Translating Strategies into Actions to Improve Care Coordination for Students with Chronic Health Conditions

NASN
National Association of School Nurses

Collaboration to Support Students with Chronic Health Conditions

Education and Health Partnerships

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INTRODUCTION

In the United States, about one quarter of children and adolescents have a chronic health condition such as asthma, food allergies, seizure disorders, diabetes, or poor oral health.[1] Each day, these and other health conditions must be managed for the student to remain present and ready to learn at school. Evidence demonstrates the important link between student health and academic success.[2]

While federal and state regulations require schools to provide services and accommodations for students with chronic health conditions, efforts to do so at the school level are often disjointed. School leaders and personnel may receive little or no guidance from the district or state levels—or from education or health agencies—to implement structured protocols or algorithms for collaboration and coordination. Yet research suggests that students who receive direct healthcare and/or care coordination have fewer visits to healthcare provider offices, urgent care centers, and emergency rooms, and report fewer hospitalizations.[3]

Care coordination is a key principle in school nursing practice for the 21st century.[4] The National Association of School Nurses (NASN) identifies Care Coordination as one of five key principles in the *Framework for 21st Century School Nursing Practice*.[4] NASN takes the position that care coordination and its related practice components guide the school nurse and provide the mindset to manage chronic health conditions in school-age children.

Healthcare providers and insurers often speak about care coordination[5], but the term can be confusing within the school community because it has different connotations for families, healthcare providers, community stakeholders, and schools. As other healthcare systems—including primary care, specialty care, community-based care, and inpatient care—have implemented care coordination strategies (such as engaging families and optimizing teams), they often have not included schools in the conversations. In addition, the school nurse's role in care coordination of students has often been misunderstood. The definition of care coordination, its key characteristics, and resulting care coordination activities must be tailored to include all those who interact with children in the school and larger community. Accomplishing this requires the collaboration of multiple stakeholders and a unified vision.

"My teacher reminds me to go to the nurse to use my inhaler, every four hours. And I go to the nurse if my lungs feel tight or I can't breathe. The nurse gives me my inhaler and records it."

Ellie, 4th grader
Chronic health condition: Asthma

For this reason, NASN convened its *Strategy to Action Roundtable* in Atlanta, Georgia, in April 2018. Funded in part by the Centers for Disease Control and Prevention (CDC), the 1½-day workshop had three objectives:

- Articulate a common definition of care coordination for school and community stakeholders and decision makers to guide management of students' chronic health conditions.
- Identify factors in schools and communities that facilitate or impede implementation of policies and practices for care coordination of students with chronic health conditions.
- Discuss approaches for translating strategies for care coordination into actions to provide effective management of chronic health conditions in schools.

Participants included school nurses, public health representatives, community-based healthcare providers, school administrators, parents/caregivers, researchers, and the project's national advisory board (see the Acknowledgments section). After hearing from several experts in the field and reviewing numerous definitions of the term *care coordination*, the participants crafted a new definition customized for the school community.

Next, drawing on background information that included a literature review and environmental scan*, the participants expanded upon CDC-recommended strategies to develop suggested actions which school communities can take to improve care coordination for students with chronic health conditions. Although not physically in attendance, several students provided short videos describing their experiences with managing their chronic health condition at school. These personal perspectives greatly informed the roundtable discussions.

*In addition to the environmental scan, notes from the National Association of Chronic Disease Directors' (NACDD) *School Health Open Forum: Supporting Students with Chronic Conditions* (April 12, 2018, presented by Dr. Mary Kay Irwin of National Children's Hospital, Columbus, OH) and the NACDD *Management of Chronic Conditions in Schools Community of Practice/1305 2017-2018 Summary* also provided valuable foundational information.

Recommendations for All Stakeholders

The in-depth discussions that took place during the roundtable produced the recommendations outlined on the following pages. Participants also suggested the development of numerous tools and resources and identified additional partners for schools to engage in support of care coordination for students with chronic health conditions. This document is not meant to be a prescriptive specification, but rather a springboard for potential steps that schools and school districts can take to support students with chronic health conditions, helping those students achieve health and academic success with school nurse-led care coordination.

Health and education leaders in local school communities—especially those responsible for implementing programs that support the health and academic success of students—are the primary audience for this document. The secondary audience includes state health and education leaders who are positioned to support system change at the individual school and district levels.

Note: While these recommendations focus on students with chronic health conditions, care coordination can be applied to the entire student population to promote health, well-being, and academic success.

SCHOOL NURSE-LED CARE COORDINATION

After roundtable participants had reviewed existing definitions and gathered input from experts in the field, they crafted a new definition for *care coordination* for the school community:

Care coordination refers to the oversight and alignment of multiple evidence-based components and interventions that support the health and well-being of students with chronic health conditions.

While led by the school nurse, care coordination requires various stakeholders to work together as a united team to address student health and academic success. This team-based model requires consistent engagement and communication among the student, parents/caregivers, community-based providers, and others who interact directly with the student. Their goal: Manage the chronic health conditions so students can remain present at school and ready to learn.

Effective care coordination enables students to independently manage their chronic health condition, as developmentally appropriate, both inside and outside of school. Characteristics of school nurse-led care coordination for students with chronic health conditions include:

- Making students and their families central to school-based healthcare, which requires an authentic connection between each student, each student's family, and the school.
- Going beyond medical issues to address the "whole child"[6] by considering behavioral health, family and social supports, and assistance with issues that hinder the student's ability to focus in school.
- Identifying the student's health and academic goals and related activities in collaboration with the student, the family, and the school health team (for example, school nurse, school psychologist, and/or unlicensed school personnel) and the medical management team (for example, the healthcare provider, pharmacist, physical therapist, and dentist).
- Incorporating the student's health goals and related activities into a student-centered plan of care—the Individualized Healthcare Plan (IHP)—to support student academic success and address family needs, concerns, and preferences. Based on healthcare provider orders and the nursing assessment of the student, the IHP reflects the team effort of students, families, healthcare providers, school

AN ARRAY OF DEFINITIONS[7]

Many definitions of care coordination exist, as illustrated below.

The deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for healthcare and community services are met over time. (NQF, 2014, p.2)

Pediatric care coordination is a patient and family centered, assessment driven, team based activity, designed to meet the needs of children and youth while enhancing the caregiving capabilities of families. Care coordination addresses interrelated medical, social, developmental, behavioral, educational and financial needs to achieve optimal health and wellness outcomes. (Antonelli, McAllilster, & Popp, 2009, p. vii).

Care coordination is referred to as the "glue" of our healthcare system, the process that transpires between patients, families, and members of the healthcare team to organize care and assures that everyone and every service is aligned and working toward the same goals. (Lamb, 2013, p. 3)

Care coordination should be a team- and family-driven process that improves family and health care practitioner satisfaction, facilitates children's and youth's access to services, improves health care outcomes, and reduces costs associated with health care fragmentation, which can lead to under- and overutilization of care. (AAP, 2014)

A person-centered, assessment-based interdisciplinary approach to integrating health care and social support services in which a care coordinator manages and monitors an individual's needs, goals, and preferences based on a comprehensive plan. (Berenson & Howell, 2009)

The lack of a common definition presents ongoing challenges to planning, implementing, and evaluating outcomes of care coordination for students with chronic health conditions. With that in mind, roundtable participants crafted a new definition specifically for the school community: **Care coordination refers to the oversight and alignment of multiple evidence-based components and interventions that support the health and well-being of students with chronic health conditions.**

personnel, and other appropriate community members. The IHP includes prevention measures; required school-level accommodations; treatment and emergency response; consent for information sharing across sectors; and expectations for recording and communicating incidents to parents/caregivers, community-based healthcare providers, and other partners.

- Translating information from the student's IHP to enhance team members' understanding. This may mean, for example, reviewing an emergency care plan with school personnel who have responsibility for the student or providing input to educational planning teams when health barriers may affect student's academic performance.
- Periodically assessing the student's progress in meeting the identified goals.

- Periodically convening collaborative meetings that include the student, family, and identified school and community stakeholders to ensure ongoing support takes a flexible, tailored approach. Adapting to developmental changes in the student and to circumstantial changes at home, in the community, and at school results in the best approach to meeting the student's health and academic goals.
- Harmonizing care coordination activities by addressing all aspects of a student's life that impact health, well-being, and readiness to learn and flow from the student's home, community (including the student's medical home), and school. This typically includes identifying community resources and support groups, educating school personnel, sharing data observations and care plan outcomes (with appropriate consent) with both the school's health team and the student's medical management team, and engaging with interprofessional stakeholders.

School Nurse Responsibilities

Because school nurses are on the front lines of providing care coordination for students with chronic health conditions, they have numerous responsibilities that fall into five main categories.

Surveillance and Case Finding

- Identify students who have chronic health conditions.
- Identify students who would benefit from care coordination in the management of their chronic health conditions.

Planning, Implementation, and Evaluation

- Provide for or facilitate care all day, every day. This includes school-sponsored events, such as field trips, and time on the bus going to and from school.
- Explain the in-school care coordination process to families and healthcare providers.
- Conduct a thorough nursing assessment that includes family capacity, student and family culture, social determinants of health and education, developmental needs, health literacy, and the student's school schedule.
- Develop an IHP based on orders from the healthcare provider, the nursing assessment, student/family priorities, school accommodations needed, and evidence-based strategies to address the health goals. The IHP identifies the human resources needed to implement it—such as unlicensed assistive personnel, licensed practical nurse, or registered nurse—as well as supplies, to be provided by the family, that are needed at school. It also includes community support groups and resources to address the physical, social, and emotional needs of students and families.
- On a regular basis, assess the student's progress in meeting goals identified in the IHP.
- On a regular basis and with appropriate consent, share data, observed trends, and care plan outcomes with the school health team and the student's medical management team.
- Develop an emergency care plan to address emergencies that occur at school.
- Participate in education planning teams, serving as the health expert who can address

"Sometimes when I take a test, my blood sugar is high—and when my blood sugar is high, I constantly have to go to the bathroom. Some teachers don't understand that. I have a nurse's pass, but sometimes they still don't let you go."

Nicole, 12th grader
Chronic health condition: Type 1 Diabetes

health barriers that may affect a student's academic performance.

Data Collection and Use

- Identify, collect, and use health and education data to inform school and community health professionals about the needs for and outcomes of care coordination programming. Data may be drawn from the School Health Index, Youth Behavioral Risk Surveillance Survey, Community Health Needs Assessment, or data collected by the school nurse as part of documentation.
- Measure progress in meeting goals for care coordination.

Education

- Provide consistent and credible messaging.
- Educate students and their families about improving self-management of chronic health conditions using specific and age-appropriate materials.
- Provide training for school personnel, families, and students on topics such as:
  - Links between student health, school attendance, and academic achievement.
  - Characteristics of a student-centered approach.
  - Impact of child and adolescent development and culture, including examination of potential gender differences in how youth might approach their chronic disease management.
  - Overview of the signs and symptoms of pediatric chronic health conditions.
  - Potential emergencies and how to respond.
  - Developmentally and age-appropriate self-care strategies for students.
- Use evidence-based, linguistic and culturally appropriate education programs, such as *Kickin' Asthma*, as well as multiple methods for dissemination of information (both in person and web-based).
- Include school-sponsored, out-of-school-time providers when disseminating information, resources, and trainings.
- When appropriate, educate school administra-

tion about the requirements for implementation of nursing delegation to identify, train, monitor, and evaluate unlicensed assistive personnel in support of a student's IHP.

- Provide training to healthcare providers on the best ways to collaborate with education leaders. Follow up after trainings to answer questions and address any misunderstandings.
- Deliver tiered training to school personnel.
  - Tier 1—General information about common pediatric chronic health conditions—such as asthma, diabetes, food allergies, and epilepsy—how to accommodate symptoms (such as fatigue), and how to respond to health emergencies.
  - Tier 2—Student-specific information (such as an emergency care plan) for school personnel responsible for a student with a known chronic health condition.
  - Tier 3—Student-specific information for unlicensed school personnel who provide direct care.

Student and Family Support

- Identify a process that supports a consistent flow of health information between the home and the school. Tell families which school personnel are responsible for collecting and processing information, and obtain the signatures required for exchanging that information. Develop forms that families find easy to understand.
- Talk with families about options for financial coverage of their child's health care.
- Connect families and students to community resources and partners, such as camps, support groups, affinity groups, and mental health and social services agencies.
- Connect families with primary or specialty healthcare providers, as needed.
- Help schedule healthcare appointments.
- Provide continuity of care during times of transition, such as when a student changes grade levels or schools, moves between inpatient healthcare and school or between pediatric and adult care, or experiences changes in family structure.
- Engage in community activities and identify resources that address social determinants of health which impact students and families, such as access to care, health insurance, transportation, stable housing, and sustainable food sources.

Roles and Responsibilities of Other Stakeholders

To be successful, student care coordination depends upon collaboration among a team of stakeholders. While the school nurse takes the lead in care coordination, the following stakeholders also have important and complementary roles and responsibilities in supporting students' management of chronic health conditions.

Families and Students

Schools are the first community setting where children manage their chronic health conditions without the direct supervision of family members, which can lead to family stress. Fulfilling these responsibilities can help reduce stress while

"My asthma has limited me during PE and recess, but my rescue inhaler helps me. The school nurse helps me by giving me my inhaler."

My'Teiz, 2nd grader
Chronic health condition: Asthma

increasing the likelihood of student health and academic success:

- Inform the school nurse of a student's chronic health condition and learn about the school's care coordination process.
- Understand the school's documentation requirements and how to submit the requested materials.
- Before each new school year begins, collaborate with the child's healthcare provider to obtain medical orders to provide care at school.
- Provide consent that allows sharing of information among the healthcare provider(s), family, and school/school nurse.
- Participate in development of the student's IHP and other education plans as appropriate, including the student's health and education goals.
- Establish a communication plan with the school.
- Provide notice of changes in the student's condition and/or changes in the healthcare provider's plan of care.
- Advocate for resources, policies, and practices in the school and community to support management of chronic health conditions in school.

Medical Healthcare Providers

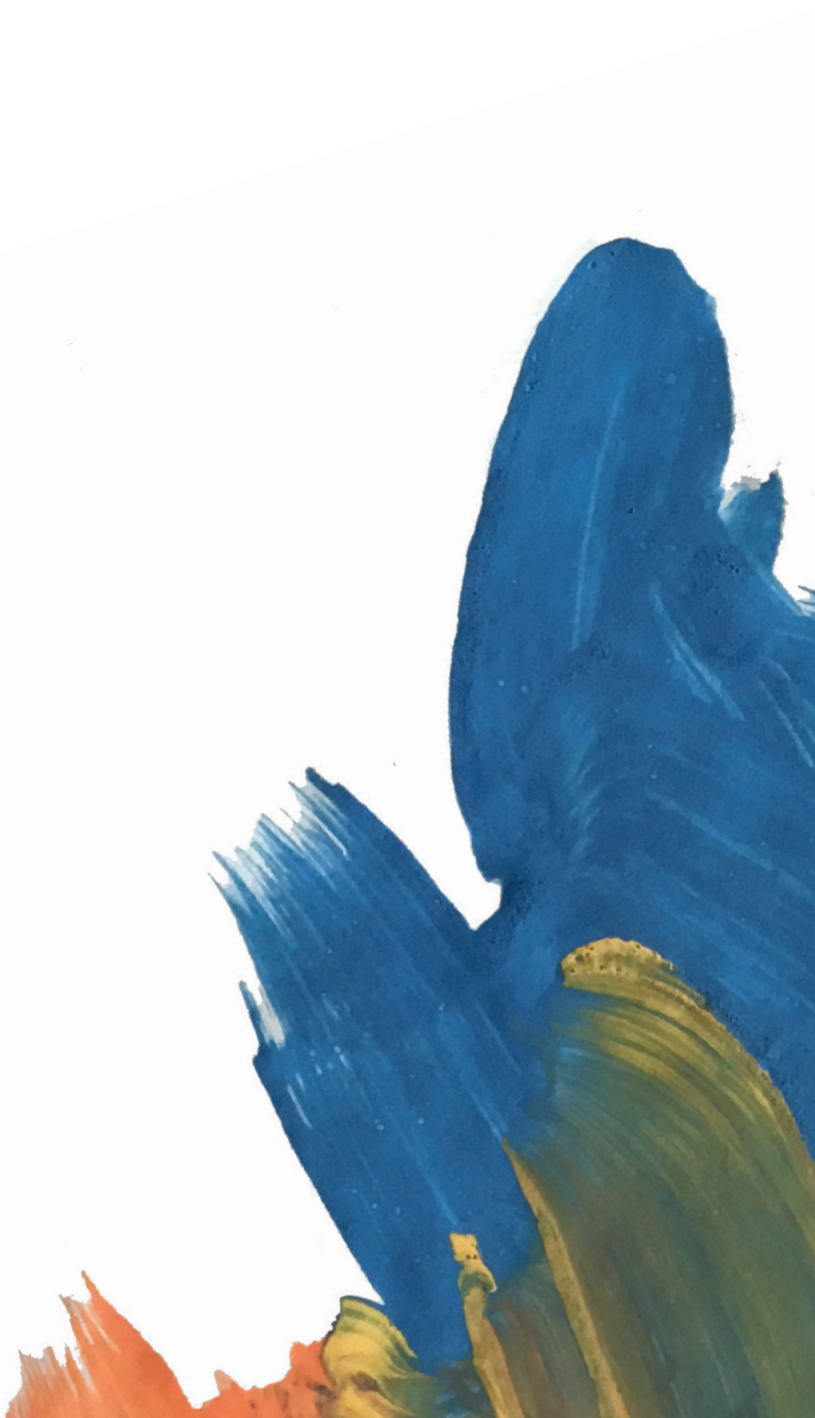
To provide for a seamless continuum of care, medical healthcare providers should:

- Connect with school nurses to become familiar with local schools' policies and practices, such as the documentation required, the consent required to share information, options for sharing electronic health records, and preferred communication channels.
- Have a process in place to communicate with the school as soon as a student's health status and/or treatment plan changes.
- Collaborate with schools to create a standardized approach to documentation for use in multiple schools or school districts.
- Provide professional development opportunities or information exchanges on topics related to care coordination for students with chronic health conditions.
- Serve as a school's healthcare provider or on a health-related committee, such as the School Health Advisory Committee or School Wellness Committee.

Schools

School nurses need the time and opportunity to engage in care coordination activities, such as conducting literature reviews, talking with healthcare providers and families, developing IHPs, and conducting individual and classroom education. In addition to prioritizing time for those activities, schools should:

- Promote a positive school climate where students can seek help from trusted adults[8].
- Require adequate staffing of on-site personnel to implement the plan of care, including access to a school nurse all day, every day.[9]
- Include school nurses on child health and education planning teams.
- Ensure school nurses have adequate resources and technology to carry out care coordination at school and school-sponsored events.
- Provide professional development for school nurses and school personnel, such as off-site learning opportunities, e-learning modules, print resources, collegial networks, and webinars.
- Address the importance of chronic health condition management at school during school or district-level professional development days.
- Educate school personnel on chronic health condition management for students. Content might include identifying the social and emotional needs of children and adolescents, particularly those with chronic health conditions; helping youth develop coping and self-advocacy skills; and recognizing the impact of trauma, Adverse Childhood Experiences (ACEs), and social determinants of health on students' education and ability to manage chronic health conditions.



MOVING FROM STRATEGIES TO ACTIONS[6]

After reviewing strategies for schools identified by the CDC and participating in in-depth discussions, the project team developed four recommended actions for improving care coordination. These recommended actions are intended to be led by the school nurse with the support and assistance of school health champions at the state and local levels, including families and the students themselves.

Action 1: Engage Families

Many families of students with chronic health conditions are not familiar with the comprehensive nature of school health services or with the policies, procedures, and resources to support them. They are often apprehensive about a school's ability to keep their children healthy and safe. Families may also have unmet needs that they don't necessarily mention and which health or education stakeholders don't always ask about.

By engaging families in the care coordination process, school nurses enable parents/guardians to share their perspectives and empower them to become better advocates for their children. These steps can facilitate family engagement:

- Create a welcoming, trusting, and inclusive school environment that emphasizes the value of family involvement. This involves providing staff development on how to engage families, as well as encouraging families to take active roles in changing the school health environment supporting their children.
- Educate families about the correlations among management of chronic health conditions, school attendance, and academic success, providing them with key questions to ask of the school.
- Provide training so families can more effectively advocate for the needs of their children at school. The topics should include expectations for school nursing, what school health services are available, and how those services can benefit the child.[8]
- Encourage peer support by providing opportunities for networking among families.
- Connect with families[8] through multiple school communication channels and events, asking how families prefer to be involved. Ideally, the school nurse should develop a plan for ongoing communication between the school and each family, utilizing school websites,

newsletters, email blasts, text messaging, and the family resource room.

- Work with families to prioritize school health activities and events in which to participate, such as the school wellness committee, community resources, and communication with the school and healthcare provider.
- Sustain family engagement[8] by creating a team to oversee this area—if an existing school health team does not already do so—and continually identify and address the challenges that keep families from becoming connected and staying engaged.

Action 2: Collaborate with Partners

Care coordination requires a team effort involving stakeholders from inside and outside the school. Traditionally these partners have worked independently of one another, often duplicating efforts and resources. Working together strengthens collaboration and communication related to the care of students, as well as builds a strong team to advocate for policy and system-level changes.

Led by the school nurse, a care coordination team can take these specific steps:

- Identify key health and education partners.
  - District superintendent
  - School principals
  - Paraprofessionals
  - Social workers
  - School counseling staff
  - General and special educators
  - 504 coordinators
  - School Resource Officers
  - Transportation staff
  - PTA/PTSA groups
  - Before- and after-school programs
  - Hospitals
  - Local healthcare providers (pediatricians, specialty providers)
  - Dentists
  - District school nurse supervisor
  - School-based health centers

CDC's STRATEGIES FOR SCHOOLS[10]

The Centers for Disease Control and Prevention (CDC) has identified strategies to increase and improve care coordination in schools and to support the roles and responsibilities of key stakeholders within the school community:

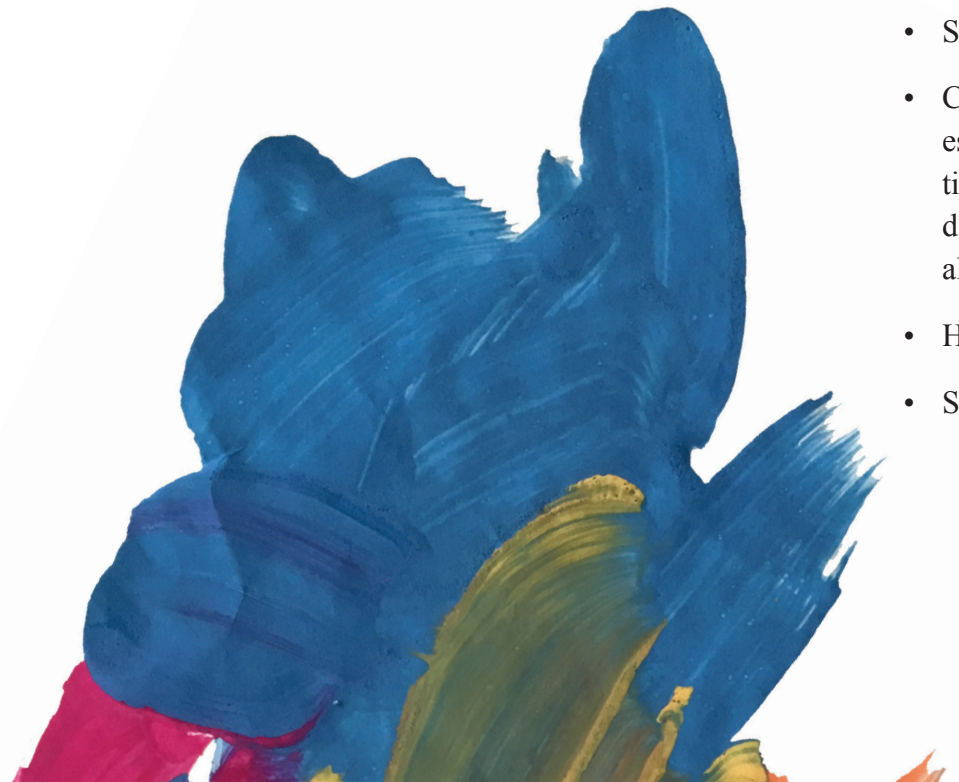
- Develop a coordinated system to meet the needs of students with chronic health conditions.
- Offer school-based health services and care coordination for students with chronic health conditions.
- Provide specific and age-appropriate education to students and their families to improve self-management of chronic health conditions.
- Ensure school staff have access to professional development opportunities that focus on improving the health and academic outcomes of students with chronic health conditions.
- Provide appropriate counseling, psychological, and social services for students affected by chronic health conditions.
- Provide a safe physical environment that has appropriate nutrition, physical education, and physical activity opportunities for students with chronic health conditions.
    - Health department (local and/or state)
    - Payers and insurance companies
    - Foundations
    - Universities
    - Local or state chapters of healthcare provider associations (for example, American Academy of Pediatrics, American Academy of Family Physicians)
    - State chapters of pediatric disease organizations (such as American Lung Association and American Diabetes Association)
    - State school nurse associations
    - State school nurse consultant
- Incorporate a focus on chronic health condition management into existing school health teams, such as the School Health Advisory Committee or School Wellness Committee. Ideally, expand the team's membership to include some of the key partners listed above and lead the team in creating, building, and sustaining a partnership that focuses on care coordination.
- Facilitate the sharing of expertise to enhance school health services in support of students with chronic health conditions. The goal is to create a common understanding of the barriers and facilitators associated with providing care coordination to these students and then addressing the concerns identified—such as securing consent, confidentiality of health and education records, state health and education laws, and federal laws. This may involve inviting healthcare professionals to join school personnel in discussing management of pediatric chronic health conditions and implications for the school setting.

- Collaborate with key partners on standardization of care coordination (for example, forms for sharing information).
- Identify a liaison—such as a school nurse supervisor or state school nurse consultant—who can encourage collaboration among education and health officers across the district and possibly between the district and state.
- Collaborate with disease-specific organizations, such as local affiliates of the American Lung Association or the American Heart Association, to produce resources and provide professional development.

Action 3: Develop, Expand, or Strengthen Systems and Infrastructure

Optimal care coordination requires having systems and infrastructure in place that support collaboration between health and education. Together with the school nurse, education officials should consider implementing the following steps:

- Develop and implement school and district policies to support and sustain care coordination for students with chronic health conditions. The policies should be flexible and not inadvertently punitive to students—particularly those related to grading, testing, or absenteeism. They need to accurately reflect state and federal laws, such as HIPAA and FERPA, and address such topics as:
  - School wellness
  - Chronic health condition management
  - School health services staffing
  - Information exchange among school, home, and healthcare provider
  - Confidentiality of student health information
  - Staff professional development
  - Consistency across education plans that establish expectations for accommodations for students with chronic health conditions (for example, 504 plans, Individualized Education Program plans)[8]
  - Home instruction
  - School-sponsored events



"When I was little, there was no full-time nurse so a secretary in the office was trained by the school nurse to help me check blood sugar. The nurse came at lunch to give me injections until I learned to do that myself.

"When I started wearing a pump and CGM [Continuous Glucose Monitor], it helped me be a lot more independent. But I still needed support. Now I am fully independent, carry everything with me, and check and treat in class. It keeps me from missing out on the learning even when I am having a rough diabetes day.

"One of the most difficult things about having diabetes in school is that people don't understand how serious it is. Because I look healthy and participate in sports and everything else, they don't realize it can be life-threatening at any moment—and that takes a lot of mental and emotional energy.

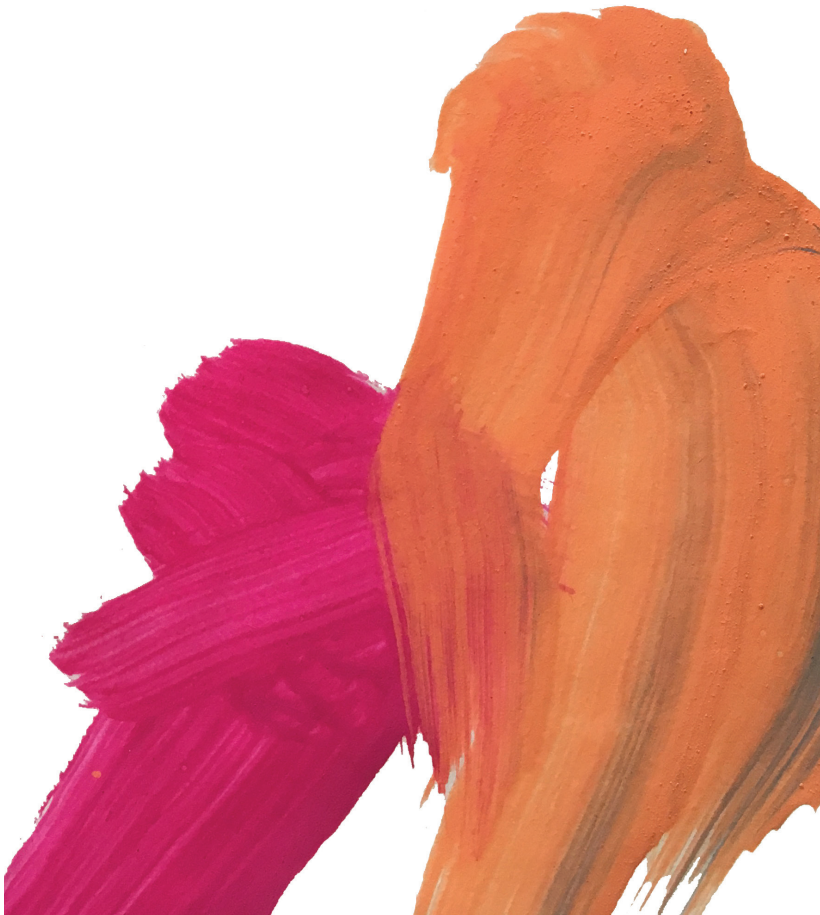
"We make it look easy, I think, but T1D takes a lot of behind-the-scenes work with the nurse so I can be safe and healthy, especially at school."

Sophie, 9th grader
Chronic health condition: Type 1 Diabetes

- Create policies that allow health forms to be updated every 12 months and as needed, rather than at the beginning of each school year.
- Develop a system for completing or updating health information before the new school year starts.
- Advocate for and implement evidence-based best practices—such as Medicaid reimbursement to schools—to support and sustain care coordination for students with chronic health conditions.
- Offer numerous opportunities for information sharing and timely communication between the school and families, employing letters home, "meet and greet" events, social media postings, cloud platforms, parent/family portals, family inclusion in school health planning, transition planning between schools, and transition planning between the school and healthcare setting.
- Create procedures to facilitate information exchange among the school nurse, family, and appropriate school personnel, as well as between the school nurse and healthcare provider. This may require obtaining legal assistance to explore options for record sharing and/or requesting district-level access to a direct communication channel with healthcare providers, such as secure HIPAA messaging.
- Advocate for technology resources, such as electronic systems that facilitate management and collection of data and sharing of information among providers.

- Promote use of telehealth programs that connect students to healthcare providers, especially when social determinants of health limit access to care.
- Make greater use of technology to improve workflow efficiencies and facilitate Medicaid billing. An electronic health system can effectively integrate health and academic indicators—such as attendance, discipline, grades, and time out of class—to support students and identify early warning signs of student challenges or concerns.
- Connect chronic health condition management to other school and community priorities. Examples include:
    - Chronic absenteeism
    - Positive school climate and culture
    - School wellness plans
    - Disaster/emergency plans
    - Community Health Improvement Plans
    - School Improvement Plans
    - Healthy lifestyles for the entire school community, not just students
- Include the school nurse on instructional teams and during creation of education plans for students with chronic health conditions.
- Standardize home instruction guidelines, such as establishing criteria for when a student is eligible for home instruction and the qualifications for home instruction teachers.
- Educate stakeholders on the need for every school to have access to a school nurse every day, all day, to ensure equity and access to evidence-based healthcare services.[9]
- Advocate for access to a medical healthcare provider in every school district.
- Focus advocacy efforts on closing system gaps (such as lack of comprehensive integrated data systems that include electronic health records, communication breakdowns, omission of school nurses from student health and education teams or community-based health teams, and lack of a school district physician or full-time school nurse on site.)

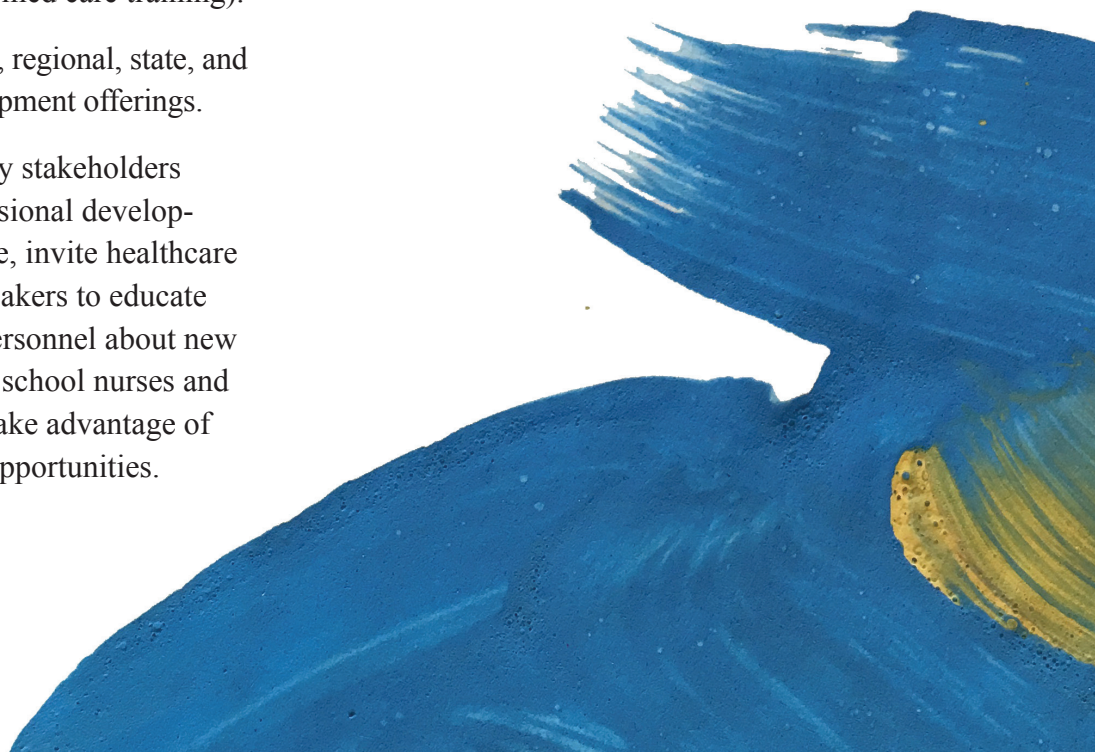
Note: To help strengthen school health policies, practices, and programs, use the CDC's *School Health Index* for routine assessment.[11]

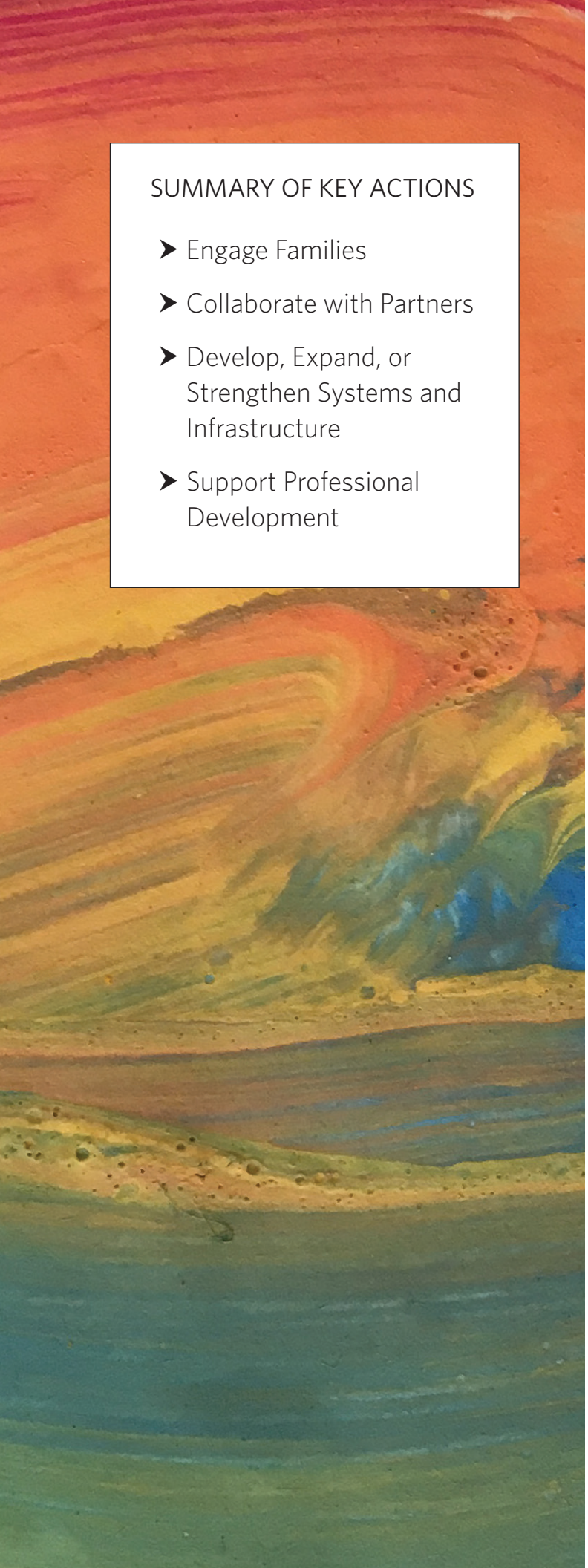


Action 4: Support Professional Development

Increasing understanding about the connection between student health and academic success is critical for developing the mindset of the school community. These steps emphasize that care coordination is a key non-academic support for students with chronic health conditions.

- At the state level, collaborate with the school nurse consultant, department of health, department of education, and leaders within the school nurse organization to provide state-specific professional development for school nurses.
- Disseminate professional development that is national in scope, including evidence-based clinical guidelines, the scope and standards of school nursing practice, NASN's *Framework for 21st Century School Nursing Practice*™[4], and the *Whole School, Whole Community, Whole Child* model.[7]
- To avoid duplication of efforts or resources, when possible coordinate and combine care coordination education with other tiered training for school personnel (for example, First Aid, CPR, and trauma-informed care training).
- Compile and publicize local, regional, state, and national professional development offerings.
- Collaborate with community stakeholders to garner support for professional development offerings. For example, invite healthcare providers or other guest speakers to educate school nurses and school personnel about new treatment protocols; enable school nurses and school personnel to easily take advantage of professional development opportunities.
- Develop a mechanism for delivering regular training to school personnel and community stakeholders on topics related to school health.
- Access federal Title II and IV funding to support professional development for school nurses and school personnel.[12]





SUMMARY OF KEY ACTIONS

- Engage Families
- Collaborate with Partners
- Develop, Expand, or Strengthen Systems and Infrastructure
- Support Professional Development

A Unified Call to Action

Health and education leaders who recognize the important link between student health and academic success will also recognize the need to collaborate on care coordination to help students manage their chronic health conditions while in school. Led by the school nurse, coordinated action steps—both great and small—undertaken by professional stakeholders can secure a student-centered approach to health and learning for students with chronic health conditions. These steps will benefit students, their families, and the educational mission of schools.

Collectively, we must put children first, engage the community, identify and use available resources, and press for additional health supports to ensure student well-being and academic success. For its part, NASN has made a commitment to working in partnership with stakeholders to develop materials such as fact sheets, training resources, templates, and forms to help schools improve care coordination for students with chronic health conditions (see Appendix).

For more information on supplemental messages, tools, and resources to implement the recommended actions, contact NASN at nasn@nasn.org or www.nasn.org.

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APPENDIX

NASN Tools and Resources in Development

Participants in the *Strategies to Action Roundtable* identified numerous ways that NASN can support state and local education and health partners in their work to promote care coordination to manage chronic health conditions in school-age children. Together with these partners, NASN will continue to work toward creating a "circle of support" for students with chronic health conditions. Through new or enhanced partnerships, NASN will amplify messaging about policy and program planning action steps and garner support for prioritizing care coordination in schools so students with chronic health conditions be healthy and ready to learn.

Suggestions from roundtable participants include:

1. Create fact/tip sheets or talking points for school administrators, parents/families, and school personnel. Topics might include:
    - How care coordination aligns with and supports ongoing efforts in education, such as ensuring a safe and supportive school climate and culture and reducing chronic absenteeism.
    - Consent and information on privacy laws and parental consent for information sharing to address perceived road blocks of FERPA and HIPAA.
    - Best practices for sharing information with the school, including medical forms, field trip forms, and other communication vehicles.
    - Examples from the field in identifying students with chronic health conditions to share among school staff.
    - Transition planning.
    - Delegation.
    - The role of each member of a child's "circle of support."
    - The school nurse's leadership role in care coordination.
    - Descriptions of various health and education plans, including IHP, ECP, 504 plan, and IEP accommodation plan.
2. Create sample letters for school nurses to send to students' homes.
3. Examine the possibility of supporting bi-directional data sharing between student electronic health records (EHR) at school and community-based healthcare providers. This would require training staff to utilize EHRs to coordinate care.
4. Develop and disseminate sample language to use in local wellness policies and/or emergency response and crisis management plans.
5. Continue educating stakeholders about the need for every school to have a school nurse, which ensures equity and access to evidence-based healthcare services, and access to a school physician in every school district.
6. Create and disseminate samples of materials for use by school nurses:
    - Standardized, user-friendly intake/medical management forms for students with chronic health conditions that can be used across different settings.

- An information packet for parents/caregivers that describes care coordination and the roles and responsibilities of stakeholders.
- Templates for standardized forms that cover a range of chronic conditions, for use in multiple settings.
- Guidance on state laws and regulations that limit or influence the use of standardized forms.
- Consent forms.
- Other forms that students with chronic health conditions need to complete before attending school.

7. Develop a model for a standardized school nurse orientation or professional development that includes care coordination concepts, based on NASN's Framework for 21st Century School Nursing PracticeTM.
8. Create and disseminate a tiered training model and materials for teachers and school personnel, based on the National Diabetes Education Program. Such content might be placed on a teacher learning hub as part of continuing education requirements.
    - Basic—signs and symptoms that identify problems
    - Intermediate—knowing how to do basic first aid or response functions
    - Advanced—assisting with chronic disease management
        - Tier 1: General information about common pediatric chronic health conditions (such as asthma, diabetes, food allergies, epilepsy), how to accommodate symptoms (such as fatigue), and how to respond to health emergencies.
        - Tier 2: Student-specific information (such as an emergency care plan) for school personnel responsible for a student with a known chronic health condition.
        - Tier 3: Student-specific information for unlicensed school personnel responsible for providing direct care.
9. Provide training to out-of-school-time personnel to enhance their professional development with basic, intermediate, and advanced levels of knowledge on chronic condition awareness and management (as described above).
10. Compile and share resources for specific professional development content (as described above). Audiences would include:
    - Education groups, such as teachers' unions and superintendents' associations.
    - National nonprofit organizations that promote student health and well-being in schools, such as Attendance Works, SHAPE America, Boys and Girls Clubs, Alliance for a Healthier Generation, Healthy Schools Campaign, American Cancer Society, and organizations representing out-of-school-time interests.
    - Associations representing the stakeholders listed above.
11. Develop social media examples for use on Twitter and Facebook.