REPORT OF THE
DEPARTMENTS OF EDUCATION AND HEALTH

REPORT ON THE NEEDS OF MEDICALLY FRAGILE STUDENTS

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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EXECUTIVE SUMMARY

During its 1993 legislative session, the Virginia General Assembly adopted a joint resolution (SJR 306) requesting that the Department of Education in conjunction with the Department of Health study the needs of medically fragile children in Virginia The request was initiated in response to several concerns brought to the attention of members of the General Assembly

First, several children, considered to be medically fragile, had been placed in a nursing home outside of their parents' city or county of residence The nursing home staff attempted to enroll several of these children in the school division of the county where the nursing home was located These children were denied admission because their legal residency remained in the city/county of their parents' residence Consequently, the school division where the nursing home was located was under no legal obligation to provide educational services to these children

Second, anecdotal evidence and limited research indicated an increased enrollment of children with chronic illnesses and ongoing medical needs in the public schools of the Commonwealth The types of services, the service providers, the training of the service providers and the policies related to the provision of medical or health services varied greatly from school division to school division throughout the Commonwealth Concerns were raised regarding the adequacy of the services, the appropriateness of teachers, paraprofessionals, school nurses and administrators conducting some of the medical or health procedures, and the lack of training for those persons conducting these procedures

SJR 306 specifically set out nine objectives for the study, requesting the Departments of Education and Health to

"(i) identify and determine the number of medically fragile children in Virginia,

(ii) determine which of them are citizens of the Commonwealth and their place of residence ,

(iii) determine the nature and severity of their disabilities and treatment needs,

(iv) determine the number of medically fragile students being served in the public schools and the nature and severity of their disabilities,

(v) identify the types of health maintenance and treatment procedures and the types of staff persons necessary to conduct these procedures,

(vi) determine the responsibility of public schools to provide such health maintenance and the types of staff persons necessary to conduct these procedures,

(vii) determine the impact on and liability of those responsible for providing such services to students,

(viii) determine the level of guidance given by the local school boards to staff regarding the provision of health services to students, and

(ix) the level of interagency collaboration to determine the need for policy and regulatory changes to improve the delivery of educational, social, health, and medical services to such children "

In addition to SJR 306, the 1993 General Assembly considered two bills, Senate Bill 720 and House Bill 2188, which would have required registered nurses be employed by each school division in the Commonwealth This legislation was defeated However, the Senate Education and Health Committee requested the Board of Education to study how funds for health services are used in each school division and report this information to them The Department of Education incorporated this study of funding into the study requested in SJR 306, and these findings are included as Appendix A

Because of the complexity of issues and the interagency nature of service delivery to medically fragile children, the study team was comprised of staff from the Departments of Education, Health, and Mental Health, Mental Retardation and Substance Abuse Services Critical team members represented various advocacy organizations and service providers Several team members and reviewers contributed essential legal and medical knowledge relevant to the needs of medically fragile children The interagency team was responsible for identifying and researching various issues, developing consensus on the scope of the study, formulating recommendations to resolve identified problems and drafting a written report

The study team developed and administered a comprehensive survey of public schools to profile medically fragile students and obtain other data as requested in the resolution Information was also obtained from various sources on the number of medically fragile children receiving services in settings other than public schools

Recommendations of the study team are listed below

1 School divisions should develop a "health service plan" for each student who is a medically fragile child as defined by this study

2 Local school divisions should develop policies that address the provision of services to students who are medically fragile to include staff selection and training, roles and responsibilities

3 Local school divisions should develop policies to address the emergency medical needs of students, including those who are medically fragile.

4 The local Health Advisory Board, required by §22 1-275 1 of the Code of Virginia, should take an active role in assisting school divisions in developing policies related to children who are medically fragile

5 School divisions should provide periodic in-service or opportunities for school staff to attend programs to increase staff awareness and understanding of the general health issues faced by schools and the needs of medically fragile students, specifically

6 For risk management purposes, school divisions should document the health services provided to any medically fragile or other students.

7 Nursing homes in the Commonwealth that elect to establish pediatric units should be licensed under both Chapter 5 of Title 32 1 of the Code of Virginia and under Chapter 10 of Title 63 1 of the Code.

8 School divisions should review and evaluate their policies and procedures relative to Section 504 of the Rehabilitation Act of 1973

9 The Department of Education, in conjunction with the Attorney General's Office, should review and evaluate the need for legislation establishing statutory immunity for school personnel performing acts within the scope of their employment while providing health related services to the medically fragile population

10 The Department of Education, in collaboration with the Department of Health, should develop and update procedural guidelines

11 The General Assembly may wish to consider further study, focusing on the needs of families with medically fragile children

CHAPTER I
Overview

Legislative History

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Study Approach

Because of the complexity of issues and the interagency nature of service delivery to medically fragile children, the study team was comprised of staff from the Departments of Education, Health, and Mental Health, Mental Retardation and Substance Abuse Services. Critical team members represented various advocacy organizations and service providers. Several team members and reviewers contributed essential legal and medical knowledge relevant to the needs of medically fragile children. The interagency team was responsible for identifying and researching various issues, developing consensus on the scope of the study, formulating recommendations to resolve identified problems and drafting a written report.

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Report Organization

Chapter II of the report will discuss issues related to medically fragile children, including the definition of medically fragile and a statistical profile of these children Chapter III will discuss the services provided to medically fragile students, and Chapter IV will report on issues relative to the impact of such students on service providers, particularly findings related to staffing, training and liability Chapter V presents ancillary findings Chapter VI includes detailed recommendations. Finally, appendices are included to provide additional detail or technical information.

CHAPTER II
Children Who Are Medically Fragile

Definition of Medically Fragile

While all children enrolled in school have health care needs, there are more children in school with a broader range of complex health care needs than ever before Three reasons for this increase are cited First, advances in medical technology have made it possible for babies who were once not expected to survive to reach school-age, albeit with complex medical needs Second, these same advances in technology also have made it possible for children who are dependent on medical equipment or who have chronic medical conditions to participate in regular and special education outside of hospital or home settings The philosophy of care for children who are medically fragile has changed to encourage this integration of the child into home and school as much as possible Finally, schools are serving an increasing number of children who suffer from Acquired Immune Deficiency Syndrome (AIDS) and from the effects of in utero exposure to drugs and alcohol

Consequently, schools are faced with providing an educational program to children whose health care needs are sometimes complicated and involved This has raised many concerns, including

- fiscal responsibility for the maintenance of the student's health care needs in the school setting,
- level of care required to maintain the students' needs in school,
- role of parents, teachers, school nurses and other school staff in providing services to the student in the classroom,
- liability of school staff who provide services to these students, and
- questions of residency when the child is not living at home but still requires educational services

Medically fragile refers to children who are technology-dependent, children with complex or special health care needs, children who are chronically ill or children who are other-health impaired A number of sources have been consulted in order to develop a working definition of medically fragile for this study In a technical memorandum prepared for the United States Congress, the Office of Technology Assessment defines a child who is technology-dependent as "one who needs both a medical device to

compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability."

Surgeon General C Everett Koop (1987) uses the term "children with special health care needs" to refer to children with a wide range of disabilities and illnesses whose health care needs might be mild or severe, short-term or chronic The American Academy of Pediatrics defines chronic illnesses as "conditions that last at least three months, require extensive hospitalization or in-home health services " The Council for Exceptional Children (1988) uses the term "medically fragile" and adds further clarification by emphasizing that children "who require specialized technological health care procedures for life support and/or health support during the school day [and who] may or may not require special education " Finally, another definition states that medically fragile children "have a chronic condition and/or require technology or ongoing support for survival " (Bruder, 1990)

Because terminology varies in meaning for different professionals and in different settings, clarifying which "medically fragile" children are addressed by this study is essential to minimize misunderstandings and to interpret findings As used in this study, **"children who are medically fragile" are those with a chronic condition and/or who require technology or ongoing support to prevent adverse physical consequences.** The needs of these children can be categorized according to the level of services required as shown in Figure 1

Figure 1

Level A Children with one or more conditions who require **continuous, ongoing** specialized health care procedures These procedures include but are not limited to

- mechanical ventilation
- continuous administration of oxygen
- continuous cardio-pulmonary monitoring
- combination of procedures such as tracheostomy care, gastrostomy feeding and tube care, oxygen administration, chest physical therapy and suctioning

Level B Children who require an **intermittent** specialized health care procedure or procedures These procedures include but are not limited to

- nasogastric feedings
- gastrostomy feedings
- parenteral nutrition
- oral feedings where a documented risk of aspiration exists
- oral, nasal and pharyngeal suctioning
- tracheostomy care
- urinary catheterization
- ostomy care
- medication via injection, inhalation or complex regimens

Level C Children with identified conditions of unusual severity who require specialized services **episodically** due to the potential for occurrence of a medical crisis These conditions include but are not limited to:

- uncontrolled seizure disorders
- unstable diabetes
- poorly controlled asthma (reactive airway disease)
- allergies with a history of anaphylactic shock
- severe immune deficiency

Profile of the Medically Fragile Child in Virginia

In order to estimate the number of medically fragile children in Virginia, the following entities were surveyed

- approximately 1,800 public schools,
- 12 special education programs that are state-supported,
- five educational programs in facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services, and
- 40 local interagency councils that coordinate Part H services to children ages birth to two

Other settings where these children may be served were not included for various reasons Surveying certain facilities would result in a duplicated count because these children are also included in the school survey (e g , acute care hospitals) Some sites that could be surveyed did not target the population as specifically defined by the three levels of services (e g , hospices) Finally, some children are served in settings that cannot be surveyed (e g , children at home with Medicaid waivers)

Given the survey limitations, the data should be used only to provide a baseline of information about medically fragile children in Virginia, and should be interpreted in terms of the specific treatments set forth in the definition of medically fragile The data indicate that approximately 8,500 children statewide are receiving treatments or procedures that would identify them as "medically fragile " Approximately 8,000 of these children are in the public schools, with one-third of the public schools reporting that they have no medically fragile students On average statewide, there are approximately five medically fragile students in each school These data indicate that school divisions with numbers of medically fragile students may assign them to certain schools in order to assure appropriate staffing and efficient use of resources in providing services

Education Needs of Medically Fragile Students

While most of the students who are medically fragile are being served in regular or special education classroom settings, some receive educational services in other locations and through other service delivery models Children with the most severe and chronic medical conditions often require long term placement in residential facilities where their complex health care needs are met by trained licensed professionals on a 24-hour a day basis These children may reside in state-licensed institutions such as the training centers of Virginia's Department of Mental Health, Mental Retardation and Substance Abuse

Services, private residential schools, private intermediate care facilities for the mentally retarded, hospitals; or nursing homes

Educational services for these children are provided in different ways, with the majority participating in education programs within the residential setting The classes are taught by staff of the local school system or educational staff hired by the facility Those children in institutions, and those children who remain in their homes and do not attend a school, receive "homebound instruction "

Homebound instruction is available to both regular and special education students who are enrolled in public schools but whose medical needs prevent regular attendance. Eligibility is determined by local school personnel on the basis of medical information submitted by a licensed physician or licensed clinical psychologist. Homebound instruction is used for regular education students whose health conditions may interfere with consistent school attendance (e g , students receiving dialysis, or radiation and chemotherapy) For these students, homebound instruction is intended to be temporary, usually does not exceed a nine week period, and is offered only during the regular school year The number of instructional hours vary, however, elementary school students should receive a minimum of five hours per week or twenty hours per month The minimum number of instructional hours for secondary school students is five hours per week for two credit subjects or ten hours per week for three or four subjects

Homebound instruction can also be the designated placement for special education students, based on the terms of their IEP or 504 plan For these students, homebound instruction may continue year round without any restrictions on the number of instructional hours

Currently, the specialized health-related services of medically fragile students in public schools may be identified and addressed in a formal or written plan for children with identified disabilities, in a written health services plan, or through informal agreements and arrangements among parents, teachers and administrators As evident in the definition of medically fragile children, the service delivery needs of these students are unique and vary according to the·

- ❑ complexity, severity and occurrence of a condition,
- ❑ frequency of treatments and procedures that must be provided,
- ❑ type of treatments and procedures conducted, and
- ❑ skills and training needed by those providing the service

For this reason, services to medically fragile students are generally determined on a case-by-case basis, taking into consideration students' unique needs and the availability of services and staff in a given school division

CHAPTER III
Services to Medically Fragile Children

Required Service Delivery in the Public Schools

Medically Fragile Students with Identified Disabilities

Students with medically fragile conditions who are identified for special education services under the federal **Individuals with Disabilities Education Act** (IDEA) are entitled to a free and appropriate public education that emphasizes special instruction and related services to meet their unique needs Based on survey data, approximately 36 percent of the medically fragile students being served in Virginia's schools are eligible for special education services These students, by law, are required to have an individualized education plan (IEP) that is developed by a team of people to include the parents, teacher and school division representative In addition to the educational goals and objectives set forth for the child, the IEP must address any related services required to support the child in the least restrictive environment appropriate These related services include, but are not limited to, support in physical and occupational therapy, medical services and school health services

Other federal legislation which may affect the provision of health-related services to children who are medically fragile is **Section 504 of the Rehabilitation Act of 1973** ("Section 504") Section 504 provides that no otherwise qualified individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving federal financial assistance Section 504 prohibits discrimination against a person based on his handicapping condition and requires programs to provide access and accommodations for the disabled

A "handicapped person" under Section 504 is any person who has, or is regarded as having, a physical or mental impairment which substantially limits one or more of life's major activities such as caring for one's self, performing a task, walking, seeing, hearing, speaking, breathing, learning or working Examples of students who have been found eligible for services under Section 504 include students who are HIV-positive and students with tuberculosis, heart problems, asthma, rheumatic fever, cystic fibrosis, sickle cell anemia, hemophilia, cancer or severe allergies However, not every student with these conditions will qualify The student must meet the Section 504 definition of handicapped

As indicated by the school survey, approximately five percent of the medically fragile students in Virginia's public schools have a 504 plan These

are students with special needs that require some accommodations and services for them to participate in and benefit from public education programs and activities These accommodations may include, but are not limited to, special scheduling of classes, barrier-free access, preferential seating, administering of medication or providing other health services during the school day Students receiving services under Section 504 may be eligible for related services without meeting the more specific criteria required to be eligible for special education under IDEA

Appendix B contains a detailed description of federal legislation and criteria for the provision of school health services and excludable medical services to special education students

Medically Fragile Students With No Identified Disabilities

The survey data indicate that the majority of the medically fragile students in Virginia's schools (59 percent) have no identified disabilities and therefore have neither an IEP or a 504 plan that would address the provision of health-related services Service provision to this segment of the medically fragile population may be addressed by an individual health services plan, or through formal or informal arrangements among school personnel and parents

As indicated by the public school survey, approximately 36 percent of the medically fragile children being served by public schools have individual education programs (IEP) under IDEA and approximately five percent have service plans under Section 504 of the Rehabilitation Act of 1973 The low percentage of students with Section 504 plans raises concern related to local school division compliance with the requirements of Section 504. A number of these students could require some type of health procedure during the school day and not be a student with a disability under IDEA, however, it appears that, given the definition of "children who are medically fragile" set forth in this study and used in the public school survey, some children in the remaining 59 percent would likely be considered "handicapped" under Section 504

Public school systems have been required to implement the provisions of Section 504 since its passage in 1973 The regulations implementing the statute's requirements have been in existence since May 1977 The perception has been that there are children who should be found eligible for accommodations under Section 504 who have not been so classified The statistics gathered as part of this study provide some evidence of this problem

Service Delivery Model

Studies indicate that the increase in the number of medically fragile students will continue throughout this century This increase will significantly impact the service delivery systems currently operating in school divisions Health care reform increases the likelihood that more children may be served by the community, which includes the public schools Existing federal

legislation requires that students meeting special education criteria be served by their local school division in the least restrictive environment For these reasons, more students who are medically fragile are being served by a greater variety of service delivery systems and personnel in school divisions This trend is expected to continue and will necessitate collaboration among educators, health care professionals, and parents

A survey of school divisions indicates that very few school divisions currently have policies and procedures regarding the provision of services to medically fragile students Of the 80 school divisions responding, only 12 reported having policies or procedures in place regarding service provision to medically fragile students Policies, where they exist, differ by school division and range from general guidelines to more detailed and documented guidelines, specific procedures, and skills checklists for a host of treatments for health care services It is not known how many school divisions require health service plans for children with health-related needs For the most part, services to these students are based on individual arrangements among school personnel and parents at the school level

School divisions may need to be more creative and flexible in providing service delivery models to the population of students Traditional models and use of personnel may overburden school divisions and prove costly and unsuccessful in providing safe and appropriate services Staff in schools will need to become more familiar and competent in tasks not traditionally performed in the school setting

In creating more efficient service delivery systems, it is essential that school divisions consider the following

- ❑ develop guidelines and procedures to provide safe and efficient delivery of services,
- ❑ identify creative ways to bring in health care professionals to do child specific training for staff,
- ❑ incorporate the parent and teacher in planning for the educational and medical needs of the child, and
- ❑ provide for accommodations in service delivery when there are changes in the child's health care needs

Best practice models currently exist in Virginia and other states which provide safe and appropriate service delivery systems to medically fragile students and can be replicated in those school divisions which are experiencing difficulty serving these students

Residency and Educational Services

The issue of which school division is responsible for providing an education to a child (regular or special education) generally relies on the child's residency Two Virginia statutes must be reviewed in order to determine residency for the purposes of receiving an education Section 22 1-3 of the Code of Virginia is the general residency statute for the provision of educational services

> **§22.1-3. Persons to whom public schools shall be free.** -- The public schools in each school division shall be free to each person who resides within the school division Every person of school age shall be deemed to reside in a school division when he or she is living with a natural parent, a parent by legal adoption, or when the parents of such person are dead, a person in loco parentis who actually resides within the school division, or when the parents of such person are unable to care for the person and the person is living, not solely for school purposes, with another person who (i) resides in the school division, and (ii) is the court-appointed guardian, or has legal custody, of the person, or when the person is living in the school division not solely for school purposes, as an emancipated minor

Section 22 1-215 of the Code redefines residency for children eligible for special education who live in certain residential facilities However, the scope of this section is very narrow and fails to address certain situations in which children are living in residential facilities located in jurisdictions other than where their parents reside The statute reads, in part

> **§22 1-215. School divisions to provide special education; plan to be submitted to Board.** -- Each school division shall provide free and appropriate education, including special education, for the handicapped children residing within its jurisdiction in accordance with regulations of the Board of Education
>
> For the purposes of this section, "handicapped children residing within its jurisdiction" shall include (i) those individuals of school age identified as appropriate to be placed in public school programs, who are residing in a state institution operated by the Department of Mental Heath, Mental Retardation and Substance Abuse Services located within the school division, or (ii) those individuals of school age who are Virginia residents and are placed and living in a foster care home or child-caring institution or the provisions of Chapter 10 (§ 63 1-195 et seq) of Title 63 1 as result of being in the custody of a local department of social services or welfare or being privately placed, not solely for school purposes
>
> The Board of Education shall promulgate regulations to identify those children placed within facilities operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services who are eligible to be appropriately placed in public school programs
>
> The cost of the education provided to children who are not residents of the Commonwealth and are placed and living in a foster care home or child-caring institution or group home located within the school division and licensed under the provisions of Chapter 10 of Title 63 1 shall be billed to the sending agency or person by the school division as provided in subsection C of §22 1-5 No school division shall refuse to educate any such child or charge tuition to any such child

Currently, § 22 1-215 does not apply to children living in pediatric nursing homes for non-educational reasons that are not licensed as child-

caring institutions under Chapter 10 of Title 63 1 of the Code Therefore, the issue is governed by the general residency section, §22 1-3. This presents a problem when the child is placed in a facility located in a school division other than the parents' residence The local school division of the parents' residence is responsible for providing a free appropriate public education However, if the responsible school division has an appropriate program available but the child is not present to access the program because of living in a different jurisdiction, how does the child access educational services? Because Section 22 1-215 does not address this issue, the school division where the facility is located does not appear to have a responsibility to educate the child This creates situations where children have gone without educational services

In addition to pediatric facilities, there are other situations where children could be placed in residential facilities outside of their parents' city or county of residence for non-educational reasons that are not addressed by §22 1-215 For example, group homes licensed under § 37 1-179 1, not Title 63 1 of the Code of Virginia

CHAPTER IV
Service Providers

Staffing in the Public Schools

A full range of school personnel provide services and assistance to medically fragile students Service providers are identified as school nurses, nurses' aides, teachers, paraprofessionals, transportation personnel, administrative support staff, parents, other students and other school staff. Staffing patterns in school divisions vary considerably across the state. In general, school health services in Virginia may be provided by staff employed by the schools or by contractual health personnel Most frequently, the role of coordinating services for medically fragile students is assumed by a school nurse However, there are several school divisions in Virginia who have not designated anyone to be responsible for coordinating school health services and the educational needs of medically fragile students

Data for the 1991-92 school year, collected by the Virginia Association of School Nurses, reflects that 28 school divisions do not have a school nurse The survey found that 36 school divisions do not have a registered nurse on staff Some of these school divisions may contract with local health departments to provide students with access to nursing services

Ideally, all schools with medically fragile students would have a full-time, well-trained school nurse who could serve as the coordinator of services for children with special health needs But assigning school nurses to be directly responsible for meeting the needs of medically fragile students is not feasible due to budgetary and logistical constraints. Further, the nature and the number of children requiring health services means that even if a school nurse were available in every school, it would still be logistically impossible for the school nurse to be the sole service provider for children who are medically fragile Also, a school nurse may not have the experience, knowledge or specialized training to meet the needs of these students. The requirements of some students for continuous care would limit the ability of the school nurse to meet the health needs of other students in the school or division

At least one school division has an Other Health Impaired (OHI) coordinator to work with school health or medical personnel Such a position appears particularly valuable in school divisions with relatively large numbers of medically fragile students and special education students The OHI coordinator

- serves as a liaison between educators and medical support personnel,

- interprets the effects of medical conditions on student educational performance,
- attends study team meetings on children with chronic medical conditions,
- consults with teachers on child specific needs (medical and educational for regular and special education students),
- serves as an IEP case managers or assists in IDEA case management if the student's condition is health-related, and
- assists principals in the interpretation and implementation of guidelines and procedures

Training

Training of staff on the management of health-related procedures in the school setting varies in school systems around the Commonwealth In some systems, training on health-related procedures may be a demonstration by the parent or another teacher In other systems, training may consist of detailed in-service, including a skills checklist, by a health care professional There appears to be no systematic approach to training statewide, with little or no documentation available

Virginia schools were surveyed to identify who conducts treatments and procedures, what types of treatments and procedures are being done, and who trains the persons providing health care in the school setting In an effort to determine the nature and seventy of medically fragile conditions being addressed, the survey data have been grouped according to three levels, these levels of A, B, and C, with A being the most serious, categorize medically fragile students according to the complexity and frequency of their medical needs Refer to Figure 2

When asked to identify "who perform the procedures conducted in your school," respondents identify classroom personnel (teachers and teacher's aides) more frequently than other group of school personnel in all three categories (Level A 35%, Level B 39%, Level C 30%) For the most critical procedures (Level A), nursing personnel perform 34% of the procedures, followed by other non-professional staff such as clinic aides and office staff (19%), parents (6%), and therapists (5%) For procedures that address children with moderate conditions (Level B and Level C), nursing personnel and non-professional staff conduct the procedures almost as frequently as each other (Level B 24%, 25%, Level C 29%, 28%), followed by parents (7%, 8%) and therapists (6%, 4%)

These survey data suggest that classroom personnel, on average, perform procedures more often than nursing personnel, non-professional staff,

parents or therapists However, further analysis of the data provides important findings For example, with Level B procedures, classroom personnel generally perform the feeding procedures which occur more frequently. Nursing personnel are identified as performing procedures which generally occur less frequently such as tracheostomy care, suctioning, administration of oxygen, clean intermittent catheterization, heparin lock and central venous catheter care and peritoneal care Notably, clinic aides and office staff are most frequently identified as performing ostomy care, continuous urethral catheter care, and administering injections

The most complex procedures (Level A) are as likely to be performed by classroom personnel as nursing personnel With Level C procedures, classroom personnel are most likely to perform severe seizure monitoring and response, nursing personnel are most likely to perform nebulization, and non-professional clinic aides and office staff are most likely to perform monitoring of blood glucose levels This latter finding is consistent with the finding that this group is most likely to administer injections which is an expected outcome of close glucose monitoring

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Figure 2

Level A Procedures and treatments for children with one or more conditions who require continuous, ongoing specialized health care include

- ❑ care/monitoring of mechanical ventilator
- ❑ continuous administration of oxygen
- ❑ continuous cardio-pulmonary monitoring

Level B Procedures and treatments for children who require an intermittent specialized health care include

- ❑ special oral feedings to prevent choking
- ❑ nasogastric or oral gastric tube feeding
- ❑ gastrostomy feeding
- ❑ chest physiotherapy
- ❑ ostomy care
- ❑ continuous urethral catheterization care
- ❑ clean intermittent catheterization
- ❑ central venous catheter care
- ❑ administration of fluid or medication by a central venous catheter
- ❑ use of a heparin lock
- ❑ peritoneal dialysis care
- ❑ tracheostomy care and suctions
- ❑ intermittent administration of oxygen
- ❑ administering injections

Level C Procedures and treatments for children with identified conditions of unusual severity who require specialized services episodically due to the potential for occurrence of a medical crisis include

- ❑ nebulization
- ❑ severe seizure monitoring and response
- ❑ hemodialysis shunt care
- ❑ monitoring blood glucose levels

When asked to respond to the question "Who trained the person(s) performing the procedure or treatment?", survey data suggest that nursing personnel (registered nurses and licensed practical nurses) most often conduct the training in all three procedure groupings Registered nurses conduct the training at a ratio of seven to one as compared with licensed practical nurses Next most frequently identified are parents, then others, physicians and clinic aides Thus, licensed health providers (registered nurses and licensed practical nurses 44%) and parents (31%) are providing training nearly 75% of the time for caregivers in the school system when specialized health care procedures are required for children who are medically fragile

The procedures are variously performed in the classroom, clinic, administrative offices and in other school locations For example, all special and tube feedings are performed most often in the classroom, as are tracheostomy and suctioning care, administration of oxygen, chest physiotherapy and seizure monitoring In contrast, cardio-pulmonary monitoring, nebulization, ostomy, clean intermittent catheterization care, central venous catheter care, dialysis, monitoring blood glucose and administering injections are most often performed in the school clinic Clean intermittent catheterization, special feeding techniques and seizure monitoring and response are likely to occur in "other" places in the school

Survey results raise a concern regarding the amount and adequacy of training being conducted in school divisions serving children who are medically fragile Health care procedures provided to children who are medically fragile should be conducted by a trained person This training should be provided by a qualified health care professional in conjunction with the student's parent or guardian Joint training of the teacher or other staff providing the service allows the parent to give child specific information and the health professional to give information on the procedure and the disability while monitoring the staff person's ability to perform the procedure "Qualified" in this context refers to a health professional who is experienced in the specific procedure for which staff are being trained Health professionals available to the school may include

- physicians,
- registered nurses (i e , transition nurse from hospital, home health nurse, public health nurse, or school nurse),
- respiratory therapists, and
- nurse practitioners

Initial training should include the delivery of the service to the child, the recognition of an emergency situation, and the implementation of emergency procedures While training must include general information about the procedure, it is imperative that training be child specific as well After the initial training, short-term follow up should occur to answer any questions the provider may have after delivering the service for a while and monitoring should occur

on a regular basis (e g., every six months) In addition, follow-up should occur after any major hospitalization or illness to ensure that the child's situation has not changed.

Other than child-specific training, school divisions should identify other staff who may need more general information or increased awareness of the needs of medically fragile students. Topics, which may need to be addressed depending on an assessment of need, include·

- legal issues and responsibilities related to students with chronic health care needs or who are medically fragile or technology dependent,
- role of the school division in serving these students;
- working in the educational environment with students who have contagious diseases (school personnel are currently required to receive training on universal precautions due to bloodborne pathogens),
- implications of health issues on a student's education program (e g., students who are undergoing chemotherapy may experience some cognitive deficits during that period);
- working with health service providers, parents and families of children with special health care needs,
- safety issues at school and on the bus,
- service delivery models for chronically ill students;
- identifying and accessing community resources;
- stress management and the grief process, and
- current health care practices in the educational setting

Liability

A review of the data received in the public school survey indicates various staff are providing health services to medically fragile students From the survey, it is not unusual to find teachers or paraprofessionals performing tracheostomy care, gastrostomy care and feedings, clean intermittent cathetenzation or other procedures Those individuals often voice concerns about the lack of or the inadequacy of the training provided to them prior to their implementing the health-related services for this population Further, they often raise questions about their personal liability if they are required to provide these services It is apparent from the comments and questions from these school

personnel that they do not receive sufficient information about the legal requirements related to providing health services to children who are medically fragile as well as their personal liability if they provide those services Oftentimes, the issues are as basic as whether the local school division is required to provide the services and whether or not a teacher or other school employee can be required to provide such services and if so what steps should the school division undertake to minimize liability

In reviewing the issue of which staff person should provide services, the local school division may want to consult their school board attorney for guidance In particular, the local school division should be aware that the Individuals with Disabilities Education Act (IDEA) requires that school health services be provide by a qualified nurse or other qualified person The Virginia Board of Education's Regulations Governing Special Education Programs for Children with Disabilities in Virginia, January 1994, at Part I defines qualified as

> mean[ing] a person has met the State Board educational agency approved or recognized certification, licensing, registration or other comparable requirements which apply to the area in which he or she is providing special education and related services In addition, the professional must meet other state agency requirements for such professional service and/or Virginia Licensure requirements as designated by State Law

This requirement may potentially impact on their policies pertaining to which staff should provide these services Additionally, given that only one-third of the medically fragile students identified by school divisions are "disabled" under "IDEA," the question of qualifications of the staff providing services to the majority of students remains open School divisions should consult their local school board attorneys regarding whether the staff providing health services to children eligible under IDEA are considered qualified, as well as, whether the qualifications or training of the service providers for the population of other than "disabled" students is an issue

In addressing the issue of personal liability, there are few published decisions that address school district liability for injuries to students who are medically fragile In one case, Nance v. Matthews, 622 So 2d 297 (Ala 1993), 20 IDELR 3, a student brought a suit for damages against a school principal, school nurse, special education director, and special education aide The complaint was based on the negligent supervision and training of the aide by the principal, nurse and special education director, as well as, the aide's negligent failure to catheterize the student The principal, nurse and special education director were protected by discretionary function immunity from liability for negligent supervision

Usually, the cases addressing the issue of school division liability involve playground, physical education, science labs and school bus accidents Existing judicial decisions in those cases are based largely in state tort law

utilizing the doctrine of negligence Simply stated, negligence is an intentional act or omission demonstrating a failure to use reasonable or ordinary care. In order to establish negligence, the following elements must be proven.

(1) a duty of care,

(2) an act which breaches the duty to perform to the appropriate standard of care so as not to expose an individual to an unreasonable risk of injury,

(3) the act or omission caused the injury, and

(4) damage or injury did in fact occur

One possible defense in a negligence suit is the doctrine of sovereign immunity This doctrine protects governmental agencies and employees who commit acts of negligence while performing acts within the scope of their employment Sovereign immunity applies only to negligent acts, not intentional or malicious acts The viability of the defense is based on the facts of each case

The doctrine of sovereign immunity for governmental employees has been partially or completely eliminated by legislative or judicial decisions in some states However, in 1988, the Supreme Court of Virginia upheld the application of sovereign immunity for school employees It is important to note, however, that given the trend nationwide to eliminate the defense and given the right case, this may not always be the case in Virginia It is also worth noting that some states have addressed civil liability in this area by establishing statutory immunity As with the question of qualifications of staff providing health services, school divisions should consult their local school board attorney regarding the issue of liability, including the defense of sovereign immunity

CHAPTER V
Ancillary Findings

Family Support

A concern often raised during this study was the issue of family support The stresses, both financial and emotional, placed on families of children who are medically fragile can be extreme The current practice of strongly discouraging the placement of medically fragile children in institutions and providing appropriate care for the children at home and in school often means that parents may take on an additional role of medical caregiver Although these families are most often willing to provide such care for their children, they may do so with great sacrifice These families often need support services, such as respite care

While respite care is available through the Medicaid program for the families of some medically fragile children (e g , those children that are considered "technology-dependent"), there are many families who do not qualify for Medicaid assistance Even where Medicaid options are available, many parents are not aware of these options and need to have understandable information readily available to them Communities, including public schools, may be able to increase awareness of support options and provide greater information and referrals to these families

Other Students with Health Needs

There are other students in Virginia public schools who have health care needs but do not meet the definition of medically fragile Evidence of this larger population was addressed by school personnel in the survey as well as in discussions with school health care providers, other school personnel and parents Some are children with other chronic conditions and health impairments, while others are groups of children with milder symptoms of conditions which if more severe could leave them medically fragile Medically fragile children as defined by the study comprise a subset of the greater population of children with unique or special health care needs The data obtained from the survey reflects that less than one percent, approximately 8,000 out of one million, of students enrolled in Virginia's public schools are medically fragile This percentage is consistent with national figures on incidence

Nationally, children with special health conditions represent about ten to fifteen percent of the population of children and youth from birth to twenty years of age These estimates emerge consistently from secondary analyses of population-based and clinical studies of prevalence Of this group, about ten

percent, or one to two percent of the total population, are considered to have a severe chronic illness, defined as one that interferes significantly with normal functioning and development **Appendix C** presents information indicating the established national prevalence and incidence rates for these conditions, and the estimated number of children in Virginia who experience these conditions based on the established national rates and Virginia population estimates.

Whatever the diagnosis or severity of the condition, children and youth with special health care needs are at high risk of developing behavioral problems and low academic achievement. Children or adolescents with health concerns may need special considerations in the school setting at some point. The range of services potentially needed is broad and may include the following

- support therapies including physical, occupational, speech and language,
- adaptive physical education,
- schedule modifications,
- building accessibility,
- toileting or lifting assistance,
- school health services including administration of medications, implementation of medical procedures, emergency preparations, and case management,
- counseling services, and
- awareness training and support for peers and school staff.

CHAPTER VI
Recommendations

Recommendation 1 School divisions should develop a "health service plan" for each student who is a medically fragile child as defined by this study. This plan is in addition to an existing IEP for students eligible for services under the Individuals with Disabilities Education Act or a 504 service plan for students who qualify for services under Section 504 of the Rehabilitation Act of 1973, although it may be developed in conjunction with either of these plans It is recommended that the planning team consist of the following

- ❑ parents,
- ❑ child, if appropriate,
- ❑ teacher,
- ❑ school health coordinator,
- ❑ special education administrator, if the child receives special education,
- ❑ Section 504 coordinator, if the child receives services under Section 504,
- ❑ guidance counselor,
- ❑ building principal,
- ❑ transition nurse, if applicable, and
- ❑ other service providers (e g , occupational or physical therapist)

The length and complexity of this plan should vary depending on the student's needs **Appendix D** provides a sample plan The plan should include information addressing the following

- ❑ description of the child's medical condition,
- ❑ limitations of the child in the school setting,
- ❑ specific transportation needs, if any
- ❑ provision of medication, if applicable,
- ❑ procedures to be performed by school personnel,
- ❑ where and when the procedures are to be performed,
- ❑ who will perform each procedure,
- ❑ training,
- ❑ schedule for review and monitoring of training,
- ❑ emergency procedures, and
- ❑ handling of teacher/paraprofessional absences

Recommendation 2 Local school divisions should develop policies that address the provision of services to students who are medically fragile to include staff selection and training, roles and responsibilities

Recommendation 3. Local school divisions should develop policies to address the emergency medical needs of students, including those who are medically fragile. Topics include medication administration, cardio-pulmonary resuscitation certification, first aid certification and implementation of the bloodborne pathogen standards (universal precautions) promulgated by the Occupational Health and Safety Administration. These policies should include provisions for dissemination and training to ensure that teachers are reminded of procedures and new teachers receive necessary training.

Recommendation 4 The local Health Advisory Board, required by §22.1-275.1 of the Code of Virginia, should take an active role in assisting school divisions in developing policies related to children who are medically fragile. These advisory boards are required by law to assist schools with the development of health policy in the school division and the evaluation of the status of school health, health education, the school environment and health services. Prior to policy development, the local Health Advisory Boards may want to first determine the prevalence range of student health care needs and identify key issues that need to be addressed concerning the delivery of school health services to students.

Recommendation 5 School divisions should provide periodic in-service or opportunities for school staff to attend programs to increase staff awareness and understanding of the general health issues faced by schools and the needs of medically fragile students, specifically. Communication and coordination with school board attorneys and local risk management departments is also recommended. Possible topics include:

- legal issues and responsibilities related to students who are medically fragile or who have chronic health care needs,
- role of the school divisions in providing health services to students who are medically fragile or who have chronic health care needs,
- working with students who have contagious diseases,
- educational implications for students with special health care needs;
- working with health service providers, parents and families of children with special health care needs,
- safety issues related to medically fragile children, and
- service delivery models for medically fragile children

Recommendation 6 For risk management purposes, school divisions should document the health services provided to any medically fragile or other students. Services should be documented as frequently they are provided

Recommendation 7 Nursing homes in the Commonwealth that elect to establish pediatric units should be licensed under both Chapter 5 of Title 32.1 of the Code of Virginia and under Chapter 10 of Title 63.1 of the Code. A "child-caring institution" means any institution maintained for the purposes of receiving children for full-time care, maintenance, protection and guidance separated from their parents or guardians, except

- a bona fide educational institution whose pupils, in the ordinary course of events, return annually to the homes of their parents or guardians for not less than two months of summer vacation,
- an establishment required to be licensed as a summer camp by Title 35 1, and
- a bona fide hospital legally maintained as such

Although a nursing home's primary purpose may not be providing full-time care for children, a nursing home that has a separate pediatric wing providing full-time care and maintenance for children is a child-caring institution and should be licensed as such If licensed under Title 63 1, the facility falls under the Standards for Interdepartmental Regulations of Residential Facilities for Children (CORE regulations) The purpose of promulgating CORE is to have a uniform set of regulations to ensure adequate care, treatment and education in facilities providing full-time care to children If licensed under Title 63 1, those children in nursing facilities who require special education would be considered residents of the school division where the facility is located as stated in §22 1-215 and therefore entitled to education services without question

Because the facts may differ from one situation to another with regard to residential facilities other than pediatric nursing homes that are not addressed by §22 1-215, it is not practical to recommend a solution to address every situation At a minimum, those facilities that are serving children and are not addressed in §22 1-215 should not accept a child unless the facility has made arrangements to provide for the educational needs of the child

Recommendation 8 School divisions should review and evaluate their policies and procedures relative to Section 504 of the Rehabilitation Act of 1973. School divisions should conduct these activities with the assistance of their "504 Coordinator," required by 34 Code of Federal Regulations Section 104 7 As part of this review and evaluation, school divisions should pay close attention to those students who receive health services but have not been found eligible for services under the Individuals with Disabilities Education Act or Section 504 of the Rehabilitation Act of 1973

Recommendation 9 The Department of Education, in conjunction with the Attorney General's Office, should review and evaluate the need for legislation establishing statutory immunity for school personnel performing acts within the scope of their employment while providing health related services to the medically fragile population

Recommendation 10 The Department of Education, in collaboration with the Department of Health, should develop and update procedural guidelines related to

- handling of body fluids,
- anaphylaxis reaction,
- providing basic health care,
- providing specialized health care,
- transporting medically fragile students, and
- administrative procedures (i e , developing health service plans, staff development, sample forms and documentation)

The Departments should seek assistance and consultation from representatives of parents, regular and special education teachers, school nurses, primary care providers and other health care providers

Recommendation 11: The General Assembly may wish to consider further study, focusing on the needs of families with medically fragile children. Such study should be broader than issues surrounding the education of these students A study might consider the need for comprehensive family support services, examine barriers to care within the Medicaid program, and identify recommendations to be forwarded to the federal government concerning the need for flexibility in waiver services

A STUDY OF
SCHOOL HEALTH EXPENDITURES
FOR 1991-92

Virginia Department of Education

November 1993

1991-92 SCHOOL HEALTH EXPENDITURES

Study Origin

Among the bills considered by the 1993 General Assembly were Senate Bill 720 and House Bill 2188 These bills contained identical provisions to amend Section 22 1-274 of the Code of Virginia which currently mandates that school boards provide pupil personnel and support services, permitting school boards to employ school nurses and other health professionals or to receive those services from a local health department The proposed amendment would have set ratios for school nurses to students and required the Board of Education to monitor the progress of school boards in meetings these ratios

Neither bill passed, but the Senate Committee on Education and Health approved a motion to request the Board of Education to conduct a study of school health expenditures Senator Elliot Schewel, in a May 14 letter to President James P Jones, requested the Board of Education, to "determine how school health funds are used in each locality and provide, by December 1, 1993, a detailed analysis of school health expenditures to the Senate Committee on Education and Health and on Finance "

Study Team

Concurrently, Senate Joint Resolution No 306 requested the Department of Education to work with the State Health Department to study the needs of medically fragile children in Virginia The analysis of school health expenditures was included as part of the overall work of this interagency study team A full report on their findings and recommendations is scheduled for completion in December 1993 John Rickman, Principal Specialist in the Policy and Planning Division of the Department of Education analyzed school health expenditures for 1991-92 to comply with Senator Schewel's request and as a component of the broader study mandated by Senate Joint Resolution No 306

Study Method

Expenditure data reported by local school divisions on the 1991-92 annual school reports was used to determine how school health funds were used in each locality The annual school report includes a section for Health Services expenditures School divisions are instructed to report expenditures for physical and mental health services which are not direct instruction in this section Included are activities that provide students with appropriate medical, dental and nursing services

It should be noted, however, that six school divisions did not report expenditures in the health services section in the 1991-92 report Expenditures for these activities may have been included in another section of the annual school report In addition, several school divisions have health services for their students provided by local health departments The extent of the health services provided by local health departments cannot be determined based on information provided in the annual school reports

Study Findings

Total Statewide Expenditures

In 1991-92, local school divisions reported expenditures of $24 2 million for school health services As noted on Attachment A, the majority of these expenditures (85%) were for salaries and fringe benefits The remaining expenditures included purchased services (10.5%) and materials and supplies (2 8%)

School nurse positions represented the largest component (65%) of these costs Other positions reported on the 1991-92 annual school report included nurse supervisors, occupational and physical therapists and nurse aides Expenditures listed under purchased services included fees for physicians, occupational and physical therapists, and nurse services provided by local health departments

Per Pupil Expenditures.

The average 1991-92 per pupil expenditure for school health services was $ 23 99 The per pupil expenditures ranged from $0 00 to $ 84 27 Attachment B lists the school health expenditures reported by each local school division in the 1991-92 annual school reports as well as the per pupil expenditure for each local school division

As noted on Attachment C, the average per pupil expenditure varies based on a locality's relative wealth The poorer localities (those with a local composite index below 25) spent an average of $15 28 per pupil for school health services In contrast, the localities with a composite index above 50 spent an average of $35 80 per pupil Those wealthiest localities (with a 80 composite index) spent an average of almost $41 per pupil

School Nurse Positions

In 1991-92, a statewide total of 519 school nurse positions were included in the annual school reports Most school divisions (99 of 135, or 75 percent) employ school nurses The school nurse positions per 1,000 students for these school divisions ranged from 023 school nurse positions per 1,000 students to 2 85 positions per 1,000 students Consistent with the pattern in overall expenditures for school health, the poorer localities employed fewer school nurses per 1,000 students than the wealthier localities, 302 positions per 1,000 students versus 627 positions per 1,000 students The statewide average was 52 nurse positions per 1,000 students

In addition, the local health departments provided nursing services to the local school divisions In 1991-92, the local health departments reported providing over 162,000 hours for nursing services, including health screening, conducting educational classes, physical exams and immunizations These hours, provided by the local health departments, were equivalent to an additional 115 school nurse positions statewide

Attachment D lists the 1991-92 nurse positions employed by each school division and the number of hours provided to the school divisions by the local health department

1991-92 SCHOOL HEALTH EXPENDITURES

	Amount	Percent
Salaries & Wages		
Administrative Positions	$330,274	
Other Professional Positions	2,649,149	
School Nurses	10,498,701	
Technical Positions	2,268,701	
Clerical Positons	376,558	
Total	16,123,383	66 7%
Fringe Benefits	4,387,615	18 1%
Purchased Services	2,530,346	10 5%
Internal Services	342	0 0%
Other Charges		
Travel	109,773	
Miscellaneous	233,854	
Total	343,627	1.4%
Materials and Supplies	680,740	2 8%
Capital Outlay		
Replacement	47,975	
Additions	69,679	
Total	117,654	0 5%
Total Expenditures	$24,183,707	100 0%

1991–92 SCHOOL HEALTH EXPENDITURES

	DIVISION	Total Expenditures	3/31/92 ADM	Cost Per Pupil	1991–92 State Payment
001	ACCOMACK	$231,682	5,152	$44 97	$55,621
002	ALBEMARLE	125,436	10,034	12 50	56,833
003	ALLEGHANY	87,940	3,130	28 10	32,579
004	AMELIA	42,030	1,647	25.52	15,494
005	AMHERST	71,560	4,587	15 60	51,067
006	APPOMATTOX	79,823	2,294	34.80	25,801
007	ARLINGTON	111,525	15,123	7 37	8,359
008	AUGUSTA	109,331	9,898	11 05	80,646
009	BATH	0	779	0 00	2,039
010	BEDFORD	144,143	8,583	16 79	84,998
011	BLAND	5,211	1,041	5 01	10,256
012	BOTETOURT	10,285	4,189	2 46	37,030
013	BRUNSWICK	115,711	2,644	43 76	30,613
014	BUCHANAN	143,163	6,141	23 31	73,146
015	BUCKINGHAM	0	2,047	0 00	20,284
016	CAMPBELL	453,394	8,241	55 02	91,637
017	CAROLINE	81,407	3,482	23 38	37,622
018	CARROLL	85,347	4,053	21 06	47,950
019	CHARLES CITY	6,509	1,025	6 35	10,156
020	CHARLOTTE	6,331	2,025	3 13	19,360
021	CHESTERFIELD	524,513	45,482	11 53	159,829
022	CLARKE	67,957	1,628	41 74	11,687
023	CRAIG	470	646	0 73	5,999
024	CULPEPER	56,848	4,930	11 53	44,499
025	CUMBERLAND	17,989	1,145	15 71	9,876
026	DICKENSON	178,701	3,494	51 15	41,383
027	DINWIDDIE	45,413	3,684	12 33	41,537
028	ESSEX	0	1,546	0 00	13,591
029	FAIRFAX	2,131,283	131,092	16 26	293,074
030	FAUQUIER	198,182	8,309	23 85	48 291
031	FLOYD	17,573	1,891	9 29	19 921
032	FLUVANNA	31,544	2,197	14 36	21,487
033	FRANKLIN	109,673	6,280	17 46	63,733
034	FREDERICK	347,101	8,413	41 26	77,079
035	GILES	27,165	2,643	10 28	29,232
036	GLOUCESTER	163,942	5,867	27 94	59,174
037	GOOCHLAND	32,484	1,724	18 84	9,941
038	GRAYSON	36,183	2,212	16 36	25,626

1991-92 SCHOOL HEALTH EXPENDITURES

	DIVISION	Total Expenditures	3/31/92 ADM	Cost Per Pupil	1991-92 State Payment
039	GREENE	82,470	1,853	44 51	19,686
040	GREENSVILLE	32,587	2,761	11.80	31,229
041	HALIFAX	0	5,185	0.00	62,219
042	HANOVER	285,665	11,689	24.44	99,625
043	HENRICO	981,322	33,289	29 48	253,687
044	HENRY	122,452	9,028	13 56	89,196
045	HIGHLAND	11,359	377	30 13	1,433
046	ISLE OF WIGHT	156,198	4,235	36 88	41,632
048	KING GEORGE	108,922	2,643	41.21	27,716
049	KING QUEEN	36,211	904	40 06	8,649
050	KING WILLIAM	83,496	1,570	53 18	15,820
051	LANCASTER	92,860	1,601	58 00	10,292
052	LEE	16,629	4,470	3.72	53,960
053	LOUDOUN	759,081	14,993	50 63	49,249
054	LOUISA	107,273	3,630	29 55	14,338
055	LUNENBURG	69,382	2,218	31.28	26,484
056	MADISON	40,096	1,892	21 19	14,349
057	MATHEWS	44,754	1,269	35 27	10,219
058	MECKLENBURG	28,357	5,035	5.63	56,091
059	MIDDLESEX	30,626	1,192	25.69	7,907
060	MONTGOMERY	76,156	8,453	9.01	83,424
062	NELSON	19,953	2,035	9 81	16,198
063	NEW KENT	50,611	1,917	26 40	18,443
065	NORTHAMPTON	156,374	2,455	63 70	28,577
066	NORTHUMBERLAND	53,115	1,437	36 96	9,494
067	NOTTOWAY	42,976	2,380	18 06	27,483
068	ORANGE	37,486	3,777	9 92	31,939
069	PAGE	82,432	3,438	23 98	35,413
070	PATRICK	31,708	2,671	11 87	30,174
071	PITTSYLVANIA	137,342	9,503	14 45	112,861
072	POWHATAN	89,192	2,362	37 76	22,957
073	PRINCE EDWARD	51,957	2,518	20 63	27,002
074	PRINCE GEORGE	59,279	5,108	11 61	62,205
075	PRINCE WILLIAM	155,809	42,936	3 63	216,760
077	PULASKI	43,694	5,408	8 08	58,309
078	RAPPAHANNOCK	15,243	995	15 32	3,769
079	RICHMOND	25,208	1,290	19 54	11,989
080	ROANOKE	112,997	13,343	8 47	111,854

1991–92 SCHOOL HEALTH EXPENDITURES

	DIVISION	Total Expenditures	3/31/92 ADM	Cost Per Pupil	1991–92 State Payment
081	ROCKBRIDGE	0	2,906	0 00	26,559
082	ROCKINGHAM	273,845	9,357	29 27	84,309
083	RUSSELL	79,433	5,081	15 63	42,935
084	SCOTT	51,617	4,059	12 72	50,233
085	SHENANDOAH	161,133	4,830	33 36	44,244
086	SMYTH	71,868	5,421	13 26	40,742
087	SOUTHAMPTON	45,623	2,614	17 45	26,615
088	SPOTSYLVANIA	503,856	12,984	38 81	123,212
089	STAFFORD	468,386	13,062	35 86	136,186
090	SURRY	56,633	1,176	48 16	3,384
091	SUSSEX	21,143	1,449	14 59	14,740
092	TAZEWELL	154,012	8,732	17 64	105,878
093	WARREN	67,824	4,333	15 65	34,593
094	WASHINGTON	104,095	7,433	14 00	83,634
095	WESTMORELAND	85,645	1,883	45 48	17,648
096	WISE	81,156	8,437	9 62	99,866
097	WYTHE	50,751	4,332	11 72	25,050
098	YORK	254,112	9,776	25 99	93,580
101	ALEXANDRIA	584,012	9,580	60 96	33,040
102	BRISTOL	43,140	2,621	16 46	26,108
103	BUENA VISTA	385	1,075	0 36	11,214
104	CHARLOTTESVILLE	262,995	4,483	58 67	31,028
106	COLONIAL HEIGHTS	127,328	2,610	48 78	25,441
107	COVINGTON	26,722	975	27 41	9,019
108	DANVILLE	100,791	8,324	12 11	92,044
109	FALLS CHURCH	42,924	1,224	35 07	685
110	FREDERICKSBURG	76,197	2,046	37 24	12,714
111	GALAX	20,444	1,152	17 75	10,685
112	HAMPTON	737,056	21,912	33 64	223,104
113	HARRISONBURG	82,826	3,275	25 29	11,588
114	HOPEWELL	159,057	4,090	38 89	45,814
115	LYNCHBURG	267,905	9,372	28 59	90,348
116	MARTINSVILLE	24,750	2,774	8 92	25,316
117	NEWPORT NEWS	1,226,838	29,487	41 61	308,977
118	NORFOLK	68,162	35,500	1 92	66,449
119	NORTON	0	901	0 00	9,645
120	PETERSBURG	171,859	5,876	29 25	55,536
121	PORTSMOUTH	726,625	18,233	39 85	210,549

1991-92 SCHOOL HEALTH EXPENDITURES

	DIVISION	Total Expenditures	3/31/92 ADM	Cost Per Pupil	1991-92 State Payment
122	RADFORD	9,580	1,505	6 37	13,829
123	RICHMOND CITY	1,599,990	26,002	61 53	198,872
124	ROANOKE CITY	118,348	12,619	9 38	108,945
126	STAUNTON	113,408	3,018	37.58	16,470
127	SUFFOLK	395,296	9,056	43 65	96,266
128	VIRGINIA BEACH	1,828,773	71,950	25.42	677,680
130	WAYNESBORO	3,543	2,804	1.26	20,615
131	WILLIAMSBURG	532,060	6,314	84.27	39,578
132	WINCHESTER	159,143	3,051	52.16	20,947
133	SOUTH BOSTON	0	1,301	0.00	14,544
135	FRANKLIN CITY	62,871	1,865	33 71	21,819
136	CHESAPEAKE CITY	1,489,988	30,080	49 53	299,866
137	LEXINGTON	4,864	674	7 22	5,823
139	SALEM	69,388	3,596	19.30	27,580
142	POQUOSON	79,817	2,320	34 40	24,515
143	MANASSAS CITY	147,559	4,972	29 68	23,360
144	MANASSAS PARK	21,876	1,342	16 30	9,615
202	COLONIAL BEACH	10,518	642	16 38	6,990
207	WEST POINT	26,417	673	39 25	7,074
		$24,183,708	1,008,317	$23 98	$7,557,182

1991-92 SCHOOL HEALTH EXPENDITURES

Composite Index	Average Per Pupil Expenditure
Below 2500	$15 28
2501 - 3500	22 05
3501 - 5000	22 76
Above 5000	35 80
State Average	$23 99

1991-92 SCHOOL NURSE POSITIONS

	DIVISION	School Nurse FTE'S	3/31/92 UNADJ. ADM	Positions Per 1,000	Local Health Dept Nurse Hours	
001	ACCOMACK	3 00	5,152	0 582	24	hours
002	ALBEMARLE	0 00	10,034	0 000	682	
003	ALLEGHANY/HIGH.	0 00	3,130	0 000	0	
004	AMELIA	1 00	1,647	0 607	30	
005	AMHERST	2 00	4,587	0 436	0	
006	APPOMATTOX	3 53	2,294	1 539	0	
007	ARLINGTON	0 00	15,123	0.000	24,327	
008	AUGUSTA	0 00	9,898	0.000	1,823	
009	BATH	0 00	779	0.000	146	
010	BEDFORD	3.10	8,583	0.361	0	
011	BLAND	0 00	1,041	0.000	10	
012	BOTETOURT	0 00	4,189	0 000	0	
013	BRUNSWICK	2 00	2,644	0 756	0	
014	BUCHANAN	2 00	6,141	0.326	300	
015	BUCKINGHAM	0.00	2,047	0 000	147	
016	CAMPBELL	2 20	8,241	0 267	0	
017	CAROLINE	2 00	3,482	0 574	38	
018	CARROLL	1 50	4,053	0 370	0	
019	CHARLES CITY	1 00	1,025	0.976	15	
020	CHARLOTTE	0 00	2,025	0 000	96	
021	CHESTERFIELD	2 00	45,482	0 044	30,544	
022	CLARKE	1 00	1,628	0.614	3	
023	CRAIG	0 00	646	0 000	0	
024	CULPEPER	2 00	4,930	0 406	181	
025	CUMBERLAND	1 00	1,145	0 873	86	
026	DICKENSON	5.00	3,494	1 431	561	
027	DINWIDDIE	1 00	3,684	0 271	75	
028	ESSEX	0 00	1,546	0 000	25	
029	FAIRFAX	0 00	131,092	0 000	42,390	
030	FAUQUIER	0 00	8,309	0 000	147	
031	FLOYD	1 00	1,891	0 529	33	
032	FLUVANNA	0 00	2,197	0 000	40	
033	FRANKLIN COUNTY	5 00	6,280	0 796	150	
034	FREDERICK	9 00	8,413	1 070	308	
035	GILES	1 00	2,643	0.378	40	

1991-92 SCHOOL NURSE POSITIONS

	DIVISION	School Nurse FTE'S	3/31/92 UNADJ. ADM	Positions Per 1,000	Local Health Dept. Nurse Hours
036	GLOUCESTER	6.00	5,867	1 023	3
037	GOOCHLAND	1 00	1,724	0.580	25
038	GRAYSON	1 00	2,212	0 452	0
039	GREENE	1 00	1,853	0 540	28
040	GREENSVILLE/EMPO	1 00	2,761	0 362	31
041	HALIFAX	0 80	5,185	0.154	0
133	SOUTH BOSTON	0 20	1,301	0.154	0
042	HANOVER	3 00	11,689	0.257	80
043	HENRICO	15 16	33,289	0.455	150
044	HENRY	2 00	9,028	0 222	252
045	HIGHLAND	0 00	377	0 000	230
046	ISLE OF WIGHT	6 00	4,235	1 417	0
048	KING GEORGE	4 00	2,643	1.513	14
049	KING AND QUEEN	1 00	904	1 106	100
050	KING WILLIAM	1 00	1,570	0 637	24
051	LANCASTER	2 00	1,601	1 249	0
052	LEE	0 00	4,470	0.000	64
053	LOUDOUN	8 50	14,993	0.567	473
054	LOUISA	3 00	3,630	0 826	145
055	LUNENBURG	1 00	2,218	0 451	72
056	MADISON	0 00	1,892	0.000	154
057	MATHEWS	2 00	1,269	1.576	3
058	MECKLENBURG	0 00	5,035	0 000	0
059	MIDDLESEX	1 00	1,192	0 839	0
060	MONTGOMERY	1 00	8,453	0 118	74
062	NELSON	0 50	2,035	0 246	102
063	NEW KENT	2 00	1,917	1 043	25
065	NORTHAMPTON	7 00	2,455	2 851	28
066	NORTHUMBERLAND	1 00	1,437	0 696	0
067	NOTTOWAY	2 00	2,380	0.840	38
068	ORANGE	0 00	3,777	0.000	123
069	PAGE	2 00	3,438	0.582	54
070	PATRICK	1 00	2,671	0 374	41
071	PITTSYLVANIA	2 00	9,503	0 210	0
072	POWHATAN	0 00	2,362	0.000	1,185

1991-92 SCHOOL NURSE POSITIONS

	DIVISION	School Nurse FTE'S	3/31/92 UNADJ. ADM	Positions Per 1,000	Local Health Dept. Nurse Hours
073	PRINCE EDWARD	2.92	2,518	1 160	6
074	PRINCE GEORGE	2.00	5,108	0 392	390
075	PRINCE WILLIAM	1.00	42,936	0.023	14,300
077	PULASKI	1.00	5,408	0 185	296
078	RAPPAHANNOCK	0.00	995	0 000	128
079	RICHMOND COUNTY	1.00	1,290	0 775	42
080	ROANOKE COUNTY	1.60	13,343	0.120	925
081	ROCKBRIDGE	0.00	2,906	0 000	217
082	ROCKINGHAM	3.00	9,357	0 321	656
083	RUSSELL	0.00	5,081	0 000	1,248
084	SCOTT	1 50	4,059	0.370	0
085	SHENANDOAH	3 00	4,830	0.621	42
086	SMYTH	1 00	5,421	0.184	20
087	SOUTHAMPTON	2.00	2,614	0.765	0
088	SPOTSYLVANIA	17.00	12,984	1.309	156
089	STAFFORD	16.50	13,062	1.263	118
090	SURRY	1.00	1,176	0.850	24
091	SUSSEX	0.00	1,449	0.000	87
092	TAZEWELL	2.00	8,732	0.229	240
093	WARREN	0.00	4,333	0.000	88
094	WASHINGTON	2.20	7,433	0.296	0
095	WESTMORELAND	2.00	1,883	1.062	47
096	WISE	1.00	8,437	0 119	68
097	WYTHE	1 00	4,332	0.231	0
098	YORK	7 00	9,776	0.716	23
101	ALEXANDRIA	15 00	9,580	1 566	10
102	BRISTOL	1.00	2,621	0.382	0
103	BUENA VISTA	0 00	1,075	0 000	145
104	CHARLOTTESVILLE	5.60	4,483	1 249	104
136	CHESAPEAKE	35 00	30,080	1 164	150
106	COLONIAL HEIGHTS	1 00	2,610	0 383	137
107	COVINGTON	0 00	975	0 000	0
108	DANVILLE	2 08	8,324	0 250	0
109	FALLS CHURCH	0 00	1,224	0 000	1,520
135	FRANKLIN CITY	1 00	1,865	0.536	0

1991-92 SCHOOL NURSE POSITIONS

	DIVISION	School Nurse FTE'S	3/31/92 UNADJ. ADM	Positions Per 1,000	Local Health Dept Nurse Hours	
110	FREDERICKSBURG	3 00	2,046	1.466	9	
111	GALAX	1 00	1,152	0 868	0	
112	HAMPTON	19 00	21,912	0.867	0	
113	HARRISONBURG	0 00	3,275	0 000	1,104	
114	HOPEWELL	4 00	4,090	0 978	49	
137	LEXINGTON	0 60	674	0 890	87	
115	LYNCHBURG	10 80	9,372	1.152	0	
143	MANASSAS CITY	2.00	4,972	0 402	1,800	
144	MANASSAS PARK	0 00	1,342	0.000	1,000	
116	MARTINSVILLE	1 00	2,774	0 360	145	
117	NEWPORT NEWS	37 00	29,487	1 255	25	
118	NORFOLK	2 00	35,500	0.056	28,129	
119	NORTON	0 00	901	0.000	18	
120	PETERSBURG	8 00	5,876	1.361	146	
142	POQUOSON	4 00	2,320	1 724	0	
121	PORTSMOUTH	28 00	18,233	1.536	26	
122	RADFORD	0 00	1,505	0.000	81	
123	RICHMOND CITY	29 00	26,002	1 115	10	
124	ROANOKE CITY	2 66	12,619	0 211	1,162	
139	SALEM	1 00	3,596	0 278	309	
126	STAUNTON	2 00	3,018	0 663	220	
127	SUFFOLK	12 00	9,056	1 325	0	
128	VIRGINIA BEACH	78 00	71,950	1 084	125	
130	WAYNESBORO	0 00	2,804	0 000	540	
131	WILLIAMSBURG	8 00	6,314	1 267	40	
132	WINCHESTER	4 00	3,051	1 311	66	
202	COLONIAL BEACH	0 00	642	0 000	8	
207	WEST POINT	1 00	673	1 486	40	
		518 95	1,008,317	0 515	162,065	hours

Pertinent Federal Special Education Legislation and Judicial Guidelines

Pertinent Special Education Legislation

The chief legislation governing the education of children with disabilities is the **Individuals with Disabilities Education Act** (IDEA) which provides federal money to assist state and local education agencies in education children with disabilities In order to receive this money, IDEA places a number of requirements on agencies wishing to receive the financial assistance IDEA entitles all children with disabilities to have available a free appropriate public education that emphasizes special instruction and related services designed to meet their unique needs This education must be at no cost to the parent, must be designed to suit the child's individual needs, and must be implemented in the least restrictive environment appropriate The appropriate educational placement for each student with disabilities must be determined on an individual, case-by-case basis. Students who are medically fragile and eligible for special education and related services under IDEA must also be educated in the least restrictive environment

The law requires that an individualized education plan (IEP) be developed for each eligible child by a team of people to include the child's parents, teacher and school division representative The IEP indicates the child's present level of performance, the goals and objectives for the child, the specific criteria to measure the child's progress, and any related services the child requires The IEP must be reviewed at least annually

Once the present level of performance, goals and objectives and related services are agreed to, the IEP team then decides in what setting the IEP will be implemented The law requires that the child must be educated in the least restrictive environment appropriate for the child As much as possible for the child, the child must be education with children who do not have a disability In selecting the least restrictive environment, the IEP team must consider, among other things, the educational and noneducational (e g , emotional, medical and social) benefits to the child and any potential harmful effects on the child These services may be met through a full cascade of programs and supportive services The placements range from a special education teacher or paraprofessional working with the regular education teacher, direct one-on-one service from an itinerant teacher, special education resource classrooms, special education self-contained classroom to private day placements, public or private residential placements, hospital teaching programs and nomebound instruction Homebound instruction is considered the most restrictive

environment by many educators because of the lack of opportunity for interaction with peers However, for some children, based on their unique needs, the IEP team may consider homebound instruction to be the least restrictive environment

The IDEA also requires that the rights of students with disabilities and their parents are protected These rights include nondiscriminatory testing in evaluation, opportunity to examine records, confidentiality, a right to request an independent educational evaluation (IEE), notice and consent, impartial due process hearing, and an opportunity to present complaints

The term "children with disabilities" is defined in IDEA as those children evaluated, in accordance with the federal special education regulations, as having autism, deaf-blindness, a developmental delay, a hearing impairment which may include deafness, mental retardation, multiple disabilities, an orthopedic impairment, other health impairment, a physical disability, a serious emotional disturbance, a severe and profound disability, a specific learning disability, a speech or language impairment, a traumatic brain injury, or a visual impairment which may include blindness, who, because of these impairments, need special education and related services

The definition of "children with disabilities" under IDEA establishes two criteria for determination of eligibility for special education First, after evaluation, the child must have one or more of the disabilities listed Second, the disability must adversely affect the child's educational performance and thus necessitate the need for special education and related services Only when a disability impairs a child from functioning in general education does special education become appropriate

Many of these children will be eligible due to multiple disabilities Some of these children will be eligible due to single disability such as a physical disability, orthopedic impairment or as an other health impaired student "Other health impaired" under IDEA means having limited strength, vitality or alertness due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia or diabetes, which adversely affects a child's educational performance " (34 CFR 300 5)

In addition to determining whether a student is eligible for special education, an eligibility committee will determine if a child is in need of related services **Related services** are defined as follows

> transportation, and such developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupation therapy, recreation, including therapeutic recreation and social work services, and medical and counseling services, including rehabilitation counseling, except that such medical services shall be for diagnostic and evaluation purposes only) as may be

required to assist a child with a disability to benefit from special education, includes the early identification and assessment of disabling conditions in children [Individuals with Disabilities Education Act, 20 U S C §1401 (17)] The term also includes school health services, social work services in the schools and parent counseling and training [34 C F R §300 13(a)]

If a child is not eligible for special education services under IDEA, the child cannot be eligible for related services since these services are designed to assist the child in benefiting from special education

504

1 Has a physical or mental impairment which substantially limits one or more of life's major activities such as caring for one's self, performing a task, walking, seeing, hearing, speaking, breathing, learning or working;

2 **Has a record of such an impairment** -- A person who has a record of having an impairment is defined as one who has a history of, or has been improperly classified as having, a substantially limiting or physical impairment, or

3 **Is regarded as having an impairment** -- A person who is regarded as having an impairment is defined as one who either does not have an impairment or does not have a substantially limiting impairment but is discriminated against as if he had such an impairment

Pertinent Judicial Guidelines

Administrative due process hearings and litigation surrounding the provision of related services to students who are medically fragile generally involve a controversy over whether the needed service is an excludable medical service (not a related service under IDEA) or a school health service (a related service under IDEA) **"School health services" are defined under IDEA as services provided by a qualified school nurse or other qualified person. "Medical services" are defined as services provided by a licensed physician to determine a child's medically related disabling condition which results in the child's need for special education and related services.** Unless the medical service is for diagnostic and evaluation purposes, it is not considered a related service under IDEA

Over the years, however, the answer to what is a school health service and what is an excludable medical service has been reexamined by the courts Analysis of the issue generally requires an answer to two questions

- ❑ Do the services in question qualify as supportive services necessary to assist the child to benefit from special education?

- ❑ Do the services in question qualify within the "medical services" exclusion?

In answering the first question, school divisions must determine whether the service is needed to enable the student to reach, enter, exit or remain in school during the day Examples of services held to be supportive services necessary for the child to benefit from special education include tracheostomy care, gastric tube care, and clean intermittent catheterization

However, some courts have held that mere supportiveness may be too broad a criterion to be the test for whether a service is necessary to assist a child to benefit from special education The courts have stated that some services may exceed the intent of the regulation These courts state that the analysis must focus on whether the service may be considered necessary for educational purposes (a supportive service necessary for the student to benefit from special education), or whether the service is primarily a response to medical, social, or emotional problems that is necessary and apart from the learning process For example, the provision of kidney dialysis is primarily for medical/health reasons, not for educational reasons This prong of the analysis is the weakest prong since it requires the Solomon-like task of separating educational needs and noneducational needs when the needs may be inextricably intertwined

The second prong is the key to the analysis and it requires a determination of whether the service in question is a school health service or an excludable medical service Over the years, most courts have rejected a strict reading of the definitions of "school health services" (i e , services provided by a qualified school nurse or other qualified person) and "medical services" (i e , services provided by a licensed physician to determine a child's medically related disabling condition which results in the child's need for special education and related services Instead, the courts have looked at four criteria in making the determination of whether a requested supportive service is a school health service and, therefore, a related service, or a medical service that is not for diagnostic or evaluative purposes and, therefore, not a related service We refer to the criteria as "the 4 C's" --

Complexity of the service
Continuity of the provision of service
Competency required of the person providing the service
Cost of the service

Using the criteria set forth above, courts have determined that tracheostomy care, gastric tube care and clean intermittent catheterization are school health services Some services have been held to be more in the nature of medical services (e g , services that are varied, intensive, time-consuming,

expensive, require expertise and constant attention) even though performed by persons other than licensed physicians. An example of a service that courts have held to be within the medical services exclusion, even though not performed by a licensed physician, is constant respirator assistance by a nurse. Also, assistance requiring a combination of services such as the provision of continuous supply of oxygen, administration of medication through a tube, administration of saline solution into the student's lungs, chest physical therapy, and suctioning out mucus collected in the student's lungs has also been held to be an excludable medical service even though performed by someone other than a licensed physician Although these services do not fall squarely within the definition of excludable medical services because they are not performed by a physician, it has been held that the legislative intent behind the exclusion of certain medical services (i.e., services performed by a licensed physician that are not for diagnostic or evaluative purposes) was to spare schools from an obligation to provide services that might be unduly expensive and beyond the range of their competence While the services are not performed by a licensed physician, it has been held that they are more in the nature of medical services

It is important to note that these factors (complexity, continuity, competency and cost) are only for the purpose of determining whether the school division is required to provide and pay for those services that the student needs performed during the school day Even if after addressing these factors it is determined that a school division is not responsible for providing a service because the service is a medical service, not a school health service, the student is still eligible to receive educational services from the school division The factors discussed above are not factors for determining whether the student will attend school

Prevalence Data for Children With Selected Special Health Conditions

Table 1

Estimated Number of Children in Virginia With Selected Special Health Conditions, State Fiscal Year 1992

Disorder	Prevalence Per Population	Number of Cases of Disorder in Virginia Based on Rate
Arthritis (Juvenile Rheumatoid)	1 1/1,000	1,837
Asthma	10/1,000	16,700
Cerebral Palsy	2 5/1,000 (0-20)	4,175
Cystic Fibrosis	0 2/1,000	334
Diabetes	1 8/1,000 (0-20)	3,006
Hemophilia	0 15/1,000 (0-20)	250
Seizure (febrile not included)	3 5/1,000	5,845
Congenital Heart Disease	7/1,000	11,690
Muscular Dystrophy	0 6/1,000	1,002
Spina Bifida	0 4/1,000 (0-20)	668
Attention Deficit Hyperactivity Disorder	30-50/1,000	5,010-8,350
Enuresis/Encopresis	50/1,000	8,350
Mild Mental Retardation	39/1,000	6,513
Moderate Mental Retardation	10/1,000	1,670

HEALTH SERVICE PLAN GUIDELINES

- Information Gathering/Sharing Prior to School Attendance

  - ❒ Where possible, obtain early notification by the parent when a student with health needs is to be enrolled for the first time or returned to school following hospitalization

  - ❒ Provide necessary training prior to the student's arrival (e.g., nasogastric tube feeding, catheterization, stoma care, blood sugar monitoring)

  - ❒ Gather the student's medical history and status Obtain a signed release of information between the school division and the child's physician or any previously involved health facilities

  - ❒ Assess the current needs of the child Are there any community resources available to assist the child?

  - ❒ Determine the implications for the classroom Does the room need to be rearranged? Do objects need to be removed?

  - ❒ Develop health services plan

  - ❒ Prepare the student, classmates and personnel for the student's integration into the school setting (For confidentiality reasons, discuss with child's parents first)

- Planning Team

  Members of the planning team may include, but may not be limited to, the following

  - ❒ parent or guardian
  - ❒ teacher
  - ❒ administrator
  - ❒ school nurse or school health contact person
  - ❒ child (if appropriate)
  - ❒ special education administrator (if the child is receiving special education)
  - ❒ school division Section 504 coordinator (if the child is receiving services under Section 504)
  - ❒ guidance counselor
  - ❒ classroom paraprofessionals
  - ❒ building principal

- ❒ transition nurse
- ❒ Medicaid waiver case manager (if applicable)
- ❒ respiratory therapist (if applicable)
- ❒ equipment vendors (if applicable)

■ Components of a Health Services Plan

❒ Description of Child's Medical Condition

This section should include a complete description of the child's medical history, current medical status and effect of the medical condition on the child's performance in school

❒ Strategies to Support the Child in the School Setting

This section should specify activities in which the child may participate, and any adaptations or modifications which may be needed (e g , no contact sports, avoid contact with particles such as sand, powder or lotion, avoid contact with magnets or antennas which emit radio waves, avoid contact with animals, avoid milk products)

❒ Feeding and Nutritional Needs

This section should describe the child's current diet, food allergies, fluid intake requirements, feeding plan and oral-motor interventions

❒ Transportation Arrangements

This section should address whether the child will ride the bus or if special transportation arrangements will be made [The Virginia Department of Education has taken the position that students who need to be accompanied by a supply of oxygen cannot be transported by school bus with the high degree of safety which must be ensured by local school divisions If school divisions are required to provide the transportation service with oxygen in the vehicle, only the driver, aide and the child should be on the vehicle when the oxygen is present] Is there a need for a paraprofessional to accompany the student during transportation? Does the bus driver need to receive special training?

❒ Accessibility Issues

This section should address any issues relevant to accessibility to the restroom or other areas of the building

- ❒ Medication to be Dispensed

  This section should include the type of medication, the amount to be dispensed, the time the medication is to be dispensed, how the medication is to be dispensed, where the medication is to be dispensed, who is to dispense the medication, and the effect of the medication on the child's performance in school.

- ❒ Procedures to be Performed by School Personnel

  This section should outline the child's specific needs and which needs will be addressed in the school setting Each procedure should be described in detail

- ❒ Where and When the Procedures are to be Performed

  This section should include the location, frequency and time of day for the procedures

- ❒ Who Will Perform the Procedures

  The specific qualifications of the individual needed to perform the procedures must be considered prior to assigning responsibility to a specific person This is also a good place to examine the need for special support services such as a paraprofessional.

- ❒ Training

  - Training should take place prior to the child entering school
  - List who will provide the training and when it will be provided The training should be provided by a health care provider and not the child's parent The health care provider and parent can conduct the training together
  - Training should be child-specific
  - Training should include the delivery of the service to the child, the recognition of an emergency situation, and the implementation of emergency procedures Everyone who may be responsible for providing emergency care should be trained
  - The training should include an opportunity for supervised practice and documentation of competency

- ❒ Schedule for Review and Monitoring of Training

  This section should include timelines for regular review and retraining on the procedures An initial review of training should occur within the first month of the child's entrance into the classroom. The training should be updated when any changes in the child's health status or educational placement occur

- ❒ Emergency Procedures

  Address potential emergency situations based on the child's condition and the child's typical reaction Include common and child-specific warning signs and symptoms List the specific actions to be taken and the order the actions are to be taken, including persons to notify. Describe the dissemination plan for the emergency plan

- ❒ Plan for Absences

  - Staff Absences

    Assign back-ups for staff and ensure that these persons receive training

  - Child Absences

    Develop a plan for home-based instruction if the child becomes too ill to attend school Outline a procedure for receiving an update on the child's health status prior to the child returning to school after an extended absence Review/revise plan after a major illness or hospitalization

Study Methodology

Development of a Definition

Many terms and definitions are used to identify children who are often referred to as "medically fragile". To clearly identify this population of children and the scope of the study, definitions from a variety of sources were incorporated into a specific definition The study team's definition of "medically fragile child" was derived from terminology and conditions identified by the Maryland ARC, and included definitions from Surgeon General Koop, the Office of Technology Assessment, the Council for Exceptional Children, and the American Academy of Pediatrics. The composite definition of children who are medically fragile used in this study emphasizes the various levels of services which may be required and the possibility of adverse physical consequences should those services not be provided

Data Collection

Public School Survey

Survey of the Population Being Served Under Part H of the Individuals with Disabilities Education Act