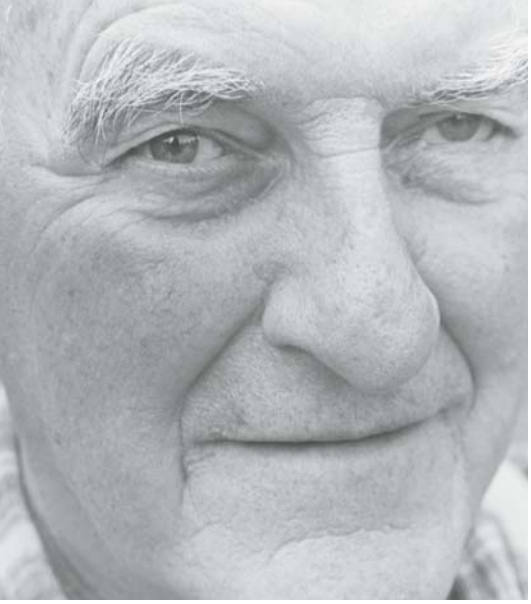
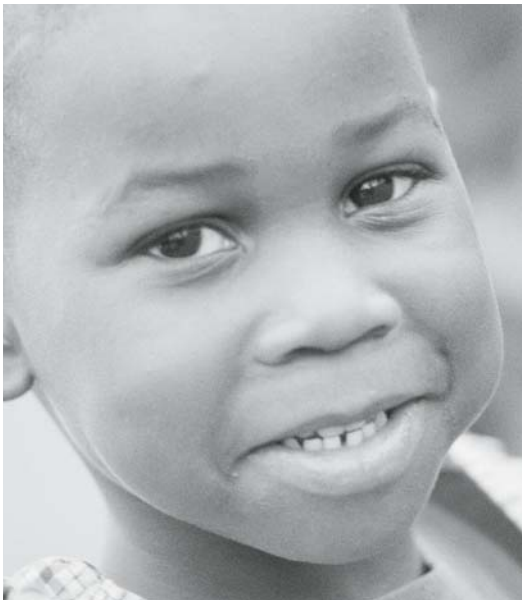


Summary Report:
School Health Matching Grants Conference

prepared for

Georgia Department of Community Health


Karen J. Minyard, Ph.D.
Executive Director
February 2003

Georgia Health Policy Center

Summary Report:
SCHOOL HEALTH MATCHING GRANTS CONFERENCE

February 26 and 27, 2003
Holiday Inn Convention Center
Macon, Georgia

Georgia Department of Community Health
Georgia Health Policy Center
Philanthropic Collaborative for a Healthy Georgia

ACKNOWLEDGMENTS

The School Health Matching Grants Initiative, the School Health Matching Grants Conference, the Summary Report, and the development of the video, *Conducting a Physical Assessment of the School-Aged Child*, were made possible through the close working partnership of three organizations.

The Georgia Department of Community Health (DCH) is the state agency responsible for administering the Medicaid program and PeachCare for Kids, which is Georgia's Children's Health Insurance Program.

The Philanthropic Collaborative for a Healthy Georgia is an informal group of foundations that have come together to learn more about health care issues affecting the citizens of this State.

The Georgia Health Policy Center (GHPC), in the Andrew Young School of Policy Studies at Georgia State University, conducts research for the development of health care policy recommendations and implementation strategies for improving the health status of Georgians.

For more information about the Philanthropic Collaborative and the School Health Matching Grants Initiative, or for additional copies of the Summary Report and the video, please contact the Georgia Health Policy Center at 404-651-3104.

Georgia Health Policy Center

Georgia State University ANDREW YOUNG SCHOOL OF POLICY STUDIES

TABLE OF CONTENTS

Wednesday, February 26, 2003

Thursday, February 27, 2003

CONFERENCE PRESENTERS

DAY ONE

Opening Remarks	**Mary Ann Phillips**, Project Director, Georgia Health Policy Center (GHPC)
Linking Health and Academic Achievement	**Diane Allensworth**, PhD, Executive Director, Kids Health, Inc.
Keeping School Health Alive	**Joyce Allers**, RN, Manager, Illness Prevention and Management, Children's Healthcare of Atlanta (CHOA) **Jackie Klopfer**, Principal, Eighth Grade Administrator, Ringgold Middle School
Medicaid Update	**Argartha Russell**, Director, Maternal and Child Health Section, Georgia Department of Community Health (DCH)
PeachCare for Kids Update	**Jana Thomas**, Director, PeachCare for Kids, Georgia DCH
Improving Dental Access	**Loren Nix**, Elementary School Nurse, Berrien County, GA **Tammy Carter**, Primary School Nurse, Berrien County, GA **Dora Nash**, Middle/High School Nurse, Berrien County, GA
Exploring Funding Opportunities	**Susan Teller Goodman**, Training Manager, Georgia Center for Nonprofits
Acting on Stress	Kaiser Permanente's Educational Theatre Program
Help for Addressing Behavioral Issues	
Mental Health Assessment	**Kristine Medea**, MA, ABS, Director of Clinical Education and Youth Programs, National Mental Health Association of GA
Substance Abuse	**Becky Vaughn**, President and CEO, Georgia Council on Substance Abuse
Navigating the Internet & Finding Funding Online	**Bernette McColley**, Special Projects Coordinator, GHPC

DAY TWO

Physical Assessment of the School-Aged Child	
Physical Assessment/Cardiac Assessment	**Deborah Bentley**, RN, CPNP, Pediatric School Nurse Liaison, CHOA
Respiratory Assessment	**Alison Ellison**, RN, PNP, School Nurse Consultant, CHOA
Abdominal Assessment	**Sandra Leonard**, RN, FNP, School Health Coordinator, Division of Public Health, Georgia Department of Human Resources (DHR)
Musculoskeletal Assessment	**Alison Ellison**, RN, PNP, School Nurse Consultant, CHOA
Neurologic Assessment	**Sandra Leonard**, RN, FNP, School Health Coordinator, Division of Public Health, DHR
Dermatology Concerns in School Health	**Betty Fitzpatrick**, RN, NCSN Regional School Nurse Liaison, CHOA
Closing Session: Linking with Other Community Resources	
Hidden Jewels in Your Own Backyard	**Joyce Allers**, Manager, Illness Prevention and Management, CHOA
Spectrum of Public Health Services	**Sandra Leonard**, RN, FNP, School Health Coordinator, Division of Public Health, DHR

PREFACE

In the fall of 2000, the Georgia Department of Community Health joined forces with the Philanthropic Collaborative for a Healthy Georgia to develop a matching grants initiative focused on school health in Georgia. The purpose of the School Health Matching Grants Initiative was to improve the physical and mental health of school-aged children by promoting healthy lifestyles and by providing access to essential health care services. The Initiative was designed to expand access by directly serving and benefiting low income and medically underserved children.

The Georgia Health Policy Center in the Andrew Young School of Policy Studies at Georgia State University, which serves as the administrative arm of the Philanthropic Collaborative, coordinated the grant review and selection process. In July 2001, a total of $901,000 was awarded by the Department of Community Health and the Collaborative to thirteen Georgia communities to support local plans for improving the effectiveness of their school health programs.

The Health Policy Center currently monitors and provides technical assistance to these grantees. As part of the commitment to build grantees' capacity, a conference was held on February 26-27, 2003, at the Holiday Inn Conference Center in Macon. Attendees and presenters at the conference included representatives from the grant programs, the Philanthropic Collaborative for a Healthy Georgia, the Department of Community Health, the Department of Human Resources' Division of Public Health, state and nationally recognized school health experts, and the Georgia Health Policy Center.

The conference responded to the technical assistance needs expressed by grantees through their progress reports and site visits. Participants had the opportunity to interact with school and community leaders as well as to hear presentations from experts with the Centers for Disease Control and Prevention, state public health agencies, and other Georgia organizations involved in improving health care for school-aged children. The first day of the conference focused on providing general information and updates on such topics as: links between school health and academic achievement; Medicaid and PeachCare for Kids; access to dental care; behavioral health issues; and funding opportunities. The second day was primarily a training session on conducting physical health assessments of school-aged children in the school environment.

This report summarizes the presentations made during the two-day conference. A video depicting the second day's presentations on Conducting a Physical Assessment of the School-Aged Child is also available. The conference, the Summary Report, and the development of the video were funded by the Georgia Department of Community Health and the Philanthropic Collaborative for a Healthy Georgia, and were coordinated by the Georgia Health Policy Center.

Wednesday, February 26, 2003

OPENING REMARKS

Mary Ann Phillips
Project Director, Georgia Health Policy Center

On behalf of the Philanthropic Collaborative for a Healthy Georgia, the Georgia Department of Community Health, and the Georgia Health Policy Center, Ms. Phillips welcomed participants to the School Health Matching Grants Conference. She indicated that she was humbled by the wealth of knowledge and experience in the room with respect to school health, and explained that the purpose of the School Health Matching Grants Conference was to share knowledge and skills and to support one another as each organization strives to improve the health status of Georgia's children.

The Philanthropic Collaborative for a Healthy Georgia is an informal, loosely structured, evolving initiative that brings together Georgia foundations to better understand and respond to the health-related challenges facing Georgia. The primary purpose of the Collaborative is to enable foundation staff and trustees to become more informed and effective in their health-related grant making activities. The Collaborative enables foundations to learn from each other, as well as from outside experts. The Matching Grants Initiative provides interested foundations the opportunity to come together and partner with state government and local communities to fund promising local initiatives.

It was the Georgia Health Policy Center's hope that the information learned during this conference would guide all participants—both presenters and grantees—in their future efforts to improve the health of Georgia's school-aged children.

The Georgia Health Policy Center serves as the administrative coordinator for the Philanthropic Collaborative. In this role, the Center researches topics, develops issue briefs, holds conferences and symposia, and coordinates the matching grants programs. Two matching grants programs have been coordinated thus far. The School Health Matching Grants Program, co-funded by the Department of Community Health and the Philanthropic Collaborative, has a total of thirteen grantees and has awarded about $901,000 to communities to increase children's access to healthcare. The Access Georgia Rural Health Matching Grants Initiative awarded approximately $1.7 million to nine networks serving thirty-seven counties. This initiative was sponsored by the Department of Community Health, the Philanthropic Collaborative, and the Robert Wood Johnson Foundation. In addition to the aforementioned grant initiatives, the Philanthropic Collaborative has developed a framework for a community cancer prevention program and is currently exploring a childhood obesity initiative.

The main objective of this conference is to provide school health programs with technical assistance regarding various aspects of school health. The conference was convened in response to issues and assistance requests raised during site visits conducted with all thirteen grantees. Ms. Phillips stated that it was the Georgia Health Policy Center's hope that the information learned during this conference would guide all participants–both presenters and grantees–in their future efforts to improve the health of Georgia's school-aged children.

After discussing the planned agenda, Ms. Phillips thanked the Georgia Division of Public Health, Children's Healthcare of Atlanta, and the Centers for Disease Control and Prevention (CDC) for their donation of conference materials.

Ms. Phillips then introduced audience participants from a variety of organizations and recognized Joyce Allers, Sandra Leonard, and Bernette McColley for their hard work in planning the conference. She also asked the grantee representatives to introduce themselves. Following the introductions, Ms. Phillips introduced Dr. Diane Allensworth, the keynote speaker, who discussed ways to link school health to academic achievement.

KEYNOTE ADDRESS:

Linking Health and Academic Achievement

Diane Allensworth, PhD, RN
Executive Director,
Kids Health, Inc.

Historically, and even as late as the early 1990's, little has been done to try to understand the influence of school health programs on academic achievement. No one had asked whether classes in health education or physical education, or the provision of health services improve academic outcomes. Through various studies, educators have learned that academic performance can improve if children eat breakfast, if they are physically fit and that if a school has a school based clinic onsite, absenteeism rates can decrease. Still, little is known about how access to the traditional school nurse services might affect academic performance. Dr. Allensworth distributed a handout, entitled Lessons Learned, which provided the participants with a synopsis about the evidence to date that links school health programs and academic achievement. She also provided an order form with which participants could order a presentation, Making the Connection: Health and Student Achievement, developed by the Society of State Directors of Health and Physical Education and the Association of State and Territorial Directors of Health Promotion and Health Education. She urged conference participants to order a free copy and share the information with their school administrators.

Dr. Allensworth posed the question, "Is student health the missing piece in education reform?" During the last two decades, primary and secondary school education has undergone a revolution, and school districts nationwide are clamoring to raise academic achievement scores. However, since there is disparity among students' scores for a variety of reasons, educators need to look at more than just "time on task" as a solution to improving academic achievement. As early as 1983, researchers were saying, "No knowledge was more crucial than knowledge about health. Without it, no other goal can be successfully achieved" [Carnegie Foundation].

The U.S. Department of Education noted, in 1991, that too many children started school unready to meet the challenges of learning and were adversely affected by drug use and alcohol abuse, violence, adolescent pregnancy, and disease. Former Surgeon General, Antonia Novello, noted that health and education go hand-in-hand, and that "to believe differently is just to hamper progress. Just as our children have a right to receive the best education available, they have a right to be healthy. As parents, legislators, and educators, it is up to us to see that this right becomes a reality."

Dr. Allensworth believes that one of the greatest advances recently made was the Children's Health Insurance Program (CHIP). In Georgia, this program is called PeachCare for Kids. This program improves childrens' access to, and reduces disparities in, health care. The American Cancer Society (ACS) has been very assertive in promoting health education and school health programs, saying "Children who face violence, hunger, substance abuse, unintended pregnancy, and despair cannot possibly focus on academic excellence. There is no curriculum brilliant enough to compensate for a hungry stomach or a distracted mind." John Seffrin, who has been the Chief Executive Officer at the ACS for about fourteen years, recognizes that although death certificates may state that a person died from cancer, heart disease, stroke, or diabetes, the root causes of these deaths are poor health habits. Because poor health behaviors begin in childhood, it is important that educators help students start out right. Coordinated school health programs offer a strategy that can make a critical difference in people's lives.

Surely no one would argue with the statement that good health is necessary for academic success. However, educators need to go beyond saying good health is important and start

cultivating and supporting good health habits in children every day so that the children will grow into adults who live long, healthy, and productive lives. Of course, no one agency or discipline can do everything, and all should work together to support the adoption of health-enhancing behaviors. A coordinated school health program has many goals and should target students, as well as engage parents, teachers, families, and communities in the effort to keep students healthy and reinforce positive behaviors. A coordinated school health program has eight components. Quality programming in each component could contribute to academic achievement as some studies have demonstrated.

1. The Family and Community Involvement Component maximizes resources by soliciting partnerships and coalitions with family members and community agencies. Data show that when parents are involved in the total education of a child, greater gains are made overall. There is greater achievement in mathematics and reading, better attendance, and more consistently completed homework. In one study, low income parents were brought in to work in the schools and were helped with their own reading so that they could better help their children. Their children's achievement was boosted because the parents' eagerness to learn excited their children about learning.

Some studies have shown that community activities increase academic achievement, reduce school suspension rates, and improve health-related behaviors. Numerous studies have also shown that if parents are brought into the instructional program and reinforce what the teacher is teaching, there are better outcomes. Involving the faith community is another promising practice.

2. Health Education addresses the physical, mental, emotional, and social dimensions of health by assisting students to develop health knowledge, health attitudes and health skills. Health education is designed to help students maintain and improve their health, prevent disease, reduce risky behaviors, and increase health-enhancing behaviors. Studies have shown that third and fourth graders who received a health education life skills program scored higher in reading and mathematics than students who had not received the health education classes.

Dr. Allensworth discussed one study that was completed by Hawkins and Catalano that provided a life skills curriculum for grades one through six, staff development for teachers, and parenting classes. There were three cohorts in this research study. One cohort received no education, the second cohort started the program in the first grade, and the third cohort began the program in grades five or six. No instruction was provided in grades seven through twelve. Comparing the full intervention and the control groups, the data showed that those people who completed the curriculum had significantly reduced rates of violence, heavy drinking, sexual intercourse, multiple sex partners and pregnancies. In addition, they had higher academic scores. Further, the study found that it is important to begin health education early in order to make the biggest impact. Currently, Hawkins and Catalano are administering a survey similar to the Youth Risk Behavior Survey (YRBS), and then using GIS mapping to identify clusters of students engaging in high risk behaviors. The plan is to then identify a specific curriculum with credible evidence of effectiveness that addresses the specific risk. Dr. Allensworth directed participants to Hawkins and Catalano's web site to learn more about the current study.

Research shows that physical activity among adolescents is related to higher self-esteem and lower levels of anxiety and stress.

3. Physical Education refers to planned sequential instruction that promotes lifelong physical activity and is designed to develop movement and sport skills and to improve physical fitness. Research shows that physical activity among adolescents is related to higher self-esteem and lower levels of anxiety and stress. There is evidence that a decrease in stress and anxiety is associated with better academic performance. If educators can get children to feel better about themselves, then the children learn better. Numerous studies show that taking time from the school day to allow children to participate in physical education does not result in lower scores on academic achievement tests.

The California Department of Education matched the Standard Achievement Test (SAT) scores with scores from the FITNESSGRAM for students in grades three, five, and nine. The FITNESSGRAM measured cardiovascular health, endurance, muscular strength, trunk strength, abdominal strength, body composition, and more. Researchers found that the more fitness standards that the students achieved, the higher the students' SAT scores were. Dr. Allensworth urged participants when choosing a fitness test to select one that focuses on health-related components such as the FITNESSGRAM.

4. School Nursing includes preventive health services, emergency care, referral management, management of acute and chronic conditions, and vision, hearing and height/weight screenings. To date, there are no studies that can provide evidence that there is a link between school nursing to achievement. If researchers expand the school nursing role and look at the school nurse working at a school-based clinic, there is some preliminary evidence that there is a link between health care services and academic achievement. Only about two percent of schools nationwide have school-based clinics, but in some of those particular schools, tremendous strides have been made in increasing attendance, decreasing dropout rates and suspensions, and promoting higher graduation rates. Dr. Allensworth used as evidence a study completed by the General Accounting Office (GAO) that examined school-linked human services. Researchers looked at twelve different schools, most of which saw positive gains in academic scores. Dr. Allensworth shared data on two of the schools. In the Texas Communities in Schools study, the services provided students included: having a physician or school nurse practitioner in the school; tutoring and mentoring; individual and group counseling; pre-employment and vocational skills training; referrals to health and social services; and home visiting. The schools decreased dropout rates from ten percent to five percent. Absenteeism went down to eighteen percent. Forty-four percent of the students who were failing mathematics raised their grades to passing. Forty-two percent who were failing English raised their scores to passing. In St. Louis, the Walbridge Caring Communities program provided primary health care, academic tutoring, recreation, daycare, and pre-employment skill training for parents. Academic achievement was improved twenty-six percent. Absenteeism was not improved.

5. Counseling and Psychological Services are activities that focus on cognitive and emotional behavior and on the social needs of individuals, student groups, and families. These services are designed to facilitate positive learning, enhance healthy behavior and development, and improve career paths. Studies have shown that counseling, social services, and psychological services are associated with academic achievement. Researchers also found that school-based social services that targeted potential dropouts increased grade point averages across all classes, increased bonding, and improved self-esteem. Children who participated in a social service intervention aimed at promoting school success by improving parent/child and parent/teacher communication improved academic performance.

6. Nutrition Services are linked to academic achievement in more studies than any other component within the school health program. Food-insufficient children ages six to eleven are more likely to receive low mathematics scores, repeat a grade, visit a psychologist, and have difficulty getting along with other children. Poorly nourished children ages twelve to sixteen are also more likely to need to visit a psychologist, be suspended from school, have difficulty getting along, and have no friends. Studies have shown that the school breakfast program increases learning and academic achievement, improves attention on academic tasks, reduces visits to the school nurse, decreases behavioral problems, and decreases absenteeism and tardiness. Children should learn about good nutrition in the cafeteria as well as in the health class. One of the best approaches seems to be integrating affordable, appealing meals with nutrition education delivered in the health class and in the cafeteria. The cafeteria can nutritionally label all foods served to children as well as post table tents and posters with nutrition information. Learning to eat in a healthy manner maximizes a child's health and educational potential for a lifetime.

Nutrition Services are linked to academic achievement in more studies than any other component within the school health program.

7. School Environment includes the physical, social, and emotional climate of the school and is designed to provide a safe and physical building as well as a supportive environment that fosters learning. In regard to the physical building, studies have shown that if a school is clean and tidy, well-painted, and looks like it is of value, children learn better. An improvement in a school's condition in one category, from poor to fair, is associated with a 5.5 point improvement in average achievement scores.

In addition to a clean and safe building, it is critical to establish a supportive environment. The National Longitudinal Study on Adolescent Health looked at outcomes and factors associated with choosing healthy behaviors. Researchers found that while parental involvement was important to making healthy choices, the school environment also mattered. One factor that students reported made a difference were caring and respectful teachers.

Another correlation study, done in Canada by Rootman and Warren, found that seventy-five percent of the children who said they "usually felt loved and appreciated" rated their health as excellent and very good. Only forty-seven percent of the children who said they "rarely" felt loved and appreciated rated their health as excellent or good. Students who said they "usually felt loved and appreciated" were:

- Three times less likely to use cigarettes;
- Two times less likely to use marijuana;
- Three times less likely to drink to excess;
- Five times less likely to engage in unsafe sex;
- Four times more likely to get regular exercise;
- Three times less likely to report illness;
- Three times more likely to report repeated health care visits;
- Four times more likely to say they were in excellent health;
- Thirteen times less likely to consider suicide; and
- Fifteen times less likely to be in poor health than those students who "rarely" felt loved and appreciated.

8. Worksite Wellness is the final component of a coordinated school health program. Teachers who participate in health promotion focusing on exercise, stress management, and nutrition report increased participation in exercise and have lower weight. They are also better able to handle stress and have a higher level of general well-being. Those same teachers report that they are more energetic, are absent less often, and enjoy a more optimistic school climate. Dr. Allensworth encouraged participants to begin a wellness program in their own schools, suggesting that the school nurse could begin a blood pressure management program; the physical educator could offer some exercise classes; and the home economics teacher could offer some cooking classes.

Health and success in schools are interrelated. Schools cannot achieve their primary mission if students and staff are not healthy and fit, physically, mentally, and socially.

In closing, Dr. Allensworth provided several quotes from national organizations. The National Association of State Boards of Education (NASBE) has said, "Health and success in schools are interrelated. Schools cannot achieve their primary mission if students and staff are not healthy and fit, physically, mentally, and socially." The National Governors Association (NGA) noted that "Policymakers need to focus on eliminating the barriers that affect low performing students' readiness to learn. Among these barriers are physical and mental health conditions that impact on school attendance and on students' ability to pay attention in class, control their anger, and restrain from self-destructive impulses." The United States Department of Health and Human Services (DHHS) noted that "schools have more influence

on the lives of young people than any other social institution except the family, and provide a setting in which friendship networks develop, socialization occurs, and norms that govern behavior are developed and reinforced." Dr. Allensworth stressed that the conference participants were part of that reinforcement and that they were the key to implementing quality coordinated school health programming in their schools which, in turn, could improve academic outcomes of their students.

Schools have more influence on the lives of young people than any other social institution except the family.

KEEPING SCHOOL HEALTH ALIVE-
A Facilitated Discussion

Joyce Allers, RN
Manager,
Illness Prevention and Management Children's Healthcare of Atlanta

Ms. Allers noted that conference planners wanted to give participants a chance to celebrate accomplishments and to discuss how to keep their school health programs alive in years to come. As a manager of a school health support program in metro Atlanta, Ms. Allers visits school nurses on the front lines every day and appreciates their hard work and accomplishments. She also understands being in a position that is not clearly funded and permanent. She has five regional school nurses and has to seek funding for her programs each fiscal year. She urged participants to discuss the reasons for keeping school health alive and why it is important for support to continue.

Ms. Allers shared the story of a school nurse who attended to a child who had fallen on the playground. His friends brought the ten-year-old to the school office and said that he had fallen and hurt his head. As the nurse assessed the child, she watched his mental awareness degenerate. She realized the fall was much more serious than described and called 911. The child was taken to Gwinnett Medical Center, where he was assessed and then life-flighted to Children's Hospital. He had an aneurysm that was rupturing and leaking. Today, the child is walking and talking and not in rehabilitation because of very quick action.

Ms. Allers said that Nancy Rithmire told a wonderful story of one of her nurse heroes. A child presented to the school secretary saying, "My tummy hurts. Call my daddy." The secretary was about to send the child home with daddy when the nurse arrived. The nurse noticed that the child was pale, her pulse was rapid, and her abdomen was distended. She noted that the child had fallen from a horse the previous week. She said to the father, "Don't take her home. Don't give her ginger ale. This child needs to go to the hospital." Doctors found a lacerated liver, and the child was saved. The right person at the right time is important. Sometimes, it is as simple as helping a child deal with a chronic disease.

In another recent incident, a nurse consultant had a newly diagnosed eight-year-old diabetic return to school. The child had received education on her condition, but the mother called the school nurse and said, "I don't know what we are going to do with her. She has this horrible needle phobia." It was not the insulin injections, but the glucometer testing that was getting to her. The mother said that it was a fight to get her to check her blood sugar. She wondered how she could send her back to school. The nurse consultant had just gotten a brand-new type of glucometer that can test blood sugar in the arm. This is the same type of glucometer seen on the television commercial where B.B. King says he is not going to test his blood sugar if it hurts his fingers. By the second day of using the new glucometer, the girl was up in front of her class, demonstrating blood glucose testing, even when she did not need to test her blood glucose. This nurse consultant had intervened and helped a child deal with a chronic disorder.

Sometimes nurses discover tragic conditions. During a scoliosis screening, a nurse found obvious whipping marks on a twelve-year-old's back. The nurse took him aside and said,

"Son? Do you need to talk to me about what's happening on your back?" The boy said, "I don't know, but my brother has the same marks." School administrators were able to find out that this child and his brother were being beaten on a regular basis by their stepfather. That afternoon, the Department of Family and Children Services (DFCS) removed the children from the home and interventions were begun.

The exciting thing about having a medical person in the school is that children have free and easy access to health services. Parents can find out easily whether their child's illness is something they can take care of at home or whether the child needs to see a doctor for further treatment. Ms. Allers shared a short story from Paula Cronia that showed how having a private place and interaction with a caring adult can change a child's life. A first grader's schoolwork was lacking and his participation in class was minimal. He never made eye contact with his teacher and had very little interaction with his classmates. He lacked the self-esteem and motivation that children usually display in first grade. What brought this child to the attention of the school nurse was not a physical illness, but just a few minor scrapes and scratches that were in need of proper treatment. The teacher explained to the school nurse that she was concerned as well about his general appearance. His skin and hair were dirty, and there was constant dirt under his fingernails. His clothes were soiled. His teacher told the nurse that she had observed this appearance for some time. She asked the nurse for some assistance in helping this child. The nurse treated the minor wounds and tried to talk to the boy about his home life. This took much encouragement and time, but finally he opened up. She talked to him about taking care of himself, but understood immediately that more care was needed from the parents.

She contacted his mother and explained the boy's need for improvement in appearance and hygiene. She explained to the mother that she needed to take more care and time with this child. He clearly could not handle these things on his own. It was also explained to the mother that this was a serious matter and that immediate action was expected. The next day, on his own, an exuberant boy came to the nurse's office. He was beaming. He had on what appeared to be new clothes. His hair was shiny and clean, and his overall appearance greatly improved. Most importantly, his entire attitude was different. He was so proud of his new appearance. He initiated the conversation with the nurse and was much more talkative than she had ever seen him. In the next few days, the teacher reported that the child's attitude in class was like night and day. He had come alive. He participated in activities, conversed with others, excelled in his school work, and smiled. He was much happier and much more outgoing, and was proud of himself. His improved general appearance and added support from his parent have made such a difference. The school nurse was able to help this child not just with a physical illness or a minor injury, but also with mending his broken spirit. This is just one of the many roads down which the school nurse program travels.

Jackie Klopfer
Principal,
Eighth Grade
Administrator,
Ringgold Middle School

Ms. Klopfer thanked conference planners for giving her time to talk about the successes she has had at Ringgold Middle School. She hoped that her experiences would enlighten others as they begin or continue their school health programs across the state of Georgia. Ms. Klopfer praised Ms. Shannon Jackson, School Nurse at Ringgold Middle School, for her expertise and talent in nursing. She urged all school nurses to communicate to their professional staff that they are not just the people to whom school staff send children when they are throwing up. School nurses deserve respect.

Ms. Klopfer pointed out that school nurses could do many things to gain the support of school administration. School administrators are all about instruction. They do not want to be dress code police. They do not want to make sure children take their medicine every day. They want children to learn and be successful, contributing members of society. To get to that point, schools need caring adults and school health programs within the facilities. Schools

need skilled medical knowledge from the nurses and the people who support them. Nurses should collaborate with school leaders, taking time to tell the leaders, "I know what the school vision is. I know the county mission. And I think I've got something that will help enhance what you are doing every day." Administrators' ears will perk up. They need people to help make sure children are learning at optimal levels. They want higher attendance. They want students to feel good about themselves and walk down the hall with higher heads, ready to learn.

If a faculty member or parent is disgruntled or thinks that all the school nurse does is put on Band-Aids, Ms. Klopfer suggested working with the person with whom there is conflict. They should talk to the administrator and explain, "I was working with a child whose left arm was bleeding, and another child came along with a headache, and they wanted me to get mom on the phone, and I had to send him back to class because I had to attend to the bleeding child first." The administrator should be asked to mediate, because that is the administrator's job.

School nurses… are not just the people to whom school staff send children when they are throwing up. School nurses deserve respect.

In the past, children who were sick stayed in the classroom. Being able to send them away from the classroom to have some privacy helps everyone. The child is more comfortable, the class can continue working, and germs are no longer being spread around the classroom. She encouraged them to celebrate victories, making sure that when the spring fitness training was going on that the school nurse was visible. They should ask people to give a class on health and hygiene, so the children do not pick on Joey because he does not smell good. Nurses can teach classes on drug and alcohol abuse, showing children that it is okay not to choose drugs and alcohol, though they see it every night at home. Teachers should be asked if they would like thirty extra minutes to sit at their desk and grade papers while the school nurse talks about these things. Perhaps they could take staff members' blood pressure, showing that the school nurse cares about keeping them healthy.

In closing, Ms. Klopfer invited participants to visit Ringgold Middle School and their clinic. She also offered to consult at other sites and provide an administrator's perspective to their school health program.

Ms. Allers next asked participants to share their stories about initial funding and program continuation.

Discussion Points

- Ms. Loren Nix indicated that Berrien County has two full-time RN positions that were split between two schools. The grant money allowed them to hire Dora Nash, a third RN. Unfortunately, the grant is only for one year, so this year the program has been working to obtain more funding for her position. By working with a supportive administration, the Board of Education, and other agencies, funding has been found for several more years. She indicated that the county is in the process of getting more grants to extend the program further into the future.

- Ms. Barbara Copeland went to a Georgia Association of School Nurses (GASN) meeting, and a speaker there said that programs should write grants to extend funding. She searched for funding, and found that the National Eye Institute had a grant available. She wrote and submitted a proposal, and the Institute awarded her program the money. Out of 536 applications, there were only thirty-three awardees. Her award was the only one in Georgia. She urged the other school nurses to look for grants available for school health programs and go for them. Ms. Copeland's program is using the grant money to train high school students interested in health care careers to conduct vision screenings. Nurses will then take the students into elementary schools to assist with actual screenings.

• Ms. Zoe Taylor indicated that Cook County Commission for Children and Youth received a grant in 2001 for a high school nurse and was able to hire Ms. Tammy Allen. Ms. Allen sees fifty to sixty children a day. A part-time counselor also deals with depression and suicide prevention. The grant runs out this year, but Ms. Taylor stays busy presenting the school health issue to community leaders and seeking funding to continue the school health nurse program. She noted that word got out in the high school about two weeks ago that there was no funding for the school nurse for next year. When she got back to her office, more than fifty handwritten letters were sitting on her desk from students asking community leaders for money to continue the program.

• Ms. Allers stressed that school health in high school is just as important as in the earlier grades. The problems young adults face are often serious, and not all children are blessed with wise, wonderful, and caring parents, or families with the ability to afford health care. Ms. Allers has an agoraphobic parent who cannot even get out of the house, let alone make sure the child's Medicaid card is up to date or get the child to a yearly physical or eye exam. She has had single fathers with five children who are just barely paying for rent, insurance, car, and food, and who cannot afford a $100 prescription for an infection. Often, parents are fighting so many of their own demons they have little time or energy for their children's problems. Even those parents who know how the system works and can afford everything have trouble getting bills paid after an accident.

• A participant asked if any of the programs received support from community hospitals. Ms. Sally Dobbins, from DeKalb Medical Center Foundation/City Schools of Decatur, indicated that originally their program was funded for three years by a medical foundation. That funding has now ended and the Medical Center hopes to take over the program. The school system also has allotted some of the "Safe and Drug Free Schools" money to the school health program, which will support the program through the end of 2003.

MEDICAID UPDATE

Argartha Russell
Director,
Maternal and Child Health Section,
Georgia Department of Community Health

Ms. Russell began by saying how pleasant it was to meet the faces behind the programs. She directs many programs in the Maternal and Child Health Section, but chose to focus her presentation on the two programs that she felt would mean the most to school health programs: the Children's Intervention School Services (CISS) or the Fee for Service (FFS); and the Administrative Claiming for Education Program (ACE). The CISS provides reimbursement for medically necessary health-related services (that are provided by, or arranged by, a school system) for Medicaid-eligible students with an Individualized Education Program (IEP). The program also offers coverage for medically necessary restorative and/or rehabilitative services for children under the age of twenty-one years.

The CISS program is comprised of nine intervention (rehabilitation) services, which must be provided by a physician or licensed practitioners of the healing arts. The services include audiology, nutrition, physical therapy, speech language pathology, specialized transportation, targeted case management (service coordination), nursing, occupational therapy, and counseling. The Department of Education has 180 schools eligible to enroll in the CISS program. The schools get a Medicaid number and enroll program recipients through the special education departments. Out of those 180 schools, approximately 153 are enrolled in the program. The program can be very extensive and include all of the services or just a few services on the FFS side. Schools primarily tend to begin with the speech and language pathology service. Schools that are interested should contact the Department of Community Health to find out the services for which the school would most likely be eligible.

Under the CISS, the school system is enrolled as the Medicaid provider. The school system may employ or contract with health practitioners or clinics to furnish health-related services. All health practitioners (employed or contracted) must meet Medicaid's provider qualifications. The vehicle for the program is the special education department. Students eligible for Medicaid reimbursable health-related services under the CISS program are those students with specified disabilities, as defined under the Individuals with Disabilities Act (IDEA) and who have an authorized IEP or Individualize Family Service Plan (IFSP). The plan of care must originate with the physician. **In order to be reimbursed under Medicaid, the child must have a current physician's plan or an IEP.** The IEP serves as the medical necessity document for health-related services. Nursing programs should collaborate with their special education department and attend applicable IEP meetings to discuss the medical needs of a child. The IEP is, of course, an educational model. However, education should be multi-disciplinary and should include the medical practitioner, i.e., nurses, as well.

Ms. Russell cautioned the nurses not to take over the IEP meetings, but suggested contributing to the child's welfare as a crucial part of a team, making sure the child's medical needs are being met. If the student's medical needs are being met, the child will be able to learn better. Ms. Russell said that she did not want to hear that educators were making medical determinations about students without nursing staff at the table. All medical needs and services should be noted on the IEP; then the program can bill under the Fee for Service. Medical services cannot be reimbursed if they are not noted on the IEP. Covered services for nursing include the following:

- Skilled, intermittent nursing care (e.g., suctioning, dressing changes, and catheterization);
- Administration of treatment regimens during the school day, as prescribed by the child's physician;
- Assessment of the capabilities of the child, his family, and other caretakers to carry out nursing care, medication administration or monitoring, and specific physician ordered treatments; and
- Teaching nursing self-care to the child and family or caretaker.

Documentation is critical from both the Medicaid agency and the federal standpoint. For the nurse, documentation is also critical from the legal standpoint. Each practitioner must maintain legible, accurate, and complete charts and records to support the services rendered. Services rendered should be entered in the child's record in chronological order by the practitioner who performed the service.

No particular documentation format is required, but for reimbursement purposes, records must be legible, in English, and must contain at a minimum the following:

- Date of service
- Student's name and date of birth
- Physician's written service plan or IEP
- IEP must list the names of the school representatives present at the IEP meeting; and
- The designated TCM Case Manager.

Lack of appropriate medical justification may be grounds for denial, reduction, or recoupment of reimbursement. Medicaid will only reimburse for medications administered by a licensed Registered Nurse (RN). A flow sheet or equivalent documentation may be used by the RN for daily medication administration. On the flow sheet, the nurse's full name and title must

be documented. The nurse's initials and title must be written after each medication is administered. A note summarizing the medication administered should be completed at least monthly. The note may include side effects of medication, medication monitoring note, exacerbation of symptoms, physical condition, reaction to medication, and so forth. Ms. Russell shared three nursing procedure codes with the group, noting that Y5016 is the medical administration code, the main vehicle for billing under this program. Y5017 is the treatment code, which is supposed to relate only to special education students. Y5018, the travel fee code, will be blended into other procedure codes' rates as of April 1, 2003.

Documentation is critical .... Services rendered should be entered in the child's record in chronological order by the practitioner who performed the service.

Ms. Russell introduced the Administrative Claiming for Education Program (ACE). ACE is a voluntary program that reimburses Local Education Agencies (LEAs) for administrative activities related to providing Medicaid outreach, eligibility intake, referral coordination, and monitoring activities for all students. The ACE program reimbursement is a significant source of revenue to LEAs ($10-$15 per general education student). ACE encompasses the entire student population versus CISS/FFS, which is directed to only the special education population. Although ACE does not provide 100 percent reimbursement, it does bring federal dollars back into Georgia schools. This program is compatible with CISS/FFS, but is only done quarterly, and takes less effort than CISS/FFS for similar revenue.

Medicaid Administrative Activities include the following:

- Observing children for health-related issues;
- Referring students for health-related services for follow-ups;
- Coordinating/monitoring services;
- Developing programs and planning for the delivery of health services; and
- General administration as it relates to Medicaid informing and outreach activities.

A concrete example of administrative activities would be conducting a campaign to educate families on Medicaid covered services and how to access those services. Another example would be observing students to identify which students would need a medical referral to a health care provider. Ms. Russell shared a list of eligible participants with the group and pointed out that nurses were on the list of eligible ACE program participants. She stressed that the key components of ACE are as follows:

- Quarterly Activity Time Studies
- A school's participants' roster and training per quarter
- Time study week selection (by state)
- Financials of non-federal data.

The ACE program performs three time studies per year. Time studies are conducted weekly or five consecutive days per quarter. Time studies are based on activity codes selected by the participants. ACE training is mandatory for all participants. All time study sheets must be completed and turned in for analysis and completion of the state's administrative claim to the Centers for Medicare and Medicaid Services (CMS).

In conclusion, Ms. Russell shared contact information for the CISS Operations (CISSO) Georgia Project Team, shared a CISS Program Reminder handout, and opened the floor for discussion.

Discussion Points

- A question was posed regarding clarification of eligibility in CISS as compared to the individual doctor's plan. Ms. Russell indicated that the CISS program was for special

education students. Children under Section 504 are not eligible. Services must be included in the child's IEP. General education students are not eligible for the CISS program.

• A participant asked whether an LPN could provide skilled, intermittent nursing care and administer medication under the CISS program. Ms. Russell responded that only an RN could provide services for those two codes under the CISS program and get reimbursed by Medicaid.

• Ms. Russell asked the nurses to brainstorm with administrators about how they might fit into the CISS or ACE programs. Ms. Klopfer pointed out that her school just received $2,500.00 from their last time study. The money was used to buy five laptops for the special education department. She stressed that it was important for nurses to collaborate with the administration and plan ways together to wisely use the money that comes back into the school system.

• A question was asked about how to begin the billing process. Ms. Russell told the nurses to begin by attending the applicable IEP meetings that involves medical treatments/services and build in school health services from there. The billing of CISS services is submitted by the school special education staff.

• A participant asked when ACE training would be available on the Internet. Ms. Russell responded that ACE training via the Internet has not yet been approved. The ACE plan is built around a required two-hour training. Ms. Russell stated that she recognized that it is difficult to break away from school activities to get to the training, but the onsite training must be done per CMS' directive.

• Ms. Russell clarified that the ACE program is based on the general student population. Any outreach or referral activity for every student would be included in their school's distributed FFP funds for that particular time study quarter.

PEACHCARE FOR KIDS UPDATE

Jana Thomas
Director,
PeachCare for Kids,
Georgia Department of Community Health

Ms. Thomas began by noting that PeachCare covers almost everything that Medicaid does, except targeted case management and emergency transportation. In addition, PeachCare has premiums and Medicaid does not. According to the 2003 Federal Poverty Guidelines, which were effective January 1, a family of four can earn over $43,000 a year and still qualify for PeachCare. PeachCare covers up to two hundred and thirty-five percent of the federal poverty level. This income limit is higher than most states. Georgia is one of the most generous states in regard to enrolling families. Currently, approximately 173,000 children are enrolled in PeachCare. In addition, over 132,000 children have been enrolled in Medicaid through PeachCare. The enrollment process has been simplified and improved.

If a family applies for PeachCare, they complete a PeachCare application and are enrolled in PeachCare whether they qualify for PeachCare or Medicaid. Should they be determined to be eligible for Medicaid, they receive a letter explaining the extra benefits of emergency transportation and targeted case management. They are also notified that they do not have to pay a premium. If the children later report a change in income, which changes their program eligibility, the changes are made internally. The children keep the same doctors. They are seen at the same places and have the same cards. The family is not aware or impacted by those changes, except that some months the family might have to pay a premium and other

months they will not. As families have changes in income and eligibility, the eligibility process is seamless to them.

A new claims system is being developed which will greatly improve the verification process. Both Medicaid and PeachCare will be linked in the claims system, so that even if the child switches from one to the other, there is one record that links all of their claims and enrollment history. Members can also verify their own eligibility and can change their own primary care providers online. Ms. Thomas showed participants a sample of what the new PeachCare and Medicaid card will look like. The card can be photocopied and will be linked to the child and to all numbers associated with that child, which is better for the providers, the parents, and most importantly, the child.

A provider can now file single claims on the web and will get real-time adjudication in no more than twenty seconds. Another big advantage is that if a provider files a claim and four things are wrong with it, the provider will get a list of all four errors immediately and will be able to correct and speed up payments of claims. The happier the providers are with the claims system, the more Medicaid and PeachCare patients they will take. Extensive provider searches can now be done online, allowing members and providers to search for primary care physicians, specialists, and other providers based on the proximity to their home.

Another change that is taking place at the time of the new system implementation relates to the Georgia Better Health Care Program (GBHC). GBHC is implementing a new policy in which after 90 days of enrollment with a primary care provider (PCP) a member is locked into that primary care provider for six months. The goal of this change is to help build a concept of a medical home.

Schools are the key to PeachCare's success.

Over 60,000 children have applied online for PeachCare for Kids since the PeachCare website was launched in April 2001. Twenty-seven percent of the parents said that they would not have applied if the website had not been available, making it easy to complete the application.

What can school nurses do to help promote PeachCare for Kids? In the last school year, PeachCare sent over 2.5 million fliers home with students. Web applications went up four hundred percent. Calls went up three hundred percent. Schools are the key to PeachCare's success. Ms. Thomas distributed fliers in both English and Spanish and asked the nurses to make the brochures available to children who they feel might be eligible for PeachCare or Medicaid. When families come in at the beginning of the year, in the school paperwork, they should be asked if they are uninsured, and they should be asked to consent to releasing their insurance information to the state, so that PeachCare can help them. PeachCare can partner with schools to conduct special mailings or phone calls, or supply Right from the Start Medicaid (RSM) staff to talk about PeachCare.

Discussion Points

- One participant pointed out that she and her consultants have been trying to help school nurses understand that during registration, while parents are already completing some health releases, they could use a computer to fill out an online application. If parents do not have all of the information they need, the nurses can make a telephone appointment with the parents for later. Then, during the call, the nurse could do the online application on the computer while talking to the parent, so the parents do not have to make a special trip back to the school. Nurse assistance also helps parents who are not Internet savvy.

- Ms. Thomas stated that the average time spent on PeachCare's online application is less than twenty minutes. The most difficult question on the application is, "What is your child's Social Security number?" Most parents know their own Social Security numbers,

but not their child's. If they do not have it, it does not matter. The application is designed to be very simple, so that families do not have to scramble for information they may not be able to locate easily.

• Ms. Thomas indicated that distribution of the new cards would begin in April. Beginning May 1, 2003, only the new cards will be valid for members. If a family loses the card, they can let their DFCS caseworker know or call PeachCare. DFCS can request new cards on the web or the family can request them. New cards will be mailed to them. PeachCare is encouraging providers to photocopy the card the first time they see it, so that it will be in their records. Then they still would be able to verify eligibility in the absence of a card. Providers can also verify eligibility without the actual ID number online if they have several pieces of information such as a name, date of birth, and a Social Security number. There is a place on the new website to report fraud anonymously.

IMPROVING DENTAL ACCESS

Loren Nix
Elementary School Nurse,
Berrien County, Georgia

Ms. Nix stated that Mr. Gary Chapman, the Executive Director of the Berrien County Collaborative, was not able to attend the conference but sent some interesting demographics about the county to share with conference participants. Berrien County is a small county of about 16,000 people. The county is comprised of three small towns, and Nashville is the county seat. The county has four schools in Nashville. Each school has approximately 700 children. The area is quite rural, and there are many farmers and factory workers. Poverty levels are high, with roughly half of the students on free or reduced lunches.

Many of the children do not have access to medical or dental care. With the school health grant, a new nurse, Ms. Dora Nash, was hired to cover the Middle School. All Berrien County school nurses are full time. School nurses have been in place in Berrien County for three years and have spent a lot of that time providing health education for parents, students, and faculty. During those three years, absences have decreased two percent and early dismissals related to sickness have been reduced by twenty-two percent.

The town has only two dentists, neither of whom takes Medicaid or PeachCare. The children are in desperate need. The nurses have children who come in daily with terrible dental conditions that need immediate care. It is understandable why these children cannot sit still and listen in class when their teeth are in such horrible condition. The nearest dentist who takes Medicaid or PeachCare is fifteen miles away. While that does not sound very far, for parents who have no transportation, this is a major problem. The nurses researched what might be done to help these children and finally brought in a program that has worked wonders for them.

Tammy Carter
Primary School Nurse,
Berrien County, Georgia

Ms. Carter stated that about a year and a half ago the nurses had the opportunity to go to a luncheon sponsored by Children's Healthcare of Atlanta (CHOA). Nurses love "free stuff" and there were lots of vendors with stress balls, pencils, cups, mugs, sticky pads, and more. One of the vendors at the conference was called Help a Child Smile. This group is located in Conyers, Georgia, and operates a mobile dental van that travels out to rural areas to provide dental care to children. The nurses stopped to talk to a representative about how they might get such a program to come to Berrien County. The representative asked how many people might be interested. The nurses had no idea, so they went home and developed a survey, asking parents if they would be interested in having a dental service come to the school to take care of their children. The response was overwhelming.

Help a Child Smile takes PeachCare and Medicaid. The dental service completes all of the paperwork that comes through the nurses. The dental service sends the forms to the school nurses, and the nurses send them out to the parents. If the forms come back incomplete, the children are not treated. If there is no parent signature or no consent to treat, the children are not treated. Allergies are addressed as are past experiences with dentists. It took approximately six to eight months to begin the service.

Dora Nash
Middle/High School Nurse,
Berrien County, Georgia

Help a Child Smile provides comprehensive services that include exams, cleanings, sealants, fluoride treatments, and non-mercury cavity fillings. If more extensive dental care is needed, the dentists contact the parent by telephone and let them know. At first the children, even the high schoolers, were a bit apprehensive, but now the children ask to go to the van. The staff is trained and licensed and includes dental hygienists, dental technicians, X-ray technicians, and dentists. They have a positive attitude and work well with the students. Nevertheless, the nurses remain available as back up support and escort the children to and from the van.

In 2001-2002, 250 students signed up for the dental program. The dental van came back three times that year to take care of the children. In 2002-2003, word spread about how great the program was and, consequently, 432 children enrolled. Over 700 treatments have been performed thus far to fourteen percent of the school population. After analyzing the paperwork, the nurses found that forty-nine percent of the students enrolled had never seen the dentist before they enrolled in the program. This included high school students who had never been to a dentist.

Improvements are constantly being made. There are some disgruntled dentists in surrounding counties who feel the van is taking potential clients away, even though they do not accept PeachCare or Medicaid. Ms. Carter interjected that Ms. Nix wrote letters to the two local Berrien County dentists and spoke to them personally to make sure they would not be offended. She also asked them if they would be emergency back up dentists. Both local dentists were more than supportive. The dentists in the other counties were the problem. Once, Ms. Nix had a child with a bad abscess. She called one of the dentists in the other county who took Medicaid and asked him to see this child. He said he did not have an opening for three weeks. She explained that the child had an abscess, but the dentist told her to put the child on antibiotics, and he would see him in three weeks.

The children are in desperate need. The nurses have children who come in daily with terrible dental conditions that need immediate care.

Ms. Nash explained that they were having some difficulty getting emergency access during the times when the mobile dentist is not there, but the local dentists have been very supportive in working with the nurses in trying to cover dental emergencies. Still, the most important "pro" is that the children finally have access to dental care. The van is pediatric-centered and is a wonderful setting. The most amazing result is that the children ask when the dentists are coming back. The van also extended their hours to include the after school program, and they have offered to come back during the summer school program.

Discussion Points

- Ms. Nash clarified that although the mobile dentists do not promote extractions, they will do them. Their first choice is always to save teeth. Parents are always called if an extraction is found to be necessary. Ms. Nash passed around pictures of the Help a Child Smile program.

- A question was posed regarding how emergency care was handled in between dental van visits. Ms. Nix explained that although none of the local dentists take Medicaid or PeachCare, if it is a true emergency, they would work with the parents to set up a payment

plan. Help a Child Smile also will refer the child to cooperating dentists on their list, if a child needs assistance in between van visits.

• Help a Child Smile takes children of all ages, from kindergarten to twelfth grade. The dental program also takes care of all the billing paperwork. Ms. Nash pointed out that the school nurses assist with getting the forms to and from the parents and back to the dental program, to make sure they are as complete as possible before the dental van comes to the school. However, if a form is still incomplete when they arrive, the program staff will attempt to contact the parents and complete the forms, so the child can be treated.

• Ms. Nix stated that there were no special hook-ups required by the service. All they need is a dumpster site for trash and a water drainage system in which to empty their water. The van has its own generator and equipment. The nurses passed around a booklet comprised of letters from parents and students about the dental van services and the nursing program in general.

EXPLORING FUNDING OPPORTUNITIES

Susan Teller Goodman
Training Manager,
Georgia Center for
Nonprofits

Ms. Goodman distributed several handouts and indicated that she would be speaking specifically about how nonprofit organizations might receive funds to do their work. She said that the Georgia Center for Nonprofits serves, supports, and strengthens nonprofit organizations. Member benefits include: insurance; payroll programs and other group benefits; discounted rates for workshops; special events; a help line; a bookstore; and reference resources. For more information, participants were encouraged to visit the Center's website at *www.gcn.org.*

There are many funding resources available, but only some of the resources will actually be available to school health organizations because: some will not meet the organization's strategic plan; some do not meet the organization's purpose; some are not for the organization's geographical area; and some are not for the age range the organization serves, or the race, ethnic or religious affiliation, etc. There are right ways and wrong ways to ask for money. The first step is to begin with a strategic plan that asks the following questions:

There are right ways and wrong ways to ask for money. The first step is to begin with a strategic plan.

- Why do you want the money? State your case clearly and succinctly.
- What are your goals?
- Whom are you serving? Does your target population fit the grantor's target population?
- What services are you providing? Do your services fit the grantor's interests?
- Where are you providing your services? Does your service area fit the grantor's service area?
- How much money do you need? Are you asking for too much money or too little?
- What are all of your funding resources? Do not rely on one funding source for all of your money.
- What is your annual plan for fund-raising? Show and tell how you are going to raise money for your services and what your planned budget is.

There are all types of funders from large foundations to small, individual donations. Ms. Goodman urged not to forget any of them and to search for corporate resources like the AFLAC Corporate Giving Program or foundations like the Francis L. Abreu Charitable Trust.

Local civic groups like the Elks, the Moose, churches, and neighborhood organizations often give money to local organizations. Alumni of the school, neighbors, civic leaders, and local doctors or hospitals should also be approached for money.

With regard to where organizations can find these grantors, Ms. Goodman shared a variety of sources with which to locate them, including foundation center libraries, books, the government, the Internet, friends, colleagues, and conferences. Ms. Goodman gave some specific examples of grantors that might be found by utilizing these resources in her handout. She reminded conference participants that it is a lot of work to create a grant application, and that applications must be written correctly. She stressed that they should do what funders ask, when they ask, and how they ask. Applicants should make sure their organization meets the funder's requirements, that their application is on time, and that they have followed instructions exactly. If they want one copy, only three pages long, that's what applicants should send–no more, no less. Someone at the grantor's office has to read a lot of grant applications, so applicants should not waste the reviewers' time. Grant application reviewers will remember applicants well who apply correctly. Moreover, grantors talk to one another, so Ms. Goodman also stressed that they should not send a lot of applications to everybody. Instead, they should be choosy, sending applications only to those grantors thought to be a good match for the applicant's organization. She reminded participants to use their personal contacts, networking and talking to everyone about their funding needs when the appropriate opportunity arose.

School health organizations should do what funders ask, when they ask, and how they ask.

Ms. Goodman indicated that the Georgia Center for Nonprofits offers workshops on how to write grant proposals. She then outlined the grant writing process, explaining that the first step is to gather information about possible grantors for one's particular organization. The next step is to develop a program budget and define the project. Grant proposals should contain the following sections: Executive Summary, Statement of Need (case statement); Project Description; Budget; Organization Information (including program evaluation and financial and future funding plans); and Conclusion.

She shared the following two quotes from people who review grant proposals:

- "If I can't understand the title, then I don't fund it." Whitney Tilt, National Fish and Wildlife Foundation.
- "If you haven't told us what you want by the end of the third paragraph, chances are you're not going to get it." John West, Phillips Petroleum Foundation.

Ms. Goodman urged organizations also to consider collaborating with other projects to obtain funding, checking to see if somebody is already doing what is proposed, and becoming a "project" under someone else's umbrella to have a better chance of getting funds.

KAISER PERMANENTE'S EDUCATIONAL PROGRAM PRESENTS "Acting on Stress"

The Kaiser Permanente's Educational Theatre Program

Kaiser Permanente's Educational Theatre Program (ETP) presented Acting on Stress, a live theatrical production focusing on important issues such as teacher workload and burnout, student apathy, lack of parental involvement, and increased violence in schools. Medical experts say stress can be a factor in a variety of physical and emotional illnesses, such as depression, anxiety, stroke, heart disease, digestive problems, skin disorders, weight problems, diabetes, susceptibility to infections, sleep disturbances, and impaired concentration. Throughout the production, the audience witnessed actual classroom occurrences between

students and teachers from different perspectives. Using conflict resolution methods and effective communication as tools, the ETP facilitator and the actors interacted with the audience to help audience members discover ways to reduce stress.

Kaiser Permanente's Educational Theatre Program, Georgia Region, began in 1995 and offers a unique series of dynamic theatre programs with compelling health massages to reach children, teens, and adults. These national award-winning plays promote individual responsibility for one's health, instill positive attitudes about healthy lifestyle choices, and demonstrate the benefits of positive action. Other current program offerings include the following:

- Secrets, an educational play for teens about HIV and AIDS, is performed by professional actors who are also trained HIV educators.
- Uncle Gherkin's Magical Show focuses on the grieving process after the loss of a loved one. Created for children under the age of 10, this 45-minute program incorporates puppets, audience participation, and magic.
- Fragments: Impressions of Grief focuses on the grieving process of teens and adults.
- Mumferd's Safety Tales shares important life-saving safety tips with children in a way that will entertain them as well.

Shows are offered free-of-charge, as a community service. For more information about ETP, participants were instructed to call 770-931-6068.

HELP FOR ADDRESSING BEHAVIORAL ISSUES

Mental Health Assessment

Kristine Medea, MA, ABS
Director of Clinical Education and Youth Programs, National Mental Health Association of Georgia

Ms. Medea pointed out that participants knew more about mental illness than they thought they did. She asked them to think about three questions:

- When you hear the words "mental illness" what do you think of?
- What words come to mind when you think of children and mental illness?
- When you hear the term "schizophrenic" what word comes to mind?

She suggested that the words that might come to mind are words like: crazy, nuts, looney, loco, schizo, round the bend, mad, psycho, bad kid, and manipulative. This type of language perpetuates stigma and discrimination against individuals with mental illness, a stigma that still persists to this day. People are still not comfortable telling friends that their child has a mental illness, nor are they comfortable talking about their own mental illness. Former Surgeon General David Satcher's Report on Children's Mental Health indicated that "The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country . . . it is time that we as a nation took seriously the task of preventing mental health problems and treating mental illness in youth." Ms. Medea urged participants to go to *www.surgeongeneral.gov* to peruse the complete report themselves.

Mental disorders exist in childhood, and these disorders can often be successfully treated through a multi-disciplinary approach. As many as 12.8 million children and adolescents may have a diagnosable mental health problem [Center for Mental Health Services (CMHS)], and approximately six million youth may have an emotional disturbance that significantly impairs

his or her ability to function emotionally, socially, or academically (CMHS). The World Health Organization (WHO) estimates that by 2020, child neuropsychiatric disorders will become one of the five most common causes of morbidity, mortality, and disability of young children.

In the past, children with mental illness received treatment in inpatient hospitals or in residential treatment or outpatient centers, with little family involvement. Today, treatment may be provided at home, at school, in the community, or in alternative health centers. The family also is included in the treatment. Still, too few children receive the mental health services they need, with less than thirty-three percent receiving any mental health services and only one in five of the most severely impaired receiving any mental health care at all.

Ms. Medea pointed out that early identification of mental illness is extremely important. When identifying mental illness in children, it is critical to assess their mental health in the context of familial, social, and cultural expectations about age-appropriate thoughts, emotions, and behavior. Current research suggests that biological, social, psychological and environmental factors are equally important. It is important to realize that mental disorders and mental health problems can happen to anyone. No one is immune. Problems appear in families of all social classes and backgrounds. Children at greater risk are those who have physical problems, intellectual disabilities (retardation), low birth weight, family history of mental and addictive disorders, multi-generational poverty, and/or caregiver separation or abuse and neglect.

The burden of suffering experienced by children with mental health needs and their families has created a health crisis in this country.

One in five children in the United States meets the criteria for a mental disturbance. One in ten children meets the criteria for more severe diagnoses. Mental disorders commonly diagnosed include: Clinical Depression, Bipolar Disorder, Generalized Anxiety Disorder, Post-traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, and Reactive Attachment Disorder.

Ms. Medea believes that more diagnoses are occurring now because doctors and the general public are getting better at identifying disorders rather than just labeling children "bad." She pointed out the following red flags for mental disorders:

- Change in sleeping or eating patterns
- Increase in somatic complaints (stomachaches, headaches, vague aches and pains)
- Prolonged tantruming (age inappropriate)
- Isolation (from family and peers)
- Poor concentration (academic decline)
- Sad or death themes (writing, art, or play)
- Delusions and hallucinations or self harm.

These red flags are not for any particular disorder and are more significant when there is a clustering of symptoms in one child. One should also look for a significant change in the child's baseline personality. The red flags also should be contextualized with grief reactions (from loss, divorce, death) and trauma reactions (terrorism, national tragedy, abuse either sexual or physical). The implications of untreated and under-treated mental disorders are severe. Ninety percent of the youth who complete suicide have an untreated or under-treated mental disorder. Suicide is the third leading cause of death for young people between the ages of fifteen and twenty-four. In Georgia, thirty youth between the ages of ten and fourteen completed suicide from 1994 to 1998. During that same time period, 650 youth between the ages of fifteen and twenty-four completed suicide nationwide. The bottom line is that childhood mental disorders are real, common, and treatable. Ms. Medea recommended that schools integrate mental health screening into their screening processes so that childhood mental disorders can be identified quickly and treated properly.

Discussion Points

• A participant stated that school counselors are often academic counselors and are not trained in mental health. This is a big barrier in Georgia schools. Ms. Medea trains school counselors, but the training they receive is not enough. She urged schools to at least train their counselors to recognize red flags and know when to refer a child on for mental health assessment.

• One participant explained that many of her high school students are ashamed that they have to take medications. Often, school staff find out the child has a mental disorder only when the child has not taken his or her medication and becomes uncontrollable. Ms. Medea suggested that schools make formal efforts to recognize Mental Health Month. In the high schools, recognition of Mental Health Week has been successful. This is a week where children are made aware of what mental illness is and how to identify when they are at risk. They are taught suicide prevention and learn how to identify suicidal risk factors. It is critical that school staff help the children learn how to help themselves.

Mental disorders and mental health problems can happen to anyone. No one is immune. Problems appear in families of all social classes and backgrounds.

Substance Abuse

Becky Vaughn
President and Chief Executive Officer, Georgia Council on Substance Abuse

Ms. Vaughn began by thanking the school nurses for taking care of the nation's children. She said that she was very appreciative of their hard work and was honored to be invited to present at the conference. She explained that substance abuse is the use or misuse of certain drugs that lead to dependency. Children as young as second grade are abusing drugs. Some are addicted, but most of them are abusing and are not yet physically addicted. Every person on this planet is vulnerable to addiction. There are biological factors and behaviors that may increase risk, but absolutely no one is immune to addiction. The effect is similar to heart disease, diabetes, or any other disease. Everyone is vulnerable to heart disease. Some are more vulnerable to it than others, but no one is immune. The same thing happens with addiction. Also important to consider is that the multitude of resources available for a mother whose child is a diabetic are not available to that same mother whose child becomes addicted to some type of drug.

Addiction affects everything about a person, every system, every part of the body. A healthy individual's body will tell that person when he or she needs to eat or sleep. Once addiction is triggered, the brain changes, and all of those priorities become mixed up. Serious addicts will starve to death because it does not even occur to them to eat. There are two main reasons why children begin abusing drugs. One is that getting high sounded like fun. A second reason is that a child may suffer from a mental disorder that makes them feel bad, and drugs make the child feel better. Drugs work by releasing chemicals that make people feel good, which makes people want to repeat the behavior because it feels good. Ms. Vaughn shared a picture of a brain destroyed by drug abuse. It did not look like a fried egg. Instead, the brain was pocked and irregular, as if it were destroying itself from within. She indicated that the brain will eventually heal itself from the use of most drugs, but stressed that Ecstacy is a drug that will affect the brain forever.

One in five adults grows up with an alcoholic. Fifty percent of today's alcoholics are children of alcoholics, which translates into seventy-five million Americans exposed to alcoholism in their families. It has been shown that if an adopted child whose parents were alcoholics is placed into a home where neither parents are alcoholics, that child is at a much higher risk of

becoming an alcoholic. The opposite is also true. In addition, there is a strong correlation between substance abuse and dropout rates, behavioral problems, juvenile delinquency, child abuse, and domestic violence.

Sadly, children are beginning to abuse alcohol at an average age of 13.5 years, and smoking marijuana at 14.5 years. In Georgia, underage alcohol use costs the state $2.5 billion per year. A new study recently indicated that twenty percent of the alcohol being sold in the United States is sold to underage users. Over fifty percent of the alcohol sold is sold to alcoholics. The alcohol industry is incredibly dependent on children and alcoholics continuing to buy alcohol. If every person in this country drank their low risk choice, which for most people is one or two drinks per day, the industry would lose close to seventy-five percent of their income. Smoking is still a major problem in Georgia. Spit tobacco is a growing phenomenon because schools are saying that children cannot smoke on school grounds, and the children are still addicted to tobacco. So, they have figured out that they can hide spit tobacco in school much easier than they can cigarettes. They will even swallow the stuff to keep from getting caught.

Every person on this planet is vulnerable to addiction. There are biological factors and behaviors that may increase risk, but absolutely no one is immune to addiction.

Ms. Vaughn shared a study conducted last year by The Georgia Council of Substance Abuse on the impact of substance abuse on Georgia. She shared the statistics for fifth, eighth, and tenth grades. In fifth grade, thirteen percent of the children use alcohol. Very few children at that age buy their alcohol because they get it at home. The same holds true for marijuana–children get it at home. The United States consumes sixty percent of the illegal drugs produced in the world. Obviously, the U.S. does not have sixty percent of the world's population, so the United States is doing a fine job of consuming more than its fair share. Teenage drug use is declining, but use in ages eighteen to twenty-four is increasing. Georgia spends almost ten percent of the state budget on cleaning up the problems of substance abuse. For every dollar Georgia spends on child welfare, courts, prison, and more, the state spends under a nickel on treatment and prevention of substance abuse.

There are potential solutions. Drug courts are having a phenomenal impact on people. The state is trying to get people into treatment instead of putting them in prisons. The same is happening in six juvenile courts. A federal bill is trying to do the same thing with college students, so that if young adults get in trouble, they go into treatment. This change is important because fifty percent of the people who come out of the prisons and who have substance abuse problems end up back in prison. It has been found that if they are sent through a drug treatment program, less than twenty percent end up back in prison. Some drug courts that have been operating for four years have not had a single person reincarcerated. It is clear that treatment is much more cost-effective than prison. It is also important to note that seventy percent of the people who have problems are adults in the workforce. They are not sitting at home or leaning up against a building with a brown paper bag. They are working. Insurance benefits need to cover substance abuse, like all other diseases. Prevention works. Parents play a role with their children, even if they do not think they are making a difference.

In closing, Ms. Vaughn distributed some resources that would help the school nurses if a child came to them because their parents were substance abusers or child abusers. She explained that substance abuse prevention needs to start in preschool if an impact is to be made. Substance abuse is not an individual problem, nor is it a family problem. It is not even a school problem. It is a community problem, and it involves everyone. Ms. Vaughn urged the school nurses to talk to their community leaders and find out how substance abuse is impacting their communities, then identify working programs and implement them.

NAVIGATING THE INTERNET AND FINDING FUNDING ONLINE

Ms. McColley set up a hands-on demonstration of how to leverage the Internet to benefit school health programs. While actively connected to the Internet, she showed participants how they might access the Internet to search for a host of online funding resources. She selected three online funding databases: Healthy Youth Funding Database, the National Youth Development Information Center, and the Coalition for Community Schools. She explained step-by-step how to log onto each of these sites and search for funding opportunities, sharing the following search and Internet tips:

- When searching, don't use too many limiting factors. You don't want to miss out on any potential grants.
- Search both nationally and regionally.
- When searching for school health grants, also search for adolescent, child(ren), youth, AND community grants.
- Take time to learn about the grant-making foundation or organization:
  - What have they funded in the past?
  - What is their mission?
  - What other work do they do?
- Pay attention to all instructions provided (READ)
- Pay close attention to the dates:
  - Some grants appear online, with fast approaching deadlines.
  - Others may have deadlines that have already passed.
- Be aggressive but not pushy when seeking funding. Funding is available for people to obtain.
- Be optimistic that you can find potential funding sources.
- Consider how your organization could meet the goals and mission of the potential funder.

Ms. McColley gave participants some computer time to conduct their own hands-on searches.

Bernette McColley
Special Projects Coordinator, Georgia Health Policy Center

Thursday, February 27, 2003

PHYSICAL ASSESSMENT OF THE SCHOOL-AGED CHILD

NOTE: A videotape, *Conducting a Physical Assessment of the School-Aged Child*, is to be distributed, along with this report, to participants. Brief summaries of each physical assessment segment are included below.

BASIC SKILLS

Physical Assessment of the School-Aged Child

Deborah Bentley, RN, CPNP
Pediatric School Nurse Liaison, Children's Healthcare of Atlanta

Physical assessment is the process by which practitioners gather data about a patient, through observation, acquiring a verbal history, and examination of the body.

Ms. Bentley began the basic skills assessment segment by pointing out the following resources:

- Bates Physical Assessment Book
- Mosby's Handbook
- Physical Assessment books by Springhouse Publishing

She explained that physical assessment is the process by which practitioners gather data about a patient, through observation, acquiring a verbal history, and examination of the body. Ninety-seven percent of the assessment is patient history. Ms. Bentley began with the General Survey (Remember: SOME TEAMS):

- Symmetry–equal on both sides
- Old–does the student look his or her age?
- Mental Acuity–alert, confused, agitated
- Expression–ill, in pain, anxious
- Trunk–lean, stocky, obese, barrel-chested
- Extremities–clubbed fingers, joint abnormalities, edema
- Appearance–clean, appropriately dressed
- Movement–posture, gait, coordination normal
- Speech–relaxed, clear, strong, understandable

The four major points of physical assessment are inspection, auscultation, percussion, and palpation. She stressed the importance of documentation and of designating someone to document in case of absence. What nurses document depends on the clinic and procedures of the county, but Ms. Bentley suggested that everything be documented, including phone calls made and notes sent home to parents. She noted that they should use dark ink and be succinct, making sure to abide by all rules applicable, including confidentiality and the Health Insurance Portability and Accountability Act (HIPAA).

Ms. Bentley then began the examination, discussing first the Head, Eyes, Ears, Nose, Throat (HEENT) and Neck:

- Scalp: shape, hair
- Face: symmetrical, expression, movement
- Skin: color, pigmentation, thickness, lesions
- Eye: PERLA, sclera, drainage, light reflex, extraocular movements, vision screening
- Ear: position, anatomy, drainage, hearing screening
- Nose: deformity, asymmetry, inflammation, drainage, sinus
- Mouth: lips color, moisture, integrity
- Mucosa: color, ulcers, nodules
- Gums/Teeth: inflammation, edema, bleeding, retraction, discoloration, loose or cavities, position, or shape
- Palates: hard/soft
- Tongue: color, papillae, abnormalities
- Pharynx: uvula, tonsils, color, inflammation
- Neck: symmetry, masses, lesions, lymph nodes, trachea/thyroid

Common problems found in the basic exams are:

- Headache
- Conjunctivitis
- Otitis media
- Allergic rhinitis
- Upper respiratory illness (cold)
- Viral pharyngitis
- Strep pharyngitis
- Other conditions

Ms. Bentley closed the basic assessment segment with a case study and opened the floor for discussion.

Discussion Points

- If drainage from eyes is clear and there is no "goop" and no pink in the sclera, it would probably be safe to say it is allergic conjunctivitis or a viral infection. Participants were instructed to document findings, send the student back to class, and send a note home to the parents, telling them to watch for development of pink eye.

- One nurse had a problem with the school daycare center constantly asking one of her student mothers to take her baby home because the baby might have pink eye, even though the nurse disagreed that it was pink eye. Ms. Bentley suggested having a meeting with the student's support team and the daycare worker to discuss a plan so that the student will be able to continue to move toward graduation.

- Pink eye is usually seen on one side first, but it will eventually get to the other side. Itching cannot be an accurate predictor because itching occurs with allergies and viral

The four major points of physical assessment are inspection, auscultation, percussion, and palpation.

infections as well. Bacterial is more painful. The viral infection will have some redness, but won't continue to inflame. With a bacterial infection, the conjunctiva will be beefy red. If there is a question, do periodic checks of the student to see if there has been any change. If more swelling is observed, Periorbital Cellitus should be considered. Nurses also need to stay alert for students who rub their eyes until they are red enough that the teacher thinks they need to go home. Put a cool compress on their eyes and watch them for a while. Wash their hands carefully.

Respiratory Assessment of the School-Aged Child

Alison Ellison, RN, PNP
School Nurse Consultant, Children's Healthcare of Atlanta

The components of a respiratory assessment are:

- History: interview the child for respiratory illness
- Inspection: color, facial expression, symmetry, abnormalities, work of breathing, use of accessory muscles, drooling
- Palpation and Percussion: use fingers, palm, dorsal hand.
  - Warm hands, privacy
  - Fremitus, friction rub, crepitation
  - Resonance, dullness, tympany, hyper-resonance
- Auscultation:
  - Stethoscope
  - Systematic approach: anterior, posterior, lateral
  - Assess pitch, intensity and duration of sounds from side to side
  - Adventitious (abnormal) sounds
- Olfaction:
  - Foul odor = infectious process or poor hygiene
  - Fruity odor = ketoacidosis

Some adventitious breath sounds include:

- Abnormal sounds superimposed on breath sounds
- Bronchial, bronchovescular, vesicular
- Crackles/rales
- Wheezes
- Rhonchi
- Inspiratory stridor, expiratory grunting
- Decreased or absent breath sounds

Ms. Ellison shared a website address, *www.wilkes.med.ucla.edu/intro.html,* which was created by a student at UCLA. The website includes both heart and breath sounds, normal and abnormal, and was designed to improve students' respiratory and cardiac diagnoses.

Common respiratory signs and symptoms include:

- Cough: Protective reflex to clear the airway, caused by secretions, irritation, foreign body

  Type and duration, association with infections or allergies, seasonal occurrence, time of day, associated chest pain, environmental factors, mucus production

  Past medical and family history

  Medications used

  Presence of fever

- Lower respiratory tract disease

  Fever, activity restriction (fatigue), failure to grow, clubbing, persistent tachypnea, hypoxia

- Fifth vital sign: Check capillary refill on the nail beds, if a child just doesn't look good. Make sure it refills in three seconds or less.

- Noisy breathing

  Infection, congenital malformation, irritants and allergens, foreign body, polyps, adenoids.

Respiratory problems include:

- Asthma: biggest problem after regular upper respiratory infections.

  Make sure children know how to use and watch them use their inhalers. If allowed, make sure they carry the inhalers on their persons.

  An inhaler may be checked for fullness by floating the metal canister in a bowl of water. If it sinks, it is full. If it is angled but below the water level, it is about 3/4 full. If it is half floating at an angle near the top, it is 1/4 full. If it is floating on top of the water, it is almost empty, and there are no useful doses left. (It should be noted that using this technique of floating the inhaler is safe only with Albuterol or Ventolin, or, after checking with the manufacturer.) Many drug companies recommend counting the number of puffs used per day to determine when the canister is likely to be empty, i.e., the canister may hold a total of 250 puffs and the child uses two puffs, four times a day–which would last about 31 days.

  Children with asthma may not wheeze at all, but may have dry, hacking and very irritating coughs that bother everybody in the classroom.

- Pneumonia
- Spontaneous pneumothorax
- Hyperventilation
- Cystic Fibrosis

A website address www.wilkes.med.ucla.edu/intro.html, created by a student at UCLA, includes both heart and breath sounds, normal and abnormal.

Cardiac Assessment of the School-Aged Child

Deborah Bentley, RN, CPNP
Pediatric School Nurse Liaison, Children's Healthcare of Atlanta

Ms. Bentley explained that the heart, our main organ, lies in the center of the thoracic cavity and is protected by the sternum in the front and the vertebral column in the back. It weighs approximately 250 to 350 grams, pumps approximately 6800 liters of blood per day through the circulatory system, and beats at a rate of 60-100 times per minute.

During assessment, nurses should take care to look at:

- Skin: temperature, mottling, cyanosis
- Neck vessels: carotid, jugular
- Nails: capillary refill, clubbing
- Extremities: pitting edema
- Arterial pulses: radial, popliteal, dorsalis pedis

When inspecting the chest, it is important to note (use stethoscope):

- Timing: rate and rhythm of the heart
- Spatial: where pulsation or sound is observed
- Intensity: how strong or loud is pulsation
- Character: hissing, clicking, booming

There are seven sequential areas to assess heart sounds:

- Sternoclavicular
- Aortic
- Pulmonary
- Right Ventricular
- Apical or Left Ventricular
- Epigastric
- Ectopic

It is best to do the [cardiac] assessment in sequence, first sitting then lying down, because position changes the characteristic of the sound.

During auscultation, listen first with the diaphragm using firm pressure, then move to the bell and listen for a few seconds using light pressure, progressing on the apex to the lower sternal border, and ascending very slowly. Listen to every part of the atrial ventricular valve for the "lubb" sound. The second sound will be the "dubb" sound, which is the aortic closure, followed by the pulmonic valve. It is best to do the assessment in sequence, first sitting then lying down, because position changes the characteristics of the sound.

Murmurs occur when structural defects in the heart's chambers or valves cause turbulent blood flow. It can be caused by changes in the consistency of blood or the speed of blood flow. Bruits are a murmur-like sound of vascular origin. Bruits may identify arterial disease or an arteriovenous fistula. Murmurs can be systolic or diastolic, be high, medium, or low in pitch, and be loud or soft in intensity. Location can vary. The sound pattern is blowing, harsh or musical, and the sound can radiate. Innocent murmurs are grade I and II, are of medium pitch, and the blowing is brief. The murmur may increase in intensity during held expiration and may change with position. Innocent murmurs are heard best with the bell of the stethoscope placed lightly at the second intercostal space, near the left sternal border, and while the patient is lying down. The murmur disappears when the patient sits or stands. It is also heard

during systole. Murmur grades range from grade I, which is barely audible, to VI, which is loud enough without a stethoscope, thrill palpable, and visible.

The most common of the arrhythmias in children is Supraventricular Tachycardia (SVT). SVT is caused by disturbances in impulse formation or conduction or both. The child will present a regular rhythm, with a rate of 220+ beats per minute. The treatment depends on the duration and includes Valsalva maneuver, ice/cold pack to face, and adenosine or cardioversion.

Another disorder is Long QT Syndrome. This is a congenital abnormality of the cardiac repolarization and places patients at risk of life threatening arrhythmias. This syndrome is uncommon, under-identified, and misunderstood. It is genetic, but can be acquired (drug induced). Diagnosis is made considering family history and EKG markers. Often, a family will find a family member who has a history of blackouts. The risk is Torsades de pointes, and the disorder is treated with beta blockers or surgery.

Other common cardiac defects are:

- Aortic stenosis
- Coarctation of the aorta
- Patent Ductus Arteriosus (PDA)
- Atrial Septal Defect (ASD)
- Ventricular Septal Defect (VSD)
- Tetralogy of Fallot
- Transposition of the great arteries

Syndromes and Trisomies associated with cardiac defects:

- Down's: ASD and PDA
- Marfan: Dilatation and aneurysm of aorta, aortic and mitral insufficiency, mitral valve prolapse
- Noonan: Dysplastic pulmonic valve, ASD
- Turner: Coarctation of the aorta, bicuspid aortic valve
- Williams: Supravalvular aortic stenosis, pulmonary artery stenosis
- Trisomy 13: PDA, ASD, VSD, Pulmonic/Aortic Stenosis (atresia)
- Trisomy 18: VSD, polyvalvular disease, coronary abnormalities

Ms. Bentley also presented a case study.

Abdominal Assessment of the School-Aged Child

Sandra Leonard, RN, FNP
School Health Coordinator,
Division of Public Health
Georgia Department of Human Resources

Ms. Leonard indicated that abdominal complaints could cover a spectrum of medical diagnoses, so it is important that all minor and major complaints be differentiated. There are several general considerations to think about before and during the assessment. The student should have an empty bladder and should be lying supine. The student's face should be watched for signs of discomfort during the exam. Disorders in the chest may manifest with abdominal symptoms.

After reviewing terminology relating to the abdominal area, Ms. Leonard explained that there are four steps to the physical examination of the abdomen: inspection, auscultation, percussion, and palpation. First, the abdomen should be inspected for contour, asymmetry, scars, hernias, lesions, or rashes. Unlike other exams, auscultation comes before percussion and palpation. The diaphragm of the stethoscope should be placed lightly on the abdomen. Bowel sounds should be recorded as being present or absent. Heart murmurs can sometimes transmit to the abdomen.

Percussion is not something that school nurses are going to be frequently doing in the school setting, but it does present a teachable moment. Tympany is normally present over most of the abdomen in the supine position. The children like to hear the big loud gastric bubble as compared to the dull sound over the liver, which can be very diagnostic in certain situations. One should begin with light palpation, looking for areas of tenderness, and then should proceed to deep palpation. Abdominal masses or areas of deep tenderness should be identified. Appendicitis will have rebound tenderness. One should press deeply on the abdomen and quickly release. If it hurts upon the release, there is positive rebound tenderness. To check for positive psoas sign, one should place a hand above the student's right knee, asking the student to flex the right hip against resistance. If there is abdominal pain, there is a positive psoas sign. To check for obturator sign, the student's right leg should be raised with the knee flexed, and the leg should be rotated internally at the hip.

Common acute problems found include: missed meal; menstrual cramps; medications (especially antibiotics); trauma; psychological; strep throat; constipation; diarrhea (associated with viral syndrome, bacteria, parasite); food poisoning; urinary tract infection (UTI); gastroenteritis; bacterial enterocolitis; obstruction; and appendicitis. Common recurrent problems include: chronic nonspecific; psychological; constipation; menstrual cramps; Mittleschmertz; and Sickle Cell Crisis. Other conditions that might be present are: Streptococcal Pharyngitis; medications (especially antibiotics); food poisoning; UTI and reproductive system problems such as pregnancy/ectopic pregnancy; infections/STDs; ovarian disease; and dietary indiscretion.

Ms. Leonard also presented a case study.

Musculoskeletal Assessment of the School-Aged Child

Alison Ellison, RN, PNP
School Nurse Consultant, Children's Healthcare of Atlanta

Ms. Ellison explained that a growing child's musculoskeletal system is different from an adult's system. Growth plates are present at the end of the long bones, which makes injuries and treatment of injuries different. The components of musculoskeletal assessment are: observation and inspection; palpation; evaluation of range of motion; and neuromuscular assessment. In a school setting, the exam usually is focused on the area of pain, injury, limp, or immobility. She indicated that the exam should be organized from head to toe or focused on the area of complaint. The practitioner should always evaluate areas above and below the injury as well, making sure to inspect for symmetry, deformity, and swelling. Also, one should examine the contralateral side, and palpate for pain, tenderness, and swelling. The pain scale should be used with happy and sad faces on it, so that the child can easily explain the level of the pain that they are feeling. The range of motion should be evaluated. Active is better. The child should move by himself if he can. If injured, the child should move very gently, and should be stopped from moving if the movement is painful.

Ms. Ellison reviewed the terminology related to the musculoskeletal assessment, which is important in documentation. She then discussed the musculoskeletal assessment, beginning with the neck. Common findings in the neck are torticollis; muscle spasm (slept on it wrong); nuchal rigidity; and cervical spine trauma. The clavicle is one of the most common fractures in school-aged children. Other common findings are shoulder separation and humerus shaft fracture.

Common school-age findings in the elbow are radial head dislocation (Nursemaid's Elbow); Little Leaguer's Elbow (overuse injury), and supracondylar fracture. In the forearm and wrist, fractures (radius and ulna), sprains, and soft tissue injuries are commonly found. In the hand common finds are metacarpal fractures, fingertip crush injuries, dislocations, and amputations. Common findings of the spine are Scoliosis, Kyphosis, Spondylolysis, bone tumors, and fractures. Common findings in the hip, pelvis and thigh are Legg-Calvé-Perthes disease, slipped capital femoral epiphysis, and femoral anteversion. In the knee, common school-age findings are Osgood-Schlatter's disease, meniscus injuries, ligament injuries, and dislocation of patella. Ms. Ellison pointed out that frozen sponges are a great way to apply ice in a school setting. Sponges should be dampened and kept in a plastic bag in the freezer. Bags should be sealed so they do not leak. They freeze nicely and mold well to injured areas. Ms. Ellison also noted that, as a precaution with football injuries, the general consensus is to leave the helmet on. The EMTs should remove a helmet when they arrive on the scene, if they feel it is necessary. Until EMTs arrive, manual c-spine alignment should be maintained.

The practitioner should always evaluate areas above and below the injury, making sure to inspect for symmetry, deformity, and swelling.

In the lower leg, ankle, and foot, nurses may see genuvarus and valgus, shin splints, ankle fractures and sprains, heel pain (Sever's disease), and metatarsal and phalangeal fractures. With fractures, sprains and strains, a careful history should be taken of the injury, including the mechanism, symptoms, and witnesses. During the exam, one should note pain, point tenderness, swelling, weight bearing, deformity, range of motion, neurovascular (numbness, tingling, capillary refill, color), and shock. Remember P-R-I-C-E (protect-rest-ice-compress-elevate). No ice should be used if the child has sickle cell disease, as it can exacerbate sickling. The injury should be splinted in a position of comfort and the patient referred for further treatment.

Also found is Juvenile Rheumatoid Arthritis (JRA). The arthritis is polyarticular if more than five joints are involved, and pauciarticular if one to four joints are involved. The arthritis is systemic if there are fever, enlarged nodes, and pericarditis. Joint swelling, tenderness, pain on

motion, decreased range of motion, and morning stiffness will be present. Cyclic symptoms are more common in girls. The prognosis will be variable. Treatment for JRA includes heat, anti-inflammatories, Naprosyn, Remicade, Gold, Methotrexate, and occasionally steroids. In regard to a school plan, the nurse should communicate with parents and/or care providers and develop an exercise program. The school plan also includes a medication plan, and splints, braces, or stabilizers. Symptoms should be observed and reported, and the child should be assisted with his/her mobility by making sure he/she has a good way to carry books and supplies. Nurses should be aware that attendance may be affected, and because of morning stiffness, the child may often be tardy.

Bone tumors occur in all ages and can be benign (Osteochondromas, cysts) or malignant (Osteosarcoma, Ewing's sarcoma). The school plan should be similar to any other cancer, and immune suppression, body image, fatigue, and attendance should be considerations.

Ms. Ellison also presented a case study.

Neurologic Assessment of the School-Aged Child

Sandra Leonard, RN, FNP
School Health Coordinator, Division of Public Health, Georgia Department of Human Resources

Ms. Leonard pointed out that although school nurses may not think about doing a neurologic assessment during a usual school day, they should. Next to stomachache, headaches are probably the number one complaint of school-aged children. Fortunately, most headaches are minor problems, but sometimes they are not and may be caused by serious conditions, like a brain tumor. She suggested that school nurses always do a neurologic assessment when a child presents with a headache to ensure that important symptoms are not missed, especially if the policy is to treat those headaches with analgesics.

Obtaining a headache history is ninety-seven percent of the diagnosis. The student should be asked where his/her head hurts, how badly it hurts, and more. The child should be helped to describe how he/she feels by giving some concrete examples, such as "like a knife stabbing," "sounds like boom, boom, boom," or "tight band squeezing my head." The Visual Pain Scale should be used to help the child evaluate the level of pain, and he/she should be asked to point to where his/her head hurts. When examining history, nurses should not forget the social history. Children should be asked how things are at home, with their parents, at school, and with their friends.

Next to stomachache, headaches are probably the number one complaint of school-aged children.

The assessment should begin with an examination of the child's general appearance. Do they look ill? Are they talkative? Do they seem confused? Check vital signs and hydration status, then perform a six-step screening neurologic exam:

Step 1 Check pupils with light: Follow your finger in "H" pattern.

Step 2 Look for symmetric face: Open mouth and say "Aah."

Step 3 Shrug shoulders: Look up, down, side-to-side.

Step 4 Look for + Brudzinski (involuntary pain or flexion of the knees when the neck is flexed) and + Kernig (pain or resistance when flexed knee is extended).

Step 5 Watch them walk. One deep knee. Can they jump? (If they can jump around, they might not be in as much pain as they say they are.)

Step 6 Any numbness and tingling? Have them write their name.

Other things to consider when kids present with a headache are:

- HEENT (Head-Ears-Eyes-Nose-Throat). Is something going on with that system?
- Abdomen. Remember abdominal conditions can cause headaches.
- Rashes. Does the child have one? Look at clusters of symptoms.
- Check the head and body for trauma and bruises. Children won't always tell when they are being abused.

Ms. Leonard presented a case study and pointed out that there was a head injury sheet available for participants to take home.

Discussion Points

- A participant was concerned because the father of one of her students had received the smallpox vaccine, and the family noticed that the student had a mild rash. Ms. Leonard and others suggested that the family follow-up with their physician because the father might have been contagious for a small period of time. It is best not to take chances.

- One school nurse stated that she is seeing more children wearing cosmetic contacts, which should be removed before examining their eyes. Some of the contacts look very strange, and teachers are sending children to her thinking there is something wrong with the student. Also, the children are sharing these contacts. Nurses need to make sure they educate their students on the dangers of sharing these contacts.

- Ms. Ellison told participants to go to the Children's Healthcare of Atlanta (CHOA) website, *www.choa.org*, for additional resources about school health. At this site, one can find all of the awareness sheets and other handouts CHOA has provided, as well as teacher training on Epipens.

Obtaining a headache history is 97% of the diagnosis.

Seizure Disorders

Participants then viewed a video on seizure disorders. The video explained that seizure disorders, also known as epilepsy, appear in many different forms. About 300,000 children in the United States have epilepsy, so it is likely that at one time or another, a teacher may have a student with a seizure disorder in their classroom. The video showed examples of the different types of seizures, showed teachers how to identify when a child might be having a seizure, what teachers should do in case a child in their class has a seizure, and shared educational techniques that might be necessary with children who experience seizures. The video is available for distribution. Those interested should contact Ms. Leonard at the Georgia Division of Public Health for more information (404-651-7551).

Dermatology Concerns in School Health

Betty Fitzpatrick, RN, NCSN
Regional School Nurse Liaison, Children's Healthcare of Atlanta

After pointing out handouts in the back of the room, Ms. Fitzpatrick began with an overview of infection control, explaining that three conditions are needed for a disease to occur: 1) germs; 2) a way for the germ to spread; and 3) a susceptible person. Germs live everywhere and are all over our bodies. Many germs are normal and help us fight off harmful germs. Some germs that are not harmful to us may cause disease in others. It is very important to keep our germs to ourselves. Transmission of disease happens by contact; by the respiratory system; by common sources such as food, water, and blood; and by vectors. Direct contact happens when changing a bandage or cleaning a wound. Germs may enter the body through an open cut or sore. A good example of indirect contact is when a person sneezes or coughs into their hand and then touches other objects like a phone, pencils, or doorknobs. Illness via the respiratory system occurs by droplet or airborne spread. Airborne germs are found in the fine mist around us. Droplet spread occurs when somebody sneezes or coughs. Vectors include mosquitoes, lice, ticks, flies, roaches, rats, mice, and household pets.

Ms. Fitzpatrick shared examples of Lyme Disease, Scabies, Impetigo, Strep Throat, Scarlet Fever (Group A Strep), and Pink Eye. She stressed that in order to prevent disease, everyone should practice good sanitation, universal blood and body fluid precautions, and good hygiene. In addition, vaccines should be kept up to date. She reminded the nurses that all body fluids, secretions, and excretions from all children must be treated as potentially contagious and able to spread germs. She reviewed the following universal precaution procedures:

- Use disposable single-use gloves in all situations where there is contact with blood or body fluids containing blood.
- Never delay the proper care of an injured child because gloves are not available:

  Use a heavy cloth barrier between the hands or the care giver and the source

  Wash any contaminated areas of the body thoroughly as soon as possible
- Remove the gloves immediately after completing each task:

  Pull the gloves off inside out

  Dispose of them in a childproof designated trash can with a lid

  Wash hands before and after putting on gloves

  Hint: Carry gloves in a baggy on your person. Distribute to teachers for use in their classroom and on the playground. Tell them to come to you if they need more.

Body fluids, secretion, and excretions from all children must be treated as potentially contagious and able to spread germs.

Ms. Fitzpatrick shared pictures of Fifth Disease, Mumps, Chicken Pox, Measles, Diphtheria, Tetanus, Whooping Cough, Polio, Rubella, H. flu type b, Hepatitis A, and Smallpox. All of these diseases are preventable through vaccinations. She shared the website for the Georgia State Immunization Program, *www.health.state.ga.us/programs/immunization,* where nurses may print out current vaccination schedules. She pointed out that there is no longer a need for routine vaccination of Smallpox because the disease was eradicated worldwide in October 1977. Vaccinations are currently being administered by the CDC on a special needs basis. Ms. Fitzpatrick spoke with people at CDC who agreed that while vigilance is best, and there are vaccinations being given, bioterrorism by Smallpox would be very difficult and is quite unlikely. She also shared pictures of allergic shiners, Vitiligo, Lupus, Meningococcemia Psoriasis, Dermatitis, Acne Vulgaris, Herpes, common wart, geographic tongue, spider bite, Bells Palsy, and pinworms. She directed participants to several websites for further resources, which are cited in the handouts.

CLOSING SESSION:
Linking with Other Community Resources

Hidden Jewels in Your Own Backyard

Joyce Allers, RN
Manager,
Illness Prevention and
Management, Children's
Healthcare of Atlanta

Ms. Allers pointed out that school nurses do not have the same support that nurses in a hospital might have. Therefore, it is important that participants begin to think abstractly about the resources that might be found throughout their communities. She directed participants to their binders and handouts, and suggested that the nurses seek out the following resources in their communities:

- Civic groups such as Optimist Clubs, Kiwanis Clubs, Lions, etc. All of them raise funds to help their communities in a variety of different ways and for a variety of different purposes.
- Local businesses may fill some special needs:

  Lenscrafters has given glasses to children in need.

  WalMart has given extra sets of clothes for elementary-age children.

  Target gives regular grants to their local communities. Ask the local Target manager about their grants program.

  Garage sales are good places to find gently used clothing to keep in the clinic.

  Churches: Some nurses work at a clinic for their church once a week to see low income children. They get samples from drug representatives and reuse sterilizable disposable equipment.

  Business employers: One school nurse had a company that employed most of the town. She went and asked for support for the school clinic, promising improvement in worker absenteeism.
- Doctors and dentists.
- Medicaid and PeachCare.
- Counselors and social workers.
- Other health programs in the area to identify children eligible for their services.
- The PTA, the GASN, and the National Association of School Nurses (NASN).
- Children's Healthcare of Atlanta (CHOA).
- Georgia Health Policy Center.
- The Internet to seek out resources.

Spectrum of Public Health Services

Sandra Leonard, RN, FNP
School Health, Coordinator, Division of Public Health, Georgia Department of Human Resources

Ms. Leonard reminded participants not to forget the public health resources, at both the state and national levels. Public health makes a difference in the lives of children in Georgia. She directed participants to the handouts on resources in public health that she had provided in their binders. The goal shared by public health and education is to have healthy students who become healthy adults equipped with health-related skills, beliefs, and practices conducive to a lifetime of learning, good health, productivity, and economic success. School health programs are essential to achieving that goal and the goals of Healthy People 2010 and the National Education Goals.

Ms. Leonard explained the structure of public health in Georgia and explained that the Division of Public Health can help school health programs with developing school-based policies and procedures, training school health personnel, providing continuing education and technical assistance, collecting data in the community, and identifying current and emerging vulnerable populations. Many direct services are also available, such as Children First Program, which connects families and professionals with public health and prevention-based programs; Healthy Child Care Georgia, which looks at best practices in childcare settings and conducts training; Newborn Screening Program; Newborn Hearing Screening; Health Check, a comprehensive health screening (formerly EPSDT); vision and hearing screenings; nutrition (now addressing childhood obesity); special needs children; immunizations; TB prevention (addressing an upsurge of tuberculosis in children); tobacco use prevention; abstinence education; resource mothers; community involvement program; and School Health programs. Ms. Leonard shared the Division's website (*www.ph.dhr.state.ga.us)* and her telephone number (404-651-7551).

Other announcements made at the close of this session included the following:

- The Children's Healthcare of Atlanta Manual is in the process of being approved by the Division of Public Health and the Department of Education. The manual will be distributed as soon as approval is received.
- Next year's calendar should be distributed at the summer conference, pending approval.
- CHOA is developing a database of nurses in Georgia that they will share with the school nurses as soon as it is completed.
- Participants were instructed to contact CHOA or the Georgia Health Policy Center if they had any questions or needed any assistance in the future.

Hearing no further discussion, Ms. Phillips thanked the participants for their attention and hard work, and the conference was officially adjourned.

For additional copies of the Summary Report, please contact the Georgia Health Policy Center at 404-651-3104.