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Trends in Health Care Delivery

The Increased Burden on Schools as Health Care Providers

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INTRODUCTION

In addition to teaching basic and advanced academic skills to school-aged children, society asks schools to do significantly more. Schools routinely provide food services, transportation services, liaisons to community services, social services, adult and community education, athletic entertainment, fund raising, research, support for political events, and much more. Most of these activities directly or indirectly affect the teaching and learning of schoolchildren. Despite a lack of formal training, teachers and other educational professionals have branched out into coaching, grant writing, administration, coordination, family counseling, and a host of skills required in the full-service community school (Reeder et al., 1997).

This expansion of teacher roles and skills is born of necessity. However, the largest and most challenging arena that educators are asked to address is medical issues for children.

PEDIATRICS IN THE SCHOOLS

Medical issues in the schools are a reality. At one time, medicine and education were two different professions with very little overlap. Occasionally,

a school was required to provide individualized services for children with a chronic illness, or a school building served as a location for community vaccination programs. School-based and school-linked health clinics are located throughout the United States but provide medical services to a small portion of schoolchildren (Brown & Bolen, 2008). U.S. health care has evolved to increase emphasis on access to health care (Shaw, Kelly, Joost, & Parker-Fisher, 1995). Given that 85 million U.S. children between the ages 5 and 19 are mandated to attend school, health care policy and strategies for increasing health access for children and families must involve schools (Clay, Cortina, Harper, Cocco, & Drotar, 2004). Moreover, improvements in health care for school-aged students improve readiness, improve academic achievement, and increase the probability of graduating from high school (Cook, Schaller, & Krischer, 1985). Schools are now integrated components of comprehensive health care delivery for children.

Role of Federal Legislation

Several major federal laws specifically address schools as a location for providing health care. These include the following:

- Americans with Disabilities Act (ADA; 42 U.S.C. § 12101 et seq.) and regulations promulgated by the Department of Justice
- Drug and Alcohol Treatment Records (D&A; 42 USCS § 290dd, 42 CFR 2.1 et seq.)
- Family Educational Right to Privacy Act (FERPA; 20 U.S.C. § 1232g; 34 C.F.R. Part 99)
- Health Insurance Portability and Accountability Act (HIPAA) and regulations adopted under it (45 C.F.R. chapters 160 and 164)
- Individuals with Disabilities Education Improvement Act of 2004 (IDEIA; Public Law 108-446, previously IDEA)
- OSHA Blood-borne Pathogen Standard 29 of C.F.R. 1930.1030
- Prohibition of Mandatory Medication [Child Medication Safety Act (25; Public Law 108-446; Dec. 2004)]
- Proposed New Drug, Antibiotic, and Biological Drug Product Regulations [21 C.F.R. 312.3 (b)]
- Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794)

Moreover, in many states, schools are classified as centers for health care provision for purposes of Medicaid funding. These schools are responsible for compliance with the Medicaid regulations developed by each state. Compliance with legislation, regulation, and case law on educational issues is a complex undertaking. When medical legislation, regulation, and case law are added, the burden on educators can be overwhelming.

Although meeting all the mandates of legislation and case law is a necessity, three major laws affect all schools every day. These are the Individuals with Disabilities Education Improvement Act of 2004, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

A large portion of school resources is spent attempting to comply with IDEIA, the complex federal funding law for all children receiving

special education services. IDEIA requires schools to provide specialized education services and support services (physical therapy, occupation therapy, speech and language therapy, nursing support, and social work support) to children with medical issues that substantially affect learning. All children with special education needs may be eligible to receive these support services. Children receiving special education services under the Other Health Impaired (OHI) category of IDEIA require some form of medical services. The OHI category may include attention deficit/hyperactivity disorder, acute lymphocytic leukemia, meningitis, and a host of other medical conditions. Under IDEIA, schools provide remediation and accommodation for academic issues that are affected directly or indirectly by the long-term effects of a medical issue. Children receiving educational services under the OHI require evidence from a physician of a medical issue that directly impacts academic skill development or academic performance. For children who receive services under OHI, some form of educational collaboration with medical professionals must take place. Moreover, educators must have some degree of understanding as to how the medical issue is likely to affect academic and social issues in order to develop an individualized educational plan.

Section 504 of the Rehabilitation Act of 1973 states that "no otherwise qualified individual with a disability in the United States . . . shall, solely by reason of her or his disability, be excluded from the participation in, denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance" (§ 504[a]). Section 504 requires schools to provide accommodations for children with medical issues that may interfere with access to education. Section 504 plans often address educational concerns due to temporary or chronic medical conditions or other medical concerns for which remedial educational services are not required but deviations from the routine scope and sequence of educational curriculum are needed. In addition to other chronic illnesses, drug and alcohol addiction is a health issue covered under Section 504 and must be addressed by schools. Therefore, to provide effective services, teachers and other educational professionals must have some knowledge of the scope, nature, and cause of these medication conditions, as well as the unintended effects of treatment, medications, chronicity, common emotional responses, and related effects on educational functioning.

The Americans with Disabilities Act prohibits discrimination based on disability in employment, state and local government, public accommodations, commercial facilities, transportation, and telecommunications. Schools are required to make reasonable modifications to policies, practices, and procedures where necessary to avoid discrimination, unless they can demonstrate that doing so would fundamentally alter the nature of the service, program, or activity provided. An individual with a disability is defined by the ADA as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such impairment. Children with chronic illness may be eligible to receive accommodations that require modifications in

the physical plant of the school, educational policies, or daily activities in the school setting.

Keeping Pace With the Trends in Health Care

To implement policies and curricula that allow schools to maintain compliance with the myriad laws and regulations, educators must first understand four major domains of knowledge.

The first domain is instruction of students in health literacy, problem solving and communication skills, and promotion of a sense of personal competency and self-efficacy. Health courses, physical education, sex and reproductive health education, and instruction of parents and other family members are common practices in schools. Many aspects of health care instruction include teaching students the behavioral aspects of health care, such as understanding how personal health care decisions are made, avoiding health risk behaviors, and becoming empowered to take control and responsibility for their health care decisions. Many, if not most, schools have developed an effective array of health care education programming for their students and communities.

The second domain is coordination and collaboration with outside agencies, such as public health services, emergency service providers, hospitals, primary care providers, mental health agencies, and dental care providers. Integrating various community agencies to assist schools in meeting their regulatory and legislative requirements concerning health care can be challenging. Health care agencies and schools have different cultures and often have different goals and missions. Health care agencies have their own financial pressures and time limitations. Collaboration between members of the medical and school professions can be difficult. However, it is nearly impossible for educators to meet the increasing health care burden on schools without interdisciplinary collaboration.

The third domain is developing a school environment that promotes healthy living. This includes health care policies, general school rules, supporting effective social environments (e.g., student clubs, volunteerism and associated policies, activities that promote social skills), family support systems, providing healthy role models, effective dietary practice, and the overall development of a healthy school environment. Schools have made major advances in the development of health care policies and promotion of preventative health care practice. Increasingly healthful dietary choices in cafeterias, provision of dietary information to parents, improved antibullying practices, increased quality of physical education programming, promotion of community service, and increased ecological awareness are all approaches taken by schools to advance healthy living.

The fourth domain consists of the physical plant of the school. Lighting, ventilation, noise, sanitation, and other environmental standards all contribute to a healthy environment. In addition, safety standards in the playground, classrooms, and hallways are important to accident prevention. New school construction is increasingly going "green" with substantial improvements in environmental quality and energy efficiency. In fact, almost 1,000 school buildings were considered LEED certified by September 2008; LEED certification means the building met the highest

level of energy and environmental performance (USGBC, 2008). Most importantly, knowledge of prevention, treatments, accommodations, and educational implications with regard to medical issues will be of the greatest benefit when implemented in a physical environment that is supportive and healthy for all schoolchildren.

Meeting the Additional Burden

Implementing these laws, plus a variety of statewide regulations concerning health care in the schools, is a complex undertaking. The trend in school-based health care is toward the goals of assessing risks and fostering resilience to ensure that students achieve optimal health, well-being, and academic performance (Kisker & Brown, 1996). To accomplish these ends, multidisciplinary and multiagency collaboration, community support, development of strong policies, dissemination of information, and improving academic achievement are all necessary (Stam, Hoffman, Deurloo, Groothoff, & Grootenhuis, 2006). To be most effective, school-based health care must be

- community based.
- integrated within and supportive of the educational system.
- advised by a school and community group, including parents and students.
- based on accepted standards, regulations, and statutes.
- prepared for crisis management of medical problems.
- supported by a health service management information system.
- capable of providing a range of prevention and treatment services, including those addressing tobacco control, drug and alcohol use, and obesity prevention.
- implemented by sufficient numbers of qualified staff throughout the school day.
- culturally competent and linguistically relevant.
- integrated with educational programming.
- coordinated with the eight components of a comprehensive school health program, as defined by the Centers for Disease Control and Prevention: health education, health services, social and physical environment, physical education, guidance and support services, food service, school and worksite health promotion, and integrated school and community health promotion (Shaw & McCabe, 2008).
- linked with community primary care, regional hospitals, mental health providers, dental providers, local youth- and family-serving agencies, local public health systems, emergency providers, and public insurance outreach programs.
- able to make maximum use of available public and nonpublic funds, such as Medicaid, grants, insurance reimbursement, and business partnerships.
- evaluated regularly to determine effectiveness and efficiency.

Although preventive and primary health care are important parts of school-based health care, medical trends place pressure on schools to

provide health care to children with serious illnesses as well. Due to advances in treatment and the necessity of reducing health care costs, children with severe medical issues have fewer inpatient days than in the last decade (Shaw & McCabe, 2008). Whereas many students with conditions such as leukemia, sickle cell anemia, and asthma used to spend many days hospitalized, such children now receive extensive outpatient care and fewer hospitalized days (Kyngas, 2004). This change in the location of medical treatment places more pressures on families and schools. Schools are under increasing pressure to provide homebound instruction, accommodations for medical issues in the classroom, coordination of educational needs with outpatient treatment needs (and the inevitable absences), and preparation for possible emergencies in school settings.

Knowledge of medical issues typically is not part of the curriculum in preparation programs of teachers, psychologists, or other school professionals (Shaw, 2003). Yet legal and regulatory mandates and trends in health care service delivery are placing more responsibility on families and schools. The gap between professional preparation and need for knowledgeable professionals is wide.