

Social Marketing in Schools - Pitching a Healthier Lifestyle

By Ruth Andersen, Ph.D., TDH Children with Special Health Care Needs Division

As school health professionals, we know how successful industry can be at selling its products—not all of which are healthy or helpful for the kids and adults we are trying to help each day. Research has shown, for example, that because so many kids like the colorful character Joe Camel, more of them have started smoking at an earlier age. How can we compete?

As the proverb says, “If you can’t beat ’em, join ’em.” In the private sector, companies routinely and enthusiastically use marketing principles to sell their goods and services with great success, and they have done so for decades. Only in the last few years, however, have health professionals begun to borrow those same concepts and approaches for use in campaigns that address health issues. That new use of established marketing principles and procedures is known as “social marketing.” Its success is growing, and knowing something about its basic concepts can prove useful for anyone working in school health today.

What is social marketing? As an approach to public programs and awareness campaigns, social

Continued on page 6

MORE INSIDE...

Letter from the Editor.....	2
Surfing the Net for Health.....	2
School Health Alerts Lists.....	3
Affordable Health Insurance.....	3
New Poison Control Hotline	4
TDH Pesticide Surveillance.....	4
HIV/STD Prevention Resources.....	4
Upcoming Spinal Screening Workshops...	4
Revised Spinal Screening Rules.....	4
Asthma Management Pilot.....	5
World Asthma Day.....	5
Ready Texas Nurse Emergency Response System / Bioterrorism Conference.....	5 & 14
National School Health Items.....	7
Mark Your Calendars.....	14

ON-LINE!

E-X-T-E-N-D-E-D TEXAS SCHOOL HEALTH BULLETIN

This internet version of the bulletin includes the following additional articles:

- **Special Education, School Health Services & Nursing** page 8
- **Brain Injuries and How They Can Affect a Child at School** page 11
- **Identifying Educational Implications of Chronic Illness in School Children** page 12
- **Managing Asbestos in Schools** page 13
- **Overcoming Barriers to Taking Folic Acid** page 13
- **Bioterrorism Readiness Conference for Nurses** page 14

2002 Awards for Excellence in Texas School Health Winners

By Ernesto Marquez, TDH School Health Program

Awards for Excellence in Texas School Health has selected Bradfield Elementary, Garland ISD, to receive an Outstanding Award of \$750 for their new school health program - *The Clean Hands Club*. Renee Kotsopoulos, R.N., school nurse at Bradfield Elementary, implemented *Clean Hands Club* to address absenteeism resulting from sickness. According to the Center for Disease Control, hand hygiene is one of the most effective ways to prevent the spread of communicable diseases among children.

After one year of the *Clean Hands Club*, there has been a 30% decrease in absenteeism at Bradfield Elementary.

Awards for Excellence, funded by the Texas Health Foundation and administered by the TDH School Health Program, honors fifteen school/district health programs each year that are promoting health among students and/or staff. *Awards for Excellence* supports the philosophy that health promotion must start in the formative years when children develop their skills and behaviors for life, and that effective school health programming can go a long way in promoting preventive health behavior.



Kindergartners at Bradfield Elementary wave their clean hands after their "Scrubby Bear Clean Hands" lesson.

In order to incorporate health education into their elementary school curriculum, Hairgrove Elementary, Cypress-Fairbanks I.S.D., implemented the *Teach Us Body Sense (TUBS)* program. *TUBS* combines children’s literature, videos, models, and puzzles to teach children about their bodies. Because researchers have found that simply providing facts on health is not enough to ensure better health behavior, *TUBS* uses literature and hands-on activities to capture students’ imaginations and appeal to varying styles of learning. *Awards for Excellence* is honoring Hairgrove Elementary with an Outstanding Award for a new program in the amount of \$750.

Awards for Excellence winners

will be formally honored on July 12, 2002 at the All Well Institute in Navasota, Texas. Winning programs are invited to attend a banquet dinner in their honor and receive their award in person from special guest speakers from TDH, the Texas Education Agency, and the Texas Health Foundation.

Continued on page 15

Letter From the Editor

By Michelle McComb, R.N., Coordinator, TDH School Health Program

Current events at the federal level -

Two legislative acts at the federal level have the potential to affect school health in Texas. They are known as the **No Child Left Behind Act** and the **Reauthorization of Individuals with Disabilities Education Act (IDEA)**.

Innovative Programs State Grants, Title V, Part A of the No Child Left Behind Act includes "programs to hire and support school nurses" as one of the many allowable uses of local funds. However, this isn't anything new. Currently, local revenue funds most school health services programs in Texas school districts. The largest share of a school district's budget is made up of state and local funds, with the federal share consisting of a very small percentage (unless the school is identified as a low socioeconomic school and receives Title I funds).

In summary, this act does not require the funds be used for school nurses; it merely allows it. Whether this will actually increase the number of Texas schools that employ a full-time professional school nurse or not remains to be seen. The good news is that more federal dollars will be available to state education agencies. Individual districts will be able to apply for these funds through the standard application system (SAS) through TEA. These funds are available for many other student support initiatives and are not exclusively

for school health purposes. Examples of other allowable uses of funding include: after school programs, school-based mental health services, school safety programs, CPR training in schools, etc.

The National Association of School Nurses (NASN) was invited to speak at the IDEA reauthorization forum held in Washington D.C. by the U.S. Department of Education Office of Special Education. NASN identified the following priorities:

- Related Services must include school nursing services
- Ratios of professional school nurses (RN) to students must improve
- There is a nationwide need for consistent school nurse involvement in the Individualized Education Plan (IEP) process.
- Full funding of IDEA is needed for full implementation

Applying IDEA and state statutes in Texas Schools -

The TDH School Health Program receives many inquiries from school nurses and parents regarding Individualized Education Plans (IEP) and Admission, Review & Dismissal (ARD) meeting procedures. Usually the calls are generated due to confusion about the roles and responsi-

bilities of various professional school staff, and lack of communication among staff and/or between the school staff and the parents. While the parent wants their child's needs to be met, they often lack knowledge regarding which personnel are most qualified to do so. Often times students present with multiple needs, thus requiring a full range of specialty services such as physical therapy, occupational therapy, speech therapy, nursing and special education counseling. Specific issues for consideration both at the local, state and national level include:

- The ability of ARD participants to recognize educational placement decisions versus health treatment decisions; and, allowing the appropriately credentialed employee to be responsible for those determinations
- Understanding state statutes pertaining to licensure and professional practice
- Recognizing that the expectations and standards of accountability for professionals in the school setting are different than that of a parent.
- Awareness of federal and state law.

Federal law mandates that school districts provide health related services to students with disabilities if the services are required

Continued on page 6

KUDOS!

To **Mary Jackson, R.N.**, Coordinator of the TDH School Health Program's Texas Comprehensive School Health Network. Mary was honored at the 2002 Nursing Leadership Conference in El Paso last February. Mary won a best abstract award for her presentation of the TDH School Health Program's new



school nurse manual - **The Texas Guide to School Health Programs**. The manual is available on-line at the TDH School Health Program website: www.tdh.state.tx.us/schoolhealth.

SURFING THE NET FOR HEALTH

The Texas Education Agency's (TEA) Public Education Information Management System (PEIMS) Division introduces the **PEIMS Frequently Asked Questions** web page at: www.tea.state.tx.us/peims/faq/index.cgi. Use this website to submit questions regarding TEA's collection of data from your school/district. Answers are displayed on the web page and questioners remain anonymous.



The **Nonprofit Warehouse** (NPW) at www.nonprofitwarehouse.com brings non-profit manufacturers together with non-profit organizations to encourage collaboration. NPW now has a children's eyeglasses program available to schools. In addition, NPW offers a low-cost scrub program for school nurses.

www.drugs.com offers a free, on-line drug information service. Includes a Drug Interaction program, and Drug Information listings presented at both professional and consumer levels.

The **School Health Leadership Training Kit**, developed by the American Academy of Pediatrics (AAP), is available on-line for free through the AAP Section on School Health at: www.schoolhealth.org/trnthtrn/trainmn.html. The kit targets pediatricians that are taking a leadership role in local school health programs, but also offers a large amount of presentation handouts and slides that school nurses and educators may find beneficial.

School Health Alert Lists

(The following is taken verbatim from the National Association of School Nurses (NASN) Newsletter – September 2001, Vol. 16, Number 5. Subscriptions to the NASN Newsletter and the Journal of School Nursing are benefits of membership in the National Association of School Nurses. To join NASN, access the NASN website at www.nasn.org.)

WHAT WOULD YOU DO? By Judith F. Harrigan, RN, MSN

Question: My principal wants me to develop a “Health Alert List” with student names and their problems to disseminate to all school staff. Should I do this?

Answer: Health records are considered to be a part of a student’s academic record. The federal law that addresses standards of confidentiality about student academic records, the Family Educational Rights and Privacy Act (FERPA), also known as the Buckley Amendment, states that a school may disclose personally identifiable information from a student’s academic record without consent in several situations, one of which is to school staff, within the institution, who have been determined to have legitimate educational interests. The key phrase here is “legitimate educational interests.”

Consider whether the information will directly impact the student’s academic program and ability to function in the school setting. It is both wise and appropriate to notify school staff of existing student health conditions that may require implementation or modification of an education plan or the ability to meet student health and safety needs when there is potential for an emergency. In accordance with law and local policies, school health personnel must determine which health information is educationally relevant and which school personnel would need to know the information to fulfill their professional responsibilities. For instance, if a child has an allergy to bee stings, information about that problem might be shared with classroom and physical education staff, playground staff, bus drivers, and individuals who attend field trips with the child; if a child has diabetes, information should be shared with cafeteria staff as well as others, but not with everyone who works in the school.

Decisions about who should have access to health-related information should be made by school health personnel in conjunction with students, parents, and health care providers. The health record itself does not have to be shared, and generalized “Health Alert Lists” of medical diagnoses are almost never appropriate. Specific information and interpretation of that information in functional terms (nursing diagnosis) should be provided by health services staff to appropriate individuals. Staff should understand how to recognize that a student is having a health-related problem and what to do if that problem occurs. Providing in-service programs and written procedures about health problems, such as seizures, anaphylaxis, asthma, and so forth will help prepare all school staff to intervene if emergencies arise.

Written information should be labeled “confidential” and kept in inaccessible files, and instructions should be given to recipients that the information should not be disseminated to anyone else. Although FERPA does not specifically address verbal exchanges of information, personal health and academic information should not be discussed in public places or with persons who do not have a legitimate educational interest.

Resources:

Family Educational Rights and Privacy Act, Public Law 90-247 (1974). 34 Code of Federal Regulations Part 99.

National Task Force on Confidential Student Health Information. (2000). *Guidelines for protecting confidential student health information.* Kent, OH: American School Health Association.

Schwab, N.C. & Gelfman, M. H. B. (2001). *Legal issues in school health services.* North Branch, MN: Sunrise River Press.



What federal laws on special education apply to school health services in Texas?

See the article - **Special Education, School Health Services, and School Nursing** in the **extended** on-line version of the TDH School Health Bulletin at: www.tdh.state.tx.us/schoolhealth/program.htm

CHILDREN'S HEALTH CARE COVERAGE JUST GOT EASY...

For \$18 a month or less, Texas families can qualify for health care coverage for their children. You can tell them how...

Introduce parents to TexCare Partnership. Through TexCare, uninsured children can be covered by CHIP or by Medicaid for doctor and hospital visits, prescriptions, pre-existing conditions, eye and dental care, etc.

And now is a great time because the new children's Medicaid is easier and friendlier than ever. Medicaid for kids has changed:

- Uses a new, simple, short application that families can send by mail.
- Does not require an “in-person” interview with the Texas Department of Human Services (DHS) to qualify.
- Provides on-going health care coverage for children for 6 months without requiring families report any changes in income or resources to DHS.

In addition, Medicaid and CHIP will not share any information that families provide with the Immigration and Naturalization Service (INS). For info or to apply, families can call 1-800-647-6558 or visit us on the Internet. www.texcarepartnership.com



TexCare Partnership

Children's Health Insurance To Fit Your Budget

**We think too small.
Like the frog at the bottom
of the well.
He thinks the sky is only as
big as the top of the well.
If he surfaced, he would
have an entirely
different view.**



-Mao Tse-Tung

NEW NATIONAL POISON CONTROL HOTLINE

The **Texas Poison Center Network** has announced a new nation-wide poison control hotline. This hotline can provide people with free and immediate telephone access to the regional poison center in their area. The hotline is open for calls 24 hours, everyday. The hotline is staffed with physicians, nurses, and pharmacists who are trained to provide instructions for immediate treatment if a poisoning has occurred. They are also available to answer any questions regarding possible poison risks and how to prevent them. The hotline number is **1-800-222-1222**. You may also call this number to request free Poison Hotline stickers/magnets with the toll free number printed on them. Note that the Texas poison center hotline number, **1-800-POISON-1**, is still functioning as well. For more info, call the hotline and ask for a community educator, or visit: www.poisoncontrol.org.

HIV/STD PREVENTION

The TDH Bureau of HIV/STD Prevention announces the following materials available to schools: **HIV and Youth: Communication Strategies**: Interactive presentation on youth development and basic communication skills to support youth in making mature choices. Contact Beth Kelley at 512-490-2535. **Texas Resource Guide for HIV/STD Education**: Resources for educators to use in developing curricula on HIV and other STDs. Request copies from the TDH Literature and Forms Division at 512-458-7707. **TDH Bureau of HIV and STD Prevention Website**: Information on HIV/STD prevention and care in Texas, including: testing and service delivery programs, statistics, educational materials, and the Texas HIV Medication Program: www.tdh.state.tx.us/hivstd/default.htm.

TDH PESTICIDE SURVEILLANCE PROGRAM

Thank you Texas school nurses for your great response to the Pesticide Surveillance Program's request for school health fair information! If you have any pesticide-related questions or school health fair needs, call Jennifer Sievert at **1-800-588-1248**. As an fyi, starting this year, a law goes into effect in the state of California prohibiting the use/sale of products containing the pesticide Lindane for the treatment of lice or scabies on humans.

SPINAL SCREENER CERTIFICATION WORKSHOPS

The TDH Community Public Health office in Corpus Christi, Texas is offering spinal screener certification courses throughout the year. Persons interested in obtaining TDH-certification to conduct school spinal screenings are welcome to register. The following workshops are scheduled: **April 24, June 26, August 28, October 30, and December 17, 2002**. Workshops are from 9:00 a.m. to 4:00 p.m. The Community Public Health office needs at least 10 participants per class, and is encouraging people from anywhere in Texas to attend. If interested in signing up for a workshop, contact Lulu Lehmann, RN, BSN, Community Public Health, TDH, at 361-888-7762, xt448; lulu.lehmann@tdh.state.tx.us. Or contact Sylvia Trevino RN, BSN, Community Public Health, TDH at (361) 888-7762, xt. 439; sylvia.trevino@tdh.state.tx.us.

TEXAS BOARD OF HEALTH APPROVES REVISED SPINAL SCREENING RULES

The TDH Spinal Screening Program rules have been reviewed as part of a sunset process mandated by State Government Code. The

TDH School Health Program presented rule revisions to the TDH Board of Health (BOH) in September, 2001. Revisions were designed to improve the clarity and consistency of the terminology used by the program in referring to various levels of spinal screening certification, requirements of schools, and definitions of terms related to spinal screening. The proposed rules were published in the Texas Register in October, 2001. Public comment was received and considered for incorporation into the revisions.

The BOH approved the final version of the proposed rules on March 24, 2002. The revised rules can be found at the TDH School Health Program website. A formal announcement will be mailed to all TDH-certified spinal screener trainers and to all Texas superintendents and principals in April. The revised rules become effective August, 2002. For more info on the revisions to the rules, visit: www.tdh.state.tx.us/schoolhealth/spinal.htm. Or, contact the TDH School Health Program at 512-458-7111, ext. 2140.

SCHOOL HEALTH PROGRAM SEEKING IDEAS FOR LOGO...

develop a program logo to place on all of our print material. We need a logo that will visually represent the many initiatives within our program. These include the School-Based Health Center Funding Initiative, the Spinal Screening Program, the Awards for Excellence in Texas School Health, the Texas Comprehensive School Health Network, the TDH School Health Advisory Committee, the School Nurse Consultant position, the Texas Guide to School Health Services, and this regular newsletter. We would be interested in any ideas or designs that you might envision for our logo. Please submit any and all ideas to schoolhealth@tdh.state.tx.us.



How can a nurse working on multiple campuses manage care for students who need daily procedures such as gastrostomy tube feedings and clean catheterizations?

See the article - **Special Education, School Health Services, and School Nursing** in the *extended* on-line version of the TDH School Health Bulletin at: www.tdh.state.tx.us/schoolhealth/program.htm

Medicaid / CHIP Pediatric Asthma Management Pilot

By Geri Willems, State Medicaid Office

The Texas Health and Human Services Commission (HHSC) is joining with asthma coalitions in six Texas cities to design and implement a pediatric asthma management pilot for the Medicaid/CHIP populations.

In response to SB 616 and HB 342 of the 77th Texas Legislature, the HHSC workgroup has begun negotiation with asthma coalitions in San Antonio, Dallas, San Angelo, Beaumont, El Paso and Corpus Christi with a goal of enrolling up to 100 patients at each of the six sites. The target date for enrolling patients is September 1, 2002.

In these sites, pediatric patients with a hospital admission for asthma-related conditions will be offered the opportunity to enroll in the pilot. Patient participation in the pilot is voluntary. Intervention will include standardized multiple-stage patient and family asthma management education, distribution of best practice guidelines to providers, and intensive care coordination. Potential enrollees must be of school age and have access to observation and monitoring by school nurses.

The role of the School Nurse is an essential component of this pilot program. The pilot has been designed to include an evaluation component that determines the impact of school nurses in the continuum of care in this population. The school nurse will be a vital part of the health care team and will be in close con-

tact with an Asthma Care Coordinator in each of the sites.

The Asthma Care Coordinator will notify the school nurse at the point the patient enrolls in the pilot. The school nurse will perform real-time clinical observation of the children's symptoms and/or the dispensing of appropriate asthma medications. They will also reinforce asthma education the child and the family received in the hospital and in follow-up visits to physician offices. The pilot will also document the effect of self-management skills on the number of school days missed due to asthma-related illnesses.

HHSC will perform an evaluation and assessment to determine the feasibility of replicating or transferring the asthma management techniques within the model to private practices and other areas across the state. Evaluations will be done at intervals during the two-year duration and at the conclusion of the pilot program study and will include measurement of process outcomes such as utilization rate of inpatient hospitalizations, emergency room visits, physician services, appropriate use of asthma medications, and number of absences due to asthma.

For more info regarding the pediatric asthma management pilot contact Ms. Geri Willems, State Medicaid Office, at 512-424-6530; geri.willems@hhsc.state.tx.us.

WORLD ASTHMA DAY May 7, 2002

An opportunity to draw attention world-wide to the burden of asthma.

Over 150 million people in the world are diagnosed with asthma (an estimated 14.6 million people in the U.S).

- Asthma accounts for 10 million lost school days annually
- Is the 3rd ranking cause of hospitalization among children under 15
- Costs an estimated 3.2 billion dollars a year to treat children under 18

Asthma CAN BE CONTROLLED through a joint effort between students, family, doctors, and school staff. The best defense against asthma is knowledge. For more info on World Asthma Day, go to: www.ginasthma.com or www.nhlbi.nih.gov

Organized by the Global Initiative for Asthma.

Ready Texas Nurse Emergency Response System

The Texas Nurses Association (TNA) on behalf of the nursing profession is a public partner to the Texas Department of Health (TDH) Bioterrorism Response Plan. TNA submitted a nursing response plan (Ready Texas Nurse Emergency Response System) to the TDH Emergency Management Plan, which was accepted.

The Ready Texas Nurse Emergency Response System will encompass:

- 1) Education - To assess and provide through partnerships, education for the nursing profession to serve effectively in an emergency situation.
- 2) Communication - To maintain a communication system with the nursing profession during emergency situations utilizing websites, e-mail, faxes and mail.
- 3) Management - Includes (a) creating a volume of nurses who have registered with a TNA data bank, had disaster training, had creden-

tials cleared and maintained current contact info on file. TNA can activate this system in response to TDH needs; (b) supply four 1-800 numbers that can be used to accept and filter spontaneous volunteer nurses from within and out of the state and assign as needed and as deemed appropriate by TDH; and (c) to alert key portions of the entire nurse workforce as certain skills are identified, i.e. need for nurses that are knowledgeable and skilled in immunization.

The Ready Nurse System will be activated by appropriate TDH contacts to TNA when local supply of nurses is insufficient to meet the depth and breadth of an emergency. School Nurses will be valuable members of this response team. The TDH School Health Program will electronically distribute information about educational opportunities to Nurse Administrators, ESC Health Specialists and Regional TASN presidents. School

Nurses are advised to inform their superintendents and principals about this important effort in preparing a coordinated community response to bioterrorism.

A **Bioterrorism Readiness Conference** for nurses, scheduled for July 27, 2002, will launch the Texas Ready Nurse Alert System. School nurses and other nurses from across the state will be invited to learn the foundation of disaster nursing practice and the key players when Texas must respond to a major crisis or disaster.

For more info on the Ready Texas Nurse Emergency Response System and/or the upcoming Bioterrorism Readiness Conference, contact either Marilyn Patillo, PhD, RN, Univ. of Texas at Austin, School of Nursing, 512-471-7970; mpatillo@nursing.utexas.edu, or Wanda Douglas, RN, MSN, Director of Education, Texas Nurses Association, 512-452-0645; wdouglas@texasnurses.org.

Letter from the Editor... *Continued from page 2*

by their IEP. The Texas Education Code (TEC) 21.003 (b) reads: *"A person may not be employed by a school district as an audiologist, occupational therapist, physical therapist, physician, nurse, school psychologist, associate school psychologist, social worker, or speech language pathologist unless that person is licensed by the state agency that licenses that profession. A person may perform specific services within those professions for a school district only if the person holds the appropriate credential from the appropriate state agency."* (Emphasis added)

Licensed Vocational Nurses (LVN) may not delegate to unlicensed personnel because the Vocational Nurse Act does not permit them to do so. Additionally, nursing services may not be delegated to unlicensed personnel by a superintendent, principal, teacher, special education staff member or parent. An unlicensed person who delegates is in violation of the Medical Practice Act and the Nurse Practice Act.

Therefore, multiple problems are created if an ARD meeting takes place and health related and/or treatment decisions are made without the presence of the professional school nurse (RN). Some of

these challenges include: not having the necessary paperwork from and communication with the physician, staff who are inadequately trained performing a skilled procedure, and not having adequate RN supervision, to name a few. This sets up a situation that could prove potentially risky, from both the legal and medical perspectives. Communication is often an effective means of clarifying the various professional staff roles, responsibilities and practice issues. Addressing the IEP with a student-centered perspective and a team approach may prove helpful in avoiding professional territoriality and boundary issues.

Are the professional knowledge, skills and experience of a Registered Nurse valued in Texas schools?

Quality of care and standard of practice issues are not limited to those students served by special education. These concerns apply to the general population. The following are examples of the types of telephone calls that TDH SHP staff receive on an all too often basis.... a school nurse called after being told by her supervisor that the special education students with multiple health care needs were not her responsibility and she didn't need to know

what types of treatments were being performed in the classroom or who was performing them....a district administrator telephoned when the only RN in the district notified him of her intentions to retire. He wondered if replacing her with a LVN would be "essentially the same, yet cheaper"....a caller asked why school staff send students to the school nurse for minor non-health related needs, yet when a student was severely injured in an accident during industrial arts (shop) class, his teacher telephoned the student's mother to come and pick him up without notifying the nurse of the incident until afterwards....a caller wondering about the effect of Representative Steve Israel's (D-NY) "Protecting our Schools Homeland Defense Act" which would make \$20 million dollars available for training school nurses as "first responders" in the event of a biological or chemical attack on the nation. We too wonder what implications this would have for those schools and children in Texas that do not have a full-time professional school nurse. School nurses make a difference in the lives of students, yet they can't do so if they aren't there! Being present (and informed) is a prerequisite.

Michelle E. McComb

Social Marketing... *Continued from page 1*

marketing focuses on the needs of the audience, customers, clients, or consumers. It is known as "customer centered." Social marketing borrows from commercial marketing a group of basic definitions, known as the "four P's":

1) **Product** – Our product is the behavior or attitude we want our "customers" (the "target audience,"—students, teachers, etc.) to adopt. There are hundreds of examples of products we push every day in school health, whether to students, staff, families, or even the community as a whole: Lower your stress! Eat five servings of fruits and veggies a day! Don't smoke! Don't drink! You can think of lots more examples from your experience, and you probably even have one particular issue or problem that you really focus on, perhaps because of some personal experience that makes it important to you.

2) **Price** – In our field, customers pay a price for our products in a different, non-monetary

sense. For example, if the "product" we are promoting is freedom from tobacco use, the price a teen pays for "buying" our product may be rejection by their peers who smoke. In social marketing, the concept of price refers to what someone must forego in order to gain the benefit we are promoting. Social marketing principles tell us that when we market a health behavior, we will be most successful if we make sure the price is counter-balanced by a benefit of perceptibly greater worth in the customer's eyes.

3) **Promotion** – As with commercial marketing, in the social marketing process, promotion is the means we use to convince someone that the "product" we have to offer is worth the "price" they will have to pay. In school health, our job is often to persuade someone that "it's worth it" to do what we're asking. Social marketing has learned from the world of commerce that to inform is not the same thing as to persuade. To tell a potential

customer why a Nike sneaker is a better product than some other brand, for example, is not the same as persuading that customer to pay twice as much for a pair of Nikes. In order to do that, Nike marketers came up with "Just Do It!" an advertising slogan that actually tells you absolutely nothing about Nike sneakers yet surrounds the product (and its purchaser) with an attractive aura of excitement, accomplishment, decisiveness, skill, speed, and courage.

4) **Place** – As you might guess, this term refers to where we choose to locate our promotional message or program offering. Are we using complex, in-print messages for people who can barely read? Are we placing our anti-smoking message on a radio station teens don't often listen to? Understanding the right place to put our messages and services means understanding our "customers" lives, perspectives, and needs.

NATIONAL SCHOOL HEALTH ITEMS

(Thanks to the Colorado Parent Information Resource Clearinghouse (<http://www.cpirc.org>) for allowing the TDH School Health Program to reprint these two items from their website.)

The Role of the School Nurse in Providing School Health

The following statement from the Committee of School Health of the American Academy of Pediatrics appears in the November issue of the journal *Pediatrics*. Changes in society, the provision of health care, education, and the family have increased the need and demand for school health services. New paradigms are evolving for school health services as school systems develop comprehensive school health programs to address the diverse and complex health problems of today's students. The school nurse functions as a member and often the coordinator of the school health services team. The team may include a school physician, licensed practical nurses, health aides and clerical staff, school counselors, school psychologists, school social workers, and substance abuse counselors. A pediatrician often fills the school physician role because he or she is knowledgeable about general pediatrics, school health, and adolescent health. In some schools, a pediatric family nurse practitioner functions as the school nurse and may provide additional services. If unlicensed assistive personnel are part of the school health services team, their performance of skilled nursing procedures must be supervised by the school nurse in accordance with state laws.

Some schools may have a school-based health center in or adjacent to the school, which may provide primary care and psychosocial services. The school nurse coordinates the activities of the school health services team with the child's primary care physician and/or the school-based health center to provide continuity of care and prevent duplication of services.

School-based Health Centers Continue Strong Expansion Across the U.S.

The Center for Health and Health Care in Schools (CHHCS), March, 2001 - The number of school-based health centers in the U.S. climbed to 1,380 in school year 1999/2000, a twenty percent increase over two years and nearly a seven-fold increase over the past decade, according to a national survey by the CHHCS. The survey found that the most rapid growth in centers has occurred in both historically conservative and liberal states. Since 1998, the number of centers in Mississippi and Illinois more than doubled. In Wisconsin they grew by sixty-five percent, and in Louisiana by thirty-one percent.

Go to www.healthinschools.org for more info on the results of the CHHCS survey.

The six steps in carrying out an actual social marketing campaign focus on the importance of understanding customers. They are:

- (a) Planning and choosing strategy/messages, including listening to customer input about what works;
- (b) Choosing places and materials for delivering the message;
- (c) Developing materials, then testing them with the target audience and using feedback to revise them before actual use;
- (d) Program or campaign implementation;
- (e) Assessment of the campaign's or program's effectiveness; and
- (f) Before the second generation of a promotional effort, revising/refining messages, materials, and strategies based on feedback from the target audience during the actual, initial campaign.

You will note in these steps how much influence the customers exert in the process of getting a marketing campaign off the ground. Understanding the audience helps to achieve success in changing behavior, as well as helping marketers to avoid unintended consequences. (An example of the latter is the teen girl whose dad says she refuses to eat eggs. She has seen the commercial that says, "This is your brain on drugs" while an egg sizzles in a hot frying pan. It didn't convince her to stop using illegal drugs, her dad tells researchers; it just means she won't eat eggs but pushes them away and says, "Yuck. Brains.") The social marketing process, with its timely focus on customers' viewpoints, could discover whether this is an isolated viewpoint or a prevalent one likely to make the entire campaign a waste of time and money.

With the low budgets and crowded schedules of today, not to mention our varied job descriptions, very few of us in school

health will have the opportunity to plan a social marketing campaign and carry it out. But each day, we are called upon to market some product (an idea, a behavior change, a healthy food choice) in hopes of improving the health of the kids and adults we care about and care for. Whether you're a school staff member putting up a poster on health, a school nurse seeing many students in your office each day, or somewhere else in the health continuum, knowing the basics of social marketing can help you understand how to reach your "target audience" persuasively so that you can make a difference.

For more information on applying social marketing strategies in your school health programming efforts, contact Dan Smith, Med., CHES, Community Development Specialist, TDH Public Health Promotion Program, at 512-458-7111, ext. 6209; dan.smith@tdh.state.tx.us, or Jennifer Smith, Director, TDH Cardiovascular Health and Wellness, at 512-458-7111, ext. 2209; jennifer.smith@tdh.state.tx.us.

Special Education, School Health Services and School Nursing

*The following is a reprint of an interview conducted printed in a special supplement of the **School Health Alert** (May, 2001). This interview has been reprinted with the permission of the **School Health Alert** publication staff. For more info about the **School Health Alert** or to subscribe, visit: www.schoolnurse.com/publicationssha.html.*

From an interview with Charlotte J. Burt, MA, RN, C, Student Health Services Consultant, Iowa Department of Education. Ms. Burt is a leader in the National Association of State School Nurse Consultants and the Vice-President of the American School Health Association. She participated in the national task force on confidential student information to develop Guidelines for Protecting Confidential Student Health Information. She replied with editorial assistance from Mary Bartlow, Administrative Assistant, Iowa Department of Education.

SHA: What are the school nurse's responsibilities for special student health services?

CJB: *School nurses are vital to developing a foundation based on partnerships to promote special school health services.* In our continually evolving health care system, school nurses must understand the "related health services" laws and regulations. The foundation is built on his/her ability to accurately articulate these laws, regulations and relevant court opinions. Other ways to cultivate essential partnerships are to provide policy leadership, to initiate a special school health service model and implementation procedures, and to educate communities about students with special health needs.

SHA: What federal law and rules about Special Education address student health services?

CBJ: The Individuals with Disabilities Education Act of 1997 (IDEA) (20 U.S.C. Chapter 33), originally enacted as the Education for All Handicapped Children Act of 1975, requires states receiving special education federal financial assistance to ensure all qualified children with disabilities who need special education and related services to benefit from special education have available a *free appropriate public education* (FAPE) (20 U.S.C. §1400(d)(1)(A)). The IDEA defines *related services* as, "... services as may be required to assist a child with a disability to benefit from special education..." (20 U.S.C. §1401(22)).

The regulation that implements IDEA states *related service* terms include school health services and medical services for diagnostic or evaluation purposes (34 C.F.R. §300.24(a)). The individual terms are defined: "*school health services* means services provided by a qualified school nurse or other qualified person" (34 C.F.R. §300.24(b)(12)), and "*medical services* means services provided by a licensed physician to determine a child's medically related disability that results in the child's need for special education and related services," referred to as diagnostic or evaluative services (34 C.F.R. §300.24(b)(4)).

IDEA requires states to have interagency agreements or other mechanisms for interagency coordination as methods of ensuring service provision (34 C.F.R. §300.142). Other supporting federal laws include the 1973 Rehabilitation Act (Section 504) (29 U.S.C. Chapter 794, 34 C.F.R. Part 104) and the Americans with Disabilities Act of 1990 (ADA)(42 U.S.C. 12201-12204, 12210).

SHA: How are IDEA 97, Section 504 and the ADA similar for students with special health services needs?

CBJ: Section 504 of the 1973 Rehabilitation Act covers related services as part of FAPE. The regulation's procedural requirements define an appropriate education to include the provision of education and related aids and services designed to meet individual educational needs of disabled persons as adequately as the needs of nondisabled persons are met (34 C.F.R. §104). Health services are included in the list of nonacademic services to be provided. Similarly the ADA provides equal opportunity for individuals with disabilities.

SHA: What U.S. Supreme Court decisions specifically addressed school health services?

CJB: Two are noteworthy. U.S. Supreme Court decisions supporting school health services include: 1) Irving Independent School District v. Tatro 468 U.S. 883 (1984) 83-558 stating urinary catheterization is a required health procedure under IDEA, and 2) Cedar Rapids Community School District v. Garret F. U.S. 119 S.Ct. 992 (1999) stating ventilator and other health services are required related services under IDEA. In the 1999 decision, Garret F. is a student needing health services including ventilator monitoring, back up ambu bag administration, tracheostomy suctioning, urinary catheterization, and monitoring of vital signs. The school district appealed the case to the Supreme Court following rulings from an administrative law judge, federal district court, and circuit court requiring the school to provide the services.

SHA: How did the U.S. Supreme Court reach the 1999 decision? (See *School Health Alert*, May 2000)

CJB: The U.S. Supreme Court agreed with the previous decisions that the district was obligated to provide the services based on three determining factors. First was IDEA's definition of related services and the student's need for related services to attend school. Second, a physician was not required to perform the services; therefore, the school is required to provide the services based on the Tatro "bright-line" decision. Third, the overall purpose of the IDEA

Continued on page 9

Special Education... *Continued from page 8*

is to ensure access to a FAPE so that denying these services would deny access. Experts concluded these interpretations are interchangeable between IDEA and Section 504 of the Rehabilitation Act. School districts should see the decision also applying to students needing Section 504 services. With knowledge of specific state laws and regulations, the school nurse must review and ensure that school policy is in place for qualified children needing school special health services.

SHA: How would these laws and rulings affect the school nurse's role in policy-making?

CBJ: The next level of the foundation is providing leadership to develop school policies that outline the provision of needed health services to ensure that children receive an appropriate education. Components of that policy include:

- Informing the community;
- Identifying children;
- Providing an opportunity for all eligible children with disabilities to receive FAPE and early intervention in a natural least restrictive environment (LRE) on and off the school grounds in all aspects of the educational programming, for example, transportation, health services, on the playground, in the lunchroom, auditorium, gym, school-sponsored activities, and field trips;
- Meaningfully involving family and parents; and
- Transitioning services birth to post-school

These components of the policy all relate to the provision of special health services.

SHA: What should specific special health services policy address?

CBJ: Policy should include all of the following elements and must consider applicable state laws, including the state's nurse practice act:

- Inclusion with the team, program, and plan,
- Health history and assessment,
- Prescriber,
- Qualified designated personnel service providers (delegation and supervision),
- Individualized health and emergency plan (self-care), and
- Health instruction with students, staff, and personnel.

The team considers the child's individual needs and appropriate services. If the nurse disagrees with the program or plan, the nurse is responsible for voicing an opinion. If the team makes a decision with which the nurse does not agree, the nurse files a dissenting opinion.

SHA: Is there a standard for nurses' participation? Why are some nurses invited to the child study teams or special education meetings but others are not?

CJB: Special education law supports including the nurse as a team member. IDEA 20 U.S.C. Chapter 33, Part B, Sec. 1414(d)(1)(B) describes the individualized education program team members to include a person who can interpret the implications of results and other persons who have knowledge or special expertise about the child, including related services personnel as appropriate. School procedure may indicate the composition of the child study team. Nurses can ask to be included in child study teams and demonstrate the value of their contributions. The nurse must request to be included in the team whenever a child receives related health services, and if necessary, cite the IDEA definition of team members.

SHA: What type of service model and procedures create the next level of this foundation?

CJB: It is critical to ensure that all student needs are met and all steps are taken in an appropriate order. Various education-planning models can be considered for adoption. For instance, an *education-planning model* begins with knowing the child, family, and community resources. The model continues with gathering a health history; conducting health assessment; identifying the team; planning; developing individual health and emergency plans; preparing a written program or plan; indicating needed services, provider, and time for the services; education and training of the child, peers, school personnel, and community providers followed by the child attending school with the plan in place. **The child with special health needs must have a plan in place before attending school to ensure safety and appropriate services.** Follow-up on implementation of the plan means monitoring and evaluation. Throughout the process, consideration is given to the families' cultural beliefs and practices, physician's orders, procedures and equipment, the level or complexity of required services, the child's ability to participate, the school environment and climate, and environmental accessibility and accommodations (Porter, Haynie, Heintz, Caldwell, & Palfrey, 1997, p. 42).

SHA: How can a nurse with multiple schools manage the care for students in more than one site who need daily procedures, like gastrostomy tube feedings and clean catheterization?

CBJ: The school is obliged to provide services for a child to benefit from education. The nurse uses problem solving following assessment of the students to determine how services can be provided safely. Considering the state's nurse practice act, the nurse determines how, who, what and where to provide the services. Generally, if the service does not require the skills and expertise of a registered nurse, he/she may consider delegation or assignment of the task through a written plan, checklist, training, continuing supervision of the performing staff, and documentation. To provide services safely, additional nursing personnel may need to be hired.

Continued on page 10

Special Education... *Continued from page 9*

SHA: How should school nurses inform others about students with special health care needs?

CJB: The final and very important building block of this partnership foundation is educating others and communicating with the community about students with special school health needs. A school nurse can pursue strategies to inform the community through: a) presentations; b) articles in school, community, and school-home publications; c) brochures; d) newspaper articles; e) public service announcements; and f) information on a web site. Communication content may include information on requirements, policy, procedures, the model for implementation, and examples of school health services.

SHA: What other issues face the school nurse with respect to serving students' special needs?

Other current school health service issues include the cost to administer services, qualified personnel and service providers, resources, interagency agreements, and students' access to public and private insurance.

SHA: Nurses have specific concerns. For example, what can the school nurse do when a principal allows parents to train classroom staff, usually the special education aide, to perform services like urinary catheterization or tube feeding?

CJB: The registered nurse is responsible for a written individual student health care plan which specifies safe service delivery. The plan is discussed with the principal, but the nurse guides its implementation. Enlist the principal to participate in planning and to develop the staff training process, but specify the safe ways to provide services. Include parental information in the plan to tailor the procedures for the student. Asking the parent to demonstrate how the care is provided at home shows respect for their experience but may also identify techniques that need to be corrected or at least modified for the school setting.

SHA: What do school nurses need to know about emergency care plans for students with known risks like seizures?

CJB: An individual emergency care plan is needed if the child has care requirements or orders beyond the general school emergency procedures. The plan needs to be developed and agreed upon by the teacher, family, health care provider and school staff. Contingency procedures should be included. The written plan should accompany the child or be in each activity area the child attends (e.g., physical therapy) and reviewed with all staff who have contact with the student. Simulation drills are essential to assess staff readiness and skills and confirm that all communication methods function, e.g., parent's mobile telephone, intercom. School bus drivers and monitors need to know the plan, have a copy, be trained and demonstrate the actions in a practice drill and become confident in properly implementing the plan. In some cases, a student also needs an individual school or bus evacuation plan and backup plan. The plan is carried with the student and taught to any staff or other students

who will carry it out. The plan considers school layout, student safety and the staff responsible.

SHA: How would you summarize the school nurse leaders' role?

CJB: School nurse leaders actively work to develop a foundation of partnerships that create positive results for students, families, and communities. They do that by understanding the laws and regulations, developing policies and procedures, advancing a model, and educating the community.

{TEXAS SCHOOL HEALTH BULLETIN EDITOR'S NOTE: While Texas Education Code allows a school's chief administrator to assign to non-licensed personnel the task of administering medication, state law does not allow them authority to delegate medical or nursing treatments. In Texas, a registered nurse may delegate tasks if the patient's condition is stable and predictable and the task is routine. With any new treatment or change – a prudent professional nurse would personally perform the task or directly observe it. For more information on the delegation rule see the following section of the Texas Nurse Practice Act at the Board of Nurse Examiners website: DELEGATION OF SELECTED NURSING TASKS BY REGISTERED PROFESSIONAL NURSES TO UNLICENSED PERSONNEL - §§218.1 - 218.11: www.bne.state.tx.us/r&r-toc.htm and www.bne.state.tx.us/rr218.htm#218.7. Also, see the TDH School Health Program's Delegation of Health Services in Texas Public Schools brochure at: www.tdh.state.tx.us/schoolhealth/delegate.htm }

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Brain Injuries and How They Can Affect a Child at School

By: Larry Swift, TBI Project Director, Kathy Griffis-Bailey, Project Coordinator, and Susan Valley, MSW, Project Coordinator, TDH - Texas Traumatic Brain Injury Project

SUSAN' STORY

Susan was 7 years old when she was hit by a car while riding her bike. She broke her arm and leg. She also hit her head very hard. The doctors said she had sustained a concussion. She stayed in the hospital overnight, but came home the next day. At first she needed help, mostly due to her broken limbs. Her teacher and her mother worked together to bring schoolwork home, and at first, they thought she was keeping up with the class. In a few weeks, she was able to go back to school, but complained of being tired, having headaches, and not being able to see as well as before the accident. She visited her pediatrician, obtained glasses, and did improve a little. Her physical problems improved, and the external injuries healed well, but before long, she began to be disruptive, break classroom rules, and often wanted to stay home.

This is an imaginary, but likely, scenario for a child with a "mild" brain injury. In the absence of additional appropriate evaluation and intervention, it might be the beginning of a lifetime of being misdiagnosed and misunderstood, experiencing feelings of defeat and discouragement, and having unduly limited potential. Whether the injury is mild or severe, whether the child is in the regular classroom or in special education, it is extremely important to understand the differences between consequences as a result of traumatic brain injury (TBI), and those that occur as a result of other disabilities.

FACTS AND FIGURES

Traumatic Brain Injury (TBI) is the *number one* cause of death and disability of children and young adults in the United States. More than one million children sustain brain injuries every year with approximately 165,000 requiring hospitalization. More people are disabled by TBI than by spinal cord injury, Alzheimer's disease, Cerebral Palsy, and Multiple Sclerosis combined. Traumatic brain injury ranks among the most serious health problems in the U.S. today.

In Texas, more than 2,000 children are *permanently disabled* by TBI each year. However, in 1999, according to the U.S. Department of Education, only 863 students in special education in Texas were identified as having a traumatic brain injury. School personnel may not have the information necessary to correctly identify the child as having a history of TBI, but when any of the changes discussed below are present, the possibility of a TBI diagnosis should be considered. School nurses can play a significant role in obtaining medical history information regarding a possible traumatic brain injury for children both in the regular classroom and in special education.

SHORT-TERM AND LONG-TERM ISSUES FOR SCHOOL PERSONNEL

Though motor vehicle accidents are the most common cause of head injury in children, school personnel always should be alert for head trauma caused by other common childhood injuries, such as those that occur from team sports like football or soccer, or those that occur as a result of falls from playground equipment or from bicycles, skateboards, or scooters. Even a seemingly mild blow to the head can have important consequences. Any blow to the head, even without a loss of consciousness, should be considered potentially serious. The child should be monitored closely for confusion, disorientation, headaches, blurred vision, dilated pupils or pupils of unequal size or reactivity, weakness or numbness, vomiting, unusual sleepiness, slurred speech, agitation, prolonged crying, convulsions or seizures. If any of these near-term signs or symptoms occurs, return to class or play should be delayed and medical assistance sought immediately. School nurses should be consulted and teachers, coaches, and parents provided information about precautions, including both short-term and long-term consequences.

Both immediate and long-term changes can occur after a child experiences a sudden trauma to the head. The long-term consequences in a student's functioning may be noted immediately when the child returns to school or may not occur for several years after an injury. Even when schools are aware of an earlier injury to a child, parents and teachers may fail to attribute the injury to the problems that emerge months or years later.

According to the Research and Training Center on Community Integration of Individuals with Traumatic Brain Injury, four facts are important to remember about long-term changes following a TBI: (1) Changes will vary greatly from student to student; no two will be alike. (2) These changes are unlikely to disappear fully over time; the student's recovery will most likely be only partial. (3) Negative consequences may not be seen immediately, but only emerge when developmental demands reveal

Continued on page 12

Brain Injuries... Continued from page 11

deficits and problems. (4) An injured brain is less likely to meet the increasingly complex tasks children must face as they get older.

School health personnel or teachers may see any or all of the following types of changes in a student. Not all will be seen in every child. They may vary from day to day and over time. Other people and activities may affect this as well:

- **Physical changes:** tiredness, lack of interest, headaches, awkward movements, slowed reactions, heightened sensitivity to noise or light;
- **Cognitive changes:** forgetfulness, sudden failure in learning new material, word-finding difficulties, problems with organizing materials, inattention, easy distractibility, trouble following directions, needs help starting and finishing tasks.
- **Emotional changes:** moodiness, lability, depression, anxiety, acts younger than his/her age.

- **Behavioral changes:** irritability, impulsiveness, aggressiveness, inability to deal with unexpected events, easily frustrated over minor incidents, speaks out of turn, hits others, breaks rules, makes embarrassing comments, doesn't fit in with classmates.

Source:

(Mary Hibbard, et al. "Students with Traumatic Brain Injury: Identification, Assessment, and Classroom Accommodations," *Research and Training Center on Community Integration of Individuals with Traumatic Brain Injury, Department of Rehabilitation Medicine, Mount Sinai School of Medicine, New York City, November, 2001*)

MORE INFORMATION

For more information on TBI, contact the Texas TBI Project Staff at (512) 458-7111, ext. 3069, or visit the TBI web site located at www.tdh.state.tx.us/braininjury. Email your questions to brain.injury@tdh.state.tx.us. Information is also available from the Brain Injury Association of Texas at the Family Help Line: 1-800-392-0040, or on the web site at www.biatx.org.

Identifying Educational Implications of Chronic Illness in School Children

(Thanks to the Colorado Parent Information Resource Clearinghouse (<http://www.cpirc.org>) for allowing us to use this item from their website.)

Children with chronic illness often fall between regular and special education, coping with accommodations until problems that could have been anticipated can no longer be ignored, states an article in the *Journal of School Health*. Examples of chronic illnesses of concern include asthma, diabetes, hemophilia and cystic fibrosis. The author discusses the often-confusing terminology used to refer to children with health conditions, the educational consequences of chronic illness, and implications for schools. In discussing the use of terminology, the author highlights several relevant legal definitions and explains the difference between the terms "chronic health condition" and "special health care needs." She outlines the drawbacks of using diagnoses to define chronic health conditions, instead favoring a non-categorical approach that is "based on a condition's consequences as well as its origins."

The article further examines the differences between chronic illnesses and special needs, noting that "[n]o legal mandate exists to serve children with chronic illness," and many children with chronic illnesses cannot be covered under the Individuals with Disabilities Education Act (IDEA). Nonetheless, schools have a legal responsibility to identify students with special educational needs: "[s]chools do not need to wait...until students with chronic illnesses perform poorly before identifying them as requiring services."

The article concludes with five recommendations to help schools identify the educational implications of childhood chronic illness:

- 1) Schools need to recognize this population is growing, and the shift away from inpatient acute care to community-based management of chronic illness means schools, families and health care providers must work together;
- 2) Schools must identify students with chronic illness – school health records, however, many be misleading in that they reflect self-disclosed medical diagnoses;
- 3) School nurses, guidance counselors, teacher, psychologists, and administrators need to develop a systematic approach for identifying and working with children with chronic illness;
- 4) Schools need to differentiate between accommodation of a health problem and provision of educational services. For example, to accommodate children with asthma, a teacher might allow them to carry their inhalers to class, but to accommodate chronic absenteeism due to asthma may require providing extra time to make up missed homework; and
- 5) Schools need personnel who can think differently and creatively about this group of students, rather than routinely moving them into existing programs not developed to meet their educational and health needs.

Source of above article: *MCH Alert*, National Center for Education in Maternal and Child Health, February 18, 2000: Thies, Kathleen M. "Identifying the Educational Implications of Chronic Illness in School Children." *Journal of School Health*. 1999; 69(10): 392-396.

Managing Asbestos in Schools

By: Roxanna B. Guerrero, TDH Toxic Substances Control Division, Asbestos Program

The Asbestos Hazard Emergency Response Act (AHERA) went into effect in 1986, and the Environmental Protection Agency (EPA) developed regulations requiring each local education agency (LEA) to develop plans for managing asbestos in its school buildings. All nonprofit elementary and secondary schools, public and private, must adhere to these regulations. In 1985, Texas Department of Health (TDH), Toxic Substances Control Division entered into a cooperative agreement with the EPA to inspect schools (grades K-12) to ensure that they were in compliance with AHERA. In February 2001, the EPA granted a waiver to TDH, thereby transferring the authority for enforcement of AHERA to TDH.

According to the EPA's "How to Manage Asbestos in School Buildings: The AHERA Designated Person's Self Study Guide", January 1996, removal of asbestos building material is not the best course of action because improper removal may create a dangerous environment for building occupants. Rather, each LEA must identify all asbestos and create an effective operations and maintenance program in order to sustain a safe environment and promote good, long-term health of children.

In creating this management plan, an inspection must first be performed by accredited inspectors, licensed by TDH, for each school building under the LEA's jurisdiction. These inspectors identify all asbestos-containing materials and have samples analyzed in accordance with AHERA regulations. Each LEA should have a management plan developed by an accredited management planner, also licensed by TDH, and a designated person must then implement appropriate response actions and develop an operations and maintenance program. Periodic surveillances must be performed every six months by an individual that is familiar with the school to verify changes in the condition of the asbestos. Reinspections must also be performed at least once every three years by accredited inspectors, licensed by TDH, to verify changes to the condition of the asbestos. Everyone who may come in contact with the identified material must be adequately trained, and all building occupants

should be notified that management plans are in place and are available for review. This notification should be issued annually to all workers, building occupants, or their legal guardians. All documents created in response to the management plan must be added to the management plan as they are created.

TDH inspectors meet with school officials and/or their AHERA designated person and inspect certain school facilities and their management plans. If any discrepancies exist, the TDH inspectors forward their reports to the TDH central office located in Austin, Texas. If further action is warranted, then the Asbestos Enforcement Section will issue either a Warning Letter or Notice of Noncompliance (NON).

The most severe violations cited against schools include, but are not limited to, the following: failing to have a management plan; failing to use an accredited management planner; failing to reinspect every three years; and failing to include new school buildings in an existing management plan. Although less severe violations are common, the most severe violations warrant a NON. If an LEA receives a NON, it must ensure that the schools come into compliance in a timely manner; otherwise, TDH will issue a notice of violation with a substantial monetary penalty amount.

Once the management plan is in place and compliance is reached, parents, teachers, staff, and parental organizations may review the management plan and feel confident that their LEA is protecting its building occupants in the best way possible.

If you would like more information on asbestos and AHERA, please visit our website at: www.tdh.state.tx.us/beh/TSCD and link to either the Asbestos Programs Branch or the Industrial Hygiene Branch. If you have any questions, please contact either Gordon Leeks or Ken Ofunrein at 512-834-6603 or 800-452-2791 (toll free in Texas).

Overcoming Barriers to Taking Folic Acid

By: Richard Burley, RD, TDH MCH Nutrition Consultant

In January 1999, the National Folic Acid Health Communication Campaign began an effort to complement folic acid promotional efforts already underway in several states, including Texas. One component of this campaign was a baseline survey, out of which came some important discoveries! The survey identified barriers that, confirming earlier March of Dimes surveys, prevent women from taking folic acid supplements.

Research has shown that when women have adequate amounts of folic acid in their diets from the moment that they are impregnated, their newborns have fewer neural tube defects (NTDs). For this reason that the Texas Department of Health, the March of Dimes,

and other agencies have recommended that all women of childbearing age need a minimum of 400 micrograms (mcg) of synthetic folic acid every day. They also recommend that women consume either a multi-vitamin or a serving of highly fortified cereal that has 400 (mcg) of folic acid and foods that are rich in folic acid (like leafy green vegetables, beans, peanuts, broccoli, orange juice, and other citrus fruits). Clearly, it is important to help women overcome their barriers, but how can we motivate women to take folic acid?

Results from the survey mentioned above inform us of common barriers that prevent women from taking folic acid. Let us examine

Continued on page 14

Folic Acid... *Continued from page 13*

some strategies providers can employ to motivate women to overcome these barriers. Some of the women surveyed said they often forgot to take their folic acid. Providers can help women figure out a way to remember, such as taping a simple note onto the refrigerator. Some of the women said they did not feel any different after having taken folic acid. They apparently expected to feel better after taking folic acid. Providers can let clients know that they need not “feel” the folic acid in order for it to work. Some women stated that folic acid made them feel nauseous. Providers should be alert to clients’ diet records and history of recent illness. Nausea may be the result something else in the diet that might best be temporarily eliminated. Other methods of treating nausea should be emphasized, such as eating small, frequent meals. Some women felt that they simply could not afford folic acid. Women can be assisted to identify low cost forms of folic acid supplements, such as generic versions of multi-vitamins. Providers can also refer clients to services that can help them to budget their money effectively. Some women mistakenly believed that their current diet already provided them with adequate amounts of folic acid. In cases like these, providers can simply reaffirm the folic acid recommendation. However, providers should be careful to validate these clients and praise them for their good dietary habits. Some women had the idea that folic acid would

somehow cause them to gain weight. Providers can explain that folic acid is a B vitamin and does not contribute to weight gain.

There are other things that providers can say to encourage their clients to take their folic acid supplements. For example, some women feel better and have more energy when they take folic acid. Providers can also let clients know that it is better to start taking folic acid *before* pregnancy, because by the time a woman finds out she is pregnant, the fetus may already have irreversible NTDs. Folic acid also plays a vital role in the production of red blood cells and will prevent megaloblastic anemia (characterized by a reduced number of red blood cells). Finally, recent studies have shown that folic acid may prevent heart disease, stroke, and certain types of cancer (especially colon cancer).

Providers should not underestimate potential they have in one on one counseling to motivate clients to protect their health. In the case of folic acid, an ounce of prevention is worth far more than a pound of cure! Women in Texas CAN prevent birth NTDs from occurring if they are given the right information and encouragement! If you have any questions regarding this information, contact Richard Burley, RD, MCH Nutrition Consultant at (512) 458-7111 ext. 3684



Bioterrorism Readiness Conference for Nurses - July 27, 2002 - 8:30 a.m. – 4:30 p.m.

Purpose: In light of recent events and potential threats to homeland security, all nurses must now expand their practice to include basic competencies in disaster preparedness, response and recovery. The Texas Nurses Association, The University of Texas at Austin School of Nursing, Texas Department of Health and the American Red Cross have partnered to train and organize Texas nurses to be prepared in the event of mass casualties. The purpose of the conference is to provide nurses, faculty and students across the state of Texas an overview of emergency response, disaster management, and practical disaster nursing skills. The conference also will launch the Ready Texas Nurses Alert System, a collaborative effort between TNA and TDH to meet the needs of Texas in times of major disasters.

Target Audience: Registered Nurses, Licensed Vocational Nurses, Nursing Students, Retired Nurses, School Nurses

On-Site Locations in Austin: Texas Department of Health state office, 1100 W. 49th Street, and the University of Texas at Austin School of Nursing, 1700 Red River.

TDH Public Health Region Video Conference Sites: locations and addresses to be determined. Contact your TDH Region for more information. Specific sites will be published by May 20th.

Conference Objectives: By the end of the conference, participants should be able to:

1. Explain the federal disaster response plan and State of Texas emergency plan.
2. Define types of disasters and their major health effects.
3. Discuss unique requirements of mass casualty situations.
4. Define terrorism and impact of potential use of weapons of mass destruction on preparedness and response.
5. Discuss the nurses’ role in recognizing, reporting and treating of emerging infections.
6. Discuss the nurses’ role in the management and triage at chaotic disaster sites.
7. Conduct a primary 90-second and secondary 3-5 minute rapid field patient assessment.
8. Discuss the requirements of a Triage Nurse, general liability and state nursing practice act.
9. Discuss the varied roles nurses can play in disaster preparedness, response and recovery.

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Questions/suggestions:
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Publication #05-10958

HAVE YOU SUBSCRIBED
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If you do not already have a subscription, provide the info below and the TDH School Health Program will send each future issue directly to you. There is no charge. Send info by fax: 512-458-7350 - Attn: School Health Program, or to schoolhealth@tdh.state.tx.us.

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We need your feedback! Tell us what you would like to see in the bulletin. Send us submissions - an anecdotal story, artwork, accolades, or anything else of interest to school nurses in Texas!

Awards for Excellence... *Continued from page 1*



A Hairgrove Elementary student proudly dons her interactive "body part" outfit

Awards for Excellence provides fifteen cash prizes to school health programs each year in amounts of \$750 to \$1500. Any type of program designed to meet the health needs of students, faculty, staff and/or the greater school community is eligible. This year, fifty-four schools and/or districts submitted an awards proposal for their health program. Only fifty-four out of more than 7000 campuses/districts in Texas addressing the health needs of their students/staff, and we encourage them to apply for an award. All applicants receive (1) constructive feedback on their programs and (2) a free *Awards for Excellence* t-shirt. Applications for next year's competition will be available on-line in January, 2003. Email schoolhealth@tdh.state.tx.us to request a notification when the application is available.

2001/2002 AWARD WINNING SCHOOL HEALTH PROGRAMS

NEW PROGRAMS - Excellence Awards (\$1000)

Comal Elementary, Comal ISD - First Aid, CPR and Babysitter Certification
Lubbock-Cooper ISD - LCISD Crisis Response Plan
Mesita Elementary, El Paso ISD - "Spot Light Health" Fittest Class Program

Outstanding Awards (\$750) -

Alamo Achievement Center, San Antonio ISD - Alamo Drug Education
Bradfield Elementary, Garland ISD - The Clean Hands Club
Garland I.S.D. - "Teach to Reach, Reach to Teach"
Gladys Polk Elementary, Brazosport ISD - Little Lifesavers
Hairgrove Elementary - (TUBS) Teach Us Body Sense
Park Crest Elementary, Garland ISD - Lay Lice to Rest

ESTABLISHED PROGRAMS - Excellence Awards (\$1500)

Brownfield Middle School, Brownfield ISD - "Hand in Hand" Program
Irion County ISD - W.O.W. - Working on Wellness
Wichita Falls ISD - CPR Program

Outstanding Awards (\$1000) -

American Youth Works - Creating Better Healthcare Consumers
Lozano S.E. School, Corpus Christi ISD - Healthy Bodies, Healthy Minds
West Orange-Cove CISD - "Piecing Together Healthy Lives" Employee Wellness



MARK YOUR CALENDAR!

MAY

Asthma & Allergy Month
Bike Month
Better Sleep Month
High Blood Pressure Education Month
Mental health Month
Drinking Water Week (5-11)
Suicide Awareness Week (5-11)
Cinco de Mayo - May 5
World Asthma Day - May 7
Mother's Day - May 12
Natl. Employee Health Day - May 15
World NO TOBACCO Day - May 31

JUNE

Hug Holiday Week! (9-15)
Father's Day - June 16

JULY

Baked Beans Month
Independence Day - July 4

AUGUST

Immunization Awareness Month

More health-related dates at:
www.foodandhealth.com/calendar