State of
Chronic Absenteeism and School Health

A Preliminary Review for the Baltimore Community

April 2012

The Baltimore Student Attendance Campaign | Elev8 Baltimore

Baltimore Student Attendance Campaign

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About this report

This report was prepared by The Baltimore Student Attendance Campaign and Elev8 Baltimore, with support from the Annie E. Casey Foundation, Atlantic Philanthropies and Open Society Institute – Baltimore. Contributing to the report were Carson Research Consulting, Inc.,Michelle Gourdine & Associates, and The Hatcher Group.

About the Baltimore Student Attendance Campaign

The Baltimore Student Attendance Campaign builds on the collective energy of city and state agencies, parents, students, universities, foundations, public interest groups, and nonprofits. Its goals are to improve access to attendance data, develop positive preventions and early intervention strategies, address barriers to regular attendance, and initiate a campaign to make attendance a high priority city-wide.

About Elev8 Baltimore

Elev8 Baltimore partners with schools, families and the community to make sure that every student is ready to success in school and in life. The Elev8 Baltimore approach to school health empowers students and parents to take control of their own health. Students attending school in the Elev8 Baltimore network have access to confidential physical exams, immunizations, dental and vision services, and management of chronic conditions, such as asthma and diabetes. Our team of school health partners includes Baltimore Medical System, Johns Hopkins Medical Institutions, the Baltimore City Health Department, Healthy Teen Network, and Planned Parenthood of Maryland.

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Introduction

One in four students in Baltimore City were absent from school 20 days or more during the 2010-2011 school year—a proportion more than double the Maryland state average (MSDE, 2012). Excused or unexcused, students who are absent 20 days or more over the academic year are considered chronically absent. Chronic absenteeism is a recognized predictor of poor educational outcomes and is associated with school dropout (Baltimore Education Research Consortium 2011).

There are many reasons a student might miss school; physical or mental health conditions can be key contributors (Kearney 2007). Health-related issues can increase absenteeism (Moonie 2010), and there is evidence that access to school-based health services can improve attendance, health and education outcomes for students facing these challenges (O'Brien, 2010; Bruzzese, 2009; NASBHC, nd)

To address the problem of health-related absenteeism, Elev8 Baltimore and the Baltimore Student Attendance Campaign collaborated to prepare a preliminary review of absenteeism and school-based health services (referred to in this report as school health) in Baltimore City. This review aims to analyze existing data, policies, and programs to create a snapshot of what is currently being done to address health-related absenteeism in the city. While not an exhaustive analysis of school health, it is a first look into the links between absenteeism and school health from a local, state and national perspective. The purpose is to stimulate conversation and collaboration among stakeholders from diverse groups and perspectives. Ultimately, we seek to develop short- and long-term actions that can address absenteeism and establish a nationally recognized approach to school health.

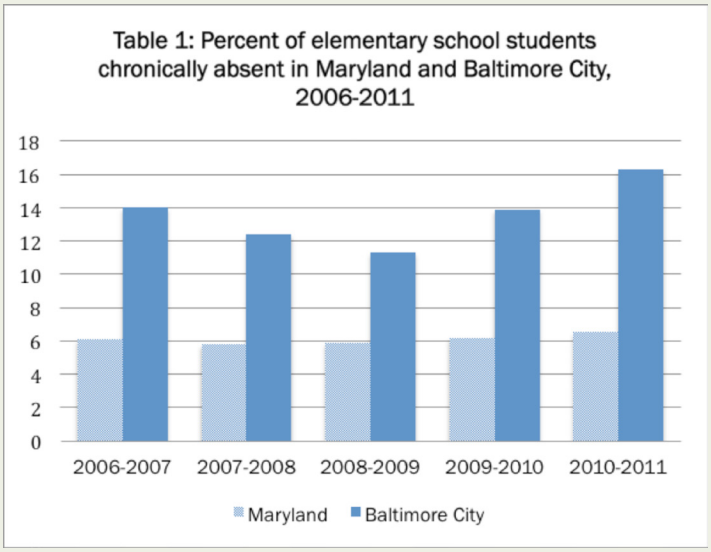
Defining Absenteeism

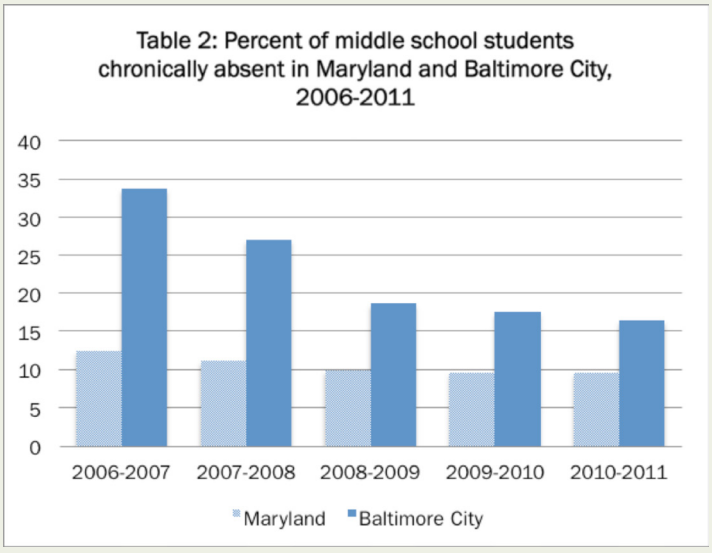
During the 2010-2011 school year, 25 percent of Baltimore City students were chronically absent compared to 11.3 percent of Maryland students overall (MSDE, 2012). Across the country, some localities, including Maryland, define chronic absenteeism as missing 20 days or more, while more define it as missing 10 percent of the school year. This makes it difficult to calculate a national chronic absenteeism rate or to compare rates between jurisdictions.

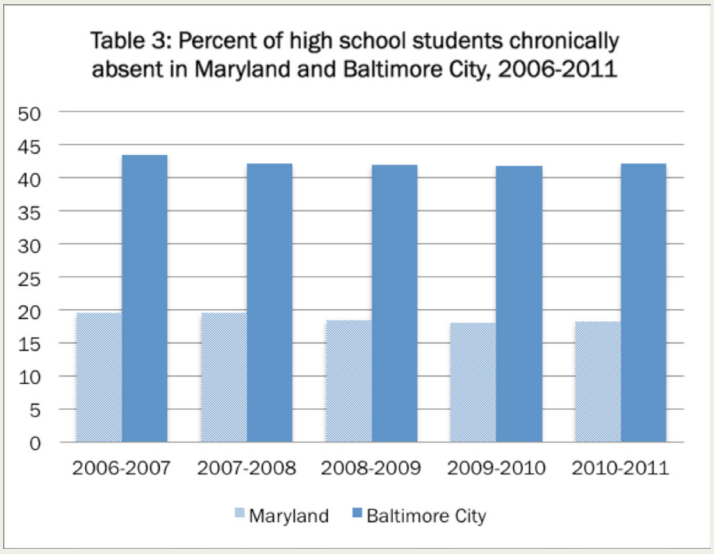
In Maryland, an absence from school can be excused for student illness, death in the immediate family, court summons, religious observation, school-authorized work or activity, hazardous weather conditions, state emergency, lack of authorized transportation, and suspensions. Any unexcused absence from school is considered an incident of truancy. In Maryland, there are four common ways that school attendance is calculated:

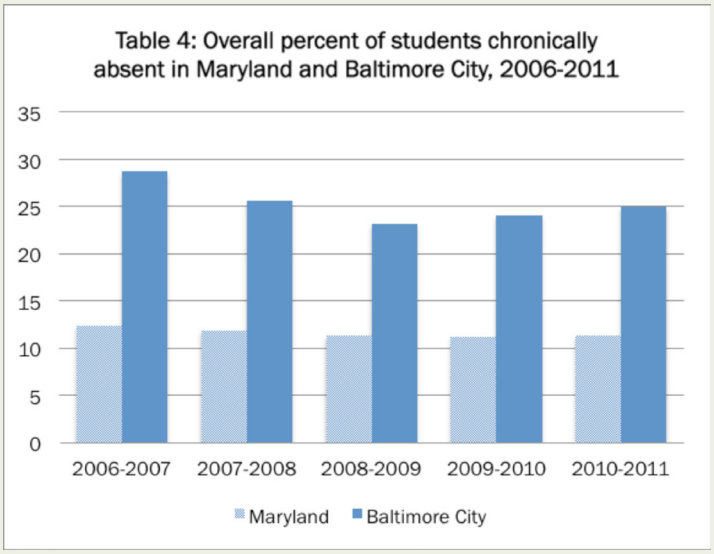
1. Average daily attendance: the total number of students present each day divided by the total number of students enrolled;
2. Habitual truancy rate: the percentage of students enrolled in school for 91 days or more that had unexcused absences for 20 percent or more of the days enrolled;
3. Rarely absent rate: the percentage of students who have missed fewer than five days, both excused or unexcused;
4. Chronic absence rate: the percentage of students who missed 20 days or more, both excused and unexcused. These measures do not give an accurate picture of the number of students that miss school for excused reasons and, more specifically, for preventable, health-related issues.

There is a persistent disparity between the percent of students chronically absent in Baltimore City compared to Maryland overall. The difference between the local and state levels is even more dramatic when looking at the percent of chronically absent students by school level. During the 2010-2011 school year in Baltimore City, 16.3 percent of elementary school students, 16.4 percent of middle school students, and 42.2 percent of high school students were chronically absent compared to 6.5 percent, 9.5 percent, and 18.2 percent statewide, respectively (MSDE, 2012). Tables 1-4 show the percent of students chronically absent in Maryland and Baltimore City from the 2006-2007 school year through the 2010-2011 school year.









Consequences of Chronic Absenteeism

Students who are chronically absent from school are more likely to fall behind academically, sometimes permanently, display behavior and discipline problems, leading to suspension and expulsion, and are more likely to drop out of school.

Students who are chronically absent miss out on valuable instruction time. This makes it difficult for them to keep up academically. Their absences can also affect the learning pace of their classmates, as teachers must try to bring absent students up to speed, while teaching to a different set of children in the classroom each day. A national study of chronically absent kindergarteners showed lower academic performance when they reached 1st grade. For poor children who are unable to make up for lost instructional time through other resources, this translated to lower 5th grade achievement (Chang & Romero, 2008).

By the 6th grade, chronic absences are a strong indicator of a future dropout. A study by the Baltimore Education Research Consortium found that students who were chronically absent in the 9th and 10th grades had higher dropout rates. Moreover, the study found that attendance for these students had actually begun to decline dramatically in the three years prior to their dropping out of school. The majority of students that drop out of school had missed between a year and a year-and-a half of school from the 6th grade to the point at which they dropped out (BERC, 2011).

In Baltimore City, the school district has developed procedures for addressing both consecutive and sporadic absences from school, as well as set of attendance best practices (Appendix B). The procedures involve the student, parent/guardian, and school staff at increasing levels, and focus on getting students with excessive absences back in school once an attendance problem is recognized.

For example, after six consecutive days absent, the school's attendance monitor or team should take steps such as consulting with the school nurse to determine from the student's absenteeism history possible reasons for the absences. After 10 sporadic absences, a home visit is coordinated with the family preservation specialist. The attendance best practices suggest ways that schools can improve attendance by setting school-wide priorities areas such as reaching out to students and families, data collection, and utilizing resources in the school and community.

Key contributors to chronic absenteeism

- Health and mental health issues
- Family barriers
- Financial Barriers
- Community and cultural barriers
- Personal barriers
- School-related factors

Causes of Absenteeism

City Schools conducted an analysis of district-wide attendance data, reviewed literature of best practices, partnered with the Student Attendance Work Group, and conducted focus groups with students from more than 15 high and middle schools in order to generate a list of common causes of poor student attendance. Barriers to attendance can be found at the personal, family, school and community levels, with reasons that include financial, health and mental health issues. The list (Appendix A), while not intended to be comprehensive, is a snapshot of problems that are linked to chronic absences.

Excessive absence and truancy can be indicators of deeper issues. It is imperative that teachers, principals and school support staff work closely with students, parents and community partners—with the full support of City Schools' district office—to address the underlying causes of school absenteeism by utilizing school and community resources in order to improve student attendance.

Linking Student Health and Absenteeism

Health outcomes have a direct and significant effect on school readiness, engagement, behavior, attendance, and academic performance (Basch, 2010). Children that live in urban areas with high rates of poverty are exposed to a higher number and greater concentration of risk factors such as high unemployment, teen pregnancy, crime, juvenile violence, and school dropout. Because of this, they face significantly higher risk for poor physical and socio-emotional outcomes. Some of the major health conditions and issues faced by children and youth in Baltimore City and their effect on school attendance are outlined in this section.

Uninsured students

The link between lack of health insurance and school absenteeism has long been established. Children without health insurance coverage commonly do not seek medical care, including preventive visits, and do not get prescriptions filled, increasing their risk of disease and episodes of school absences (Oslon, Tang, & Newachek, 2005). Although the exact number is unknown, one estimate put the number of uninsured children, aged 19 years or younger, in Baltimore City at 9,357 or 6.2 percent in 2009 (AECF, 2009).

Despite the availability of programs such as the Maryland Children's Health Program, many children in Baltimore remain without insurance. According to state regulations, students must complete a physical examination upon school entry. If students have not completed a physical due to lack of insurance, or any other reason, this is to be reported to the Baltimore City Health Department. After this initial assessment, it is not clear how often insurance status is assessed throughout a student's career in the City Schools.

Asthma

Asthma is a chronic respiratory disease that causes episodic attacks of wheezing, coughing, and shortness of breath; in its most severe form, it can be fatal. Children living in urban minority communities usually have higher rates of asthma in severe forms for several reasons, including limited access to health care and poor disease management. The prevalence of asthma in Baltimore is high. The number of children hospitalized for asthma in Baltimore City increased from 961 in 2008 to 1,071 in 2009 . The Centers for Disease Control and Prevention's (CDC) 2007 Youth Risk Behavior Survey (YRBS) indicated that among students in grades 9-12, 27.9 percent of Baltimore City students in reported that they had ever been told they had asthma compared to 23.7 percent in Maryland and 22 percent nationally (in 2009) (CDC, 2011).

In 2009, **1,071** children in Baltimore City were hospitalized for asthma.

Asthma is one of the major risk factors associated with chronic absenteeism and affects absenteeism on several different fronts. Acute asthma flare-ups may cause children to miss school in order to receive medical attention. In addition, asthma also decreases a student's cognition, connectedness with and engagement in school and thus decreases student motivation to attend and succeed in school, consequently lowering the chances of educational attainment (Basch 2010). Studies show a correlation between asthma status and absenteeism, and that absenteeism increases with worsening severity (Moonie, 2006; Moonie, 2008).

Why asthma is a risk factor for chronic absenteeism:

- Hospitalizations
- Need to avoid environmental triggers at school
- Sleep deprivation

Lead Exposure

Lead poisoning is one of the most pervasive pediatric environmental hazards in the United States. Approximately 250,000 U.S. children aged 1-5 have elevated blood lead levels (EBLL)[1] (CDC, 2012). Maryland has historically had significantly higher numbers of children with confirmed EBLLs. In 1998, 22.2 percent of child age 0-6 tested in Baltimore had an EBLL compared to 8.7 percent in Maryland and 7.7 percent nationally (MDE, 2000; CDC,

Promising Practice: Asthma-Friendly School Initiative

The Maryland Asthma Control Program implemented the Asthma-Friendly School Initiative to maximize asthma management and reduce environmental asthma triggers in schools. The initiative is an effort to coordinate existing policies and programs to support students with asthma. Many of the elements of the initiative are also supported by state regulations and school health services standards.

There are six components of an asthma-friendly school:

- identifying and tracking students with asthma
- maximizing asthma management through the use of asthma action plans and case management
- coordination of asthma management with parents/guardians and health care providers
- supportive policies regarding access to asthma medication
- proactive maintenance of buildings and school facilities to reduce asthma triggers and improve indoor and outdoor air quality
- asthma education for students and staff.

Schools can apply for training and assistance to become an asthma-friendly school and can be awarded for reaching and maintaining levels of asthma friendliness. As of 2011, 32 Baltimore City schools were designated asthma-friendly.

1 An EBLL is a blood lead level greater than 10 micrograms of lead per deciliter of blood, the level at which the CDC recommends public health actions be initiated.

2011). There were concerted efforts to decrease lead poisoning levels in the late 1990s and while levels for the state have dropped significantly, the percent of children that test positive for EBLL in Baltimore City remain above both the state and national levels. In 2009, 1.8 percent of tested children ages 0-6 in Baltimore City had EBLLs compared to 0.5 percent in Maryland and 0.64 percent nationally (MDE, 2010; CDC, 2011).

Elevated amounts of lead in the body are toxic, especially to children; lead poisoning affects major organs including the heart, kidneys, bones and nervous system. Long-term exposure to lead in children may lead to permanent learning and behavior disorders. Characteristics of lead poisoning that have implications for learning include: lower overall IQ levels, deficits in speech and auditory processing, lower reading levels, attention and behavior disorders, increased levels of distractibility and daydreaming, lack of organization and persistence, difficulties following directions, and higher rates of dropping out of school (Coalition to End Childhood Lead Poisoning, 2012).

Elevated blood lead levels among children ages 0-6 were **3.6 times** more prevalent in Baltimore City, compared to the Maryland state average.

Promising Practice: Coalition to End Childhood Lead Poisoning

The Coalition to End Childhood Lead Poisoning is a national non-profit organization that creates, implements, and promotes resources, programs and policies that aim to eliminate childhood lead poisoning and home-based environmental health hazards. Their services include family advocacy, legal services, outreach and education, policy and legislation, lead hazard reduction, and technical assistance for cities, states, and other programs in developing their own comprehensive lead elimination plans.

Behavioral Health Issues

ADHD

It is estimated that more than four million school-aged children in the U.S. have received a diagnosis of Attention Deficit/Hyperactivity Disorder (ADHD)[2] (Pastor & Reuben, 2008). A survey of parents in 2007 reported 10.4 percent of children in Maryland ages 2 to17 had ever been diagnosed with ADHD, compared to 8.2 percent nationally. This was an increase for Maryland from 8.0 percent in 2003 (Data Resource Center for Child & Adolescent Health, nd). In 2007, a six-month estimated prevalence of 4.1 percent of Baltimore City youth ages 9 to 17 were currently diagnosed with ADHD and 10.3 percent had a current diagnosis of any type of disruptive behavior disorder (BMHS, 2011).

10.3 percent of Baltimore City youth aged 9-17 were diagnosed with a disruptive behavior disorder in 2007.

Children with ADHD experience many problems in school that mainly stem from their inability to concentrate. Children affected by ADHD are more likely to exhibit tardiness and absenteeism due to sleep problems caused by the disorder. Long-term retrospective studies have shown that youth diagnosed with ADHD are almost three times more likely to drop out of school compared to other students because of their symptoms, which contributes to low levels of educational attainment (Barbesi, et al., 2007). The presence of a medical professional in the school who can administer medications is an important resource for students in managing their ADHD, allowing them to remain in school.

2 ADHD refers to a heterogeneous spectrum of behaviors usually observed initially in children between the ages of three and six concerning focusing attention, hyperactivity, or both that causes functional impairment in school, home, and other social context.

Violence

Children exposed to violent and aggressive behavior at home or in school may develop mental health and behavioral problems that ultimately influence educational outcomes. Exposure to violence limits academic progression by either increasing depression or disruptive behavior (Youngblade, et al., 2007). Children who experience depression typically have intrusive thoughts, lower energy and motivation, and poor concentration. In contrast, children who exhibit disruptive behavior may show signs of aggression, impulsiveness and hyperactivity (Schwartz & Gorman, 2003) all of which contribute to academic difficulty. Violence exposure, especially in schools, is also linked to absenteeism. Fifty percent of suspensions during the 2010-2011 school year in Baltimore City were for attacks, threats, or fighting compared to 30 percent statewide (Maryland State Department of Education, 2012). Children who are victims of violence in school are more likely to report that they do not belong in school; in addition, children who perceive school as an unsafe place are more likely to avoid going to school (Brookmeyer, Fanti, & Henrich, 2006). More data is needed on the prevalence of depression and anxiety among Baltimore City youth.

Food Insecurity and Nutrition

Food insecurity refers to the limited or uncertain availability of nutritionally adequate and safe foods, or the limited and uncertain ability to acquire acceptable foods (Cook & Frank, 2008). Food-insecure families often cope by skipping meals or by relying too much on low-cost unhealthful food, leading to an increased risk of poor health, malnutrition, or obesity. According to a report by the U.S. Department of Agriculture, 14.5 percent of households were food-insecure at some point in 2010. In all, 16.2 million children lived in food-insecure households. On average, 12.5 percent of Maryland households were food-insecure from 2008 to 2010 (Coleman-Jensen, et al., 2011). The likelihood of being food-insecure increases with poverty. In Baltimore City, 28.4 percent of children live below the poverty level;[3] 35.4 percent of children live in families receiving Supplemental Nutrition Assistance Program (SNAP)[4] or cash assistance (Emple, 2011).

35.4 percent of Baltimore City children live in families receiving Supplemental Nutrition Assistance Program or cash assistance.

Food insecurity has detrimental effects on physical and mental health and academic and behavioral functioning of school-aged children. Studies using the National Health and Nutrition Examination Survey (NHANES III) have shown that children who experience food-insecurity have poor health, are

Promising Practice: Expanded School Mental Health Services

School-based mental health programs provide a number of prevention and intervention services, delivered in a school setting by school system personnel. Expanded school mental health (ESMH) aims to build upon this by expanding the level of services for youth by building partnerships between the schools, families, and the community. Baltimore City Public Schools began implementing ESMH in the 2008-2009 school year. Mental health providers from the school and community collaborate to implement a full array of prevention, mental health promotion, early intervention, and treatment programs for students. In the 2010-2011 school year, 102 schools had a clinician as part of this effort. An example of this is the 6th Grade Expanded School Behavioral Health Initiative – a collaboration between City Schools, Baltimore Substance Abuse Systems, and Baltimore Mental Health System. It was designed to provide targeted mental health and substance abuse prevention to 6th graders at risk of dropping out. Preliminary results of the initiative showed an increase in math and reading assessment scores and in attendance from the previous school year for students that participated compared to their peers (Baltimore Mental Health Systems, 2010).The initiative was in 37 Baltimore City school during the 2009-2010 academic school year (Baltimore Mental Health Systems, 2011).

3 In 2011, the poverty level for a family of four with two children was a yearly income of less than $22,811 (U.S. Census Bureau, 2012).
4 For October 2011 through September 2012, the qualifying income level for SNAP for a family of four was a gross yearly income of less than $29,064 (United States Department of Agriculture, 2012)

at greater risk of malnutrition and iron deficiencies, and suffer more from headaches, stomachaches and colds compared to children who come from food-secure homes (Alaimo, Olson, Frongillo, & Briefl, 2001; Cook & Frank, 2008). Children who come from food-insecure families often suffer academically. They have lower math scores, are more likely to repeat a grade, have more difficulty getting along with other children, are more likely to be suspended from school and have higher absenteeism rates (Alaimo, Olson, & Frongillo, 2001; Jyoti, Frongillo, & Jones, 2005).

Obesity is an increasing problem in the United States among school-aged children. With the excess weight, children become more susceptible to diseases such as type II diabetes and hypertension. Overweight children are also exposed to negative social experiences such as peer rejection and bullying which may lead to behavior problems such as low self-esteem, anxiety disorders and depression. These mental health conditions may contribute to an overweight or obese child scoring poorly in school (Geier, et al., 2007). The 2009 Youth Risk Behavior Survey reported that 12.2 percent of Maryland high school students were obese while another 15.6 percent were overweight. This was comparable to the national average of 12.0 percent obese and 15.8 percent overweight. From an educational viewpoint, obese children and adolescents have been found to report many more missed school days than the general student population leading to poor academic performance (Taras & Potts-Datema, 2005). City-specific data is needed to develop a complete picture of the prevalence of the problem in Baltimore City.

Promising Practice: Family League of Baltimore City's Snack and Supper Programs

Recognizing that many Baltimore families struggle to provide good food to their children each day, the Family League of Baltimore City has participated in the At-Risk, After-School Snack and Supper Program for more than six years. These programs provide snacks and suppers to out-of-school time program throughout the city. The Family League is the largest provider of suppers in Maryland, serving more than 6,200 youth at 125 program sites in 2011.

Dental Health

Nearly **1 in 3** kindergarteners in Maryland had untreated tooth decay during the 2005-2006 school year.

According to the surgeon general's report on oral health in America, tooth decay is the single most common chronic childhood disease. Nationally in 2009, 4.4 percent of 2-4-year-olds, 6.2 percent of 5-11-year-olds, and 9.5 percent of 12-17-year-old children had unmet dental needs (NHIS survey). During the 2005-2006 school year, screenings of 1,292 Maryland public school students in kindergarten and third grade were performed. Almost 30 percent of the third graders and 33 percent of the kindergarteners had untreated tooth decay (Altema-Johnson, 2010). Better data collection is needed in this area to have a more complete picture of the situation in Baltimore City. In 2011, the Maryland Dental Action Coalition made mandatory school dental screenings one of its priorities.

Children in low-income families are twice as likely to suffer from tooth decay and are more likely to be untreated for the disease compared to children from more affluent families. Lack of medical insurance is a strong predictor of whether children receive proper dental care; uninsured children in the U.S. are two and a half times less likely to receive dental care than their insured counterparts, even though children from families without dental insurance are three times more likely to have dental needs than children with insurance.

Additionally, dental problems also affect children's ability to concentrate and to be present and active in school; more than 51 million school hours are lost each year to dental-related illness with children between 5 and 17 years missing

nearly two million school days in a single year nationwide due to dental health-related problems. In some cases, children with dental problems become susceptible to repeated infections in their ears and other parts of their bodies because their infected teeth are continually pouring pathogens into their systems, leading to an increase in missed school days (Sundaram, 2010).

Vision

Vision problems in children range in severity from mild refractive errors to permanent vision impairment and blindness. The most recent estimates of vision problems in school from the National Health and Nutrition Survey showed that 9.7 percent of 12-19-year-olds in the U.S. had vision problems with the rates of visual impairment significantly higher for minorities. More than 90 percent of the visual impairment among 12-19-year-olds was due to uncorrected refractive error which is often correctable with glasses (Vitale, Frances, & Sperduto, 2006). There is considerable evidence supporting the association between vision-related learning problems and educational outcomes.

Vision problems inhibit a student's ability to read a line of text. Students who have vision problems usually have shorter attention spans, avoid reading, lose their place when reading and have difficulty remembering what they read. More data is needed on the prevalence of vision problems in Baltimore City, but low-income and minority youth remain at greatest risk for under-diagnosis and under-treatment of vision problems, mainly due to their lack of access to eye care services. Although Maryland and City Schools regulations mandate some vision screenings for students in Baltimore City, they are not done for all grades. Additionally children and families may encounter barriers to acting on recommendations from these screenings. More city-specific data is needed on the status of vision screening and follow through in Baltimore City.

Reproductive Health

A teen birth[5] is any live birth to a girl under 20 years of age. In 2007, the Baltimore City teen birth rate was 66.4 births per 1000 teens aged 15-19, almost double the Maryland rate of 34.4 births per 1,000 and 1.5 times greater than the national rate of 42.5 per 1000 teens (Healthy Teen Network, 2010). In 2006, there were 1,739 babies born to young women under 20 years of age in Baltimore City. Of these, 65 percent were born to young women ages 18-19; 33 percent were born to girls ages 15-17 and 2 percent were born to girls under 15 (Healthy Teen Network, 2010).

In 2007, the teen birth rate in Baltimore City was nearly **double** the Maryland average.

Teen pregnancy is associated with poor educational and economic outcomes for both the teen mothers and children. Teens who become pregnant are more likely to be chronically absent, less likely to stay in school, and less likely to complete high school or college. These teens are also more likely to live in poverty and have subsequent non-marital teen births (Basch, 2010).

Current estimates show that nearly half of all teens in the U.S. have had sex and more than one-third are sexually active (have had sex in the past three months). The rates of sexually transmitted infections have historically been high among Baltimore youth. In 2007, the rate of chlamydia in 15-19-year-olds in Baltimore was 6,749.9 per 100,000; this was triple the Maryland state rate of 2,268.5 and the highest of all age groups surveyed (Healthy Teen Network, 2010). Although not directly associated, the high prevalence of teen sexual activity coupled with high rates of non-marital teen births has important educational, health and social consequences that contribute to the ability of a student to attend and succeed in school.

5 Teen births is used here as a proxy for teen pregnancy. The actual rate of teen pregnancy is difficult to measure because teen miscarriages, abortions, and pregnancies that do not result in a live birth are often not recorded accurately.

Standards for School Health

Centers for Disease Control and Prevention's Coordinated School Health Model

As discussed, there are many health-related factors and conditions that can contribute to chronic absenteeism. The CDC developed the Coordinated School Health (CSH) model to address the relationship between student health and well-being and educational outcomes. CSH is a systematic approach to improving students' health and learning in school. Recognizing that school health is usually a patchwork of different federal, state and local programs and policies, CSH proposes coordination between these many parts. This approach brings together school administration and staff, students, families, and community members to assess the school's needs, set priorities, plan, implement, and evaluate all health-related activities. There are four goals of this coordination: 1) increased health knowledge, attitudes, and skills; 2) increased positive behaviors and health outcomes; 3) improved education outcomes; and 4) improved social outcomes.

Coordinating school health into a systematic approach can help schools to

- eliminate gaps and reduce redundancies across the many initiatives and funding streams;
- build partnerships and teamwork among school health and education professionals in the school;
- build collaboration and enhance communication among public health, school health, and other education and health professional in the community; and
- focus efforts on helping students engage in protective, health-enhancing behaviors and avoid risk behaviors.

Promising Practice: Statewide CSH Success Stories

Tennessee was the first state in the nation to mandate and fund a coordinated approach to improving students' health in each of its school districts. This was the result of collaboration between Tennessee's Departments of Education and Health with support from non-governmental partners. They began their efforts to implement a CSH program by focusing on increasing awareness of and support for the model. In 2000, a five-year pilot program was implemented in 10 counties. Results of this pilot program showed reductions in absenteeism and increases in the availability of health and social services and opportunities to participate in physical education. School health advocates used these results to leverage $15 million to expand the CSH program statewide (CDC, 2008).

North Carolina's Department of Public Instruction and Division of Public Health established School Health Leadership Assemblies. The purpose of the Assemblies is to assist superintendents and health directors in promoting partnerships between public health and public education and to identify strategies and resources to improve student health and academic outcomes. As result of the assemblies, superintendents and health directors have become champions for CSH. Some of their accomplishments include creating a School Health Advisory Council in every school district and advocating for school nurses.

The California Department of Education's School Health Connection Program works with the Department of Health Services to conduct state and local leadership institutes. Participating school districts learned how to build organizational capacity for promoting school health programs and how to leverage other resources to support these programs. For example, the Los Angeles Unified School District created a CSH District Council, launched CSH pilot programs, formally adopted a Policy and Blueprint on Wellness, and created the district's first comprehensive program to address childhood obesity and diabetes.

There are eight components to the CSH model:

1. Health education to help students acquire the skills and knowledge to make healthy decisions, adopt health-enhancing behaviors and achieve health literacy;
2. Physical education to help students gain the skills and knowledge for a lifetime of participation in physical activity;
3. Health services to ensure access or referral to primary health care services;
4. Nutrition services to give students nutritious and appealing meals that reflect the U.S. Dietary Guidelines for Americans and other nutrition criteria;
5. Counseling, psychological, and social services to improve students' mental, emotional, and social health, including individual and group interventions, assessments, and referrals;
6. Staff health promotion to improve school staff health, contributing to improved health status, morale, and commitment to the school's overall coordinated health program and creation of positive role modeling for students;
7. Family and community involvement to respond to the health-related needs of students;
8. Healthy environment, both physical and psychosocial, to promote a healthy learning place.

Maryland Standards for School Health

The Code of Maryland Regulation (COMAR) for School Health Services Standards, developed in 1991, mandates health coverage in Maryland schools by a school health services professional. Below are the standards set out by COMAR for school health services (MSOS, 1991).

School health services for all students

Each school should maintain a health suite. There are two primary models of staffing at health suites: A school may have its own registered nurse (RN) or one that is assigned to several schools. The health suites are, at a minimum, staffed by a full-time health aide. Health aides are certified nurse's assistants and are able to work under the supervision of a nurse. School-based health centers (SBHC) are health suites that are staffed with a full-time RN and medical assistant, and a part-time nurse practitioner or doctor, allowing for a wider range of services to be offered. Staffing is determined based on school enrollment and need. Each school is required to submit detailed data on the services they provided. Health suites constructed or renovated after January 1, 1993, should be handicapped-accessible, include a lavatory, telephone, and space for waiting, exams and treatment, storage, resting, and private consultations. There should be a room provided in the school for conducting hearing tests.

Physical examinations are required for all students entering the Maryland public school system for the first time. The exams must be completed by a physician or nurse practitioner in the nine months before or six months after enrollment. Each year, each school should report to the local Board of Education or Health Department the number of students entering school without a physical exam because of lack of insurance, insufficient financial resources, or any other reason. These totals are then reported to the Maryland Department of Health and Mental Hygiene. Efforts are to be made to accommodate students and families in obtaining a physical exam, but students cannot be excluded from school for lack of one.

Identifying and assisting students with special health needs

A review of all student health records should be done by a designated school health services professional (DSHSP) or school health services aide. The review includes mental hygiene and dental records, and documenting the student's primary health care provider. Students with health problems or concerns identified through the review are referred to

a DSHSP for a health appraisal. The health appraisal may include health observations, interviews, screenings, and conferences with parents, students, educators, and other health professionals. If a health problem is identified through the health appraisal, students or parents or both should be notified and assisted in selecting recommended services by the DSHSP. Assistance can include identifying a primary care provider and follow-up, health counseling, and referrals. Screening should be in accord with the mandated or recommended screening programs from the Department of Education and Department of Health and Mental Hygiene and include hearing and vision screenings for students entering the school system or the 1st, 8th, or 9th grades. The results of the hearing and vision screenings are reported to the Department of Health and Mental Hygiene and, if possible, the number of students receiving recommended services is reported as well.

Students with special health needs that require particular attention during the school day should have a statement of those needs and a nursing care plan for emergency and routine care prepared by the DSHSP. The DSHSP should make appropriate school personnel aware of the students in the school who have special needs that may require intervention during the school day. The DSHSP and principal should identify school personnel that may need additional in-service training to provide recommended services and supports to students with special health needs. The DSHSP is able to serve on all levels of the student services team to ensure that students' special health needs are considered.

School health emergency services

At least one adult at each school other than the DSHSP should be currently certified in both the First Aid Program of the American Red Cross and in adult or pediatric cardiopulmonary resuscitation, and present during the regular school day and during school-sponsored athletic events. An emergency information card should be maintained for all students and updated at least annually.

Mental health services

Each school system in Maryland is required to provide school mental health services under a School Psychology Program. Through consultations, observations, and assessments, the program aims to prevent or remedy emotional, educational, or behavioral problems. Baltimore Mental Health Systems (BMHS) coordinates mental health services for Baltimore City schools. Previously, BMHS had contracted with various mental health providers throughout Baltimore City. During the 2011-2012 school year, BMHS moved to a new strategy of dividing the city into quadrants, each to be supported by one of four mental health agencies: Catholic Charities, Hope Health Systems, University of Maryland, Baltimore, or Change Health

Promising Practice: Student Attendance Work Group

The Student Attendance Work Group (SAWG) was a joint effort of the city of Baltimore and City Schools (December 2008 – March 2010). The work group was charged with investigating reasons for the high rates of student absence from school and identifying policies, practices and public, private and community resources necessary to dramatically increase the number of children who attend school every day. The SAWG developed a set of recommendations to address the problem of poor school attendance in Baltimore City. The group made recommendations such as improving attendance data collection and reporting, focusing on high-priority populations, emphasizing the use of incentives, addressing transportation issues, and improving student engagement. They also developed 16 recommendations for improving attendance through health services and interventions. These recommendations fell into four categories: 1) increase the number and scope of health services provided in schools; 2) leverage funding, partnerships, and resources to improve health services; 3) increase awareness, enrollment, and access to health services; and 4) implement practices that directly address the issue of health related chronic absenteeism through professional development and data collection strategies. A complete list of the recommendation is available in Appendix D.

Systems. That agency would supply all the mental health and substance abuse services to the schools in its quadrant. One hundred schools had an expanded school mental health service provider during the 2011-2012 school year. In 2008, just over 9,000 students in Baltimore utilized school based mental health services. In 2010, 47,979 students in 102 schools had access to an expanded school mental health program.

Physical education

A physical education instructional program should be provided for all students in grades pre-kindergarten to 8. A physical education program should be proved for grades 9-12 that enables students to meet graduation requirements. The Maryland Physical Education Content Standards include skillfulness, biomechanical principals, motor learning principals, exercise physiology, physical activity, and social psychological principals. The DSHSP should consult in planning, implementing, and evaluating those aspects of a physical education program that relate to the health and safety of participants. Additionally, any students involved in interscholastic sports should have a physical exam before participating. Coaches must complete a course on prevention and care of athletic injuries.

Staff development and dissemination of school health services information

The local Board of Education and Health Department jointly develop and annually implement an in-service training plan that includes an orientation to the school health services for all school staff and specific health programs required by federal, state, and local law for all DSHSPs. At the beginning of each school year, all parents and students should be informed of the school's health services program. This should include information on staffing, emergency care, medications, and communicable diseases.

The local school superintendent and the local health officer require the development of a local school health council with assistance from the Maryland State School Health Council. The DSHSP (other than a physician) and the school health services aide should receive nursing direction from a registered nurse designated by the local Health Department or the Board of Education. Health services provided in the school should be coordinated with other health services in the community. The local school superintendent and health officer should certify annually to the Department of Education and the Department of Health and Mental Hygiene that the school health services program meets the COMAR regulation and is being implemented.

Baltimore City Standards for School Health

School health services in Baltimore City are jointly managed by the Baltimore City Health Department and City Schools. Health services are provided in 192 health suites serving 206 Baltimore City public schools. In addition, the Baltimore City Health Department manages the school-based health center (SBHC) program. As of September, 2011, there were 19 SBHCs operated by the Baltimore City Health Department or Baltimore Medical System, a federally qualified health center. Appendix C gives an overview of the Baltimore City School Health Services. This includes the staffing structure, a comparison of services provided at health suites and centers, consent standards, financing, and evidence of effectiveness.

Baltimore City Schools Local Wellness Policy

In addition to adhering to COMAR, City Schools developed a Local Wellness Policy to promote and protect students' health, well-being, and ability to learn by creating school environments that support healthy eating and physical activity. The Policy outlines the coordination of City Schools and outside partners to actively promote student health (BCPSS Board of School Commissioners, 2006).

Nutrition Education Goals

Students in pre-kindergarten through 12th grade should receive behavior-focused nutrition education. Students in pre-kindergarten and kindergarten should receive three 30-minute sessions per week; 1st through 5th graders receive three 45-minute sessions per week; 6th through 12th grades receive one full semester of nutrition education.

In addition to nutrition education for students, opportunities for whole school professional development should be provided on one or more scheduled professional day each school year. Professional development opportunities should be provided for teachers delivering nutrition education in the context of comprehensive school health education. A member or members of the School Improvement Team should serve as the Local Wellness Policy Contacts, planning, implementing, and evaluating nutrition activities for staff, students and parents.

Physical Education Goals

All City Schools should comply with COMAR regulations on the requirements of physical education instruction and have a physical education curriculum aligned with the Maryland State Department of Education Voluntary State Curriculum Framework. Every student should have the opportunity to participate in a comprehensive physical education program

Nutrition Standards and Other School-based Wellness Activities

Schools should create an environment that provides consistent wellness messages. Programs that promote American Dietary Guidelines, such as Culinary Arts Club or Garden Club, should be an on-going part of after-school programs. All summer programs should include a nutrition education component. There should be regular opportunities for staff, students and families to participate in wellness activities and parent nutrition workshops should be implemented.

Promising Practice: Baltimore Medical System-operated School-based Health Centers

Baltimore Medical System (BMS) operates eight school-based health centers (SBHC) in Baltimore City. BMS has implemented standards and guidelines set out by both COMAR and the City Schools Local Wellness Policy, as well as developing procedures that address the issues of health-related chronic absenteeism.

There are several ways that BMS tracks and assesses chronic health conditions. Monthly tracking forms list the number of students identified with chronic health problems, among other health information. Students whose chronic illness is interfering with school attendance and performance may be referred to the Chronic Health Impaired Program (CHIP). CHIP is a Home and Hospital initiative through Baltimore City Public Schools that provides at-home supplementary and remedial instruction to students with chronic illnesses who are frequently absent from school. To be eligible for Home and Hospital services, students with medical needs must have a physician complete the Medical Application. BMS has also developed a chronic illness management plan that brings together the school-based health clinician, primary care physician, and parent to create an individual strategy for a student. Guidelines for Adolescent Prevention Services (GAPS) is a health assessment offered to every student that visits a BMS health center. The GAPS assessment identifies health areas of concern so that a clinician can follow up with the student. Areas covered in GAPS include depression and family planning. Students complete the assessment on their own. Additionally, hearing and vision screenings are required annually for students entering the 1st, 8th, or 9th grade, or who are new to the school system.

School health staff and other school staff such as social workers or parent advocates are needed to follow up with the parents and student to make sure that the student is enrolled. If the school health staff is unable to follow-up with the parent, the case is handed over to a Medical Access Coordinator who continues to try to connect the student with health insurance.

School meals should meet or exceed nutrition standard set by the USDA and the Maryland State Board of Education. There are several ways that BMS tracks and assesses chronic health conditions. Monthly tracking forms list the number of students identified with chronic health problems, among other health information. Students whose chronic illness is interfering with school attendance and performance may be referred to the Chronic Health Impaired Program (CHIP). CHIP is a Home and Hospital initiative through Baltimore City Public Schools that provides at-home supplementary and remedial instruction to students with chronic illnesses who are frequently absent from school. To be eligible for Home and Hospital services, students with medical needs must have a physician complete the Medical Application. BMS has also developed a chronic illness management plan that brings together the school-based health clinician, primary care physician, and parent to create an individual strategy for a student. Guidelines for Adolescent Prevention Services (GAPS) is a health assessment offered to every student that visits a BMS health center. The GAPS assessment identifies health areas of concern so that a clinician can follow up with the student. Areas covered in GAPS include depression and family planning. Students complete the assessment on their own. Additionally, hearing and vision screenings are required annually for students entering the 1st, 8th, or 9th grade, or who are new to the school system.

School health staff and other school staff such as social workers or parent advocates are needed to follow up with the parents and student to make sure that the student is enrolled. If the school health staff is unable to follow-up with the parent, the case is handed over to a Medical Access Coordinator who continues to try to connect the student with health insurance.

Critical Questions for Future Analysis

Pulling together the information presented in this report began with a desire to learn as much as possible about the connection between student health and chronic absenteeism. As a first look, it revealed a foundation of programs, policies and procedures on which more work can be done to move beyond the status quo to develop an innovative, comprehensive school health and attendance strategy for Baltimore City. Below is a set of critical questions for future research, discussion and planning.

Access to Data and Evaluation

- What is the current rate of health-related absences for Baltimore City?
- What is the prevalence of health conditions experienced by school-age children and youth? Specifically, rate of asthma, mental health disorders (ADHD, depression and anxiety), nutrition-related illnesses, dental disease, and reproductive health.
- What is the rate of registration for school health services?
- What kinds of health needs assessments are currently being conducted in Baltimore City schools? For which students are they done and how regularly?

Expansion and Sustainability of School Health Services

- To what extent is the staffing structure sufficient to meet the needs of students?
- What additional services are needed to respond more comprehensively to dental and vision needs of students?
- What is the best approach to link school-based health centers to schools in the community that have students who need expanded health services but are not eligible for on-site health center services?
- How do we improve coordination between school health clinicians – health aides, mental health therapists,

social workers, and others?

- How do we increase the implementation of standard assessments to improve the identification and treatment of chronic illness?
- How do we improve coordination between schools, community health centers, and hospitals to ensure students receive the appropriate prevention and treatment follow-up?
- What are the revenue sources for the funding currently contributed by the Baltimore City Health Department and City Schools?

Opportunities to Leverage Existing Programs, Policies and Procedures

- What existing partnerships and programs can be coordinated to improve health outcomes for students?
- How effectively are schools responding to health-related absences?
- How can schools better support school health services to collect data on uninsured families and proactively connect those families to health insurance?
- What support is needed to improve the implementation of health education and promotion in the schools?
- Given the presence of meal programs, how do we improve nutrition education in the schools?
- How can schools offer their staffs opportunities to improve their health and expand the number of schools with a coordinated health program?

Gaps in Programs, Policies and Procedures

- What additional programs are needed to meet the health needs of students and reduce health-related absences?
- What policy and procedural changes would increase data collection and improve school response to health-related absences?
- What additional financing is needed to improve school health programs and services?
- How are current health and wellness services and policies being evaluated for utilization, adherence, and impact?

Appendix A: Common Barriers to Student Attendance

Excessive absence and truancy can be indicators of deeper issues. It is imperative that teachers, principals and school support staff work closely with students, parents and community partners—with the full support of Baltimore City Public Schools' district office—to address the underlying causes of school absenteeism by utilizing school and community resources in order to improve student attendance.

City Schools analyzed district-wide attendance data, reviewed literature of best practices, partnered with the Student Attendance Work Group and conducted focus groups with students from more than 15 high and middle schools to generate a list of common causes of poor student attendance. The list, not intended to be comprehensive, is a snapshot of problems that are linked to chronic absences.

Health & Mental Health Barriers
Inadequate health services and lack of insurance coverage or regular physician visits
Child abuse and/or neglect
Child and/or parental depression
Drug or alcohol use and/or abuse
Poor nutrition
Asthma or other chronic illness
Dental, vision, hearing problems
Lack of immunizations
Financial Barriers
Insufficient food
Housing instability
Proper clothing not available
Homelessness
Parent unemployment
Problems communicating with social services
Students needing to work
Community/Cultural Barriers
Lack of safety in the community
Cultural traditions that are in conflict with the school calendar or school practice
Inadequate access to supportive services in economically depressed communities
Insufficient use of community agencies
Bullying due to cultural differences
Language barriers

Personal Barriers
Lack of information about the importance of regular and high attendance
Peer pressure or inability to maintain friendships
Lack of interest in education
Feelings of rejection and failure
Embarrassment due to lack of "fashionable" clothing or inadequate school uniform supply
Child believes the teacher does not like him/her
Low self-esteem
To meet with friends
Family Barriers
Insufficient parent support
Lack of family understanding of the importance of regular attendance
Child kept home for babysitting or caring for a sick parent
Family history of dropping out
Parent addicted to drugs or alcohol
Family instability inability to maintain a consistent home address or contact information
School
Teacher conflict
Inadequate communication with families about the importance of regular attendance
Failure to follow up with families when students exhibit poor attendance
Inadequate transportation
Fear of being bullied or cyber bullied
Inadequate programming – developmentally inappropriate educational experiences

BALTIMORE CITY
PUBLIC SCHOOLS

Attendance Best Practices

Implementation of these best practices is expected at all Baltimore City public schools during the 2011-12 school year.

1. **Make attendance a priority,** communicating attendance expectations to the whole school community.

2. **Establish attendance teams** that meet regularly to support school attendance plans and goals.

3. **Take action as early as possible** when attendance problems are recognized, by following protocols that highlight early identification and intervention.

4. **Use school-wide attendance data** to identify students for targeted interventions and times of year when attendance poses particular problems.

5. **Help families connect to needed resources,** such as medical services, sources for school uniforms, the school homeless liaison, food pantries, disability specific resources and supports, or connect them to family preservation specialists.

6. **Ensure accurate contact information** is on file for all students and solicit back-up phone numbers for students with a history of attendance problems.

7. **Reach out to parents, teachers and students** to discuss ways of improving attendance for all students, including special populations.

8. **Provide individualized and meaningful incentives** on a monthly, quarterly and yearly basis to recognize students who are doing well with attendance or are improving their attendance.

9. **Use existing resources in the school and community,** such as breakfast in the classroom, providing consistent recognition for good attendance and working with family and community engagement specialists in the school support networks.

10. **Promote positive student and adult relationships**, including meeting with individual students upon their return to school.

GREAT KIDS
GREAT SCHOOLS

All Baltimore City public schools are expected to follow these procedures for students with

Consecutive Absences

LEVEL 1 1 day absent	***District Office and School Staff to Repeat Previous Efforts and Follow Through at Each Level*** **District Office** ♦ Send out Global Connect phone calls about student absences to parents daily. **School Staff** ♦ Call parent/guardian to inquire about absence. If barriers to attendance exist, offer support. ♦ Upon student's return to school, ensure he or she is caught up on academic work.
LEVEL 2 2 – 5 days absent	**Attendance Monitor/Team** ♦ *Daily:* Call parent/guardian to ascertain reason for absence, identify barrier to attendance, offer support and encourage family to make school attendance a priority. ♦ *Daily:* Provide student-level attendance data to team members. ♦ *Day 2:* If absence is identified as extended, arrange for student to receive academic work. ♦ *Day 3:* If parent/guardian cannot be reached by phone, mail letter home asking parent/guardian to contact school. ♦ *Day 4:* If contact with family still has not been made, place student on "watch list" for attendance. ♦ *Day 4:* If student has an IEP, notify IEP chair about absences. If student continues to be absent, IEP team should revisit strategies to evaluate effectiveness and adjust as needed. **Teacher (pre-k to 6) or Guidance Counselor (6 to 12)** ♦ *Upon return to school:* Meet with student to inquire about high number of absences and develop a strategy plan or attendance contract with student. Make every effort to connect family to resources.
LEVEL 3 6 – 9 days absent	**Attendance Monitor/Team** ♦ *Day 6:* If parent/guardian contact has not been made, send a letter home with a certificate of mailing, asking parent/guardian to contact school. ♦ *Day 6:* Initiate home visit, when appropriate, to determine why student has been absent and offer support. ♦ *Day 6:* Determine follow-up actions specific to student's history of absenteeism, such as discussion with school nurse to investigate any physical reasons that may be barriers, referral for counseling/conflict resolution with the school social worker or psychologist or referral to SST or, for students with disabilities, to IEP team. ♦ *Day 7:* Contact family (by phone or in person) to remind them that good attendance means fewer than 10 absences in a year. Work with family on acquiring a doctor's note for absences due to illness over 6 days. **Teacher (pre-k to 6) or Guidance Counselor (6 to 12)** ♦ *Upon return to school:* Meet with student to inquire about high number of absences. Make every effort to connect family to resources. Develop a strategy plan or attendance contract with student. **Community Partners/Family Preservation Specialist** ♦ *Day 6:* Meet with attendance team to identify resources for families to help break through barriers to attendance. ♦ *Days 7-9:* Connect with family preservation specialist to identify referrals for assistance with utilities, food, food stamps, clothing and transportation or interventions such as grief counseling, parenting skills classes, drug/alcohol treatment, services for low-income families, legal services and mental health services.
LEVEL 4 10 days absent	***District office, attendance team, attendance monitors, teachers, guidance counselors, SST, IEP team and community partners should continue implementing all intervention strategies listed in levels 1-3 as well as exploring additional strategies that have not been pursued.*** ***City Schools assumes that any student who has been absent for two consecutive weeks has been contacted, the reason for absences has been documented, needed supports have been introduced and all necessary referrals have been made.***

BALTIMORE CITY PUBLIC SCHOOLS

All Baltimore City public schools are expected to follow these procedures for students with

Sporadic Absences

District Office and School Staff to Repeat Previous Efforts and Follow Through at Each Level

LEVEL 1 1 absence	**District Office** ♦ Send out Global Connect phone calls about student absences to parents daily. **School Staff** ♦ Call parent/guardian to inquire about absence. If barriers to attendance exist, offer support. ♦ Upon student's return to school, ensure he or she is caught up on academic work.
LEVEL 2 2 – 5 absences	**Attendance Monitor/Team** ♦ *Daily:* Call parent/guardian to find out reason for absence, identify barriers to attendance, offer support and encourage family to make school attendance a priority. ♦ *Daily:* Provide student-level attendance data to team members. ♦ *Day 3:* If contact is not made, send a letter home asking the parent/guardian to contact the school. **Teacher (pre-k to 6) or Guidance Counselor (6 to 8):** ♦ *Upon return to school:* Meet with student to inquire about high number of absences. Make every effort to connect family to resources, as needed.
LEVEL 3 6 – 9 absences	**Attendance Monitor/Team** ♦ *Day 6:* If parent/guardian contact has not been made, send a letter home with a certificate of mailing, asking parent/guardian to contact school. ♦ *Day 6:* Determine follow-up actions specific to student's history of absenteeism. ♦ *Day 7:* Contact family (by phone or in person), to remind them that good attendance means fewer than 10 absences in a school year and pointing out correlation betwen strong attendance and academic success. **Teacher (pre-k to 6) or Guidance Counselor (6 to 8)** ♦ *Upon return to school:* Meet with student to inquire about high number of absences. Make every effort to connect family to resources. Develop a strategy plan or attendance contract with student.
LEVEL 4 10 absences	**Attendance Monitor/Team** ♦ *Day 10:* Mail a 10-day absent letter home to family. A sample letter is available through the Office of Attendance and Truancy. Include a copy of the attendance policy and ask families to return a statement indicating they have read and understood the policy. ♦ *Day 10:* Encourage attendance at school-level attendance meetings for families and students to review why regular school attendance is so important. ♦ *Day 10:* Connect with family preservation specialist to coordinate home visits as necessary. **Teacher (pre-k to 6) or Guidance Counselor (6 to 8)** ♦ *Upon return to school:* Meet with student to review attendance contract, identify additional barriers, review attendance policy and reinforce school's expectations for excellent attendance, making connection between strong attendance and academic success. ♦ *Day 10:* Contact parent/guardian, reinforcing connection between attendance and academic success as well as providing a reminder of parental responsiblity to get children to school every day.
LEVEL 5 11 – 19 absences	**Attendance Monitor/Team** ♦ *Ongoing*: Connect with family preservation specialist, SST and IEP team for outreach strategies. ♦ *15 days*: If absences have been unexcused, complete Court Referral Form.
LEVEL 6 20 absences (chronically absent)	**Attendance Monitor/Team** ♦ *Day 20:* Mail unique 20-day absent letter to student's home. A sample letter is available through the Office of Attendance and Truancy. ♦ *Day 20:* Coordinate home visits with family preservation specialist. ♦ *Day 20:* Include student on "summer alert list" for interventions and targeted re-engagement strategies.
LEVEL 7 21+ days absent	**Attendance Monitor/Team** ♦ *Daily:* Schedule additional home visits with family preservation specialist. ♦ *Day 21and over:* Flag for SST or IEP team, as appropriate, for review of interventions and goals.

Appendix C: Baltimore City School Health Services at a Glance

Staffing Structure for Baltimore City School Health (Source: BCHD)
School Health Assessment Program (Health Suites)

- Full-time School Health Aide (SHA) – certified nursing assistant or medication technician; an additional half-time SHA for schools with population above 750 students
- School nurses (community health nurse, licensed practical nurse, school health aides and hearing and vision testers) at non-health center schools are staffed
    - o 1 day per week for populations of 1-250
    - o 2 days per week for populations of 251-500
    - o 3 days per week for populations of 501-750
    - o Full-time for population above 750

School-Based Health Centers

- Nurse Practitioner (with a physician serving as preceptor on site part-time each week.)
- Community Health Nurse
- Medical Office Assistant
- School Health Aide
- Mental Health Professional
- Optional: Substance Abuse Counselors and Health Educators

Comparison of School Health Services (Source: BCHD)

Services Provided	Health Suites	School-based Health Centers
First aid and emergency response	X	X
Medication administration	X	X
Health screening for hearing and vision	X	X
Communicable disease surveillance	X	X
Assistance with immunization compliance	X	X
Health education and skills training	X	X
Reproductive health education	X	X
Health appraisals and referrals (medical follow-up)	X	X
Crisis intervention and counseling	X	X
Nursing care plans for special needs students	X	X
Advanced nursing skills for technology-dependent children	X	X
Participation in individualized education program and 504 process for special education needs	X	X
Participation in school improvement teams	X	X
Student and parent advocacy	X	X
Annual health maintenance, sports physicals and immunizations		X
Acute care illnesses and injuries		X
Mental health services		X
Basic laboratory tests		X
Reproductive health care		X
Access to health insurance		X

Consent Standards (Source: BCHD)

Full Parental Consent	Student Consent	No Consent Required
• Annual comprehensive physical examination • Acute injury and illness evaluation • Chronic illness care • Sports physicals • Dental services • Mental health (under age 16)	• Treatment for sexually transmitted infections • Reproductive health care • Mental health (16 and over) • Substance abuse prevention and treatment	• Case management

Financing School Health (Source: BCPS and BCHD)

Baltimore City Investment (Suites and Centers)	FY 2009	FY2010	FY 2011 (Requested)
City Schools contribution	$7,350,928	$9,577,930	$9,641,828
City of Baltimore contribution	$6,756,602	$6,390,132	$7,226,015
Total	**$14,107, 350**	**$15,967,882**	**$16,867,843**

Evidence of Effectiveness (Source: BCHD for SY2009-2010)

- 404,000 visits to the health suite (an increase from 403,000 in 2008-2009)
- 74,000 doses of prescription medication were dispensed
- 18,000 visits to school-based health centers
- 99.5 percent immunization rate
- 2,492 students received in-school preventative and restorative services
- 4,400 vision and hearing screenings were provided

Appendix D: Student Attendance Work Group Policy and Practice Recommendations for Improving Attendance through Health Services and Interventions

1. Ensure that City Schools' system-level health office is able to take advantage of local, state and federal health resources, and is coordinating optimally with Baltimore City Health Department.

2. OTC Medication: Allow school nurses/aides/clinic staff to dispense over-the-counter drugs to students with valid permission from parent/guardian.

3. Develop and implement a combined permission/application form for health-related services and resources, including OTC medication, health clinic use, dental, mental health and other available health services.

4. Make permission form widely available throughout the school year and summer, printed, in multiple languages, distributed to doctors' offices and health clinics, school health suites, community and youth programs and on-line.

5. Publicize available health services: Partner with the Baltimore City Health Department, community and faith-based organizations to publicize available services, stress their importance and address parental concerns.

6. Maximize health partnerships that will ensure students receive annual health, dental and vision examinations.

7. Target Health Staff Outreach to Chronically Absent Students: Ensure that school-based health staff uses attendance and chronic absence data to target their outreach and prioritize services and follow-up for dental, feeding, asthma, mental health or other health programs.

8. Require health services to conduct a GAPS health assessment for students with poor attendance.

9. Use chronic absence rates as a measure to help determine which schools receive expanded mental health services.

10. Prioritize professional development for staff in schools with high rates of chronic absence and high-poverty populations focusing on the supports (e.g. Daily Rap and Student Support Teams) needed to help student cope with neighborhood-based stressors.

11. Investigate and make necessary administrative and service changes to increase public funding for health clinics. Work with the Baltimore City Health Department to revamp medical record keeping procedures that will allow the health clinics to bill Medicaid for services. Examine other public funding options that would help City Schools move closer to meet national staffing standards of 1 nurse for every 750 students.

12. Identify high-quality health education programs and increase opportunities for students and parents to participate in those programs.

13. Ensure that students have daily opportunities for physical activity and that physical activity is built into the school day (recess, gym, after-school, sports or otherwise.)

14. Require school-level administrative staff to send students to health suite before determining if they should be dismissed for illness.
15. Adopt universal feeding, including dinner.

16. Adopt breakfast in the classroom system-wide, as classroom breakfast programs have been shown to improve attendance.

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