DC Action for Children

Lessons Learned from the 2016 Student Health Needs Assessment

IN PARTNERSHIP WITH

The DC Department of Health (DOH)

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ASSESSMENT TEAM

Shana Bartley, MSPH, Director of Programs
HyeSook Chung, MSW, Principal
Tim Vance, MA, Data and Research Manager
Adrienne Lloyd, Project Coordinator

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Executive Summary

Research from a range of disciplines provides compelling evidence linking the importance of student health with academic performance: when students are healthy, they are better learners. Since all children are required to attend school starting at age five, school health providers are in a unique position to regularly and consistently support student health.

The District of Columbia Department of Health—Community Health Administration (DOH) funds and oversees two major school health programs: The School Nursing Program and School-based Health Centers. In order to ensure that these programs are responsive to the needs of students in DC Public and public charter schools, the DOH commissioned this needs assessment.

The School Health Needs Assessment uses both quantitative and qualitative data to provide a comprehensive description of how the DOH's current school health programs meet the needs of students. Qualitative data was collected through semi-structured interviews with key informants across District agencies and health providers as well as through focus groups with parents and students. We analyzed quantitative data that came from a variety of sources to understand the health needs and social determinants of health for DC children and utilization patterns of the current school health programs.

The analysis revealed that students attending DCPS and public charter schools face a variety of chronic conditions in addition to common childhood ailments that can affect their ability to focus in the classroom. While school health plays a critical role in supporting student learning, these services fit in a broader system of care and supports necessary for children to thrive. Based on the data, the DOH should consider these potential next steps to strengthen school health services in an effort to better meet student health needs:

1. **Establish a shared vision for children's health in the District.**
   This new vision must be shared with various stakeholders across the District in order to fit school health into a broader system of health care that is child-centered and emphasizes improving health outcomes.

2. **Improve data collection and systems for school health services.**
   District agencies and the school sectors should work together to identify opportunities and methods to improve data collection and sharing.

3. **Create and distribute process documents and training materials that clearly define the roles and responsibilities of school health providers.**

4. **Form a school health collaborative or advisory body.**
   In order to improve city-wide coordination and to create a forum for vetting new ideas and addressing grievances, DOH could form a school health advisory body that brings together agencies and school leaders to ensure on-going communication and collaboration.

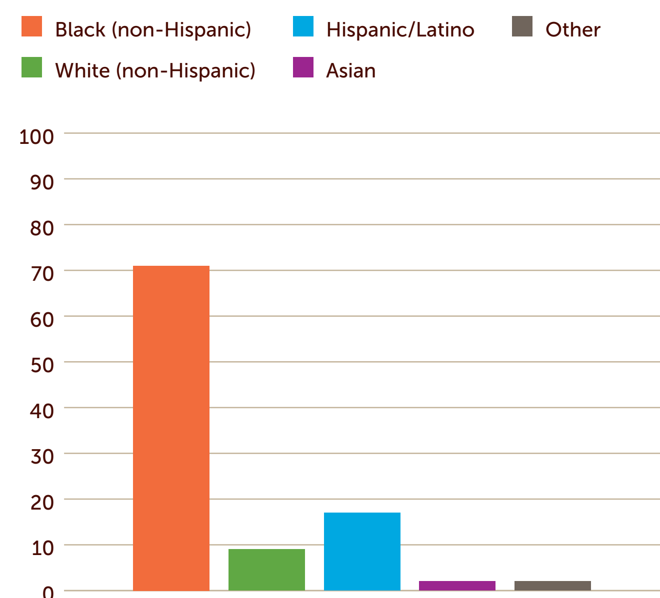
5. **Implement a more robust evaluation and quality assurance process.**
   In order to strengthen the school based health program, DOH could collect feedback from school leaders, students and parents about their experiences and satisfaction with services and providers.

Introduction

The District of Columbia is home to 115,233 children under the age of 18.[i] Of these children, 58% are black, 21% are non-Hispanic white and 15% are Hispanic.[ii] Just as there is significant racial diversity in the District, there is also significant economic diversity: approximately 29,000 children (26%) live in families with incomes below the federal poverty line, 14,000 of whom live in extreme poverty represented by family incomes less than 50% of the poverty line.[iii]

Enrollment in the District's public education system continues to grow. As of the 2014-15 school year, the District of Columbia public education system serves 85,403 children and youth between ages 3 and 18+ across two public education sectors: District of Columbia Public Schools (DCPS) and District of Columbia Public Charter Schools (DC PCS). 47,548 students attended a school within DCPS and 37,684 attended a charter school.[1] Across public school students District-wide, 70.8% are black, 9.1% are non-Hispanic white and 16.5% are Hispanic.[iv] In addition, 44% are eligible for the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF), a proxy measure of student poverty.[v] These students must navigate a variety of challenges associated with living in poverty.

Figure 1
Race/Ethnicity of Students Attending DCPS and Charter Schools (SY2014-15)



1. As of school year 2015-2016, there are 116 DCPS schools and 62 charter school local education agencies operating 115 schools.

Organized by both school sectors, the charts below summarize and expand upon the student demographic, health and economic indicators discussed above based on school location.

Table 1

DCPS				
School Location	Total Enrollment	TANF/SNAP Eligible Enrollment	ELL Enrollment	SPED Enrollment
Ward 1	5953	2365 (40%)	1841 (31%)	679 (11%)
Ward 2	2377	509 (21%)	276 (12%)	241 (10%)
Ward 3	6932	533 (8%)	528 (8%)	573 (8%)
Ward 4	6890	2617 (38%)	1821 (26%)	945 (14%)
Ward 5	4510	2517 (56%)	116 (3%)	712 (16%)
Ward 6	7109	3066 (43%)	199 (3%)	1123 (16%)
Ward 7	5531	3929 (71%)	68 (1%)	945 (17%)
Ward 8	8130	6140 (76%)	22 (<1%)	1350 (17%)

Table 2

DC PCS				
School Location	Total Enrollment	TANF/SNAP Eligible Enrollment	ELL Enrollment	SPED Enrollment
Ward 1	5689	1153 (20%)	997 (20%)	399 (7%)
Ward 2	551	43 (8%)	0 (0%)	23 (4%)
Ward 3	0	0	0	0
Ward 4	5200	1577 (30%)	791 (15%)	639 (12%)
Ward 5	7108	2717 (38%)	297 (4%)	734 (10%)
Ward 6	3629	1632 (45%)	93 (3%)	492 (14%)
Ward 7	6014	3376 (56%)	61 (1%)	1012 (17%)
Ward 8	7374	4410 (60%)	7 (<1%)	787 (11%)

School Health in the District of Columbia

The District of Columbia Department of Health—Community Health Administration funds and oversees two programs dedicated to address the health needs of students in publicly-funded schools in the District: *1) the School Nurse Program and 2) the School-based Health Center program.* These school health services provide vital resources that support children so they are able to reach their full potential.

The School Nurse Program

Although there are multiple pieces of legislation and municipal codes that inform the school health policy landscape, *DC Code Title 38, Chapter 6* (Educational Institutions, Student Health Care) is foundational. Subchapter II on the subject of public school nurses explicitly states that, "the minimum hours per week of registered nurse services at each school shall increase from 16 to 20 hours per week beginning 2 years after December 10, 1987."[vi] Additionally, subchapter II also clarifies that, "licensed practical nurses may be used to supplement the registered nurse work force in meeting the required 20 hours per week minimum registered nurse services at each elementary and middle school." Though DC code specifies minimum requirements for the school nursing program, it is important to note that, in practice, 98% of schools that receive services from DOH have more than 20 hours per week of nursing coverage.[2]

Currently, the Department of Health provides school nursing services to DCPS and charter schools through a contract with Children's School Services. **There are 160.4 full-time equivalents working in 112 DCPS schools and 57 charter school campuses.**

School-based Health Centers

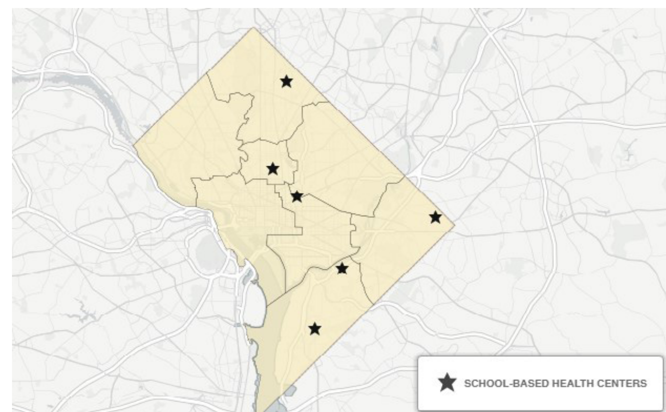
School-based health centers provide access to primary care services in schools; these clinics are uniquely designed to mitigate barriers for youth seeking adolescent-friendly health care environments. *DC Municipal Regulations Chapter 5-B, ∫ 2413* provides rulemaking for school-based health centers in the District:

"The health services shall be provided to DC Public Schools students in a school setting in accordance with the provisions of this section, standards as established by the Department of Health, and an agreement concerning school-based health centers (SHCs) executed by the DC Public Schools (DCPS) and the healthcare organization."

The Department of Health funds school-based health centers in six DCPS high schools[3] through grants with the following three providers:

1) Unity Health Care: Ballou High School, HD Woodson Senior High School, Cardozo Education Campus
2) MedStar Georgetown University Hospital: Anacostia High School
3) Howard University Hospital: Coolidge High School, Dunbar High School

Figure 2
School-based health centers



2. It is important to note that all schools are not required to obtain nursing services from the Department of Health. Local education agencies can opt to hire private nurses.
3. Eastern High School also has a school-based health center run by Unity Health Care, but it is not funded by the DC Department of Health.

Findings from the School Health Needs Assessment

The purpose of the School Health Needs Assessment (SHNA) is to assess health needs, gaps and priorities for school health services. The intent is to measure the degree to which DOH's current health services programs meet the health and wellness needs of each school community, with a focus on needs of the adolescent population, and to identify gaps and priority areas for transformation of school health service programs. Data was collected through interviews and focus groups; health services utilization data from Children's School Services and the SBHC provider was analyzed and summarized for this report. To see the full methods used, please refer to Appendix A. The needs assessment report will answer three overarching questions:

School Health Needs Assessment Research Questions

1. What are the current health needs of DC public school students, particularly middle and high school students?
2. How can the District's health services best meet the health and wellness needs of children and youth enrolled in DC public schools in order to promote total wellness of the whole child?
3. How can the District best track and monitor health outcomes for students?

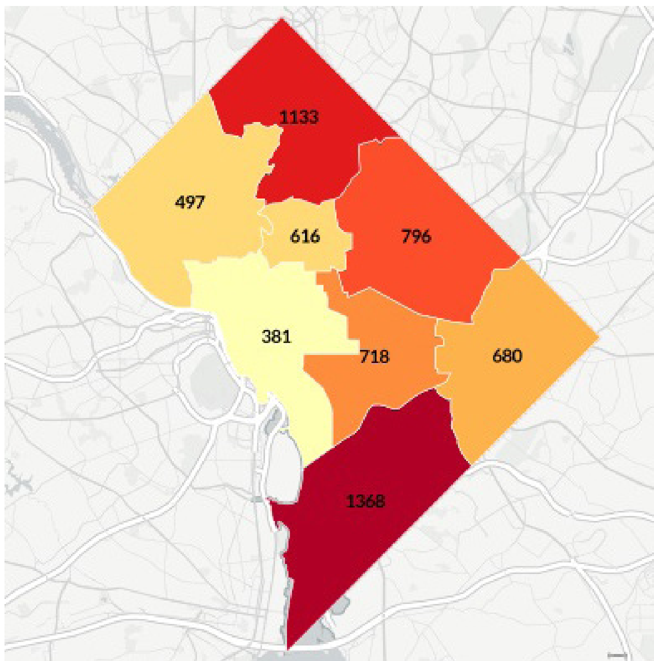
The findings below illustrate that students in DC public schools require a wide range of supports in order to reach their full potential. The analysis also raises important questions about the coordination among District agencies and the structure and capacity of the current programs to meet student needs.

Q: What are the current health needs of DC public school students, particularly middle and high school students?
A: DC students have a wide range of health needs, and their health is not improving.

Data on child and youth health in the District of Columbia illustrate the serious magnitude and range of student health needs. According to the most recent data available from the 2012 National Survey on Children's Health, 19% of children and youth reported they were not in excellent or very good health, an increase from 17% in 2003.[vii] Based on data and reports from students, parents, school leaders and school health providers, the most common health needs affecting students include a mixture of mild, acute conditions like cuts, headaches and stomachaches and complex chronic conditions including asthma and diabetes. School health providers administer a range of services that attend to the variety of student needs and concerns.

Over 28,000 (or 33%) of DC students have at least one chronic condition. **Almost six thousand students require some form of regular health services at school;** 88% of these students have multiple health problems. The distribution of children requiring regular health services varies significantly by ward as Figure 3 below illustrates.

Figure 3
Number of Students Requiring Daily Medical Attention by Ward* (SY2014-15)



**School Location*

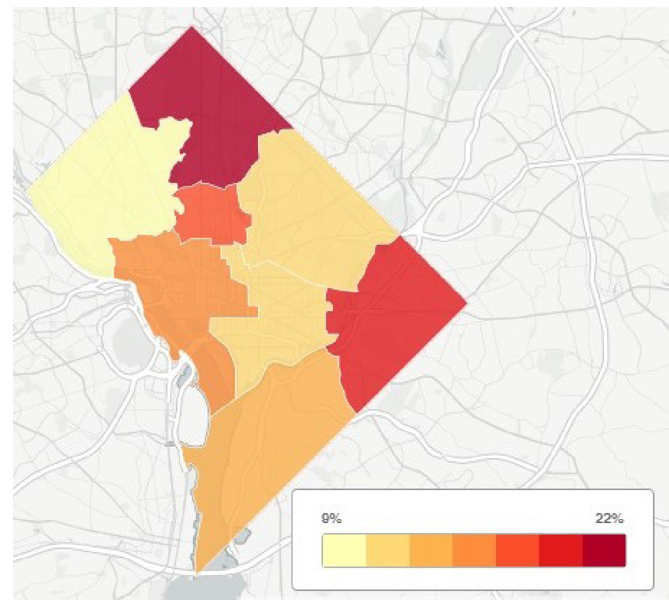
For the 2014-2015 school year, the most common chronic health conditions included[viii]:

1) **Asthma, which affected 13,365 students,**
2) **Allergies, which affected 5,204 students,**
3) **Attention Deficit Hyperactive Disorder (ADHD), which affected 1,626 students**

These conditions often require medication and/or monitoring during the day to ensure that children remain stable. Moreover, there were also other conditions that were less prevalent but require significant time and attention from the school nurse and other personnel. *While less than 1% of public school students were diabetic, 70% of all recorded special needs administrations by school nurses were for diabetic care.*[ix] Chronic disease monitoring and management are important attributes of school health services given the breadth of need among students.

In addition to chronic disease monitoring and management, school nurses also screen for other common student health conditions that can adversely affect academic performance. This includes hearing and vision screening and growth examinations; 15% of public school students that were screened for vision problems failed the examination and 2% failed hearing. Student growth examinations indicate that 9% of students were underweight while 30% were overweight or obese.[x]

Figure 4
Percentage of Students Failing Vision Screening by Ward* (SY2014-15)**



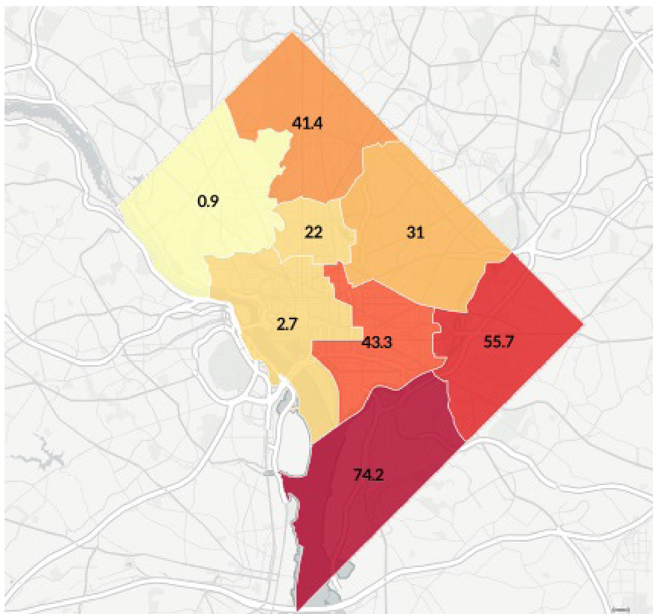
**School Location*
***This map depicts vision screening results for public school students in kindergarten, 1st, 2nd, 4th, and 6th, 8th and 10th grades, the targeted grade levels CNMC has identified for yearly health screenings.*

Many students also present behavioral health concerns that can affect their learning. Data measuring Adverse Child or Family Experiences (ACEs) suggest that a large share of children and youth in the District have experienced behavioral health risk factors. In all, over half of all children and youth in the District have experienced at least one behavioral health risk factor while one quarter has experienced two or more.[xi] Exposure to these risk factors has contributed to high levels of behavioral health issues for District students. The 2012 YRBS results indicate that 17% of children had one or more emotional, behavioral, or developmental conditions, a 2% increase from 2007.[xii] Self-reporting of attempted suicide by District youth has

consistently been double the national average of 6.3 percent. Additionally, District youth report higher than average rates of marijuana and other drugs including inhalants, heroin, methamphetamines and steroids. School nurses and SBHC's provide care for students with behavioral health issues. *During the 2014-15 school year, there were 2,025 school nurse encounters for mental health or psychosocial issues and 701 student visits to SBHCs for behavioral health concerns.*[xiii]

Moreover, data indicates that a significant number of adolescent students are sexually active. More than half of District youth responding to the 2012 YRBS indicated that they were sexually active.[xiv] Unplanned pregnancy and sexually-transmitted infections are potential concerns for many youth. While the birth rate for 15-19 year-olds in the District (33.4 per 1,000) has been steadily declining in recent years, it remains higher than the national rate (27 per 1000). Teenage pregnancies are more prevalent in particular areas of the city. For example, the teen birth rate in Ward 8 (74.2 per 1000) is over twice as high as the citywide rate.[xv]

Figure 5
Teen Birth Rate by Ward (2013)



HIV rates for youth in the District are also significantly higher than the national average with 200 children aged 13-19 diagnosed and living with HIV per 100,000 population. Furthermore, there were 5,448 and 1,528 cases of Chlamydia and Gonorrhea per 100,000 population, rates that were also well above the national average.[xvi] All three SBHC providers indicated that sexual health was one of the top reasons students visit their clinics.

The data demonstrate that students in the District's public schools have a variety of health conditions and concerns that can impact their ability to learn and reach their full potential.

Q: How can the District's health services best meet the health and wellness needs of children and youth enrolled in DC public and charter schools in order to promote total wellness of the whole child?
A: To best meet students' needs, the data indicate that DC must take a holistic approach and better integrate school and community health resources.

All participants in the Assessment process indicated support for school health services. However, the data, interviews and focus groups reflect that while services are available to address many of the needs described above, there are questions about if the current delivery model is designed to best improve health and academic outcomes for students.

The assessment revealed that there were five major areas of need for the DOH's current programs: the School Nurse and School-based Health Center Programs:

1) Communication
2) Coordination
3) Engagement
4) Management
5) Quality Assurance

Communication

The infrastructure of the school health services programs brings together multiple agencies in addition to the Department of Health. The system includes support from District of Columbia Public Schools (DCPS), Public Charter School Board (PCSB), Department of Health Care Finance (DHCF) and the Department of Behavioral Health (DBH). Interviews with DC agencies, school leaders and providers highlighted a need for increased channels of communication across all levels of school health services delivery. This includes communication between agencies, from agencies to schools and providers, and among personnel at the school. Lack of communication often leads to confusion around roles and responsibilities, unclear expectations of providers, parents and school staff and creates tensions in the system.

Coordination

Given the number of agencies engaged in providing health services to students in schools, coordination and organization are important to reduce duplication of efforts and ensure that students are linked to services that best meet their needs. To improve coordination, the agencies

must clarify their different roles and develop protocols to navigate layers of accountability between the providers and the numerous agencies involved in different aspects of school health.

Additionally, at the school level, both DC agencies and the providers highlighted need to improve coordination between the registrar and the school health providers. Since information about student health (universal health certificates and oral health assessments) and SBHC consent forms are included in the school registration packets, the registrar can support efforts to get completed forms and remind parents of the importance of these forms. This can create a unified message from the schools and the school health providers about the importance of these forms, so that students can access services and school health personnel can follow up with parents and the students' other health providers when necessary.

Engagement

Given the unique management structure of school health services and the need for more in coordination, engagement of school health providers must be improved. This includes a need for providers to more actively engage students and parents through outreach and education. It also includes school leaders reaching out directly to school health providers to participate in school events.

Management

School health providers are contractors to the Department of Health and function as support staff within the schools. Because providers are employees of private organizations and embedded in schools, the DC school health services model requires multiple levels of management. To ensure services are provided effectively and efficiently, clearly defined roles and process for sharing information and providing feedback are necessary. School leaders and providers need support from the agencies to work together and a useful way to share information and concerns.

Quality Assurance

High-quality health services are vital resources that support students to be successful learners. To improve quality, DC Agencies, school leaders, parents and students highlighted the importance of customer service skills, patient satisfaction and consistent coverage in the delivery of health services. A more child-centered approach with special attention to linkages in the community could improve outcomes by focusing more on children's needs and the system of care necessary to keep them well.

As health needs grow and more students attend public schools in DC, health and education leaders must ensure that they implement a model that provides a holistic approach to supporting students. Many of the needs identified above exemplify challenges arising from lack of collaboration and a shared vision. **Therefore, to improve outcomes for students and better leverage school and community resources, DC agencies should consider a new model. Given the diversity in schools across the city, the model must be responsive to unique students and schools while providing quality and accessible services and resources.**

Q: How can the District best track and monitor health outcomes for students?
A: Utilizing best practices research, develop a system to integrate health and academic outcomes data.

The lack of data integrating health and academic outcomes created significant challenges for this assessment. While comprehensive data on utilization exists for both school nurses and SBHCs, it is impossible to link this data with specific outcomes and improvements in student health and performance. Utilization data indicates why and how often students access services, but it does not provide information about how use of those services impact their health and well-being. While the available data demonstrate the need for school health services, it also illustrates that the health of DC students is not improving at the population level. To better monitor and assess services and track improvements, an integrated data system that captures health and education information is vital.

School leaders and providers shared an interest in sharing more data. Both groups called attention to the need to link school health data with academic and attendance data to see how access to services improves performance and supports students' ability to learn. There are a variety of known outcomes associated with school nurses and school-based health centers. Agency leaders could develop infrastructure to share important information that demonstrates the impact of school health services on student performance. Although, groups reflected that privacy requirements restrict what and how data can be shared, there are still opportunities to share some information. Representatives at the agency level are implementing memorandums of agreement to connect health and education data when possible.[4] Aggregate-level data could provide valuable information to providers and school leaders if it can be made available. It could also assist agency leaders in their efforts to better coordinate resources and evaluate their efforts.

4. Currently DCPS, DOH and DHCF have a memorandum of agreement to share data regarding students enrolled in Medicaid attending DCPS schools. This information helps Medicaid Managed Care Organizations better coordinate care by learning where their customers attend school.

Moving Forward: DC must change the school health model

With a vast body of research demonstrating the value of school health services, public health and education experts acknowledge that health intersects with learning and academic performance. This understanding gave way to the Coordinated School Health (CSH) approach that integrated health-promoting practices in the school setting.[xvii] While valuable, the CSH approach did not account for the psychosocial and physical environments that affect children's health and learning ability leading experts to reconsider this approach. Across the country and in DC, public health and education leaders are thinking about new and innovative strategies to better support students' learning and achievement. The Centers for Disease Control and Prevention (CDC), in conjunction with the Association for Supervision and Curriculum Development (ASCD), developed a new approach to child well-being designed to improve health and learning in schools.

The Whole School, Whole Community, Whole Child (WSCC) model is a child-centered approach to support student well-being that expands upon components of the CSH model.[xviii] For a child to reach their full potential, they must be healthy, safe, engaged, supported and challenged. While the WSCC has gained national prominence, it is not a one-size-fits-all model. Rather, the WSCC emphasizes the importance of collaboration among stakeholders in health and education to match local resources with the particular health needs in each school community. At the center of this collaboration, schools function as hubs that connect children to the resources they need to succeed and thrive.

Picture credit: CDC & ASCD 2015

Given the complex needs among DC students, this model provides a potential framework to address students' needs through school and community-based resources and comprehensive services. It shows that a variety of services, not limited to school nurses and school-based health centers, are needed to support children. Furthermore, the flexibility moves away from obsolete conventions about school health services like standard nurse-to-student ratios and other one-size-fits-all approaches. While the vast majority of schools have full-time nurse coverage, a single individual cannot attend to the complex student needs outlined above. Although limited, there is some data that indicates that providing full-time nursing does not necessarily lead to increased services for children.

For example, nurse-to-student ratios and full-time coverage do not appear to have a strong relationship to the percentage of students with special health care needs with an individual health plan on file. Specifically, the plots below compare the percentage of students with individual health plans (IHP) during the 2014-2015 in each school to the percentage of the school's student body that would qualify for an IHP. The expectation is that schools with a lower percentage of the student body requiring an IHP would likely have a higher percentage of students with an IHP on file. Moreover, we would also expect that schools with full-time nurses would have higher percentages of students with an IHP because a nurse would be more available to ensure the plans were complete. However, the distributions show that even though the majority of schools have full-time nurses, there is no distinct trend that indicates more students have their IHPs:

Figure 6
Complete Individual Health Plans at Schools with Part-Time Nursing Services, SY 2014-15

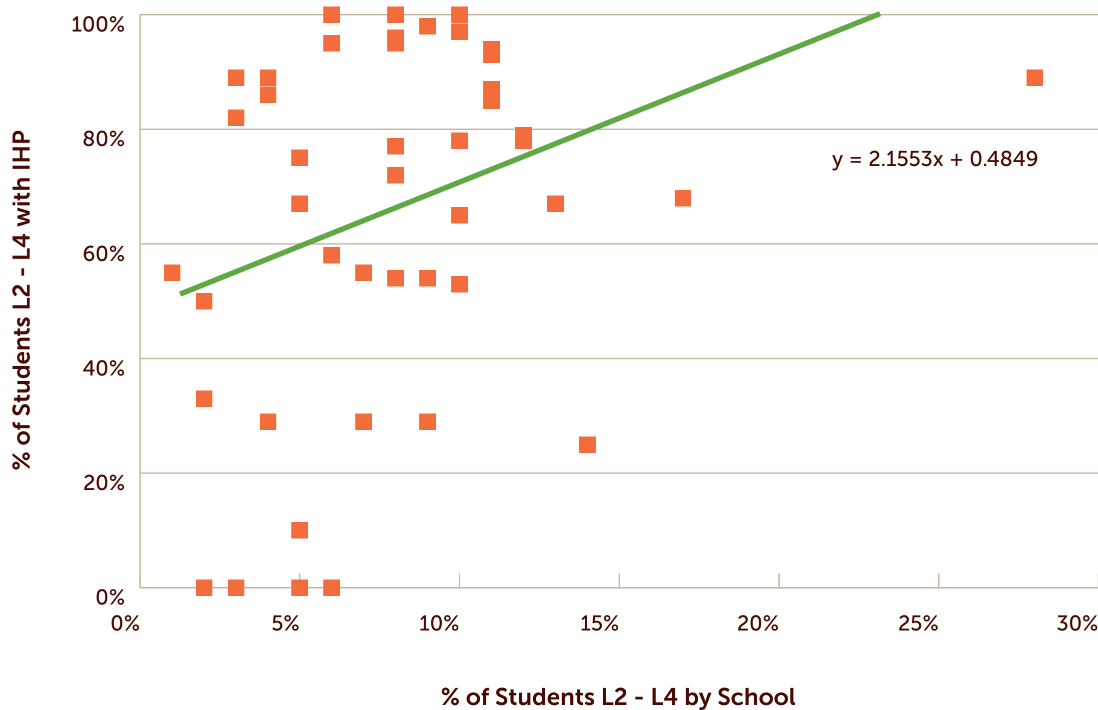
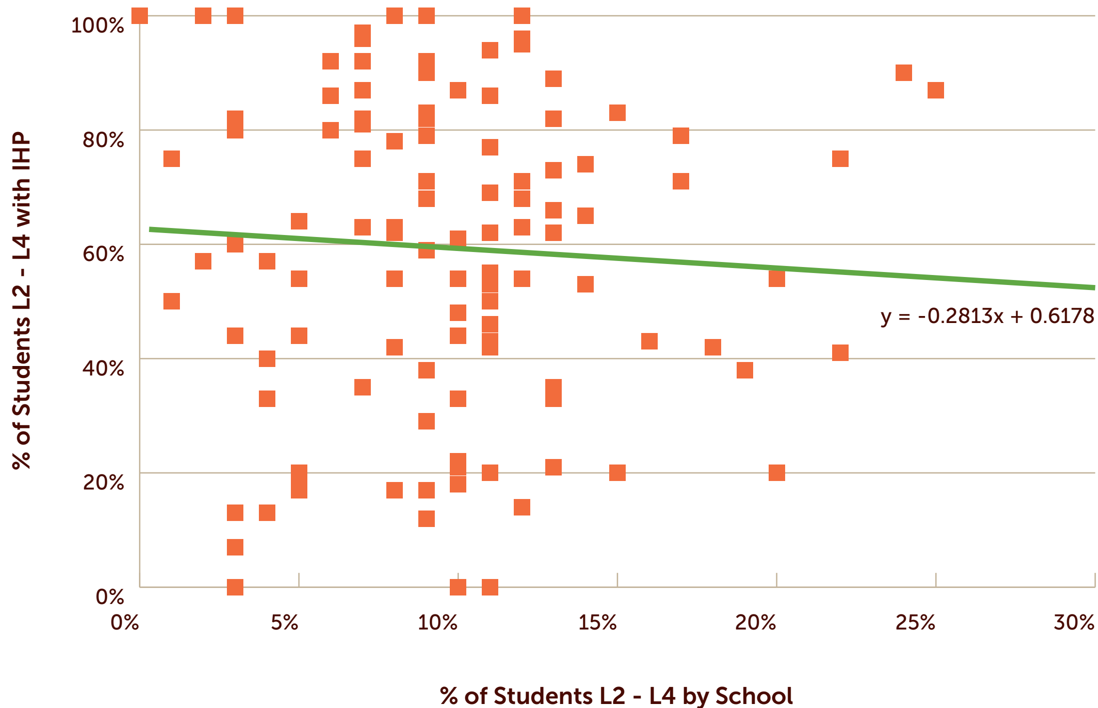


Figure 7
Complete Individual Health Plans at Schools with Full-Time Nursing Services, SY 2014-15



In short, collaboration among DC agencies, school leaders and health providers in the school and in the community is necessary to ensure a holistic approach that makes full use of school and community resources, engages families and links students to the care they need.

In order to move toward the goal of a holistic approach, the DOH should consider the following next steps:

1. **Establish a shared vision for children's health in the District.**
   By creating a new model for children's health based on the WSCC model, DOH can fit school health into a broader system of care that is child-centered and emphasizes improving health outcomes. This new vision must be shared with stakeholders across the District in order to increase collaboration among the agencies, schools, parents and providers. By establishing a shared vision and garnering support among stakeholders, all parties could work more effectively together.

2. **Improve data collection and systems for school health services.**
   Multiple parties highlighted the need for improved data collection and sharing. DOH, OSSE, DCPS and PCSB should work together to identify opportunities and methods to improve data collection and sharing. Currently, health data is not linked with education data, but there is an opportunity through the OSSE Statewide Longitudinal Education Database (SLED) to maintain relevant health data by unique student identifier. Data could include data from the universal health certificate as well as utilization of school health services. This will allow both health and education agencies to monitor attendance, assess impact of health services on students and evaluate improvements in academic outcomes over time. Student-level data will provide opportunities for rigorous analysis and should be part of a long-term evaluation strategy for implementation of comprehensive services, including school health.

3. **Create and distribute process documents and training materials that clearly define the roles and responsibilities of school health providers.**
   The interviews and focus groups revealed that various parties are unclear about the roles and responsibilities of school health providers, especially the school nurse. In order to clarify and ensure understanding of the responsibilities of school health provides, DOH could provide both written documentation and summer training materials for school leaders and teachers that clarify the role and functions of the school nurse in the school community based on federal and local laws and regulations and the vendor's grant or contractual agreements. Additionally, marketing materials for students and parents could raise awareness about the availability of school health services and help to set expectations and norms about those services and the appropriate use of those services.

4. **Form a school health collaborative or advisory body.**
   In order to improve coordination and to create a forum for vetting new ideas and addressing grievances, DOH could form a school health advisory body that brings together agencies and school leaders to ensure on-going communication and collaboration. This group could provide substantive feedback around key processes like collecting student health information, establishing memoranda of agreement for data sharing, and identifying opportunities for linkages to services in the community.

5. **Implement a more robust evaluation and quality assurance process.**
   In order to strengthen the program, DOH could collect feedback from school leaders, students and parents about their experiences and satisfaction with services and providers. This feedback can be used to inform quality improvement efforts by identifying areas where more training or targeted professional development for school health providers could be beneficial, ideas for marketing or raising awareness about services, and identifying potential gaps in services.

This assessment provides guidance for DOH, their partner agencies, schools and the community to think strategically about how best to leverage resources, improve programs and strengthen systems to ensure all children have access to high quality services at school to improve health and academic outcomes.

Appendix A: Methods

The SHNA uses three broad assessment methods to explore the primary data sources and answer the above research questions: (1) systematic review of academic literature and primary documents, (2) analysis of key informant and focus group interviews and (3) a descriptive analysis and mapping of student health data.

1. DC Action reviewed the academic literature on school health services as well as primary background documents. The literature review identified over 20 scholarly articles or government and non-profit reports on topics relevant to the research questions, focusing particularly on the Whole School, Whole Community, Whole Child (WSCC) model; the expected or known outcomes for school-based health services; and innovative school health programs and best practices from other states. Relevant primary documents included reports on student health and student health services from providers and government agencies, such as the DC Department of Health's 2013 Community Needs Assessment, as well as local and federal regulations on school health services. The synthesis and analysis of this literature forms the basis of the analytical framework and the interview protocols used in this needs assessment.

2. For this needs assessment, DC Action conducted a wide range of one-on-one informant interviews, which form the core of the findings presented in this report. These interviews provided historical context around how the current school health program was developed; information about current practices; and insights into the strengths, challenges and gaps in the current model. Interview subjects were selected from a list of potential key informants provided by the Department of Health and supplemented with other key stakeholders involved with school heath policies or school health service provision in the District, including staff from Children's National Medical Center - Children's School Services (CNMC-CSS); central office staff from DCPS and the Public Charter School Board (PCSB); staff at other agencies interested and / or involved in student health programming including the Department of Health Care Finance, Department of Behavioral Health and Department of Health - Community Health Administration and HIV/AIDS, Hepatitis, STI and Tuberculosis Administration; and service providers from School-based Health Centers. To better understand how the implementation of school health program at the school-level, informant interviews were also conducted with school leaders from nine different DCPS and DC public charter schools. National school health interview subjects were identified from notable school health programs in other jurisdictions to further our understanding of best practices in the field of school health.

   Focus group interviews were also conducted with parents, students and school nurses to better understand how these different groups perceive the strengths and weaknesses of the current school health program. Two student focus groups were conducted at different afterschool programs with middle and high school youth that attend DCPS and DC public charter schools. One parent focus group was conducted with members of a Parent Teacher Association (PTA) at a DCPS school and two parent focus groups were held with participants in parenting classes provided by one of DC's Healthy Families Thriving Communities Collaborative. Finally, one focus group was held with school nurses who were selected by CNMC-CSS to participate. Focus group sizes ranged between five and twelve participants, and were designed to last approximately one hour. Purposeful sampling was used to ensure that focus group participants were drawn from both public and public charter schools and as well as a range of grade levels and different school health service models.

   The interview protocols used in this assessment were tailored to address the particular perspectives of each stakeholder group and were informed by a review of the relevant academic literature and existing school health interview and survey protocols. Further, interview protocols were reviewed by the Department of Health prior to the data collection process. Both key informant and focus group interviews were conducted in a semi-structured format, meaning that interviews were guided

by a list of structured questions, but the exact order of the questions was not determined ahead of time and not all questions were asked at every interview. This format allowed for a more conversational approach to collecting interview data and for the interviewer to respond to the emerging perspectives and ideas of the respondents.

3. This needs assessment also includes an analysis of school and youth health data. Quantitative school health data was collected from the annual statistical reports compiled annually by Children's School Services for SY 2013-14 and SY 2014-15 as well as preliminary data from SY 2015-16 to date. Additional youth health data was collected from the DC Department of Health- Fiscal Year 2015 Performance Oversight Responses, the Youth Risk Behavior Survey (YRBS), and other government reports, all referenced in the end notes of this report. While student-level health data was not available for this needs assessment, our analysis of school-level utilization data presents a broad picture of how student health needs and school health services vary by school. School-level student health data was also geocoded using school addresses to gain a more accurate picture of how student health needs and service provision varies across the District's wards and neighborhood clusters. Finally, the locations of the School-based Health Centers and primary care facilities in the District were also mapped to identify gaps in coverage between community and school-based health resources.

Limitations

Several limitations of this needs assessment should be considered when interpreting the findings of this needs assessment.

Stakeholder Interviews

- First, focus groups, by nature, are socially constructed interactions. As a result, it is not possible to infer the extent to which participant responses are shaped by the other participants in the focus group or represent their individual perspectives.
- Second, participants in these focus groups were not selected at random from the general student and parent populations. Instead, focus groups were conducted at multiple different after school programs or parent organizations. While parents and students from a variety of schools took part in these focus groups, the findings may not be generalizable to the larger population because random sampling of participants was not possible. Instead, the focus group results were primarily used to gather various perceptions of the school health program held by different stakeholder groups rather than to assess the larger policies and procedures of the program itself.

School Health Data

- First, because the school health data that we were able to access was aggregated at the school-level, we are unable to analyze the relationship between the different reasons students visited school nurses in the health suite, or the health services they received, with their health outcomes.
- Second, student health data is not currently linked with student-level academic data in any available data system overseen by local education agencies (LEAs) or by the Office of the State Superintendent of Education (OSSE), the state education agency (SEA). This prevented an analysis of the relationship between student health conditions, or the provision of different school health services, with academic or other relevant student outcomes like attendance.
- Third, since these data are based on nurse reports, and there is no systematic method of validation, the reliability of student health data potentially may vary by nurse and/or school.

Given these limitations, a high-level, descriptive analysis using the data from CSS annual reports is included in this needs assessment. It provides an important starting point for assessing the distribution of student health needs, school health service provision and school health service utilization across public and public charter schools in the District.

Appendix B: Interview and Focus Group Participants Profile

DC Agency Interviews

Agency	Department
Department of Health Care Finance (DHCF)	Children's Health Services
Office of the State Superintendent of Education (OSSE)	Health & Wellness
Public Charter School Board (PCSB)	Intergovernmental Relations & School Support
Department of Behavioral Health (DBH)	Child & Youth Services
District of Columbia Public Schools (DCPS)	Health & Wellness
District of Columbia Public Schools (DCPS)	Specialized Instruction
Department of Health- Community Health Administration (DOH- CHA)	Cardiovascular Disease and Diabetes Program
Department of Health- HIV/AIDS, Hepatitis, STD, Tuberculosis Administration (DOH- HAHSTA)	STD Education and Outreach

School Health Services Providers

Children’s National Medical Center	Children's School Services
MedStar Georgetown University Hospital	Anacostia SBHC
Unity Health Care	Ballou/Cardozo/Woodson SBHC
Howard University Hospital	Coolidge/Dunbar SBHC

School Leader Interviews (de-identified)

Sector	Grades Served	Ward
DCPS	6-8th	3
DCPS	PK3-5th	2
DCPS	6-8th	6
PCS	6-12th	7
PCS	PK3-5th *	4, 5
PCS	PK3-12th *	6
PCS	PK-8th	5
PCS	PK3-12th	2, 5, 6, 7, 8
PCS	PK-8th	5, 7, 8

*Indicates a school that does not currently receive nursing services sponsored by DOH

Schools represented in student and parent focus groups:

DCPS

- Bell Multicultural HS (Columbia Heights Education Campus)
- Coolidge HS
- Benjamin Banneker HS
- Roosevelt HS
- Eastern HS
- Central HS (Cardozo)
- Johnson MS
- Wheatley EC
- McKinley Tech
- Savoy ES
- Garfield ES
- Amidon Bowen ES
- Malcom X ES
- Anne Beers ES
- Patterson ES
- Whittier ES
- Ketcham ES

PCS

- Cesar Chavez
- Center City PCS Congress Heights
- Excel Academy PCS

APPENDIX C: Interview Protocols

School Nurse or School-Based Health Center Practitioner

1. What are the most common health issues for the students at your school?
    a. What are the most serious health issues for the students at your school?

2. What are the most common health services you provide to students?
    a. Which of the school health services that are currently provided are the most important for supporting student health outcomes?

3. What are the biggest barriers to students accessing appropriate health services?

4. To what extent do students in your school have access to community health providers?

5. How is the SNP/SBHC impacting student health outcomes?
    a. How is the SNP/SBHC impacting student academic outcomes?

6. Which of the school health services that are not currently provided through the SNP/SBHC, if any, would most improve student health outcomes?

7. What percentage of your time at work is spent on service provision, health education, and administrative duties?
    a. What percentage of your time providing health services to students is spent caring for medically fragile students?

8. Can you describe how student health data is currently collected and used?
    a. How, if at all, can this process be improved?

9. Can you describe how nurse staffing decisions are made?
    a. In your opinion, does the current staffing model provide sufficient care?
    b. How, if at all, can this process be improved?

10. What role, if any, do other school staff members play in providing student health services (i.e. managing student medications)?

11. To what extent do you provide health services to other school staff members?

12. How do school nurses communicate with students' community health providers (parents, teachers)?
    a. How, if at all, can these processes be improved?

13. How do school nurses stay informed about, and utilize, best practices in their work?

14. What are the biggest challenges for school nurses?

15. What additional resources or supports would make the biggest difference in your ability to improve student health outcomes?

16. Is there anything else about your experience working with the SNP/SBHC that you think I should know about that I haven't asked or touched on so far?

School Administrators

1. What are the most common health issues for the students at your school?
2. How is the SNP/SBHC meeting the health needs of the students at your school?
3. How, if at all, has the SNP/SBHC impact academic outcomes for students at your school?
    a. How, if at all, does the SNP/SBHC reduce time spent on student health issues by teachers or administrators?
    b. How, if at all, does the SNP/SBHC help keep students in school and/or reduce absenteeism?
4. What are the biggest barriers to students accessing health services that meet their needs?
5. Which of the school health services that are not currently provided through the SNP/SBHC, if any, would most improve student health outcomes?
6. What role, if any, do other school staff members play in providing student health services (i.e. managing student medications)?
7. To what extent does the SNP/SBHC provide health services to school staff?
8. How does the SNP or SBHC work with parents?
    a. How does the SNP or SBHC work with community providers?
    b. How does the SNP or SBHC work with staff members?
9. From your vantage point, can you describe how nurse staffing decisions are made?
    a. In your opinion, does the current staffing model provide sufficient care?
    b. How, if at all, can this process be improved?
10. Can you describe how student health data is currently collected and used?
    a. How, if at all, can this process be improved?
11. Do you have any additional recommendations for improving the SNP/SBHC?
12. Is there anything else about your experience interacting with the SNP/SBHC that you think I should know about that I haven't asked or touched on so far?

Partner Agencies

1. What are your organization's roles in supporting student health in public and public charter schools?
2. What role does Children's National play in providing school health services?
3. What role does DOH- Community Health Administration (CHA) play in coordinating school health services?
4. What are the biggest barriers to advancing the health of DCPS and PCS students?
5. From your vantage point, how can the school health program be improved to better support student health?
6. From your vantage point, how can the school health program be made more efficient?
7. What are the biggest barriers, if any, to greater inter-agency collaboration around school health?
8. What additional roles, if any, could other partner government agencies play in improving the school health program?
9. Is there anything else about your experience working with on school health that you think I should know about that I haven't asked or touched on so far?

Children's National Administration

1. What role does Children's National play in providing school health services?

2. What role does DOH- Community Health Administration (CHA) play in coordinating school health services?

3. What are the biggest barriers to students accessing health services that meet their needs?

4. Can you describe how nurse staffing decisions are made?
    a. How, if at all, does this practice differ between DCPS and PCS schools?
    b. In your opinion, does the current staffing model provide sufficient care?
    c. How, if at all, can this process be improved?

5. How, if at all, are the health services provided by nurses contracted through the Office of Specialized Education coordinated with nurses from Children's School Services?
    a. From your perspective, why are these services provided by a separate entity/agency?

6. Can you describe how student health data is currently collected and used?
    a. How, if at all, can this process be improved?

7. Which recent school health initiatives have had the greatest impact on improving student health?
    a. How, if at all, was this impact demonstrated?

8. How are school nurses informed about, and encouraged to use, evidence-based best practice in their work?

9. How do school nurses communicate and interact with community health providers?

10. What additional roles, if any, could partner government agencies play in improving the school health program?

11. From your vantage point, how can the SNP be improved to better support student health?

12. From your vantage point, how can the SNP be made more efficient?

13. Is there anything else about your experience working with on school health that you think I should know about that I haven't asked or touched on so far?

APPENDIX D: Focus Group Protocols

Parent Focus Group

1. What are the advantages of having health services provided in schools?
2. What are the biggest student health issues that you see at your child's school?
3. If your school has a nurse, what kind of health services does the school nurse provide at your child's school?
4. Overall, do you think that the school nurse program at your child's school is able to meet the health needs of students? Of your child? Why or why not?
5. In your opinion, what are some of the reasons that students might not visit the school nurse even if they had a health issue?
6. In an ideal world, what health services would be available at school?
    a. What types of health services would you like to see provided at your child's school that currently are not?
7. Who from your child's school communicates with you about your child's health?
    a. If a school nurse identifies a potential health concern, how do they follow-up with you?
    b. What are some examples of positive or negative interactions you've had with a school nurse at the current school (or other schools).
8. Does someone from your child's school communicate with your child's primary health care provider?
    a. If so, how often and for what reasons?
    b. How, if at all, can this communication be improved?
    c. How, if at all, are you part of this process?
9. Are you confident in the quality of care school nurses provide at your child's school?
10. Would you be comfortable with your child receiving health services from a trained adult other than a registered nurse? Why or why not?
11. Do you have any other suggestions for improving the school nurse program at your child's school?
12. Is there anything else about your experiences interacting with school nurses that we should know?

Student Focus Group

1. What do you do if you have health needs or questions?
    a. What do you do if you have health needs or questions at school?
2. Overall, how do you feel about the school nurse(s) at your school?
    a. What is the point of having a school nurse?
3. In your opinion, what are some of the biggest health problems for students at your school?
4. What are some of the typical reasons that students at your school visit the school nurse?
5. What are some of the reasons why some students at your school might choose not to visit the school nurse?
6. Describe a typical interaction you would have with the school nurse; what happens?
7. What kinds of things does the school nurse do at your school?
    a. What do you think are the hardest parts of a school nurses job?
8. Do you feel comfortable talking with school nurses about health issues? Why or why not?
9. What do school nurses do a good job of? What could school nurses do a better job of?

10. (SBHC) When is the school based health center open?
    a. If it was open later or over the summer would students use it?

11. What happens if a health issue happens at school? Who gets involved?

12. How does the school nurse usually communicate with parents at your school?

13. Do you think it is important to have a school nurse at your school all the time?

14. What happens if a student has a health issue or emergency? Who gets involved?

15. Why would a student choose to see the school nurse rather than visit a doctor or health clinic outside of school?

16. Do you have any other suggestions for improving the school nurse program or SBHC at your school?

17. Is there anything else about school nurses that we should know?

Appendix E: Definitions

These terms when used in this report have the following meanings:

Adolescent
Refers to humans in the period of growth and development that occurs after childhood and before adulthood, from ages 10 to 19. For the purposes of this solicitation this term encompasses middle and high school aged students.

Access to Health Services
Means the timely use of personal health services to achieve the best health outcomes. Access to health services encompasses four components: coverage, services, timeliness and workforce.

Capacity
Refers to the ability of a given facility or system to provide health services to the population it serves.

Capacity Utilization
Refers to amount of services being delivered (or number of patients served) by a given health care facility in relation to the amount of services (number of patients) the facility could deliver (serve).

Public School
Refers to all elementary and secondary public and public charter schools in the District of Columbia.

School Based Health Centers (SBHCs)
Comprehensive primary care clinics that are located within schools.

School Health Services
Refer to DOH administered School Based Health Center and School Nursing programs.

School Nursing Program (SNP)
Refers to the DOH program to provide school nursing services at DC public and public charter schools.

Utilization
Refers to the per-patient usage of health care services, as documented and recorded by a health care provider.

Whole School, Whole Community, Whole Child (WSCC)
Refers to the model developed by the Centers for Disease and ASCD that serves as a framework for improving students' learning and health in schools.

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