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Barriers to School Health Program Expansion in Illinois: A Qualitative Study

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Abstract

The purpose of this qualitative study was to explore the issues impacting school health programs in Illinois and barriers to expansion and implementation. Despite the changing health needs of children, school health programs have not been restructured to meet them. Current literature discussed these issues in depth from the viewpoint of school health professionals; however, little data existed from the perspective of Illinois policy makers. Seven interviews were conducted at the state, regional, and local levels in order to begin an initial investigation into this perspective. Data analysis revealed several core issues; the most noteworthy include unfunded educational mandates, lack of research linking health to learning, and the lost vision of public education as a “common good.”

BUILDING A CASE FOR SCHOOL HEALTH PROGRAM EXPANSION

It began as an experiment. In 1902, Lillian Wald saw her idea come to fruition as the first public health nurse was placed in a New York City school. The success of this “experiment” in reducing absenteeism from communicable disease, malnutrition, and poor hygiene, led to the employment of nurses in school districts across the United States, thus the evolution of school nursing practice (Henry Street, n.d.). Today the National Association of School Nurses defines that practice as:

a specialized practice of professional nursing that advances the well being, academic success, and life-long achievement of students. To that end, school nurses facilitate positive student responses to normal development; promote health and safety; intervene with actual and potential health problems; provide case management services; and actively collaborate with others to build student and family capacity for adaptation, self management, self advocacy, and learning (NASN, 1999).

According to Marx et al (1998), good health is necessary for effective learning, and Peplau (1997) asserts that access to quality health care is essential to quality of life. However, as the call for school reform and improved academic achievement increases, school budgets are hard pressed to bring students up to state standards (Tyler, 1999).

As the health care crisis in this nation looms, the number of children without insurance rises (Shi & Singh, 2001). They come to school suffering a multitude of acute and chronic health problems with only a bare-bones school health program from which to seek care. According to NASN (2001), only fourteen states mandate school nursing services and Illinois is not one of them. School health advocates continue to recommend a qualified nurse in every building; however, many districts lack even daily visits by a school nurse. This requires the delegation of nursing procedures to less qualified personnel (Wolfe & Selekman, 2002). Despite growing evidence of negative health trends for children and adolescents, there has been little progress toward expansion of school health programs.

Introduction to the Problem

Historically, the major health issues that schools faced were communicable diseases (e.g. tuberculosis, diphtheria, measles, mumps, rubella, and whooping cough), malnutrition and poor hygiene (Wolfe & Selekman, 2002). As a result of immunization programs and disease control measures of the twentieth century, those illnesses have been all but eradicated. The major health issues facing today's children, also referred to as the "new morbidities" (Tyson, 1999), are the result of cultural practices and lifestyle behaviors. Marx et al. (1998) cite the following preventable behaviors established in childhood as accounting for the majority of illness and death in the U.S.: tobacco use, poor eating habits, substance abuse, behaviors that result in intentional or unintentional injury, physical inactivity, and sexual

behaviors that result in HIV infection, sexually transmitted diseases, or unintended pregnancy. Sadly, “the school nurse’s role as triage nurse, case manager, surrogate parent, mental health provider, public health nurse, and administrator is constantly expanding at the same time it is being targeted for cutbacks” (Hacker & Wessel, 1998, p. 409).

Along with a shift in the nature of health issues, the enactment of Public Law 94-142, the Education for All Handicapped Children Act (EHA) of 1975 by the federal government dramatically increased the demand for school health services. Before its enactment, the needs of many children with disabilities were not met. Special needs children were excluded from public schools, institutionalized or attended school without being properly assessed and educated. Today, the EHA is in place as the Individuals with Disabilities Education Act (IDEA). IDEA guarantees a free, appropriate public education (FAPE) to all children with disabilities in every state. IDEA mandates the provision of appropriate special education programs and related services in order to prepare these children “to lead productive, independent adult lives, to the maximum extent possible” (Public Law 105-17, 1997). Related services include the medical services necessary for a child with a disability to participate in and benefit from an educational program. This landmark legislation has created rights, education and assistance for special needs children while placing unprecedented demands on the public school system to provide these services. It’s reauthorization in December 2004 is said to “improve educational opportunities for our most vulnerable children”

(Committee on Education and the Workforce, 2004); however, the impact of revisions is yet to be ascertained.

Current statistics predict alarming trends in morbidity and mortality rates for our country's school children. In some student populations, particularly minority, urban, and rural communities, health, social and lifestyle problems are so great that school attendance and academic performance are seriously affected (Annie E. Casey Foundation, 1998). Unless these "pathologies" are addressed, the fundamental mission of schools--education--cannot be accomplished (Romano, 2001). Public schools in America become the logical place to focus health interventions for its 48 million children (NCES, 2003).

Purpose and Aims of Study

The overall purpose of this study is to gain a better understanding of the current issues impacting school health programs and the barriers that exist to their expansion and implementation. The need for and benefit of school health interventions is well documented; however, little progress has been made toward implementing evidence-based programs. A better understanding of: (a) policies affecting school health programs (b) how they are funded and (c) reasons for lack of response to identified health needs could contribute greatly to policy and funding reforms. The ultimate goal of this project is to answer the question: *What are the barriers to school health program expansion from a policymaking perspective?*

Summary

The need for school health services continues to rise as the school reform movement calls for higher academic achievement (Dryfoos, 1994); this has resulted in overwhelming demands being placed on school staff as well as on school budgets. Throughout the twentieth century, the efforts of school nurses have greatly enhanced children's health and their ability to learn. Today's crisis of increasing health needs and inadequate school health services warrants a renewed effort to improve outcomes for children in the twenty-first century. As an important first step toward responding appropriately, further research is needed. A focused inquiry to identify barriers to the expansion of school health services would provide valuable insight for health care policy makers.

REVIEW OF LITERATURE

The purpose of this literature review is to explore what is known about school health programming as well as barriers to expansion. Identifying gaps in the literature will then provide a basis for further inquiry into the reasons for school health program inadequacies. The methodology used for this review was a database search, including CINAHL, MEDLINE, ERIC, and PUBMED. The search was executed using the key words *funding AND school health programs AND barriers to expansion* in order to locate books and current journal articles addressing the topic of interest. A large number of resources, primarily from the school health community, were found. Approximately 30 were utilized for this review.

School Funding

It is pertinent at this point to briefly summarize the public education system in this country and how it is funded. Following the American Revolution, founders of the United States regarded education as essential to the new nation's survival and prosperity. In the words of Margaret Haley (Goddard, 2004), the "object of the public school in a democracy is to preserve and develop the democratic ideal." In 1852, Massachusetts was the first state to pass legislation calling for publicly funded education. By 1918 all states had passed compulsory school attendance laws (Olson, 1999).

The Department of Education describes the educational system in the United States as “decentralized” (United States Department of Education, n.d.). Individual states and local school districts have the responsibility of setting policy, staffing educational programs, and providing the funds necessary to administer their programs. The federal government plays a somewhat limited, supportive role, which includes contributing an estimated 10% toward the total spent on education. For example, in Illinois local districts shoulder 61.50% of the costs, the State contributes another 32.23%, while the federal government contributes 7.27%, as shown in Figure 1 (Illinois State Board of Education, 2002):

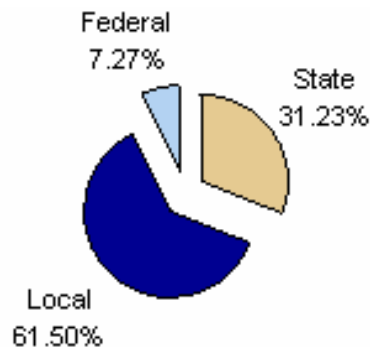


Figure 1: Revenues Fiscal Year 2002

Lack of Research

The call for research in the field of school nursing has been ongoing. In *School Nursing: A Framework for Practice*, Wold (1981) identified the primary barrier presented to school nurses: lack of research documenting the outcomes of their services. Research-based data validates the effectiveness of interventions. In the educational setting, school health services must be

documented as improving health and educational outcomes in order to make a case for funding and maintaining them. In 1994, lack of research was again identified by the National Nursing Coalition for School Health (NNCSH) as one of the major issues to be addressed to meet the increasing needs of students (School health nursing services; exploring national issues and priorities, 1995). Several studies (Bradley, 1998; Hall, 1999; Ross, 1999) indicate there is no argument about the health needs of school children, but evidence is lacking on how to meet them. Hall (1999) suggests that research would help to define, assess, and plan interventions to meet the needs of children and young people in schools. In the comprehensive year 2000 report, *School Health Policies and Programs Study (SHPPS)*, the Centers for Disease Control and Prevention identified research as a key component to the planning of effective school health services (SHPPS, 2000).

Unfunded Mandates

Since the enactment of the federal law, the Education for All Handicapped Children Act of 1975 (Public Law 94-142), schools have been mandated to "insure that all handicapped children have available to them special education and related services designed to meet their unique needs" (Public Law 94-142, 1975). The act has undergone several expansions in its 29-year history, including a name change. In 1990 it came to be known as the Individuals with Disabilities Education Act (IDEA). In order to assist states in providing special education and related services to these children, the federal government pledged to support 40% of these expenditures (United States

Department of Education, n.d.). However, the federal government has never funded more than 20% of this mandated program (NSBA, 2004). The literature does not specify how local school districts subsidize the programs and personnel necessary to provide these specialized services.

Lack of Mandates

While schools are required by federal law to provide “related services” to students with special needs, few guidelines exist at the state and local levels to insure the appropriate provision of these services. Temple (2002) looks at the issue of local school control in Illinois. According to the Illinois School Code each district addresses these issues individually, resulting in a dramatic variation among school health programs throughout the state.

The National Association of School Nurses recommends nurse-to-student ratios ranging from 750 to 125:1, depending on the health needs of the population served. In the case of the medically fragile student, the caseload assignment should be based on individual needs (NASN, 1995). Costante (2001), in her discussion of professional, practice, and management issues facing school nurses, states:

Staffing levels engender issues related to safety, accountability, and quality assurance. Determining school health staffing is generally a local function, although a few states have dictated ratios of nurses to students just as they do for teachers to students. Until school health service programs are mandated by states, ratios are meaningless...these ratios were developed

nearly 30 years ago and may not be relevant to the current educational arena in which inclusion of all students is the norm (p. 70).

Differing paradigms

Descoteaux (2001) discusses the difference in paradigms and professional language between healthcare and educational professionals. "Being a nurse...in the educational environment is often like being a square peg in a round hole" (p.296). Likewise, Wainwright, Thomas, and Jones (2000) cite the administrative separation of education and healthcare as being responsible for the lack of philosophical support for school health programs. The National Nursing Coalition for School Health (NNCSH) (1995) describes the administrative structure of school systems as being vastly different from that of health care organizations. For the most part, non-nursing personnel carry out supervision of school nurses, as well as make important health care planning decisions. For these reasons, less priority is given to health issues in the school setting. This presents nurses with ethical and professional dilemmas as well as significant quality of care issues. Periard et al. (1999) discusses the lack of school nurse managers, which leaves nurses without the power and authority to plan quality programs and meet role expectations. According to Deutsch (2000), in an effort to improve educational outcomes, administrators "focus with laser-like intensity on academic skills" (p. 8), while ignoring the potential impact school health programs could have on achievement.

Lack of Role Definition

In 1994, representatives of the National Nursing Coalition for School Health (NNCSH) articulated the need to define the role of the school nurse as well as implement school practice standards. Arriving at consensus on what constitutes best practice would provide the foundation upon which to design effective interventions to better meet the growing health needs of America's school children. The *School Health Policies and Programs Study* (SHPPS, 2000) acknowledged "school health services experts have not reached consensus about the best models for providing school health services" (p. 303). This is due largely to the fact that existing models have not been systematically evaluated as to their efficacy.

Lack of Visibility

Wolfe, in her 2001 inaugural address as President of the National Association of School Nurses, stated, "we struggle with articulating our value to others. We allow ourselves to become so submerged in the field of education that we lose our identity as nurses" (Partners with Children, p. 294). Brandt (2002) makes reference to the invisible role of nurses in today's schools. Often nurses are so busy providing services to school children that there is little time to develop strategies to enhance their visibility and provide evidence of their contributions. Therefore, it is not recognized that school nurses are the predominant health care provider that a child comes in contact with on a daily basis.

Lack of visibility is pervasive throughout the nursing profession.

Despite the fact that nurses comprise the largest group of health care professionals in the country, their voice is virtually absent from public discourse on the current state of health care. By articulating their knowledge and expertise, nurses could be involved in working towards a solution to the current health care system problems. “Nothing less than living in a safer and healthier society is at stake” (Buresh & Gordon, 2000, p ix).

The Changing Needs of Children

Current literature identifies the changing needs of children as a major reason school health program expansion is necessary. According to Hootman (2002) these include an increase in the number of families without adequate health insurance, changes in social and family structure, and the shift in morbidity trends from infectious disease to chronic disease. She also identifies technological advances in health care and case law mandates to provide for specialized health needs in schools. As Ross (1999) summarizes, “changes in society, family structure, special education legislation, health care, and the educational system have increased the demand for health services and for clinical nursing services in schools” (p. 30).

Misconceptions

In a random survey of registered voters in Illinois, Temple (2002) found that opponents of school health program expansion argue, “schools cannot be all things to all people” (p. 2). The survey revealed that Illinois residents widely believe that schools should stick to the business of educating youth

and limit interventions to activities of an academic nature. Opponents believe that program expansion would increase the dependency of families rather than empower them to take charge of their own health. According to Dryfoos (1994), other obstacles come in the form of misconceptions about the services provided, especially in the area of reproductive health. Opponents of expansion believe that school health programs only provide birth control and promote sexual activity of teens. While it is true that previous programs focused on pregnancy prevention, there are currently many other areas in need of planned interventions, including substance abuse, school drop out rate, mental health issues, injury prevention, and health promotion.

Conceptual Framework

The public policymaking process directly impacts how the educational system is administered in this country. An example of this is the Individuals with Disabilities Education Act (IDEA) that drives special education, dictating how schools educate special needs populations. And, as a result of its implementation, IDEA has a significant impact on all educational programming and funding allocation. Therefore, the framework used to guide this inquiry was the Model of the Public Policymaking Process in the United States (Longest, 2002), as seen in Figure 2. Utilizing this model provided a conceptualization of this complex process and, therefore, a means of understanding how legislation impacts the delivery of public services and programs. It also facilitated the formulation of interview questions for data collection.

The policymaking process is comprised of three phases: formulation, implementation, and modification. According to Longest (2002), “the preferences of individuals, organizations, and interest groups, along with biological, cultural, demographic, ecological, economic, ethical, legal, psychological, social, and technological inputs” influence every stage of the model. One of the most important features of the model is its cyclical nature. Within the public policymaking process, governmental decisions are made and then periodically reevaluated and modified as societal conditions change.

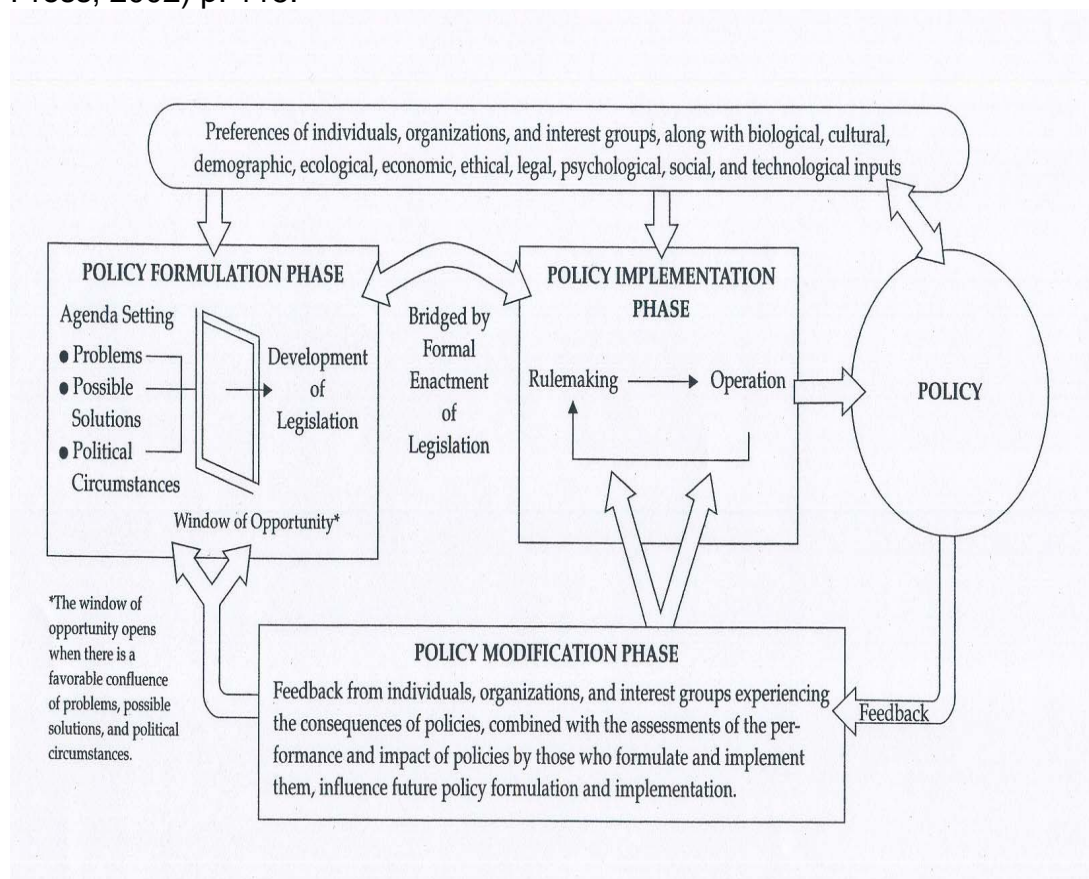
The formulation phase is carried out in the legislative branch of government and is comprised of two sequential steps: agenda setting and legislation development. Agenda setting occurs when problems and possible solutions converge with favorable political circumstance. This is referred to as the “window of opportunity” (Longest, p. 130). When this window opens, the second step can occur: development of new legislation or amendments to existing legislation.

In the implementation phase, responsibility shifts to the executive branch of government; it is the responsibility of agencies here to carry out the intent of the laws. As Longest (2002) points out, “legislators rely on the implementers to bring their legislation to life” (p. 215) by establishing formal rules and regulations for the administration of programs and services.

In the third phase, the policymaking process comes full circle. During the modification phase, the consequences of policy formulation and implementation are appraised. The consequences of legislation are

evaluated based on feedback from the individuals, organizations, and interest groups affected. Whether they result in positive or negative consequences, policies can be modified as cultural, economic, demographic, or other societal variables dictate. When the window of opportunity opens, the cycle of policymaking begins again.

Figure 2 Used with permission from *A Model of the Public Policymaking Process in the United States* by Longest (Chicago: Health Administration Press, 2002) p. 115.



Summary

It is important to note that much of the literature supporting school health program expansion comes from the social service and school health communities: health educators, psychologists, school nurses, social workers,

and special education personnel. The viewpoint of Illinois policy makers, i.e. state and local governing bodies with the power and authority to plan programs and allocate funding, was not found. Because of this gap in existing literature, barriers to program expansion cannot be completely understood. Therefore, this qualitative study was conducted as an initial investigation into the issues from a policymaking perspective. Until a comprehensive understanding of the issues from all perspectives is reached, the ever-increasing health needs of children will not be met.

METHODOLOGY

Design

The goal of qualitative studies is to develop a greater understanding of a topic when a relatively small body of relevant previous work exists (Polit & Hungler, 1999). In this study, reviewing the literature did not yield a comprehensive understanding of the barriers to school health program expansion. The perspective of Illinois policymakers or any state's policymaking groups was not found. Therefore, an initial investigation into this newly addressed phenomenon was conducted. The insights gained will hopefully lead to future inquiries and, eventually, the formulation of potential solutions. Until the issues are understood from the perspective of those in positions of power and authority to allocate resources, significant change will not occur.

The research question, *What are the barriers to school health program expansion from a policymaking perspective?* provided focus for the study. Longest's model was used to facilitate the identification of breakdowns in the public policymaking process. An interview topic guide was developed before data collection began. The flexible nature of the design allowed for adjustments in interview questions during the course of data collection. This resulted in a more accurate description of the issues from the subjects' perspective.

Sampling Method

Due to the broad nature of the topic and the number of potential subjects, a purposive sampling method was utilized in order to yield participants who were knowledgeable about the issues under study. The pool of potential subjects included Illinois public officials whose professional responsibilities involved policy making and/or funding allocation with the potential to impact public school children (i.e., public school officials, public health officials, and Illinois legislators). Names were obtained through publicly available staff directories of state and local personnel.

Sample Description

The pool of potential subjects included Illinois public officials whose professional responsibilities involved school policy making and/or funding allocation (i.e., public school officials, public health officials, and Illinois legislators). Eight potential subjects were contacted, resulting in a sample of seven. One legislative leader turned down the invitation to participate, citing lack of sufficient knowledge of the subject and reluctance to “go on record.” Of the seven participants, six were appointed to their positions and one was elected. Demographic information (Appendix A) was obtained and utilized in this section to describe the sample. In order to maintain the privacy of participants, only an aggregate description of the sample is provided here.

Data Collection Procedures

Telephone contacts were made with potential subjects utilizing the telephone script (Appendix B). The proposed research was described and

eligible subjects invited to participate. Upon agreeing, an interview was scheduled at a location of the participant's choice, which in each case was the participant's workplace or office. A letter confirming the time and place of the interview and principal investigator contact information was mailed to each participant two weeks prior to the appointment (Appendix C).

Face-to-face interviews were conducted by the principal investigator and taped for subsequent verbatim transcription. Interviews lasted between 30 and 60 minutes. In addition, field notes were taken as part of the data collection process. These contained:

- observational information about the participant's behavior
- theoretical information, documenting emerging themes and links to the theoretical framework
- methodological information, noting procedures and variations of the data collection process
- personal notes, including any personal feelings or thoughts about the process and progress of the study

Instrument

Semi-structured interviews were conducted utilizing the interview topic guide (Appendix D). The topic guide was written to probe the following areas in depth:

- In your opinion, what effect does the health status of a student have on his/her academic achievement/what effect do school health services have on the health status of a student?

- How is the gap between the IDEA's pledge of 40% funding support and the actual money allocated to Illinois schools financed?
- How is the implementation of such mandates as IDEA and No Child Left Behind evaluated in Illinois?
- Considering these mandates and the changing health needs of school children, what is your view of the ideal school health program?
- What barriers exist to achieving the ideal?

After introductions and exchange of pleasantries, information about the study was shared to familiarize participants with the research goal. The researcher encouraged them to speak freely about each topic area through the use of open-ended questions. As previously discussed, the flexible nature of the design allowed for adjustments in interview questions during the course of data collection. This resulted in incomplete answers to some of the interview questions but allowed for more accurate subject data to emerge. A conversational, yet purposeful style was maintained to facilitate the flow of ideas. Voice recordings were made of each interview for subsequent verbatim transcription.

Data Analysis Technique

Data analysis was conducted using the editing analysis style described by Polit and Hungler (1999). The principal investigator initially typed verbatim transcriptions from each audio taped interview for further data analysis. The

transcriptions were read and reread in order to identify underlying concepts and recurring themes. From these transcripts, categories and subcategories from which the themes were derived were identified. This method provided a systematic way of organizing and managing the raw data much like an editor reworks a manuscript to draw meaning from it.

Descriptive summaries of each major theme were composed using the categories and subcategories. From here, the researcher attempted to reconstruct an integrated conceptualization of the phenomenon under investigation: issues impacting school health programs and barriers to their expansion from the policy makers' perspective.

Ethical considerations

Permission to conduct this study was obtained from the Institutional Review Board at the University of Illinois at Chicago. In accordance with IRB guidelines, subjects were not recruited or enrolled prior to approval. Once approval was granted, subject recruitment began. Prior to data collection, information about the study was given to the subjects and verbal consent to participate obtained (Appendix E). Voice recordings of participant interviews did not include identifying information (e.g. name, gender, location) in order to protect individual privacy. Only the verbal consent process, researcher questions and participant responses were recorded. Upon completion of typewritten transcripts, audiotapes of interviews were destroyed. All research related records (including audio tapes, typewritten transcripts, data analysis materials) were kept confidential and secure and only the principal

investigator and faculty advisor had access to them. After five years, all research materials will be destroyed.

RESULTS

Qualitative analysis of the transcribed interviews revealed nine major themes: the impact of health on learning, governance of public education, the impact of federal mandates, the school funding crisis, the social service mindset, the lost vision, fragmentation of services, it is not the school's role, and the impact of good health programs on learning. These represent a mix of predetermined questions from the interview guide and themes that spontaneously emerged from respondent interviews. Themes and the categories from which they were derived are listed in Table 1. below:

Table 1: Themes and Derivations

Theme	Derivation
The Impact of Health on Learning	<ul style="list-style-type: none"> • Attendance is everything • Wasting your time • No connection made
Governance of Public Education	<ul style="list-style-type: none"> • Local control • Handcuffed • Dysfunctional bureaucracy
The Impact of Federal Mandates	<ul style="list-style-type: none"> • IDEA • NCLB
The School Funding Crisis	<ul style="list-style-type: none"> • Local impact • Impact at the State level
The Social Service Mindset	<ul style="list-style-type: none"> • Minister to the daily needs • The advocacy platform • Repercussions
The Lost Vision	<ul style="list-style-type: none"> • No connection to schools • No one wants to pay
Fragmentation of Services	<ul style="list-style-type: none"> • Fragmentation and duplication • The shared services model
Not the School's Role	<ul style="list-style-type: none"> • An ethical dilemma • Administrative barrier • Need local authority • Already in place
The Impact of Good Health Programs on Learning	<ul style="list-style-type: none"> • No quick fixes • It takes a community

Impact of Health on Learning

Attendance is Everything

When asked what effect the health status of a student has on his/her academic achievement, responses at both state and local levels were consistent. All respondents stated without hesitation, that a student's health directly impacts learning. Several respondents referenced Maslow's hierarchy of needs. One stated specifically, "if you don't meet the physical needs first, the other needs are secondary as far as the learning process...so I have to put health needs as number one." Another respondent stated that health status directly impacts attendance. "Attendance is everything." Not only does daily attendance facilitate student learning, it also impacts school funding because "our funding is based on attendance."

Wasting Your Time

One respondent remarked that much of the focus is on how students score on the ACT and SAT tests; however, health and physical needs must be met "or you're just wasting your time on academics." Student health is not addressed in any significant way because it competes with other educational programs. School budgets reflect a district's priorities, i.e. what percent of the total funding is devoted to the provision of health services. "It's not a lot, because it's not high on the priority list."

No Connection Made

Another respondent stated that good health absolutely affects student performance but that it has not been looked at on a large scale; the connection has not been made. Unless it is visible or obvious that health issues are compromising student performance, “we just don’t see it, it just goes by.” One respondent commented that despite the fact that research exists in support of prevention and early intervention programs, “for a lot of people, you have to relate it directly.” Further discussion involved the need for definitive studies that actually look at the health of students and how that connects to performance; and the focus needs to be on more than just reading and math scores.

Governance of Public Education

Local Control

When asked how the public education system is administered in Illinois, the state level was described as a “pass through agency” for state and federal funding. It is the state’s job to make sure that money gets to the local districts; then it is up to local control, i.e. local school boards, to decide where the funds will go. Since policies are set at the local level, each district has flexibility for much of the spending based on its priorities.

Handcuffed

Another respondent described the system as local control but within certain parameters. State and federal guidelines still must be met. There is a

balance between what is local control and flexibility and what Illinois School code and federal mandates dictate, i.e. teacher: pupil ratios, ages in classrooms, curriculum requirements, and how funds can be spent. One respondent remarked, “Yes, I have local control but then they say I have to spend a certain percentage in a set area. It’s a balancing act and it can handcuff you.”

Dysfunctional Bureaucracy

Another respondent commented that the system may be described as decentralized with local control; however, if the locals are not meeting state and federal standards, then the state has a problem with that. One respondent described state and federal educational agencies as “dysfunctional and so far off into bureaucracy that they lost track of why they’re there.” Another echoed that sentiment stating, “hopefully they can reestablish what it is we need to do to see that the children of Illinois get the most productive, beneficial education possible.”

Impact of Federal Mandates

The Individuals with Disabilities Act

Lengthy and General

One respondent indicated that implementation of IDEA takes place at the local level. Special educational services are written into the IEP (Individualized Educational Plan) for a student at the local level. It is implied that if a child needs a service, it should be written into the IEP. Another

respondent said “rules and regulations exist but they are very general...very lengthy, but general. If specific rules and regulations exist, I don’t know where.” Another commented that the Illinois School Code is an actual citation of the law, which is broad and general so there is confusion as to what it really means. Lawyers, special education organizations, or advocates may write interpretations of the mandates but state educational agencies usually will not.

Left to Interpretation

Local interpretation and case law. Another respondent commented that in America, special education is driven by federal mandates, i.e. IDEA. However, what the law really says is up to the interpretation of local districts or existing case law and court decisions. There are no specific rules and regulations to guide implementation at the local level. The details are left to local control. “There is not much guidance given on that. It boils down to the interpretation of IDEA by local districts and case law that prevails in your jurisdiction.”

Impact on best practice. When asked specifically how health needs are addressed, two conflicting answers were given. One respondent said it is required to write health services into IEPs and another said it is not. Another commented the service is identified in the IEP but not who will provide it. Another was not aware of any specific rules about staff to student ratios or qualifications of those providing health services. According to another respondent, there are staffing levels for special education teachers but it is

not broken down beyond that. Nursing services are less defined by need than by available staffing and money. As one respondent described it, “on one side nurses say we don’t have enough staff, we are compromised professionally, and on the other, the school board and administration say funding is limited.”

Program evaluation. When asked how the implementation of IDEA is evaluated, one respondent stated that IEPs are checked for what specific educational services are indicated. It was unclear from the response whether or not this involved checking written IEPs only or checking on the actual provision of these services in the classroom setting. Parent complaints were also identified as a means of program evaluation. One respondent remarked that special education programs are, for the most part, evaluated in-house. “One indicator might be whether you have ‘cooperative’ parents or not...how many hearings you have. This may not mean you have a bad program. You just might have a group of challenging parents who never feel they’re getting enough.”

Funding Gap

The one pie theory. According to one respondent, federal funds cover only about 17% of the costs of implementing IDEA, when in fact, the federal government pledged to provide 40%. The gap is made up by local dollars, “So in reality, when shortfalls are not funded, the locals have to pick it up.” Whatever is not covered by special education money comes out of local district funds and general state aid. Another summed it by saying, “basically

it's the one pie theory." As one respondent commented, services are mandated whether some one is paying for them or not so they will be provided regardless of where the money comes from.

As another respondent described it, "it's local costs and it's very heavy." To illustrate the impact on local budgets, this respondent discussed spending \$60,000 a year to meet the needs of one student's IEP and receiving \$2000 back in federal dollars. The bottom line is that schools have to provide those services. Another respondent referred to it as, "the cost of doing business."

Money drives decision-making. One respondent remarked that school revenues drive the implementation of IDEA. "Small districts are under extreme financial pressure. A few high needs students can decimate their entire budget...not just their special ed budget...their entire budget." According to another respondent, this could mean that in some districts, special education staff avoid diagnosing kids with handicapping conditions. This was described as a tough situation for professionals to face. Not only is it a question of money; it is also a question of ethics and professional integrity. "But money drives a lot."

Avoiding litigation. According to another respondent, schools are mandated to meet student needs and "we make our best effort to do that within the funding given." If it is something that has to be done for them to function in school, "then we need to provide that service." Difficulties arise when the school recommendation differs from what a parent wants for his or

her child. If parents disagree, there is a grievance procedure resulting in a hearing with the state educational agency. If a case goes to hearing, it can cost a district \$25,000 to \$30,000 in legal fees. Because of the way the laws are written, the district will most likely lose and still have the child to educate. As one respondent remarked, services are often agreed to in order to avoid litigation because “that’s so expensive.”

No Child Left Behind

The Detail is Very Difficult

NCLB (No Child Left Behind) was described by some respondents as having very specific requirements for student achievement. It applies to all students regardless of status, i.e. special education, regular education, or limited English students. It is very specific in nature with sanctions to be imposed if requirements are not met. As one respondent put it, “everyone around here would assume...that’s a pretty good target. It’s just the detail that’s very difficult.”

No Mention of Health

Other respondents described NCLB as being very academically oriented, “all kids must do this, all kids must do that,” with no mention of health. If students are not coming to school ready to learn, it does not address those issues. It does not focus on what resources are needed or what is required for students to be more successful. Several respondents described it as “punitive” rather than being supportive of educational improvement.

Educationally Unsound

One respondent described the legislation as “fundamentally, educationally unsound” and felt that every school no matter how good would eventually fail because of the way the law is written. “It’s insulting to local districts who are doing everything they can.” It was also described as an ethical dilemma for schools to measure academic achievement of special education or limited English students and expect them to do as well as students in regular programs. But if schools do not comply, funding will be withheld, and districts cannot afford to risk loss of financial support.

Good Idea, Bad Legislation

Respondents spoke openly and at length about the recent NCLB legislation. All referred to the philosophy behind it as “good”, “strong”, and acknowledged that schools need to help all students reach certain standards. However, one respondent described it as very narrow, focusing mainly on the academic success of reading and math. “But are they concerned about health? No.” Another respondent described it as “idealistic.” According to respondents, NCLB specifies that by 2014, there will be a 100% graduation rate, and students with handicapping conditions will read and write at grade level. As one respondent summarized, “No one can argue the concept...you’d leave a child behind? Of course not. You wouldn’t leave a child behind. But to meet the standards with the limited resources...you can’t do it.”

Destined to Fail

Other respondents commented that NCLB is bad legislation and destined to fail. One predicted that it will collapse on itself in 4-5 years and expressed hope that they would save the idea and recreate a more meaningful law. “Then schools can start to look at what it is they need to do to have successful students and put more emphasis on the ready-to-learn issues.”

*The School Funding Crisis**Local Impact*

All respondents spoke at length about the difficulty of maintaining quality programs when faced with fixed local revenues and limited state and federal support. Local districts are mandated to continue to meet IDEA requirements which in turn impacts regular programs by increasing class sizes, program cuts, and overall deficit spending. One respondent commented there will be even less money for health services in the future. “Districts are so bogged down in doing other things that the attention isn’t going to where it’s really needed, such as truly identifying how to help kids.”

Impact at the State Level

Budget constraints are felt at the state level as well. According to several respondents, educational agencies have undergone significant staff reduction in recent years; in addition, a frequent turnover in leadership has resulted in changing priorities. As a result, many ancillary positions have not

been filled as vacancies or retirements occur. At one time, State Board of Education services included school nursing, physical education, school counseling, and fine arts consultants. Another respondent spoke of one department struggling to perform its duties after a 70% reduction in staff. “What kind of message does that send to local districts if there aren’t specific people at the state level who specialize in these areas? The message is that it’s not a priority...so now it’s up to local districts to decide their priorities.”

The Social Service Mindset

Minister to the Daily Needs

One respondent discussed the social service mindset. As members of the helping profession, the voice of nurses, social workers, and other school professionals is not always heard. The attitude is, “I will be more effective to do what I can to minister to the daily needs than to fight the administrative battle. We all fall back to that social service model and don’t do the other side.” Often, social service providers in schools don’t take on the responsibility of fighting for the expansion of services.

The Advocacy Platform

Another respondent spoke specifically of having a great respect for school nurses but also commented on the need for members of the subspecialty to be more proactive in their role as advocates for kids. It was suggested that school nurses work through their professional organization as well as join with other nursing organizations that have more lobbying power.

This type of grassroots approach could be the catalyst for change at the legislative level; but advocacy needs to become part of the platform.

Repercussions

One respondent remarked that nurses are often reluctant to speak out on issues because of concerns for job security or stigmatization by administrative personnel. The result has been that individuals without health or nursing backgrounds are determining health policy and practice in schools. This in turn leads to programs that may not follow best practice standards. Another respondent commented that this is true across the board in nursing and health care, not just in the school setting:

Many people are making decisions about healthcare needs that have never worked in the field, who are not doctors or nurses, who have never worked with patients, who do not know everything that goes on and what it all means, yet are making decisions about it. Nurses know the practice act. If they were the decision makers, they would develop plans to be in compliance with both the Illinois School Code and the Nurse Practice Act.

This respondent went on to say that nurses should share decision-making in schools; all knowledgeable people should have an equal voice.

The Lost Vision

No Connection to Schools

Several respondents talked at length about the loss of the vision of public schools as a common good. As one respondent observed, we are

seeing communities where less than 35% of the adult population have school age children and have no personal connection to schools. “We are seeing a shift in our society away from this; we see it at referendum time...but it’s part of the American democratic theory that says this is good for all of us...all of us will participate, no matter the level of our connection.”

No One Wants to Pay

From another respondent’s perspective the original intent of public education is correct, to educate the entire population. But with fewer people having children in schools, no one wants to pay for it. “If you truly believe in an educational system and/or equality and/or the human population...we have to pay for these kids...they’re the ones who are gonna drag us down if you don’t.”

Fragmentation of Services

Fragmentation and Duplication

One respondent remarked that community services are administered through separate delivery systems that have territorial problems with each other. The outcome of this is fragmentation and duplication of services as well as increased costs to taxpayers. Another believed that public entities, including schools, should be talking to each other about how to share resources and save money. “But this doesn’t happen because it’s not in our history to do that.” Another respondent expressed concern that service delivery problems will have to reach catastrophic dimensions before finally

being addressed. “It will take a crisis that affects enough people before we say, ‘This is not working, let’s start over, let’s create a new model.’ “

The Shared Services Model

An in-depth discussion followed of the community model that is in place in other parts of the world. As an example, under the shared services model, the park district and school district would partner together to share snowplowing equipment. According to one respondent, discussions are beginning to take place about shared services as a more efficient use of tax dollars. Other countries have also integrated health clinics into schools, which then become community health care delivery centers. This model is an efficient way to meet community needs, including adults and families, rather than having separate delivery systems. “With health services, why can’t we partner together and share resources so everyone doesn’t have to reinvent and deliver it?” This respondent commented that an approach of this type might help get us back to that vision of the public school as a common good.

Not the School’s Role

An Ethical Dilemma

One respondent raised the question of whether or not it is the school’s role to provide health services. This respondent commented that some people believe it is a family responsibility rather than an institutional responsibility. Further comments referred to health services in schools posing an ethical dilemma. Right now the responsibility lies with the parent; it

is the school's responsibility to bring any problems to their attention. "But that debate has to go on and the issues worked out."

Administrative Barriers

Another respondent was of the opinion that not all administrators believe the appropriate place for special education students is with regular students. "We have not completely crossed that barrier." Additional comments included that this perception has been changing over the last five years; it is gradually becoming a grounded belief that all children can learn.

Need Local Authority

One respondent commented that mandates would have to come from state and federal levels to give local districts the authority to do more than just give medications or meet immediate needs. This respondent remarked that right now schools do not have legislation behind them to provide more in the way of health services. "There's too much liability if you step over the line."

It is Already in Place

Another respondent held a conflicting view and stated that we already have mandates for health services in IDEA and the Rehabilitation Act.

Another respondent commented that the recent reauthorization of IDEA identifies nursing services as a related service in the provision of FAPE. "We need to push for enforcement because the legislation is already in place for a lot of it."

The Impact of Good Programs on Learning

No Quick Fixes

One respondent stated that good programs can help meet educational goals, but that there is a lot more to it than that. Many factors combine to promote academic success, including improved teaching strategies, adequate teaching staff and classroom facilities, as well as addressing the ready-to-learn issues with appropriate programs and qualified personnel. Another commented that there is no simple answer. “It takes a community to raise a child.” One person or one program can not solve the problems. Another respondent believed, considering the range of issues faced by children and families today, it will take a much broader approach and more alliances within communities. “There are no quick fixes.”

It Takes a Community

Another respondent commented that it would be difficult to establish the value of good health programs because in one district several programs aimed at improving student performance were put into place simultaneously: a breakfast program, a healthier hot lunch program, a perfect attendance incentive program, as well as a school-based clinic staffed by a consulting physician and advanced practice nurses. The respondent added, “I don’t know how to get at the data. But do I believe that it impacts attendance and that our students do better? Absolutely, or we wouldn’t have that health center out there.”

DISCUSSION

The purpose of this study was to conduct an initial investigation into the barriers to school health program expansion from the viewpoint of public policymakers in Illinois. Despite alarming trends in the health indicators of children, school health programs have not been restructured to respond to their needs. Current literature discussed these issues in depth from the viewpoint of school health professionals. However, the perspective of Illinois policy makers, i.e. state and local governing bodies with the power and authority to plan programs and allocate funding, was not found. For this reason, a qualitative design was selected to explore the issues from a policymaking perspective.

A review of current literature yielded a substantial amount of data from the public health community, including school nurses, social workers, and psychologists. The need for school health program expansion is well documented. Changes in society and family structure, an increase in the number of disabled and chronically ill children, and unfunded educational mandates, compounded by an increase in the number of uninsured families have resulted in an unprecedented demand for the provision of school-based health services. The barriers to program expansion are also substantial; they

include lack of definitive research to establish the link between health and learning and educational mandates that do not address health or provide funding for the provision of services. In addition, a public health perspective has not been incorporated into educational planning and school health professionals have not been successful in their efforts to advocate for better programs.

Legislation directly impacts how educational systems are structured and administered. For this reason, Longest's Model of the Public Policymaking Process in the United States (2002) was used to guide this inquiry. As a symbolic representation of this complex process, it provides a template for conceptualizing school health policy making and understanding how it impacts the delivery of educational services. In addition, it facilitated the formulation of interview questions and provided a framework by which to analyze findings and identify breakdowns in the process.

After receiving approval from the Institutional Review Board at the University of Illinois at Chicago, face-to-face interviews were conducted with seven public policy makers at the state, regional, and local levels. Participants enthusiastically responded to interview questions, providing fresh insight into some of the core issues of this previously undocumented perspective. The individuals who participated were representative of the executive branch of government who, in the implementation phase of the policymaking process, are responsible for carrying out legislation developed in the policy formulation phase. Their message was clear: the task of

providing a quality public education is so great and resources to accomplish it so limited that they, as implementers of public policy, struggle to meet the mandates set forth by policy formulators.

Limitations

The results presented here are by no means an exhaustive account of the opinions of public policymakers in Illinois. As a master's research project conducted by one investigator, a major limitation of the study was the inability to reach saturation. Interviews could not be conducted until the data became redundant and no new themes emerged. To arrive at saturation, a much more comprehensive investigation is necessary. However, as an initial exploration, the results provide valuable insight.

Data collection was limited to policymakers in Illinois. The administration of public education and political climates in other states were not considered. Therefore, the findings cannot be generalized outside of the State of Illinois.

The perspectives of lobbyists and legislators are not represented in this study. Lobbyists influence agenda setting (Longest, 2002), which in turn influences legislators in the policy formulation and policy modification phases. As crafters of educational mandates, legislators determine the priorities of public education and allocate the funding to deliver it. One legislative leader turned down the invitation to participate, citing lack of knowledge and a reluctance to "go on record." Future studies must include the perspectives of

these influential groups in order to gain a more thorough understanding of the barriers to school health program expansion.

Interpretation of Findings

Despite the fact that data saturation was not achieved, interview questions generated a substantial amount of raw data. Participants spoke candidly and at length about the difficulties they encounter in their efforts to effectively implement educational mandates. Their willingness to contribute to the interview process was indicative of their level of professional commitment as well as the magnitude of problems that schools face.

Of the themes that emerged from data collection, some were generated in response to interview questions and others arose spontaneously, providing new insight into the barriers to school health program expansion. Participants who addressed them did so at length and with great conviction, attesting to the gravity of the issues. The themes that arose spontaneously will be discussed in the following paragraphs.

Local districts are not the only ones dealing with funding problems; state and regional educational agencies have been impacted by budget constraints as well. This is evidenced by a significant reduction in staff at the state level. Compounded by the frequent turnover in state educational leadership, the priorities of education are constantly changing which

contributes to a lack of continuity in the overall mission of schools. At the present time, addressing health issues is not given priority status.

Several respondents commented that, as members of the social service professions, support staff (i.e., social workers, school nurses, school psychologists) are not generally part of administrative teams in schools. Their roles are perceived to be that of service providers rather than influencing policy or planning program. Members of the support staff reinforce this perception by not advocating for the resources they need to provide high quality services to student populations.

Several interviews yielded philosophical discussions of public education as a central democratic principle in this country. Historically seen as a way to promote an educated citizenry and thus perpetuate the egalitarian ideal, several respondents felt that public schools no longer benefit from community support. Many times school referendums fail, leaving local districts no alternative but to cut programs. This was referred to by one respondent as “loss of the vision of schools as a common good” and suggests an interesting topic for further inquiry.

Another theme that arose spontaneously was the fragmentation of community service delivery that often results in duplication and wasted tax dollars. The shared services model was discussed as a possible alternative to provide cost effective services to children and families as well as a means for schools and communities to reconnect. As discussed in the literature review, schools are dealing with the problems of communities. Perhaps a community

model would address these problems more effectively, which suggests another potential area of study.

The most perplexing theme to emerge was the conflicting opinions on the provision of school health services. Some respondents felt that it was not the school's role to provide health services. Some respondents stated health care is a family responsibility and not an institutional one. Another respondent stated that schools could not provide expanded health services without a legislative directive. However, as another respondent stated, the mandate already exists in the form of IDEA and other public laws. From the researcher's perspective as a member of the school health community, the role expectation of school nurses is to provide health services to students in order for them to access the educational process. The findings here suggest the need for further study in order to reconcile these starkly contradictory philosophical stances.

Interestingly, when asked what their view of the ideal school health program was, many respondents did not have concrete answers. Several seemed confused by the question and asked for a definition of the term "school health program." The findings suggest that health programs are perceived only in terms of special education students and not from a public health perspective, i.e. addressing the overall health problems of a community. There was consensus however, that many factors combine to promote academic success; a multi-layered problem such as improving educational outcomes for children requires a multi-layered approach.

The responses that were generated from predetermined interview questions often echoed the viewpoints found in the literature review. Themes that arose from the interview topic guide will be discussed in the following paragraphs.

It was the consensus of all respondents that good health is essential to academic achievement. The benefits of good health were said to be twofold: (a) healthy students are present in the classroom, facilitating the learning process; (b) a high average daily attendance rate assures an optimal level of funding for school districts. A significant revelation for this researcher as a member of the school health community was: despite the fact that many respondents recognized the negative impact health can have on student performance, the connection was not made between programming to address health needs and academic achievement. The value of incorporating a public health approach was not understood.

There was lack of consensus as to the role each level of the educational system plays in the administration of public schools. Some respondents described school governance as a decentralized model, with the bulk of decision-making power at the local level. Others commented that decisions were made at the upper levels, i.e. federal and state. A general sense of powerlessness in program planning and funding allocation was evident from local level respondents. However all respondents agreed that the complex bureaucratic nature of the Illinois educational system prevented it from functioning efficiently.

The greatest amount of discussion was generated by interview questions pertaining to IDEA and NCLB. As depicted in Longest's Model of Public Policymaking in the United States, the formulation phase was carried out when the legislative branch wrote these mandates into public laws. However, it appears that rulemaking has not taken place as outlined in the implementation phase of the model. This is apparent in the confusion expressed by all respondents as to how these acts should be implemented, especially for the provision of health services. The broad language of the laws leaves implementation open to interpretation at all levels of the educational system; it also results in inconsistent service provision among local districts. If policies are to have their intended impact on the issues they address, they must be implemented effectively. Otherwise, according to Longest (2002), "policies are only so much paper and rhetoric" (p. 215). Findings also suggest that the federal government has fallen far short of its promise to provide adequate funding for implementation of IDEA. When school districts have very high needs students, the financial burden is substantial. While NCLB does not include additional funding, it sets the bar for academic achievement unrealistically high for all students, referred to by some respondents as a "one size fits all" mandate.

Implications

The fervor with which study participants contributed to the interview process and provided information is indicative of the gravity of the issues they face. The amount of data yielded by this study represents unlimited

opportunities for further research and must serve as a catalyst for further investigation. In order to win a place on the policy agenda, problems must be defined and alternative solutions proposed.

Further research is needed to establish the connection between the provision of high quality health services and improved educational outcomes. School-based clinics would be logical places to conduct studies and generate evidence-based recommendations. Schools also offer the opportunity to study the emergence of the “new morbidities”, which present a significant public health threat in this country. What better place than schools to focus investigations in order to plan effective interventions?

Findings suggest confusion and feelings of helplessness among policymakers and policy implementers as to who has decision-making power. At times, the relationship between the levels of school governance seemed adversarial. Future explorations must include the perspectives of policy implementers at all levels, as well as the perspective of policy formulators, including lobbyists and legislators. An increased understanding of all perspectives could promote cohesiveness in working toward the common goal of educating children.

The bridge between policy formulation and policy implementation must be strengthened if the intent of educational mandates is to be realized. Longest (2002) divides the implementation phase of policymaking into two separate activities: rulemaking and operation. Because laws do not contain specific language, the second phase usually begins with the development of

rules and regulations to guide implementation. This provides implementers with the specifics on how to fully operationalize public laws. The findings of this study suggest a breakdown in the implementation of educational mandates such as IDEA and NCLB.

An important debate that needs to take place in the public arena is that of ethics: social justice vs. market justice. Public education falls under the social justice umbrella. It is the right of all children in America and is compulsory until the age of sixteen. Under this umbrella, schools are mandated to provide the services necessary for special needs children to access a public education. Considering the cohort of disabled children that emerged as a result of technological advances in health care, why is the health community not asked to share the responsibility? As the law is written, an unintended consequence of IDEA is that the responsibility of implementation lies solely with the educational community. Interestingly, none of the respondents raised this question during the course of the interviews. Part of the difficulty lies in the fact that healthcare falls into the realm of market justice; individuals only have access to the healthcare they can afford.

Perhaps the most important implications of this study are for school nurses. School nursing is a specialty area. As health care professionals, they possess specialized knowledge and advanced training in the delivery of nursing care to school children. And as professionals, they have the responsibility to evaluate the effectiveness of their practice and make

adaptations as client needs change. As advocates for children, they must look far beyond the social service mindset of caring for daily needs and make their voice heard in the public discourse on the delivery of public education. Who better to identify client needs and recommend program improvements than those working on the front lines with children every day?

First, school nurses need to become knowledgeable about how schools are funded in Illinois. They need to understand the microeconomics of school budgets at the local level, as well as school funding at the state and federal levels. Secondly, school nurses need to have the professional confidence to enter into collaborative relationships with others in the school community. Nurses bring a unique perspective to schools and to effectively advocate for children, they must participate in effective program planning.

School nurses need to join and become active participants in their professional organization. Financial contributions in the form of membership dues translate into lobbying power, which allows them to participate in agenda setting activities in their state legislatures. Contributions of personal time, attending meetings and becoming involved in activities, also strengthen professional organizations. There is strength in numbers; a group willing to speak with one voice and work toward a common goal is more effective than one individual confronting problems alone.

In addition, the school nursing organization needs to reach out to other professional organizations. According to Joel (2002), “the nursing profession is viewed by legislators, consumers, and other health-care professionals as

being a fragmented profession in which individuals have their own agendas” (p. 113). Territorial barriers must be overcome if health care delivery is to improve for all of our clients. By joining other nursing organizations and opening up their own to other professionals who care about children, school nurses can effectively engage in the legislative process and influence policy decisions.

As discussed in the introductory section of this study, historically, the mission of school health programs has followed the public health model. Early in the twentieth century, the health issues of school populations were identified and effectively addressed. So effectively that childhood diseases (e.g. diphtheria, measles, mumps, rubella) have been nearly eradicated. In the twenty-first century, the public health mission for schools needs to be refocused. As indicated in the literature review and interview data collected, quality health programs have not been implemented to effectively meet the changing needs of today's school children:

Considering that almost every child in America participates in the educational system, the potential for school health services to make a difference in the lives of children and families is substantial. Forty-eight million children spend the majority of their waking hours in a public school setting (NCES, 2003). Therein lies the opportunity to make a positive impact on the health of our nation. Incorporating a public health perspective into educational planning in the 21st century has the potential to dramatically improve outcomes for all children. School nurses know the issues. They

must take the lead in this effort and take their place on the public stage. By articulating their knowledge and expertise, they can become the change agents for health care reform in their communities. “Nothing less than living in a safer and healthier society is at stake” (Buresh & Gordon, 2000, p ix).

References

- Annie E. Casey Foundation. (n.d.). *High-risk kids in America during the 1990's: executive summary*. Retrieved November 22, 2002, from http://www.aecf.org/kidscount/high_risk.pdf
- Bradley, B. (1998). Establishing a research agenda for school nursing. *Journal of School Health*, 68, 53-59, Retrieved December 3, 2001 from <http://ehostvgw21.epnet.com:80/delivery.asp?deliveryoption=Citation+with+>
- Brandt, C. (2002). Enhancing school nurse visibility. *Journal of School Nursing*, 18, 5-10.
- Buresh, B., & Gordon, S. (2000). *From silence to voice: what nurses know and must communicate to the public*. Ithaca, NY: Cornell University Press.
- Centers for Disease Control and Prevention. (2001). School health policies and programs study (SHPPS) 2000: a summary report. *Journal of School Health*, 71, 253-340.
- Committee on Education and the Workforce. (2004). *President Bush signs special education reform bill*. Retrieved March 18, 2005, from <http://edworkforce.house.gov/press/press108/second/12dec/idea129304.htm>

- Costante, C. (2001). School health nursing: framework for the future, part I. *Journal of School Nursing, 17*, 3-11.
- Costante, C. (2001). School health nursing: a framework for the future, part II. *Journal of School Nursing, 17*, 64-72.
- Descoteaux, A. (2001). The school nurse manager: a catalyst for innovation in school health programming. *Journal of School Nursing, 17*, 296-299.
- Dryfoos, J. (1994). *Full-service schools: a revolution in health and social services for children, youth, and families*. San Francisco: Jossey-Bass, Inc.
- Deutsch, C. (2000). Common cause: school health and school reform. *Educational Leadership, 57*, 8-12
- Goddard, C. (2004, August 1). A century later, debate over role of teachers goes on. . *The Chicago Tribune*, p. 2/5.
- Hacker, K. & Wessel, G.L. (1998). School-based health centers and school nurses: cementing the collaboration. *Journal of School Health, 68*, 409-415.
- Hall, D. (1999). School nursing: past, present, and future. *Archives of Disease in Childhood, 81*, 181-184. Retrieved January 29, 2002, from <http://webproxy.cc.uic.edu:2067/ovidweb.cgi>
- Henry Street. (n.d.). *Overview of the first 100 years of the Henry Street settlement's history*. Retrieved November 21, 2002, from http://www.henrystreet.org/site/PagerServer?pagename=abt_history

- Hootman, J. (2002). The importance of research to school nurses and school nursing practice. *Journal of School Nursing, 18*, 18-24.
- Illinois State Board of Education. (2002). *Welcome to ILearn*. Retrieved June 8, 2004, from <http://206.166.105.128/ilearn/ASP/index.asp>.
- Joel, L. (2002). *Advanced practice nursing: essentials for role development*. Philadelphia: F. A. Davis.
- Longest, B. B. (2002). *Health policymaking in the United States*. (3rd ed). Chicago: Health Administration Press.
- Marx, E., Wooley, S., & Northrop, D. (Eds.). (1998). *Health is academic: a guide to coordinated school health programs*. New York: Teachers College Press.
- National Association of School Nurses. (1995). *Position statement: caseload assignments*. Retrieved September 4, 2004, from <http://www.nasn.org/positions/caseload.htm>
- National Association of School Nurses. (1999). *Definition of school nursing*. Retrieved November 20, 2002, from <http://www.nasn.org>
- National Nursing Coalition for School Health. (1995). *School health nursing services: exploring national issues and priorities*. *Journal of School Health, 65*, 369-384.
- National School Board Association. (2004). *NSBA legislative update-July 2004*. Retrieved July 28, 2004, from <http://www.nsba.org/site/doc.asp?TRACKID=&CID=891&DID=34151>.

- National Center for Education Statistics. (2003). *Public school student, staff, and graduate counts by state, school year 2001-02*. Retrieved March 3, 2005, from <http://nces.ed.pubsearch/pubsinfo.asp?pubid=200358>
- Olson, L. (1999). The foundation of universal education. *Education Week on the Web*. Retrieved July 30, 2004, from <http://www.edweek.org/ew/vol-18/20hist.h18>.
- Peplau, H. (1997). Is health care a right? *Image Journal of Nursing Scholarship*, 29, 220-222. Retrieved October 11, 2002, from <http://webproxy.cc.uic.edu:2445/ovidweb.cgi>
- Periard, M., Knecht, L., & Birchmeier, N. (1999). A state association surveys school nurses to identify current issues and role characteristics. *Journal of School Nursing*, 15, 12-18.
- Polit, D. & Hungler, B. (1999). *Nursing research: principles and methods*. Philadelphia: Lippincott, Williams & Wilkins.
- Public Law No. 94-142, 94th Congress (1975) (enacted) Retrieved July 30, 2004, from <http://thomas.loc.gov/cgi-bin/bdquery/>
- Public Law No. 105-17, 105th Congress (1997) (enacted). Retrieved July 30, 2004, from the General Accounting Office Reports Online via GPO
Access: http://frwebgate.access.gpo.gov/cgi-bin/useftp.cgi?IPaddress=162.140.64.21&filename=publ17.105&directory=/diskc/wais/data/105_cong_public_laws
- Romano, J. (2001). The complicated task of managing school health programs. *Journal of School Nursing*, 17, 126-130.

- Ross, S. (1999). The clinical nurse specialist's role in school health. *Clinical Nurse Specialist*, 13, 28-33, Retrieved January 29, 2003, from <http://webproxy.cc.uic.edu:2067/ovidweb.cgi#TT1>
- Shi, L. & Singh, D. (2001). *Delivering health care in America*. Gaithersburg, MD: Aspen Publishers.
- Streubert, H., & Carpenter, D. (1999). *Qualitative research in nursing: advancing the humanistic imperative (2nd ed.)*. Philadelphia: J.B. Lippincott.
- Temple, M. (2002). Opinions of Illinois voters about coordinated school health programs. *Journal of School Health* 72, 1-9, Retrieved July 10, 2004, from <http://webproxy.cc.uic.edu:2626/citation.asp?>
- Tyson, H. (1999). A load off the teachers' backs: coordinated school health programs. *Phi Delta Kappan*, K1-K8.
- United States Department of Education. (n.d.). *History: twenty-five years of progress in education children with disabilities through IDEA*. Retrieved June 10, 2004, from <http://www.ed.gov/policy/speced/leg/idea/history.html>.
- United States Department of Education. (n.d.). *Overview of education in the United States*. Retrieved July 30, 2004, from http://www.ed.gov/offices/OUS/PES/int_over.html#intro
- Wainwright, P., Thomas, J., & Jones, M. (2000). Health promotion and the role of the school nurse: a systematic review. *Journal of Advanced*

Nursing, 32, 1083-1091, Retrieved August 8, 2004, from
<http://webproxy.cc.uic.edu:2067/ovidweb.cgi>

Wold, S. (1981). *School nursing: a framework for practice*. North Branch,
MN: Sunrise River Press.

Wolf, L. (2001). Partners with children. *Journal of School Nursing*, 17, 292-
295.

Wolf, L. & Selekman, J. (2002). School nurses: what it was and what it is
[Electronic version]. *Pediatric Nursing*, 28, 403-407.

Appendix A

Demographic Information

- 1) In general terms, describe your professional responsibilities in your current position.
- 2) Do you hold an appointed or elected position?
- 3) Describe your previous professional responsibilities.

Appendix B

Telephone Script

Hello, my name is Paula Bauman and I am a graduate student in the College of Nursing at the University of Illinois at Chicago. In order to complete the requirements for a Master's of Science in Nursing, I am seeking your participation in a research study. The purpose of this study is to explore the issues that impact school health programs in Illinois and the barriers that exist to their expansion. Your professional responsibilities include policy design and funding allocation that impacts public schools in Illinois, is that correct?

If you agree to participate, I would like set up an appointment to ask you a few questions pertaining to school health programs. The interview will take approximately 30-60 minutes to complete and will be audio taped for transcription at a later date. An example of the type of questions to be asked is: "in your opinion, how important is the provision of health services to the academic achievement of public school students/what is the value of providing school health services?" Prior to the interview, you will be asked for your verbal consent to be included in the study.

Do you have any questions?

What is your address?

What would be a good time and place to meet for the interview?

Thank you. You will receive a letter confirming our appointment within a few weeks. I will also include information on how to contact me, if necessary, prior to our meeting.

Appendix C
Confirmation Letter

Date

Dear Sir or Madam:

Thank you for agreeing to participate in a research study about the issues

impacting school health programs in Illinois and barriers to their expansion. We will be

meeting at _____ on _____
(location) (date)

at _____. The audio taped interview will take approximately 60 minutes.
(time)

If necessary, I can be reached at the College of Nursing in Rockford:
815-395-5624.

Sincerely,

Paula S. Bauman, Master's Candidate, RN
University of Illinois at Chicago
College of Nursing
Rockford Regional Program
1601 Parkview Avenue

Rockford, IL 61107

Appendix D
Interview Topic Guide

- In your opinion, how important is the provision of health services to the academic achievement of public school students/what is the value of providing school health services?
- How is the gap between the IDEA's pledge of 40% funding support and the actual money allocated to Illinois schools financed?
- How is the implementation of such mandates as IDEA and No Child Left Behind evaluated in Illinois?
- Considering these mandates and the changing health needs of school children, what is your view of the ideal school health program?
- What barriers exist to achieving the ideal?
- Who else should I talk to about these issues?

Appendix E

Subject Information Sheet

You are being asked to participate in a research study about issues that impact school health programs in Illinois. I am conducting this study to fulfill the requirements of a Master's degree in the College of Nursing at the University of Illinois at Chicago. You have been asked to participate in the research because, as a public official in the State of Illinois, you are involved in policy design and funding allocation that impacts public schools. I ask that you listen to this information about the study and ask any questions you may have before agreeing to participate. Your participation in this research is voluntary. Your decision whether or not to participate will have no negative consequences. If you decide to participate, you are free to withdraw at any time.

The purpose of the research is to gain a better understanding of the issues impacting school health programs in Illinois and barriers to their expansion and implementation. While current literature discusses these issues in depth from the viewpoint of school health professionals, the perspective of Illinois school policy makers is lacking. Therefore, face-to-face interviews will be conducted in order to gain insight. Voice recordings will be made of interviews to insure accuracy in the reporting of the findings.

Results will be in the form of a general summary of overall responses. Your identity as a participant will be confidential and will not be linked to the data in any way. Only the principal investigator will be conducting subject recruitment, data collection and data analysis. A waiver of written consent was requested and granted from the Institutional Review Board of the University of Illinois at Chicago because 1) the research involves no more than minimal risk to participants, and 2) without a signed consent form, there will be no written documentation linking the identity of individual participants to the data. Interview questions are not of a personal or sensitive nature; they pertain to issues that you, as a public official, would encounter during fulfillment of your professional role. In order to minimize the unlikely occurrence of loss/breach of confidentiality, audiotapes will contain only the following: 1) this reading of the "Subject Information Sheet", 2) your verbal agreement to participate in the study, 3) the interview questions and 4) your

responses. There will be no information on the tapes identifying you. All research-related material will be kept in a locked file cabinet in a locked office. Only I, as the principal investigator, will have access to these materials and will make typewritten transcriptions of interviews from the audiotapes. The faculty sponsor will be given access to the audiotapes and transcripts immediately after transcription is complete in order to verify accuracy. Audiotapes will be destroyed within 7 days of transcription. Limited demographic information about you will be gathered in order to provide an accurate description of the sample when the findings of the completed study are reported (Demographic Information sheet will be read). The sample description will be a general summary of professional responsibilities and whether the sample was comprised of elected or appointed public officials or both. This information will be obtained after the interview is complete and the recorder turned off.

There is no direct benefit to you as a participant. The study has the potential to expand the general awareness of school health programming issues from an administration perspective.

If you agree to participate in this research, you will be asked to do the following things:

- Provide your verbal consent to be involved in the study
- Participate in a one-time face-to-face interview with the principal investigator lasting 30-60 minutes. The interview will consist of approximately seven general questions about school funding and school health services in Illinois. (Example: In your opinion, what effect does the health status of a student have on his/her academic achievement/what effect do school health services have on the health status of a student?)

The sample size will be no less than five and no more than ten public officials from the State of Illinois.

In summary:

- As the principal investigator, I am the only person who will know you participated in the study. No information revealing your identity or linking it to the data will be released to others or reported in the study results.

- As principal investigator, I will be transcribing the audiotapes into typewritten narratives for subsequent data analysis. After transcription is complete, the faculty advisor will have access to the tapes to check for accuracy of the typewritten narratives. Within seven days of transcription, all audiotapes will be destroyed.
- There will be no reference to name, place, or other identifiable information made on the tapes. Interview tapes, transcripts, and research related documents will be stored in a locked file cabinet in a locked office in order to prevent access by unauthorized personnel. Results of the study will be reported as a general summary of participant responses, with no reference to individual responses. After a period of five years, all records will be destroyed and electronic files overwritten.
- There are no costs involved and you will not be paid or offered other gifts for your participation in this research.
- You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also choose not to answer any questions and still remain in the study.

I, as a graduate student, am the principal investigator of this study. My name is Paula Bauman and I can be reached at 815-395-5624. The faculty sponsor is Dr. Martha

Dewey Bergren, clinical assistant professor, College of Nursing, University of Illinois at Chicago. Dr. Bergren can be reached at 312-996-1321. Feel free to ask any questions you have now. If you have questions at a later date, you may contact the principal investigator or faculty sponsor at the above telephone numbers.

If you have any questions about your rights as a research subject, please contact the UIC Office for the Protection of Research Subjects at 312-996-1711 or toll free at 866-789-6215.

You may keep this information sheet for your reference.

Do you have any questions at this time?

If there are no further questions, please indicate your consent to participate in this research study by saying: I agree to participate in this research.

