59.5 per 1,000 students.¹⁴ There was considerable variability across districts, with the range being 0 to 692 screenings per 1,000 students. One-third of oral health screenings were performed by school nurses (Table 13).

Type of Oral Health Activity	% of Districts Performing Activity	Number of Students (All Districts)
Oral health screenings by a school nurse	35.4	15,018
Oral health screenings by a dentist or hygienist	54.4	25,547
Referrals to a dental provider	67.1	9,155
Referrals completed	46.8	2,497
Screenings of third grade students	54.4	5,413
Dental sealants applied in school	41.8	12,287
Flouride rinse treatments applied in school	57.0	26,146

Source: *Monthly Activities Reports* submitted by 79 districts in the Essential School Health Services program.

8. Health Education, Tobacco Prevention, and Support Groups

School nurses are often called upon to provide health education and deliver presentations. In this teaching role they provide information to students, staff, and community members on topics such as nutrition education, life threatening allergies, and human growth and development. Throughout the 2008-2009 school year, school nurses in 80 districts reported making 13,612 classroom presentations. In a typical district, each full-time school nurse delivered 0.9 presentation every month (range: 0 to 10.4 presentations per nurse per month). The types of presentations given most frequently were fitness/nutrition/wellness, life threatening allergies, and oral health/hygiene (Table 14).

¹⁴ Rate is based on those districts that performed one or more oral health screening activities.

**TABLE 14. Number of Wellness/Safety Presentations
and Number of Participants, by Topic Area
September 1, 2008- June 30, 2009**

Topic Area	Number of Presentations Per Month	Number of Participants Per Month		
		Students	Staff	Community
Blood Borne Pathogens	51.1	134.5	1,290.6	3.9
CPR/AED Programs	42.3	168.2	400.1	34.7
Crisis Team	21.1	371.5	272.0	5.2
Environmental Health	32.8	998.8	235.0	99.9
Fitness/Nutrition/Wellness	252.4	5,033.0	491.5	142.8
Growth/Development	108.0	1,727.3	80.5	71.6
Life Threatening Allergies	212.8	1,667.1	1,936.4	48.3
Mental Health/Wellness	58.2	1,394.7	177.4	26.6
Oral Health/Hygiene	282.9	7,848.5	267.8	45.7
Other	299.6	8,348.0	1,302.3	308.8

Source: *Monthly Activities Reports* submitted by 80 districts in the Essential School Health Services program.

Health education was also promoted through the preparation of flyers and mailings. During the school year, school nurses were involved in the creation of a total of 26,702 health promotion / education flyers or mailings. In the typical district, each nurse was involved in the creation of 1.1 flyer or mailing per year.

During the school year, school nurses in ESHS districts provided the following tobacco prevention/cessation and substance abuse services:

- 68 districts reported a total of 1,574 assessments of students for suspected substance abuse.
- A total of 477 tobacco group prevention meetings were held in 28 districts, in which attendance summed to 13,387 students and 538 adults.
- A total of 114 tobacco group cessation meetings were held in 25 districts, in which attendance summed to 507 students and 140 adults.
- Individual tobacco cessation counseling sessions were delivered to 1,675 students and 293 adults in 39 districts.¹⁵
- In 21 districts, students were referred to other tobacco prevention/cessation services 285 times, and adults were referred to outside sources 43 times.

¹⁵ This number is expected to rise in FY10 when the training on School Nurse Individual Interventions to Assist Students to Stop Smoking is resumed. (See discussion on the UMASS program)

During the 2002-2003 school year, the MDPH School Health Unit collaborated with the University of Massachusetts, Department of Preventive and Behavioral Medicine, in conducting a randomized controlled trial (RCT) to determine if school-nurse intervention could help individual students stop using tobacco. The intervention consisted of a series of scheduled appointments with content designed to address tobacco triggers, barriers to quitting, and helpful techniques. The student was required to designate a quit date. The study was implemented in 71 Massachusetts schools. The results demonstrated the feasibility and potential efficacy of this intervention in increasing self-reported short term (6 week and 3 month) quit rates among adolescent smokers who wished to quit.

Based on these outcomes, the National Institutes of Health (NIH) awarded the University of Massachusetts Medical School (UMMS) a four-year grant to test this intervention in a randomized controlled trial, designed to be delivered by the school nurse in the course of her/his routine clinical duties through four individual 15 to 20 minute sessions with individual teens. As a result of the partnership with the UMMS Department of Preventive and Behavioral Medicine and the MDPH School Health Unit, thirty-six public high schools with an enrollment of at least 350 students are currently participating in this NIH grant study.¹⁶ Prior to the NIH study, the Northeastern School Health Institute had been offering trainings to school nurses based on the results of the 2002-2003 study.¹⁷ These trainings have been temporarily discontinued so as not to affect the NIH study results, but will resume in FY10.

¹⁶ It is anticipated that approximately 1,000 teens will be recruited during the course of two years with baseline assessments including salivary cotinine (metabolic of nicotine) and follow-up assessments 3 and 12 months following baseline. Cotinine validation and 12 month follow-up assessment is considered the gold standard of tobacco research.

¹⁷ The Northeastern School Health Institute is the continuing education vendor for the MDPH School Health Unit, providing relevant programs for approximately 2,000 school nurses a year.

Support Groups

Table 15 summarizes participation in student support group activities led or assisted by school nurses. It does not include tobacco-related support groups which were discussed previously. Across all topic areas, a total of 350 support group meetings were conducted every month.

TABLE 15. Participation in Support Group Activities, by Topic Area September 1, 2008- June 30, 2009 (n=80 districts)					
Topic Area	% of ESHS Districts Offering Group	Monthly Group Meetings	Monthly Participants		
			Students	Staff	Parent/ Community
Alcohol or Substance Abuse	27.5	28.2	115.6	9.1	50.0
Anger/Conflict/Violence Management	18.8	16.8	109.3	17.1	1.2
Asthma	16.3	12.5	31.5	13.3	7.9
Diabetes	30.0	14.1	29.9	14.6	13.1
Emotional / Psychosocial Support	40.0	86.8	204.8	96.2	9.8
Food Allergy	32.5	12.9	27.9	71.8	13.0
Gay/Bisexual/Lesbian/ Transgender	8.8	7.0	46.2	13.1	0.6
Health Careers	17.5	6.3	64.4	6.8	1.8
Nutrition/Physical Activity	48.8	63.3	336.1	181.2	36.3
Peer Leadership	16.3	11.3	173.2	16.7	2.2
Other	62.5	90.8	643.2	187.5	82.6
Total*		350.0	1,782.1	627.4	218.5

Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program.

* Those participants that are in more than 1 group may be counted twice.

The type of support group most likely to be offered was "Nutrition/Physical Activity." This type of group was offered by 48.8% of districts and attracted the highest number of participants, among both students and staff. The second most common type of support group was "Emotional/psychosocial," offered by 40.0% of districts. Support groups in the "Emotional/psychosocial" area met more frequently than the other types of support groups.

In nutrition programs, school nurse support can extend beyond making support groups available. Some students come to school without adequate breakfasts or lunches, and school nurses provide food and/or snacks. During the school year, school nurses reported they provided snacks a total of 103,938 times.

9. Nursing Case Management

Data from the monthly activities report revealed that, beyond providing direct care to students, school nurses spent a significant portion of their day performing case management duties that included communication with families, other school staff, and community health care providers about student health concerns. During the school year, school nurses from 67 districts conducted:

- a total of 775,526 health counseling and education communications with parents (including phone calls and letters, but excluding meetings and home visits), with the typical district reporting 590.2 communications per month (range: 9.3 to 9,316.5 communications per month);
- a total of 780 home visits, with the typical district reporting 0.2 home visits per month (range: 0.0 to 22.4 home visits per month);
- a total of 309,061 communications with other school staff about student health issues, with the typical district reporting 307.4 communications per month (range: 8.5 to 4,061.4 meetings per month);
- a total of 73,866 communications with other agencies and health providers about student health issues, with the typical district reporting 31.1 communications per month (range: 1.0 to 1,415.4 phone calls per month).
- a total of 25,845 case management meetings, with the typical district reporting 14.5 meetings per month (range: 0.0 to 569.5 meetings per month).

The following chart shows median case-management activity levels per school nurse FTE per month across the 67 participating districts:

**TABLE 16. Nursing Case Management Activities:
Student-Health Related Activities Per Month Per Nurse FTE
September 1, 2008 - June 30, 2009**

Type of Activity	Activities Per Month Per FTE
Communications with parents	65.6
Communications with staff	23.6
Communications with community agencies/providers	3.6
Case management meetings	1.3

Source: *Monthly Activities Reports* submitted by districts in the Essential School Health Services program.

For children with special health care needs, nursing case management involves the development of Individual Health Care Plans (IHCPs) designed to maximize their potential for learning. An IHCP, usually developed by the school nurse in conjunction with the student’s family, the school physician, other school staff, and relevant community health care providers, is an individualized care plan that stipulates a student’s specific medical, nursing, emergency care, and educational needs while in school during the school day. IHCPs are reviewed on a regular basis to ensure that students receive the appropriate health care they need during the school day.

During the 2008-2009 school year, 79 ESHS districts reported:

- a total of 30,550 IHCPs for the year, with the median district reporting 230 IHCPs (range: 0 to 3,558 IHCPs);
- a median rate of 21.1 IHCPs per full-time school nurse (range: 0 to 161.7 IHCPs per full-time school nurse).

Program Development

School nurses perform program planning and development activities in coordination with other school district professionals, in areas such as environmental health, policy development, crisis management, and emergency preparedness. In addition, nurses attend meetings that contribute to their professional development. Meetings may be held at a specific school building or at the school district level. During the 2008-2009 school year, school nurses in 79 districts attended 1,286.0 program and professional development meetings per month (Table 17).

TABLE 17. Number of Program Development Meetings Attended by School Nurses, by Topic Area	
September 1, 2008 - June 30, 2009	
Topic Area	Number of Meetings Per Month (All Districts)
Crisis Management	172.6
Emergency Preparedness	86.8
Environmental	21.0
Mental Health	80.7
Policy Development	137.7
Professional Development	387.2
Other	400.0
Total	1,286.0

Source: *Monthly Activities Reports* submitted by 79 districts in the Essential School Health Services program.

Students With Special Health Care Needs

1. Types of Special Health Care Needs

School nurses provide care for students with a wide variety of special health care needs. Table 18 shows the rates by type of condition. These rates are based on information provided to the school nurse by the student's primary care provider, who conducts a physical examination and submits a School Health Record once every 3 to 4 years. This information is supplemented by parent reports (on emergency cards and health information forms) submitted annually. Conditions not requiring special nursing care in school may be less likely to be reported to school nurses. For those conditions, these data may under-count the true rate in the student population. In 79 ESHS districts, a total of 134,729 students with special health care needs were reported to school nurses (28% of the ESHS population). The most commonly reported physical/developmental condition is asthma (Table 18). The asthma rate increased from 97.7 in 2006-2007 to 116.2 per 1,000 students in 2008-2009. Other common conditions include allergies, migraine headaches, seizure disorder, and cardiac conditions. The most commonly reported behavioral/emotional condition is Attention-Deficit/Hyperactivity Disorder (ADHD).

**TABLE 18: Number of Students With Special Health Care Needs
Reported to School Nurses in ESHS Districts
(Number and Rate Per 1,000 Enrolled Students)
September 1, 2008 - June 30, 2009**

	Number (All Districts)	Rate Per 1,000 Students (All Districts)
Physical/Developmental Conditions		
Allergies:		
Bee Sting Allergies	2,420	5.1
Food Allergies	16,520	34.6
Latex Allergies	842	1.8
Asthma	55,465	116.2
Autoimmune Disorders (Arthritis, Lupus, etc.)	777	1.6
Blood Dyscrasias:		
Hemophilia	107	0.2
Sickle Cell Disease	598	1.3
Other Blood Dyscrasias	1,192	2.5
Cancer	391	0.8
Cardiac Conditions	3,765	7.9
Celiac Disease	457	1.0
Cystic Fibrosis	175	0.4
Diabetes Type I	1,303	2.7
Diabetes Type II	250	0.5
Inflammatory Bowel Disease (IBS, Crohn's, etc)	1,278	2.7
Migraine Headaches	4,827	10.1
Neurologic Conditions:		
Cerebral Palsy	860	1.8
Spina Bifida	169	0.4
Seizure Disorder	3,802	8.0
Neuromuscular Degenerative Disorder	596	1.2
Other Physical/ Developmental conditions	14,755	30.9
Behavioral/Emotional Conditions		
ADHD/ADD	24,704	51.8
Autism	4,361	9.1
Depression	5,651	11.8
Eating Disorders	703	1.5
Other Behavioral/Emotional conditions	9,524	20.0
Total Students With Special Health Care Needs	134,729	282.3

Source: *Status Reports* submitted by 79 districts in the Essential School Health Services program.

2. Students With Do Not Resuscitate (DNR) Orders

For some students who are terminally ill, parents and medical providers may determine that cardio pulmonary resuscitation should not be performed, and a Comfort Care/Do Not Resuscitate order will be prepared. During the school year, 14 students with DNR orders were reported to school nurses.

3. Cardiovascular Health and Automated Electronic Defibrillators (AEDs)

An automated external defibrillator (AED) is a portable device used to restore normal heart rhythm to patients in cardiac arrest. If cardiac arrest is not treated within a few minutes, the condition is fatal. AEDs located in ESHS districts were used 4 times during the school year (3 times with staff, 1 time with a visitor). In 2 of those cases, use of the AED successfully restored a heart rhythm and the patient had a pulse when Emergency Medical Services (EMS) arrived.

Approximately two-thirds (68.4 %) of the ESHS school districts have at least one AED in all of their school buildings, up from 29.7% in 2003-2004 (Table 19) and 66.7% in 2007-2008. Only 1 ESHS district has not deployed any AEDs in any of their school buildings, and 26.7% of school buildings in ESHS districts do not have an AED.

	2003-2004		2008-2009	
	n	%	n	%
Total buildings	870		989	
AED Status of Building				
No AEDs	596	68.5	264	26.7
One AED	218	25.1	529	53.5
More than One AED	56	6.4	164	16.6
Total districts	91		79	
AED Status of District				
No AEDs in any building	30	33.0	1	1.3
At least one AED in all buildings	27	29.7	54	68.4
At least one building with more than one AED	36	39.5	66	83.5

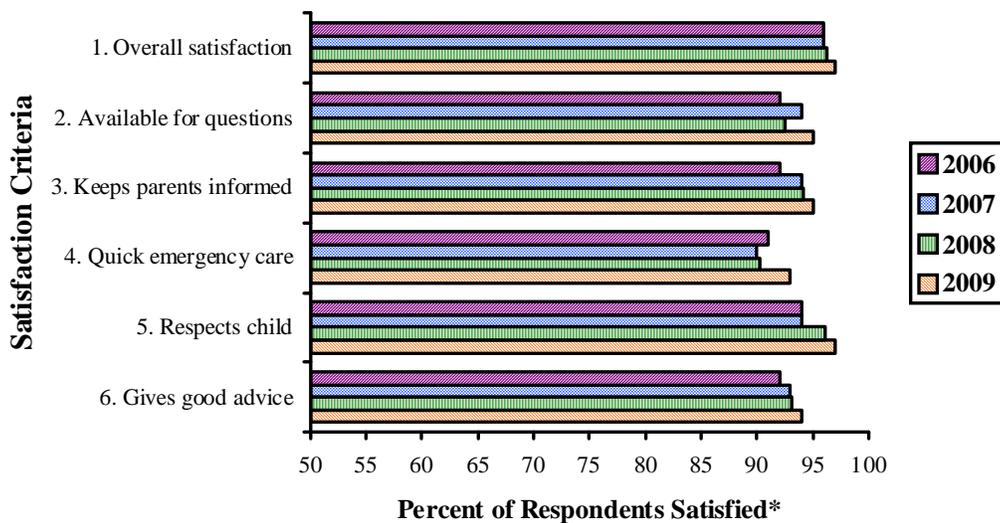
Source: *Status Reports* submitted by districts in the Essential School Health Services program.

Note: Since the group of districts participating in the ESHS program is not the same as it was in 2003-2004, the number of buildings is greater than it was in 2003-2004 even though the number of districts is smaller.

Client Satisfaction

In order to assess parents' perceptions of the quality of care that their students receive at school, a client satisfaction survey was conducted. Parents of students who received school health services were asked to complete a brief questionnaire. Each district is surveyed once every three years. In these districts, parents of approximately 100 students receiving health services are mailed a questionnaire and then requested to complete the questionnaire and return it to DPH. Parents of students at all grade levels are included in the sample. In the 2008-2009 school year, 1,193 parents returned completed questionnaires (38.5% of the 3,100 parents who were mailed questionnaires). Parental satisfaction rates on the measured criteria ranged from 93 to 97 percent (Figure 5).

FIGURE 5. Percentage of Parents Satisfied with School Nursing Services in ESHS Districts
 2005-06 (n = 1,323), 2006-07 (n = 1,663), 2007-08 (n = 1,599),
 2008-09 (n = 1,193)



* Parents were deemed "Satisfied" if they "Agreed" or "Strongly Agreed" with the statement.

Detailed description of the Satisfaction Criteria:

1. I am very satisfied with the care my child receives from the school nurse.
2. If I have a question or concern, I can reach the school nurse for help without any problem.
3. The school nurse does his or her best to keep me informed about my child.
4. In an emergency at school, my child can get nursing care quickly.
5. The school nurse treats my child with respect.
6. I value the advice given by the school nurse

Actions to Promote Healthy Weight

Previously Funded Essential School Health Services Districts

As part of the Essential School Health Service Performance Improvement Program, portions of the questionnaire entitled “Nutrition, Exercise, and Obesity: What’s happening in Your School Districts?”¹⁸ are distributed annually by SurveyMonkey to the 79 nurse leaders in the Essential School Health Service program. While each respondent represents an entire district, not all schools in a district would necessarily answer the same way. For example, actions which may be fully in place among elementary schools may not be in place among high schools. Shown in the tables below are the FY2010 responses of the 65 school districts whose funding was renewed in FY2009, and provides comparison figures for districts funded by the ESHS program in prior years. In Table 20 below is the percentage of respondents reporting obesity concerns. Shown in tables 21 through 23 below is the percentage of respondents who reported the school action or policy as being either fully or partially in place.

Obesity Concern in the Community

Most Nurse Leaders (91%) report that obesity is a concern in the community. Most (95%) report some school efforts to improve the nutritional quality of meals and snacks available to students. While 86% report school staff support these efforts, parents were seen as somewhat less supportive of these efforts (58%).

Table 20. Obesity concerns

Obesity and Nutrition	05-06	06-07	07-08	08-09	09-10
1. Obesity is a concern in the community?	60%	70%	74%	87%	91%
2. Efforts are being made in school to improve the nutritional quality of meals and snacks available to students?	68%	84%	83%	96%	95%
3. School staff support efforts to improve the nutritional quality of meals and snacks, for example, reduce fat and/or caloric content or replace sugared drinks with water or 100% juices?	56%	70%	71%	87%	86%
4. Parents support efforts to improve the nutritional quality of meals and snacks, for example, reduce fat and/or caloric content or replace sugared drinks with water or 100% juices?	37%	42%	50%	59%	58%

* Percentages of respondents reporting affirmatively on a 1-5 point scale with 1 = yes, a lot; 5 = no, not much.

Physical Activity

¹⁸ The survey includes a sample of questions from the CDC’s School Health Index.

Less than half of the respondents report that all students receive at least 150 minutes of PE per week. In addition, while less than half of the respondents report that their schools spread PE over at least 3 days per week, this number has more than doubled over the past five years.

Table 21. School actions undertaken to increase physical activity

Increased Physical Activity	05-06	06-07	07-08	08-09	09-10
5. Providing at least 20 minutes of recess each day	85%	93%	93%	94%	91%
5a. Monitors encouraging students to be active at recess	80%	84%	88%	89%	89%
6. Using a sequential PE curriculum that is consistent with state or national standards	90%	95%	96%	98%	98%
7. All students receiving at least* 150 minutes of PE per week	21%	24%	32%	32%	35%
7a. Spreading PE over at least 3 days (preferably 5 days) per week	23%	28%	33%	38%	48%
8. Promoting walking /biking to school	35%	40%	46%	58%	54%

Nutrition

School actions to improve nutrition are reported in Table 22. Most respondents reported their schools provided a variety of foods on menus and offered low-fat and skim milk every day, but a much smaller percentage of respondents reported that their schools offered appealing low fat items in vending machines, parties, and after-school programs.

Table 22. School actions to improve nutrition

Improved nutrition	05-06	06-07	07-08	08-09	09-10
9. Providing a variety of foods on school menus	86%	89%	94%	92%	97%
10. Offering low-fat and skim milk every day	98%	99%	100%	100%	100%
11. Offering at least one appealing low fat item from each of the following food groups every day: fruits, vegetables, grains, and dairy products?	91%	94%	96%	91%	95%
12. Allowing ample time for lunch and breakfast	79%	82%	91%	85%	95%
13. Vending machines exist in school?	94%	96%	92%	88%	92%
14. Restricting access to vending machines (among districts with vending machines)	91%	93%	96%	88%	88%
15a. Offering appealing low fat items in vending machines	32%	42%	54%	56%	40%
15b. Offering appealing low fat items at parties	25%	35%	51%	66%	63%
15c. Offering appealing low fat items at after school programs	27%	35%	45%	66%	65%

School Nurse

School nurse actions to improve physical activity and nutrition are reported in Table 23. Compared to five years ago, school nurses are now more likely to collaborate to improve physical activity and nutrition, and to have a system in place for measuring BMIs . In addition, there was a large increase in the percentage of respondents reporting BMIs to families and

* Please note in late FY07 the MDPH issued the Comprehensive Growth Screening Guidelines which will facilitate school districts in addressing these issues.

physicians, and in the percentage of respondents using a written protocol for managing students identified as at risk for weight.*

Table 23. School nurse actions to improve physical activity and nutrition

Improved physical activity and nutrition	05-06	06-07	07-08	08-09	09-10
16. Promoting physical activity through:					
• Educational materials	83%	83%	92%	92%	91%
• Individual advice	95%	95%	100%	100%	100%
• Small groups	53%	50%	67%	68%	58%
• Presentations	55%	67%	75%	64%	65%
17. Promoting healthy eating through:					
• Educational materials	85%	89%	94%	88%	95%
• Individual advice	96%	96%	100%	97%	98%
• Small groups	57%	54%	62%	48%	57%
• Presentations	56%	68%	70%	65%	66%
18. Collaborating to promote healthy eating and physical activity through:					
• Policy development	66%	89%	87%	89%	91%
• Curriculum development	47%	55%	67%	82%	77%
• Unit and lesson planning	44%	49%	62%	72%	62%
• Special events/planning	56%	59%	72%	77%	78%
• In service training	40%	50%	63%	58%	60%
Having a system in place to measure student BMI's	90%	93%	99%	98%	100%
Reporting BMI's to students family	49%	46%	55%	66%	94%
Reporting BMI's to students physicians	19%	17%	20%	17%	52%
Managing students identified as at risk for weight using a written protocol	13%	12%	21%	14%	36%

Newly Funded Essential School Health Service Districts

Shown in the tables below are the FY2010 responses of the 11 school districts whose ESHS funding began in FY09 (and who had not been funded the prior year). The percentages reported below may be expected to fluctuate from year to year due to the small number of respondents in this group.

Shown in Table 24 below is the percentage of respondents reporting obesity concerns. Shown in tables 25 through 27 below is the percentage of respondents who reported the school action or policy as being either fully or partially in place.

Obesity Concern in the Community

As shown by Table 24, concerns about obesity are reported to have increased in the communities served by newly funded districts. Most of the respondents report that school and school staff are making efforts to improve the nutritional quality of meals and snacks available to students. Support for these efforts among parents has increased.

Table 24. Obesity concerns

Questions	08-09	09-10
1. Obesity is a concern in the community?	73%	91%
2. Efforts are being made in school to improve the nutritional quality of meals and snacks available to students?	91%	100%
3. School staff support efforts to improve the nutritional quality of meals and snacks, for example, reduce fat and/or caloric content or replace sugared drinks with water or 100% juices?	91%	91%
4. Parents support efforts to improve the nutritional quality of meals and snacks, for example, reduce fat and/or caloric content or replace sugared drinks with water or 100% juices?	55%	73%

Physical Activity

Of the 6 listed types of actions schools might take to increase physical activity, there were increases in 3, decreases in 2, and no change in 1. The action these schools were least likely to undertake was "all students receiving at least 150 minutes of PE per week."

Table 25. School actions undertaken to increase physical activity

Increased Physical Activity	08-09	09-10
5. Providing at least 20 minutes of recess each day	100%	91%
5a. Monitors encouraging students to be active at recess	82%	91%
6. Using a sequential PE curriculum that is consistent with state or national standards	91%	91%
7. All students receiving at least 150 minutes of PE per week	27%	36%
7a. Spreading PE over at least 3 days (preferably 5 days) per week	36%	45%
8. Promoting walking /biking to school	55%	45%

Nutrition

All of these schools offer low fat items on menus. While only about half offer low fat items in vending machines, parties, or after school programs, there was some improvement over the prior year in all these areas.

Table 26. School actions to improve nutrition

Improved nutrition	08-09	09-10
9. Providing a variety of foods on school menus	91%	100%
10. Offering low-fat and skim milk every day	100%	100%
11. Offering at least one appealing low fat item from each of the following food groups every day: fruits, vegetables, grains, and dairy products?	91%	91%
12. Allowing ample time for lunch and breakfast	82%	73%

13. Vending machines exist in school?	91%	82%
14. Restricting access to vending machines (among districts with vending machines)	90%	91%
15a. Offering appealing low fat items in vending machines	27%	45%
15b. Offering appealing low fat items at parties	36%	55%
15c. Offering appealing low fat items at after school programs	36%	55%

School Nurse

Compared to the prior year, more school districts reported promoting physical activity and healthy eating, and more school districts reported collaborating to promote these activities. In addition, all of the respondents now report a system in place for measuring BMI's. The percentage of districts reporting having procedures for reporting BMIs and for managing students at risk for weight increased over the prior year, though newly funded districts are somewhat less likely to perform these activities than previously funded districts.¹⁹

Table 27. School nurse actions to improve physical activity and nutrition

Improved physical activity and nutrition	08-09	09-10
16. Promoting physical activity through:		
• Educational materials	73%	91%
• Individual advice	82%	100%
• Small groups	18%	27%
• Presentations	27%	45%
17. Promoting healthy eating through:		
• Educational materials	82%	82%
• Individual advice	100%	100%
• Small groups	18%	45%
• Presentations	45%	55%
18. Collaborating to promote health eating and physical activity through:		
• Policy development	73%	64%
• Curriculum development	55%	64%
• Unit and lesson planning	27%	45%
• Special events/planning	36%	55%
• In service training	18%	55%
Having a system in place to measure student BMI's	82%	100%
Reporting BMI's to students' families	18%	64%
Reporting BMI's to students' physicians	0%	36%
Managing students identified as at risk for weight using a written protocol	0%	9%

¹⁹ Please note: In late FY07 the MDPH issued the Comprehensive Growth Screening Guidelines which will facilitate school districts in addressing these issues.

References

- Chabra, A. & Chavez, G. (2000). A comparison of long pediatric hospitalizations in 1985 and 1994. Journal of Community Health, 25(3), 199-210.
- Cedar Rapids Community School District v. Garret F*, 119 S.Ct. 992, 29 IDELR 966 (U.S. 199). To view the full decision, go to: <http://supct.law.cornell.edu/supct/html/96-1793.ZS.html>
- Centers for Disease Control and Prevention (nd). Number (in Millions) of Civilian/Noninstitutionalized Persons with Diagnosed Diabetes, United States, 1980–2006. Retrieved January 11, 2010 from <http://www.cdc.gov/diabetes/statistics/incidence/fig1.htm>
- Clements KM, Barfield WD, Ayadi F, Wilber N. Preterm birth-associated cost of early intervention services: an analysis by gestational age. Pediatrics 2007;119:e866–e874.
- Coffman JM, Cabana MD, Halpin HA, Yelin EH. (2008) Effects of asthma education on children's use of acute care services: a meta-analysis. Pediatrics. 121(3):575-86.
- Expert Committee Recommendations on the Assessment, Prevention and Treatment of Child and Adolescent Overweight and Obesity (2007). http://www.ama-assn.org/ama1/pub/upload/mm/433/ped_obesity_recs.pdf. Accessed January 8, 2008.
- Hannon, TS; Rao, G; Arslanian, SA (2005). Childhood Obesity and Type 2 Diabetes Mellitus. Pediatrics, 116 (2), 473-480
- Leslie, L., Sarah, R., & Palfrey, J. S. (1998). Child health care in changing times. Pediatrics, 101(4), 746-751.
- Massachusetts Department of Elementary and Secondary Education (2008). State Profile: Enrollment Data. <http://profiles.doe.mass.edu/>. Accessed October 7, 2008.
- Massachusetts Department of Public Health (2009). Data Health Brief: Epinephrine Administration In Schools (School Year 2007-2008).
- Palfrey, J.S., Haynie, M., Porter, S., Bierle, T., Cooperman, P., Lowcock, J. (1992). Project school care: Integrating children assisted by medical technology into educational settings. Journal of School Health, 62(2), 50-54.
- Pennington N & Delaney E. (2008). The number of students sent home by school nurses compared to unlicensed personnel. Journal of School Nursing 24(5):290-7.
- Raymond JA. (2009). The integration of children dependent on medical technology into public schools. Journal of School Nursing;25(3):186-94. Epub 2009 Apr 10.
- Schutte, E. B., Price, D. L., & James, S. R. (1997). Thompson's Pediatric Nursing. Philadelphia: W. B. Saunders.
- Sheetz, A, Developing School Health Services in Massachusetts: A Public Health Model. Journal of School Nursing. 2003; 19(4): 204-211.
- Small, M.L., Majer, L.S., Allensworth, D.D., Farquhar, B.K., Kann, L., & Pateman, B.C. (1995). School health services. Journal of School Health, 65(8), 319-326.
- Smolensky, E. & Gootman, JA, (2003). Working Families and Growing Kids: Caring for Children and Adolescents Washington: National Academies Press.

Thurber, F., Berry, B., & Cameron, M.E. (1991). The role of school nursing in the United States. Journal of Pediatric Health Care, 5(3), 135-140.

Uphold, C.R. & Graham, M.V. (1993). Schools as centers for collaborative services for families: A vision for change. Nursing Outlook, 41(5), 204-211.

U.S. Bureau of the Census. (2000). Statistical Abstract of the United States (120th ed.). Washington, D.C.; 60 & 655.

U.S. Department of Health and Human Services. (2000). U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health. Washington, DC: Author. Retrieved January 8, 2010, from <http://www.surgeongeneral.gov/topics/cmh/cmhreport.pdf>

Wold, S.J. (2001). School health services: History and trends. In N.C. Schwab & M.H.B. Gelfman (Eds.), Legal issues in school health services (pp. 7-54). North Branch, MN: Sunrise River Press.

Wyman, L. (2005). Comparing the number of ill or injured students who are released early from school by school nursing and non-nursing personnel. Journal of School Nursing, 21(6), 350-355.

APPENDIX A

School Districts and Student Enrollment Essential School Health Services Program: 2008-2009

	DISTRICT NAME	REGION	ADMINISTRATION	ENROLLMENT
1	Acton-Boxborough	Metro West	Regional Academic	6,040
2	Amesbury	Northeast	City or Town	2,458
3	Andover	Northeast	City or Town	6,123
4	Arlington	Metro West	City or Town	4,654
5	Ashburnham-Westminster	Central	Regional Academic	2,426
6	Attleboro	Southeast	City or Town	5,937
7	Barnstable	Southeast	City or Town	5,667
8	Belchertown	Western	City or Town	2,655
9	Berkshire Hills (Stockbridge)	Western	Regional Academic	1,376
10	Billerica	Northeast	City or Town	6,100
11	Boston	Boston	City or Town	55,923
12	Braintree	Metro West	City or Town	5,352
13	Bridgewater Raynham	Southeast	Regional Academic	5,863
14	Brockton	Southeast	City or Town	15,312
15	Brookline	Boston	City or Town	6,321
16	Cambridge	Metro West	City or Town	5,770
17	Canton	Metro West	City or Town	3,097
18	Central Berkshire (Dalton)	Western	Regional Academic	2,039
19	Chelsea	Boston	City or Town	5,602
20	Chicopee	Western	City or Town	7,774
21	Douglas	Central	City or Town	1,759
22	East Longmeadow	Western	City or Town	2,857
23	Fall River	Southeast	City or Town	9,985
24	Fitchburg	Central	City or Town	5,155
25	Framingham	Metro West	City or Town	8,154
26	Gardner	Central	City or Town	2,727
27	Gateway (Huntington)	Western	Regional Academic	1,220
28	Georgetown	Northeast	City or Town	1,701
29	Gill-Montague	Central	Regional Academic	1,082
30	Gloucester	Northeast	City or Town	3,398
31	Granby	Western	City or Town	1,110
32	Hadley	Western	City or Town	672
33	Hampden Wilbraham	Western	Regional Academic	3,627
34	Hampshire	Western	School Union	1,898

	DISTRICT NAME	REGION	ADMINISTRATION	ENROLLMENT
35	Harwich	Southeast	City or Town	1,350
36	Haverhill	Northeast	City or Town	6,840
37	Holyoke	Western	City or Town	6,025
38	Hudson	Metro West	City or Town	2,982
39	Lawrence	Northeast	City or Town	12,221
40	Leominster	Central	City or Town	6,233
41	Lexington	Metro West	City or Town	6,235
42	Lowell	Northeast	City or Town	13,400
43	Ludlow	Western	City or Town	3,103
44	Lynn	Northeast	City or Town	13,273
45	Mansfield	Southeast	City or Town	4,912
46	Marblehead	Northeast	City or Town	3,261
47	Marshfield	Southeast	City or Town	4,720
48	Medford	Northeast	City or Town	4,822
49	Middleborough	Southeast	City or Town	3,541
50	Nashoba	Central	Regional Academic	3,358
51	Natick	Metro West	City or Town	4,721
52	Needham	Metro West	City or Town	5,115
53	New Bedford	Southeast	City or Town	12,609
54	Newburyport	Northeast	City or Town	2,263
55	Newton	Metro West	City or Town	11,700
56	North Andover	Northeast	City or Town	4,604
57	North Attleborough	Southeast	City or Town	4,742
58	North Berkshire (Clarksburg)	Western	School Union	363
59	Northampton	Western	City or Town	2,758
60	Northboro Southboro	Metro West	School Union	4,903
61	Northbridge	Central	City or Town	2,526
62	Pittsfield	Western	City or Town	6,120
63	Plymouth	Southeast	City or Town	8,280
64	Provincetown	Southeast	City or Town	172
65	Quincy	Metro West	City or Town	8,968
66	Randolph	Metro West	City or Town	2,966
67	Rockport	Northeast	City or Town	1,003
68	Sandwich	Southeast	City or Town	3,574
69	Scituate	Metro West	City or Town	3,241
70	Somerville	Metro West	City or Town	4,877
71	Springfield	Western	City or Town	25,801
72	Stoughton	Southeast	City or Town	3,862
73	Taunton	Southeast	City or Town	7,865
74	Walpole	Metro West	City or Town	3,923

	DISTRICT NAME	REGION	ADMINISTRATION	ENROLLMENT
75	Waltham	Metro West	City or Town	4,751
76	West Bridgewater	Southeast	City or Town	1,289
77	Weston	Metro West	City or Town	2,403
78	Weymouth	Metro West	City or Town	6,861
79	Wilmington	Metro West	City or Town	3,764
80	Worcester	Central	City or Town	23,109
	TOTAL			477,243

Notes:

Source: Massachusetts Department of Elementary and Secondary Education (DESE)

ESHS-funded districts may include schools not included in DESE -defined districts, so the enrollment numbers shown above may differ from those provided by DESE.

“Region” refers to the six geographic regions defined by the Executive Office of Health and Human Services (EOHHS).

APPENDIX B

Scope of Service Essential School Health Services Program

COMPONENTS

Each program must meet or continue to meet the following seven components as described below:

- 1. School health service program infra-structure**
- 2. Collaboration with the comprehensive, coordinated health education program, tobacco control program, etc.**
- 3. Plan for linkage of students with primary care providers, dental providers, behavioral/mental health programs (as needed), community prevention programs, and health care insurance.**
- 4. Development of a management information system.**
- 5. Implementation of performance improvement (continuous quality improvement) and evaluation programs.**
- 6. Services to private schools located in the applicant's community**
- 7. Collaboration/consultation/networking among school nurses.**

For a more complete description of each of these components, please contact the School Health Unit.

APPENDIX C

Data Collection Methods

Contractual obligations require districts in the ESHS programs to submit a monthly report to MDPH. This report, the ESHS **Monthly Activities Report**, provides a detailed, standardized summary of the health services activities that took place in the district during the prior month. It includes a count of the number of encounters, medications administered, medical procedures, and other types of services provided.

Information for these reports is gathered from each school nurse. In most districts, school nurses enter health encounter data into a computer database loaded on a computer located in the school health office. The database facilitates data reporting as well as helps the nurse maintain systematic records and schedule follow-ups.²⁰ Nurses are encouraged to enter information during or directly after a health encounter. Each district in the ESHS program selects its own database software. Across the program, ten or more different software products are used, although the majority of districts use one of two popular applications. Within a district, all school nurses usually use the same software product. The software products operate differently. Many districts use a networked database that links all schools to the same database and permits the data coordinator to run district-wide data reports, while other districts use stand-alone databases in which data reports must be run separately at each school before being compiled at the district level. Due to resource constraints, nurses in a few school districts maintain paper logs and manually tabulate the data. Although districts use different software applications and some districts tabulate data manually, all districts are required to tabulate their data the same way and to submit a standard data report to MDPH. In any event, information is gathered from each school nurse in the district, tabulated, and entered into the Monthly Activities Report form in summary (or aggregate) form.

In addition, districts in the ESHS programs submit **status reports** once a year. This report measures progress in meeting program objectives, and includes performance measures relating to health services infrastructure, MIS development, linkages to all aspects of the health delivery system, and quality evaluation. It also summarizes the number of health screenings performed and health surveys administered during the school year. The mentored school districts in the program submit this report once a year, beginning in 2009-2010.

The statistics in this report were derived from the monthly activities reports submitted by districts participating in the ESHS program. Over the course of the 2008-2009 school year, monthly encounter data were collected successfully from all of the 80 ESHS award recipients (100% of program total), serving a total of 472,358 students (49% of the state public school enrollment total). For these school systems, MDPH received 774 (97%) of the 800 expected monthly reports.

²⁰ Paper logs are still used to record data elements that are not typically included in most school health software programs. For example, one item that is usually logged by hand is “Number of support group meetings.”

For the 80 districts that form the basis of this report, the median student enrollment was 4,629, with a range of 172 to 55,923 students. This sample includes school districts from many areas of the state. It includes urban, suburban, and rural districts; city, town, and regional school systems; and large, medium, and small districts.

Data Analysis Methods

In order to reduce the potential for confusion, the statistical concepts and terms used in this report are described below.

For each measurement or “indicator,” a ***district-level statistic*** is determined in each district by calculating a monthly average for the 10-month evaluation period. The **monthly average** for a particular district is calculated by adding the total number of events or encounters that occurred in a particular district during the evaluation period and dividing that total by the number of months included in that evaluation period. Because it is awkward to refer constantly to the “monthly average for the district” or the “district-based monthly average,” these data are referred to as the **district average**. These two terms--the monthly average and district average--are used interchangeably in this report. All monthly averages in this report were calculated over the same ten-month period (September through June).

Wherever possible, standard units of analyses (*rates*) are used, as they facilitate both cross-district and historical comparisons, which can provide context and meaning to the statistics. The standard units of analysis that were used most frequently in this report are the monthly rate per 1,000 student health encounters, the monthly rate per 1,000 enrolled students, and the monthly rate per full-time equivalent (FTE) nurse. The **monthly rate per 1,000 student health encounters** is calculated by dividing the monthly average for that indicator by the total number of student health encounters in that district and multiplying the result by 1,000. Similarly, the **monthly rate per 1,000 enrolled students** is calculated by dividing the monthly average by the total number of enrolled students in that district and multiplying the result by 1,000. Rates per thousand enrolled students were calculated utilizing October student enrollment figures provided by the Massachusetts Department of Education (see Appendix A). Finally, the **monthly rate per full-time equivalent (FTE) nurse** is calculated by dividing the monthly average by the total number of Registered Nurse FTEs in that district. Sometimes the rate is not based on an average of *monthly* data but on aggregate data for the full year. For example, **the rate of health screenings per 1,000 students** is determined by dividing the total number of screenings *for the whole year* by the number of students enrolled and multiplying the result by 1,000.

Program-wide statistics describe not individual districts, but the ESHS program as a whole. In these calculations, each district represents a data point that is used in calculating summary statistics. For example, if averages are calculated for 100 districts, the result is a collection of 100 district averages that can be arrayed from lowest to highest along a frequency distribution. When frequency distributions are *skewed* (that is, the values tend to clump around either the lowest or highest value, rather than around the middle), the *median*, rather than the *average*, is used to measure central tendency. *Because most of the ESHS frequency distributions were skewed, the median is used throughout this report.* The **median** represents the number above and below which exactly 50% of the districts fall. It is a better measure of central tendency than the

average for skewed data, because the average tends to be more affected by extreme values. The most common use of median in this report is with district-based monthly averages; for a particular indicator, the median for the group of ESHS districts (a *program-level* statistic) is the district average (or monthly average) above and below which exactly 50% of the individual district averages fell. The **range** of a set of district averages refers to the lowest and highest values across the entire group of ESHS districts. The district with the median value for an indicator is sometimes referred to as the **median district** or the **typical district**. The median value across all the monthly district averages is also referred to as the **median district average**.

Medians can also be calculated for rates. For example, the **median Emergency Referral rate** (i.e., Emergency Referrals per 1,000 health encounters) is calculated by first putting the total number of Emergency Referrals in the form of a rate (for each district, dividing the total number of Emergency Referrals by the number of student health encounters and multiplying by 1,000), and then finding the median of these rates.

Data Limitations

This report focuses on the delivery of school health services by nursing staff. Project sites do not serve as a representative sample of the Commonwealth's schools. Therefore this report should not be used to make generalized statements about health services in all Massachusetts public schools. Furthermore, caution should be exercised when comparing ESHS statistics across years. Each year the set of districts that report data changes to some degree, which creates somewhat different sample sets. For example, in the 2000-2001 school year, 74 districts reported data, whereas in the school year 2003-2004, 103 districts reported data. In addition, in years prior to 2001, the number of districts that reported data (approximately 25) was drastically lower than in more recent years (approximately 100). Due to this difference in data sets, comparisons to data from years prior to 2001 would be considerably less valid. Also, data has not always been available for all months of the school year. Most notably, in the 2002-2003 school year, only the months September through December were reported. This noted, after 2001 the core group of districts has been relatively stable, and the sample size is large enough such that comparisons are not without merit. Where statistical differences are large, and trends continue for several years, comparisons are more likely to be meaningful.

The descriptive data presented here also do not capture the dynamic and multi-faceted nature of health services delivery in a school system, which would require in-depth qualitative analysis of the program participants. Differences in data collection and data tabulation procedures may account for some of the variability observed across districts. Furthermore, a small percentage of the school districts in the program did not have computerized records of office visits and relied on paper logs and hand tallying of data by individual nurses. In these cases, it is impossible to control for factors such as data-entry errors at the district level, consistent misinterpretation of data elements, and numerical “guesstimates” provided by participants. Some of these data quality problems can lead to significant under- or over-counting. Finally, interpretation of the data is limited because we have not attempted to analyze the influence of school district demographics or other participant differences.

Participating districts were required to implement, in a short period of time, both program innovations that entailed major organizational change and, in most cases, the development of an internal data collection system. Therefore, this report represents a preliminary attempt to measure

the health services activity in participating school systems. Improvements in data collection procedures, data collection tools, and data collection instructions and training occur on a continuing basis, leading to corresponding improvements in data validity and reliability.