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A report from the Center for Health and Health Care in Schools on the policies, politics and financing of health programming in schools

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Do School Health Services Meet the Needs of Children with Asthma?

Whether school health services are currently meeting the needs of children with asthma is questioned in an article in the September 2006 issue of the journal *Pediatrics*, published by the American Academy of Pediatrics.

Based on a survey of school nurses responsible for health care in urban and rural school districts in one state—Pennsylvania—the article concludes that much of what is recommended as best practice in child asthma management is lacking in many school systems. While the researchers did not study whether the shortcomings they found in Pennsylvania are present in other states, they noted that poor adherence to 2002 National Heart, Lung and Blood Institute (NHLBI) policies for asthma management at school is widespread.

Here are some findings from the Pennsylvania survey:

- The prevalence of asthma among schoolchildren in Pennsylvania is 9.3 percent, according to the state Department of Health, slightly higher in urban than rural areas;
- Registered or licensed practical nurses are physically present as few as 8 hours a week in some schools, with nursing coverage more comprehensive in high schools than in elementary schools;
- Asthma-related equipment (peak flow meters, nebulizers, spacers) were available for student use in only half of urban schools, slightly more in rural schools, most often in the health office. Rural schools were more likely than urban schools to allow students to carry their own inhalers while at school (72 percent rural and 47 percent urban) and several districts reported that inhalers were not available at all in their schools;
- In all schools in the study sample, fewer than one-third of children with asthma had asthma management plans on file, and those plans that were available often lacked important information such as protocols for handling emergencies and how to contact parents or physicians. Other recommended components of asthma management programs—peak flow monitoring procedures, plans for physical education participation, a list of specific asthma triggers, and procedures for storing and administering medication—were even less likely to be included;
- Both urban and rural nurses noted lack of time as a major obstacle to asthma management in their school settings, followed by lack of clear policies about asthma management. Few cited lack of administrative support as an obstacle;
- Staff who know what to do for a severe asthma attack were reported to be available in more than 80 percent of urban and rural schools;
- More than 90 percent of both urban and rural schools had emergency response plans for medical emergencies, and two-thirds had rapid response systems linking the school campus to emergency medical services;
- The primary ways school nurses learn which students have asthma are parental notification, medical history, an examination form from a physician, and a medication order. Often, however, the school nurse's first indication that a child suffers from asthma is when the child presents with asthma symptoms in the school health office;
- Support services for children with asthma and their families, such as counseling and support groups, were

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available in relatively few schools, and case management was provided in only one-third of schools.

Clearly needed to improve school-based asthma management in Pennsylvania, and probably elsewhere, the researchers noted, are “more consistent availability of staff who are knowledgeable about asthma and symptom management,” including more nurse staffing and more widespread asthma education for teachers, administrators, and other staff members; more universal use of asthma management plans; and maximum access to inhalers, including increasing the numbers of children who are allowed to self-carry and self-administer asthma medications.

The Pennsylvania study was conducted by the Department of Health Policy and Administration and the College of Medicine at Pennsylvania State University and was funded by a grant from the Center for Rural Pennsylvania. It appears in the September 2006 issue of the journal Pediatrics.

See also:

School Children with Asthma: An Introduction

<http://www.healthinschools.org/sh/asthma.asp>

Improving Childhood Asthma Outcomes in the United States: A Blueprint for Policy Action http://www.healthinschools.org/ejournal/2002/june02_1.htm.

California Looks for Mental Health/Academic Achievement Links

Psychologists have talked about it for decades, and some school systems have tried to implement the psychologists’ ideas, but California is the latest convert to the notion that promoting students’ social and emotional skills plays a critical role in improving their academic performance.

In a closely watched experiment, the state is calling for applications by public or private groups that can show ability to bring education and mental health systems in the state together for school-based early interventions, as a way of improving children’s academic skills and preventing more severe mental health problems in the future.

The request for proposals points to recent research by Joseph Durak, a Loyola University psychologist, and Roger Weissberg of Yale University, who analyzed more than 300 research studies of programs that attempt to address children’s emotional and social needs as well as their academic achievement.

Writing in the *New York Times* in August 2005, Weissberg and Timothy Shriver, president and chairman, respectively of the Collaborative for Academic, Social, and Emotional Learning,

CASEL, pointed out some of the research review’s findings, including that an average student enrolled in a social and emotional learning program ranks at least 10 percentile points higher on achievement tests than students who do not participate in such programs, has better attendance and more constructive classroom behavior, likes school more, has a better grade point average, and is less likely to be suspended or otherwise disciplined.

All of that “vindicates what has long been common sense among many teachers and parents: that children who are given clear behavioral standards and social skills, allowing them to feel safe, valued, confident, and challenged, will exhibit better school behavior and learn more to boot,” Shriver and Weissberg observed. They suggested Congress should keep in mind when reauthorization of the No Child Left Behind Act comes up in 2007 that “The two kinds of learning [emotional and academic] are intimately connected. That means that promoting students’ social and emotional skills plays a critical role in improving their academic performance.”

In California, the new Mental Health Services Act approved by voters in November 2004 is intended, according to official documents, to bring about “an unprecedented level of cooperation” between mental health agencies and schools to provide school-based emotional and social learning programs. Exactly how that is to be done will apparently depend on the responses the state receives to a request for proposals, but California is providing substantial funding for the projects, all of it from state general revenues. That may make California the first state to make such a local commitment; individual school districts in a number of other states, including Illinois, have mounted school-based mental health programs using federal funds from the Safe and Drug-Free Schools Act.

What Is ‘Social and Emotional Learning’?

In their *New York Times* editorial, Shriver and Weissberg offered a description of what they mean by “programs that address students’ emotional and social needs.”

“Social and emotional learning is the process through which children learn to recognize and manage emotions. It allows them to understand and interact with others, to make good decisions and to behave ethically and responsibly. The best social and emotional learning programs engage not only children, but also their teachers, administrators, and parents in providing children with the information and skills that help them make ethical and sensible decisions—to avoid bullying, for instance, or to resist pressures to engage in destructive or risky behavior such as substance abuse. When they are well designed and executed, such programs have consistently achieved these goals, turning out students who are good citizens committed to serving their communities and cooperating with others.”

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Information about the California initiative is available at <http://www.cde.ca.gov/fg/fo/profile.asp?id=691>.

See also:

Pediatrics Academy Urges School-Based Mental Health Services
http://www.healthinschools.org/2004june04_alert.asp
Expanding Mental Health Services at School: Lessons from the Caring for Kids Program
<http://www.healthinschools.org/comm/nasbhc6-8/sld001.htm>

What Happened When San Francisco Changed Its Lunch Program

Schools across the United States are being asked to consider whether they may be at least partly responsible for the current rise in childhood overweight and obesity, considering that children often eat two or more meals a day at school and schools are often the site of easily available soft drinks and non-nutritious snacks.

Schools sometimes respond that children will not eat the fruits, whole grains, and vegetables that are considered more healthful, and they express concern that changing the options available at school will drastically reduce the number of youngsters who participate in school meals, thereby decreasing revenues from school food services, which are expected in most districts to be self-supporting.

To try to find out what actually happened when one school district took giant steps to reform its nutrition programs, researchers examined in detail the experience of a middle school in San Francisco, California.

As reported in the September 2006 issue of the *American Journal of Public Health*, California already had in place a Childhood Obesity Prevention Act that became law in 2003, requiring elementary and middle schools to remove access to all soft drinks during school hours.

Local districts have the option to institute even more comprehensive policies, and San Francisco in the 2003-2004 school year did exactly that by developing district-wide nutrition policies that require:

- Elimination of foods not meeting 'minimal nutritional value' standards;
- Restrictions on the amounts of fat and sugar in every item sold and consumed; entrees sold in school cafeterias may contain not more than 30 percent of total calories from fat, 10 percent of calories from saturated fat, and 35 percent of sugar by weight;
- Minimum levels of nutrients in all snack foods and side dishes sold at every school, kindergarten through 12th grade;

- Snacks and side dishes that meet the entrée standards and contain specified levels of vitamins, minerals, protein, and fiber;
- Sales of snacks and side dishes in vending machines or at sporting and after-school events restricted to foods on the updated district-approved list.

Although the state law mandates that soft drinks not be sold in middle or elementary schools at any time, San Francisco extended the ban to include high schools.

The San Francisco Unified School District's Nutrition Committee, a group of parents, educators, and community members who were active in changing the SFUSD nutrition standards, had predicted that changing the items available in school snack bars or student stores would encourage more students to go through the school lunch lines. To test this thought, researchers looked at what happened in Aptos Middle School, the first school to implement the changes.

In the 859-student, culturally diverse school (reported as being 21 percent African American, 35 percent Asian American, and 24 percent Latino), in the 2002-2003 school year, sodas, Twinkies, Slim Jims, and giant pizzas were replaced with sushi, fresh soup, deli sandwiches, 100 percent fruit juice, and baked chicken with rice. Desserts included fruit cups and fresh fruit. Giant round pizzas were replaced with individual slices and a salad, and extra-large cheeseburgers were replaced by modest-sized hamburgers.

The outcome: During the final full month of food sales before the changes went into effect, Aptos food service lost nearly \$1,000. Two months later, in May 2003, Aptos made more than \$2,000, with a particular boost in profits from sales of a la carte and snack bar items.

The effects on student health will take longer to evaluate, but researchers note that the figures on participation indicate that students "will chose healthier options without detrimental effects on the economics of student meal services."

Researchers who looked at the Aptos experiment, which has since been expanded to additional schools in the San Francisco Unified School District, note that an important element in student acceptance of the revised school menus was student input. At Aptos, students were polled on their food preferences, and their input, which included the addition of fresh deli sandwiches, pasta, and ethnic-specific foods such as sushi, was relayed to the Nutrition Committee and formed the basis for the new snack bar menus.

The research report, "Healthier Choices and Increased Participation in a Middle School Lunch Program: Effects of Nutrition Policy Changes in San Francisco," is published in the September 2006 issue of the American Journal of Public Health. Request for reprints can be sent to mheyman@peds.ucsf.edu.

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See also:

Nutrition and Obesity—What’s Ahead for School Food?

<http://www.healthinschools.org/focus/2004/no1.htm>

Are Your Kids Eating Healthy at School?

<http://www.healthinschools.org/parents/lunch.htm>

Bottlers Agree to Limit Soft Drinks in Schools

<http://www.healthinschools.org/2006/may4a-alert.asp>

Imposing Personal Responsibility for Health

Making individuals more responsible for their own health seems intuitively like a good idea, but it’s hard to work out the details of any program to make that happen, and we don’t yet know what works and what doesn’t, according to articles in the August 24, 2006, issue of the *New England Journal of Medicine*.

If individuals do all the right things—exercise, maintain a healthy weight, don’t smoke or abuse drugs, practice safe sex—does that meet the personal responsibility requirement, or is there more—keeping doctor’s appointments, for example, and not using the emergency room except in emergencies? And is there a suspicion that a lot of the advice individuals are being given about their own health may not be saving money or improving health but just shifting the onus—and the cost—to patients instead of their insurers or healthcare providers?

One state, West Virginia, is currently trying the personal responsibility idea in its Medicaid program, and the journal’s authors see implications beyond its effect on needy West Virginians. Especially, they note, it raises a lot of issues for healthcare providers.

The West Virginia plan, which was speedily approved by the federal Centers for Medicare and Medicaid Services (CMS), was said by CMS administrator Mark McClellan to make Medicaid enrollees in West Virginia “part of an emerging trend in healthcare that empowers patients to make educated, consumer-driven decisions related to their own treatment.” What that involves, specifically, is that West Virginia Medicaid recipients are being required to sign contracts pledging to take their medications, keep their appointments, participate in healthcare screenings, and adhere to health improvement programs as directed by their healthcare providers. Patients who don’t uphold their end of the bargain will have some of their Medicaid benefits reduced or eliminated.

Any healthcare provider would welcome patients who were so compliant, but in general, physicians and other clinicians continue to provide care even when patients do not cooperate, the articles note. The authors believe West Virginia’s plan violates all three fundamental principles enumerated in the Physician Charter on Medical Professionalism—the primacy of patient welfare, the principle of patient autonomy, and the principle of social justice. On the point of social justice, they point out that the plan will penalize Medicaid patients for circumstances that are frequently

not in their control—missing appointments because of lack of transportation or the need to stay home with a sick child, for example.

And what physician, they wonder, would recommend that a person with diabetes who misses appointments lose the ability to attend diabetes education classes? And what physician wants to be faced with a sick child with asthma whose benefits have been reduced to four prescriptions a month, when she gets pneumonia and an antibiotic would make five?

Officials in the West Virginia Bureau for Medical Services point out that in addition to the penalties for noncompliance, Medicaid beneficiaries will be rewarded for adhering to their membership agreements with age-appropriate services that focus on wellness, including diabetes care beyond basic inpatient and outpatient services, cardiac dependency and mental health services.

The articles “Imposing Personal Responsibility for Health” and “Personal Responsibility and Physician Responsibility—West Virginia’s Medicaid Plan” appeared in the August 24, 2006, issue of the New England Journal of Medicine.

WORTH NOTING

A New Look at Lactose Intolerance

In an update of guidance for pediatricians, the American Academy of Pediatrics this month summarized what’s known about the condition known as lactose intolerance, which can produce gastro-intestinal discomfort in infants, children, and adolescents. The guidance notes that much has been learned about the condition since AAP issued its previous guidelines in 1978 and 1990, including how it is diagnosed (by dietary lactose elimination or tests including noninvasive breath testing or invasive internal biopsy) and the importance of providing an alternative source of calcium for children who are placed on dairy-free diets. Given newer approaches, including the use of partially digested products such as yogurts, cheese, and pretreated milk, it is not usually necessary to eliminate milk and other dairy products entirely, the guidance notes, especially in light of evidence that avoidance of dairy products may lead to inadequate calcium intake and consequent suboptimal bone mineralization. The article “Lactose Intolerance in Infants, Children, and Adolescents” appears in the September 2006 issue of *Pediatrics*, journal of the American Academy of Pediatrics.

Study Will Test Ways to Lower Diabetes Risk

As schools opened this fall, sixth graders in 42 middle schools began taking part in a study sponsored by the National Institute of Diabetes and Digestive and Kidney Diseases in the National Institutes of Health to try to determine whether changes in school food services and physical education classes will lower

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risk factors for type 2 diabetes. The HEALTHY study is assigning schools randomly to a program group that implements the changes and a comparison group that continues to offer food and PE common to most middle schools. Students in the program group will have cafeteria and vending machine choices that are lower in fat, include more fruits and vegetables, and offer drinks with no added sugar. They will also have longer and more intense periods of physical activity and will participate in activities and awareness campaigns that promote long-term healthy behaviors. After two and a half years, all students will be tested for diabetes risk factors, including blood levels of glucose, insulin, and lipids. They will also be measured for fitness level, blood pressure, height, weight, and waist circumference. Results from the study, which is being conducted by researchers from universities in Texas, California, North Carolina, Oregon, Pennsylvania, and Washington, DC, are expected in 2009.

Asthma and Enrollment in Special Education

A cross-sectional study in 24 randomly selected New York City public schools found that 34 percent of children enrolled in special education had been diagnosed with asthma, compared to 19 percent of children in the general population. Noting that children are placed in special education for a variety of reasons, including learning disabilities, researchers said there is no known relationship between asthma and learning disabilities but speculated that inadequate asthma management, resulting in lost school days and frequent use of emergency care, may contribute to a greater risk of special education for asthmatic children, particularly in urban communities where poverty and other variables may contribute to the incidence of asthma. The study, "Asthma and Enrollment in Special Education among Urban Schoolchildren," is published in the September issue of the *American Journal of Public Health*.

NEWS ALERTS

The following information appeared during the month of August 2006 in the News Alerts section of the website of the Center for Health and Health Care in Schools, at www.healthinschools.org.

August 3, 2006

2006-2007 Flu Vaccine Production Starts

Four manufacturers are set to begin production of an estimated 100 million doses of vaccine to protect the U.S. from seasonal influenza in the coming 2006-2007 flu season, the federal Food and Drug Administration (FDA) announced yesterday. At the expected level of 100 million doses, there should not be a repetition of the flu vaccine shortages that have created problems in recent years, the FDA said. This year's vaccine will include one strain of the flu virus that was used in last year's vaccine and two new strains. Because new influenza virus strains emerge every year, the vaccine is tailored each year to protect against the specific vi-

ruses that the World Health Organization and the FDA's Advisory Committee believe are most likely to be around in the coming season. The four manufacturers approved to market vaccines in the United States are Chiron Vaccines, Ltd.; GlaxoSmithKline Biologicals; Medimmune Vaccines, Inc.; and Sanofi Pasteur, Inc.

August 7, 2006

Senate Passes Bill to Encourage Autism Screening, Intervention

In its final session before recessing for the month of August, the United States Senate August 3 unanimously passed legislation amending the Public Health Service Act to step up federal support for autism research, screening, diagnosis, and intervention through federally supported "centers of excellence" and grants to states. The bill, S. 843, originally introduced in 2005 by Senator Rick Santorum (R-PA), calls for the federal National Institute of Mental Health to spearhead research on autism and for the National Institute of Child Health and Human Development, with the National Institute on Deafness and Other Disorders, to provide for "collaborative programs of excellence in autism." The bill also requires the Secretary of Health and Human Services to provide information and education on autism to health professionals and the general public and for the Health Resources and Services Administration (HRSA) to award grants or cooperative agreements to states for statewide autism programs. The legislation must now be passed by the House of Representatives. Bills can be read and tracked on website <http://thomas.loc.gov>.

August 9, 2006

Program Aims to Reach Hispanic Youths to Prevent HIV

An HIV prevention program that emphasized abstinence and condom use as culturally accepted and effective methods to prevent sexually transmitted diseases succeeded in reducing the incidence of risky behaviors in Hispanic adolescents in grades 8 through 11, according to report in the August issue of *Archives of Pediatrics and Adolescent Medicine*. Heterosexual contact has been shown to be the major mode of HIV transmission among Hispanic adolescents, researchers noted, and studies have found lower condom use among Hispanic adolescents than among black or white adolescents. Called "Cuidate (Take Care of Yourself) The Hispanic Youth Health Promotion Program," the intervention consisted of six 50-minute modules delivered on consecutive Saturdays to small, mixed-gender groups in English or Spanish. Details of the study are available in the *Archives* at <http://jama.ama-assn.org>.

August 16, 2006

Study Finds Autism Affects Entire Brain

A study reported in the August 2006 issue of the journal *Child Neuropsychology* strongly suggests that autism is a disorder in which the various parts of the brain have trouble working together to accomplish complex tasks. That is different from

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previous thinking about autism—that it’s primarily a disorder of social interaction—and suggests that both children and adults with autism have abnormalities in brain circuitry that prevent various parts of the brain from interacting. This would explain, researchers said, why children with autism in the current study did well on tasks that require only one region of the brain at a time but had difficulty with complex tasks. “Our paper strongly suggests that autism is not primarily a disorder of social interaction, but a global disorder affecting how the brain processes the information it receives—especially when the information becomes complicated,” said Dr. Nancy Minshew, senior author of the study. The study was conducted by researchers in the Collaborative Program of Excellence in Autism, a research network funded by the National Institute of Child Health and Development and the National Institute on Deafness and Other Communication Disorders.

August 17, 2006

Census Bureau Cites Growing Immigrant Population

In a report issued August 15, the U.S. Census Bureau said the United States population at the end of 2005 was an estimated 288,378,137 persons, with more than 12.4 percent of the population foreign-born. The report, which focuses on the demographics of communities, including some of the largest and smallest cities and towns in the country, notes that the percentages of persons who were not born in the United States was much higher in some cities, such as Los Angeles and New York, where as many as one-third of the population were not U.S. citizens at birth. Some other localities had much smaller immigrant populations—Lynchburg, VA, for example, where only 2 percent of the population is foreign born, and Muncie, IN, with 2.8 percent. The exact figures for specific towns and cities are available online at American FactFinder on the Census website, www.census.gov. The report, which is intended to help communities plan for future development, including schools, notes that slightly more than 20 million of the 2005 population were under five years of age. The median age of the U.S. household population was 36.4 years.

August 23, 2006

FDA Proposes to Automate Drug Information

The federal Food and Drug Administration (FDA) today issued a proposed rule to make access to information about therapeutic drugs now on the market “more efficient and effective” by automating the process by which drug firms register themselves and their products with the FDA. Users of the list, which currently contains information about more than 120,000 drug products, include healthcare providers and healthcare payers, as well as government agencies such as Medicaid and Medicare. “Having drug makers submit drug information electronically will help to keep an up-to-date inventory of drugs on the market,” said U.S. Health and Human Services Secretary Mike Leavitt. “This will help us maintain more accurate information and make it easier for us to respond to drug emergencies such as recalls and shortages.” The FDA said the proposed rule is part of a broader federal effort to modernize the management of health information.

August 24, 2006

FDA Approves Plan B for Women Over 18 Years

The following is the text of an announcement by the federal Food and Drug Administration today concerning over-the-counter availability of the “morning after” contraceptive known as Plan B:

“The U.S. Food and Drug Administration (FDA) today announced approval of Plan B, a contraceptive drug, as an over-the-counter (OTC) option for women aged 18 and older. Plan B is often referred to as an emergency contraception or the ‘morning after pill.’ It contains an ingredient used in prescription birth control pills—only in the case of Plan B, each pill contains a higher dose and the product has a different dosing regimen. Like other birth control pills, Plan B has been available to all women as a prescription drug. When used as directed, Plan B effectively and safely prevents pregnancy. Plan B will remain available as a prescription-only product for women age 17 and younger. Duramed, a subsidiary of Barr Pharmaceuticals, will make Plan B available with a rigorous labeling, packaging, education, and distribution program.”

The FDA noted that today’s announcement “concludes an extensive process that included obtaining expert advice from a joint meeting of two advisory committees and providing an opportunity for public comment on issues regarding the scientific and policy questions associated with the application to switch Plan B to OTC use.”

August 31, 2006

CDC Updates STD Treatment Guidelines

In a comprehensive 144-page set of guidelines for the prevention and treatment of sexually transmitted diseases released earlier this month, the Centers for Disease Control and Prevention details steps to be taken by healthcare providers in treating and counseling individuals. The guidelines note that prevention and control of STDs are based on five major strategies:

- education and counseling of persons at risk on ways to change sexual behavior;
- identification of asymptotically infected persons and of symptomatic persons unlikely to seek diagnostic and treatment services;
- effective diagnosis and treatment of infected persons;
- evaluation, treatment, and counseling of sex partners of persons who are infected with an STD; and
- pre-exposure vaccination of persons at risk for vaccine-preventable STD.

The new guidelines, which update treatment guidelines issued in 2002, were developed by the CDC in consultation with a group of professionals knowledgeable in the field of STDs who met in Atlanta, Georgia, in April 2005. The full text of the guidelines is available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5511a1.htm>.