ACKNOWLEDGMENT

We would like to thank the AAP Friends of Children Fund for its continued support of the AAP Healthy People 2010 Grant Program for Chapters.
# HEALTHY PEOPLE 2010 GRANT PROGRAM FOR CHAPTERS

## SCHOOL HEALTH PROGRAM SUMMARIES: GOALS, OUTCOMES, AND FUTURE PLANS

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction .................................................................................................................. 1</td>
</tr>
<tr>
<td>Program Selection Criteria and Process ...................................................................... 2</td>
</tr>
<tr>
<td>Program Summaries</td>
</tr>
<tr>
<td>I. Building Bridges Between Pediatricians and .......................................................... 3</td>
</tr>
<tr>
<td>School Nurses – Alabama Chapter</td>
</tr>
<tr>
<td>II. Coordinated Adolescent Mental Health ................................................................. 7</td>
</tr>
<tr>
<td>Program – Arizona Chapter</td>
</tr>
<tr>
<td>III. We Are Responsible – Parent Teen Driving ......................................................... 11</td>
</tr>
<tr>
<td>Agreement – Maryland Chapter</td>
</tr>
<tr>
<td>IV. Caring for Adolescents Through Outreach and .................................................... 14</td>
</tr>
<tr>
<td>Education – Utah Chapter</td>
</tr>
<tr>
<td>V. Working Together for Fit and Healthy Students .................................................... 18</td>
</tr>
<tr>
<td>Vermont Chapter</td>
</tr>
<tr>
<td>AAP School Health Initiatives and Resources .............................................................. 23</td>
</tr>
</tbody>
</table>
INTRODUCTION

Healthy People 2010 presents a comprehensive, nationwide health promotion and disease prevention agenda. It is designed to serve as a road map for improving the health of all people in the United States during the first decade of the 21st century. Healthy People 2010 represents the third time that the US Department of Health and Human Services (HHS) has developed 10-year health objectives for the nation.

In 2002, the AAP Board of Directors approved the Healthy People 2010 Grant Program for Chapters and assigned the oversight role for this grant program to the District Vice Chairpersons (DVCs) Committee. The overall goal of the program is to help chapters establish networks in their communities to support the development and implementation of programs that address pediatric objectives within the US Department of Health and Human Services’ Healthy People 2010 initiative.

In May 2008, the DVCs reviewed the Healthy People 2010 pediatric objectives and determined that children’s school health was the topic area on which the Healthy People 2010 Grant Program should focus for 2008. Through the support of the AAP Friends of Children Fund, the AAP offered a grant opportunity to chapters to help them develop and implement programs that facilitated collaboration between chapters and schools in building infrastructure to support preventive health education.

Five chapters were awarded grants of $20,000 each to fund their programs. The period of performance began on June 1, 2008 and concluded on May 31, 2010. As stipulated in the terms of the agreement, chapters were required to submit final reports at the conclusion of the grant period. Highlights from those reports are included in this publication.

The program summaries described in this compendium provide five different approaches to building infrastructure in schools to support preventive health education. The summaries include information on the program goals, collaborative partners, evaluation tools, outcomes, unanticipated barriers, and future plans. Contact information is provided for each project director if you would like more information about a particular program.

Each of these pilots demonstrates promising practices that warrant further study to determine their long-range effectiveness. In the short term, all 5 chapters forged new partnerships, activated communities to address this important issue, and have plans to continue this work.
A Request for Proposal was mailed to all chapter presidents, vice presidents and executive directors. The programs were required to adhere to the following criteria:

- Specifically address an objective within the Healthy People 2010 leading indicator relating to community networks
- Be a new program, or include an innovative component that builds on existing community resources
- Include a letter of support from the chapter (limited to one application per chapter)
- Demonstrate that the program is integrated into chapter activities
- Demonstrate applicability beyond the target population
- Describe collaboration with school personnel (other partners are welcome, but school partners are required)
- Include an evaluation component to promote project sustainability
- Include a concrete timeline for goals to be accomplished
- Include evidence that the chapter has the capacity to manage the grant
- Be led (or directed) by a Fellow of the American Academy of Pediatrics

Priority was given to proposals that:
- Demonstrated innovative and creative approaches
- Addressed hard-to-reach populations
- Demonstrated continuation of the program beyond initial funding
- Addressed one of the AAP priority issues

Using the above criteria as a guideline, a score sheet was created to assist the District Vice Chairpersons Committee members in assessing and ranking the applications. Committee members used the criteria to score the proposals. In an effort to encompass a variety of programs, a concerted effort was made to select chapters with dissimilar activities and target populations. The process for narrowing the number of chapters who were finalists as well as those who ranked in the top 50 percent was also discussed. Ultimately, the committee members selected the Alabama, Arizona, Maryland, Utah, and Vermont chapters as recipients of the Healthy People 2010 school health chapter grants.
PROGRAM SUMMARY

1. ALABAMA CHAPTER

Grantee: AAP Alabama Chapter

Program Name: Building Bridges Between Pediatricians and School Nurses

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PROGRAM DESCRIPTION & GOALS

Through Building Bridges Between Pediatricians and School Nurses, the Alabama Chapter of the AAP has developed a framework for Alabama pediatricians to effectively link to local school nurses and other school stakeholders to address the social, emotional, and health needs of school-aged children and adolescents in their communities. As resources and educational levels vary tremendously by schools in Alabama, and recognizing that school nurses play a critical role in administering school health services, this project assessed the school health environment at the local level and worked toward creating sustainable partnerships among school nurses, administrators, other school personnel and chapter members. These linkages helped to identify local school initiatives that define the role of the pediatrician in the provision of coordinated school health to improve the health status of youth across the gamut of the Healthy People 2010 school health objectives. The goals of this project were as follows:

1) Conduct a statewide survey of community-specific health needs of school-aged children that assesses the Healthy People 2010 leading health indicators and school nurse concerns not addressed by the 2010 objectives, and identifying resources that can be provided by pediatricians at the local level

2) Plan and conduct interdisciplinary focus groups in three pilot locations to gather feedback from key school stakeholders and develop a strategy for local collaboration that can be replicated in other areas

3) Use the results of the statewide survey and focus groups to identify educational programs and communication methods favored by nurses and school stakeholders that can be delivered by pediatricians in the three pilot communities
COLLABORATION

This project brought together several state and health-related collaborative partners. Joining the chapter was the Alabama Association of School Nurses, the Alabama Department of Public Health, the Alabama Department of Education, the School Superintendents of Alabama, the Alabama Association of Secondary School Principals, the Alabama Association of Middle School Principals, the Alabama Child Nutrition Directors, and the Alabama Action for Healthy Kids.

EVALUATION & MEASUREMENT

The chapter evaluated the project in a number of ways, from keeping track of the goals they accomplished to utilizing existing data that was readily available. The following evaluation methods were utilized to evaluate the project:

- Reviewed existing surveys on statewide school health
- Conducted focus groups to gather feedback from key school stakeholders in 3 pilot locations (Auburn City School, Boaz City School, and Dallas County School) to:
  - Address the needs of school nurses
  - Gather input from stakeholders
  - Survey school health needs
  - Identify workable and sustainable collaborative solutions at the local level
- Reviewed data from the statewide survey and focus groups to prioritize school health education tools needed by school nurses and the community
- Conducted focus groups to develop specific strategies for collaboration and implementation of the evaluation
- Conducted a pre-meeting survey for pediatricians to determine perceptions about barriers, communication, school administrators, physicians’ role, and forms/procedures
- Conducted a survey for pediatricians to identify their preferred form of communication (eg, phone, fax, email)

OUTCOMES

The following briefly summarizes the outcomes that occurred as a result of the program:

Program Outcomes

- Assembled a multi-disciplinary statewide committee to work with the Alabama Chapter of the AAP School Health Committee to:
  - Determine the scope and components of a statewide school health survey
  - Identify three local pilot sites to conduct interdisciplinary focus groups (rural, suburban, and inner-city)
  - Develop a stakeholder assessment to use in the focus groups
- Engaged stakeholders including the Alabama Association of School Nurses, the Alabama Department of Public Health, the Alabama Department of Education, the School Superintendents of Alabama, the Alabama Association of Secondary School Principals, the Alabama Association of Middle School Principals, and the Alabama Child Nutrition Directors
• Designed and approved a statewide survey to assess a number of HP 2010 indicators, school health concerns, and pediatricians’ role in working with school nurses to find out what hinders them from doing their job, aside from staffing issues
• Tabulated and distributed survey results
• Developed a focus group protocol for 3 focus group sites and held meetings
• Piloted the Physician-School Nurse Communication Form

The following are efforts agreed upon by school systems and others to help improve communication:

- Share backline telephone or fax numbers and key contact personnel
- Use a secure website, email, or listserv to address medical issues between school nurses and pediatricians
- Place a recorded message on the physician phone line (e.g., if you are a school nurse and calling about a student, push 1)
- Encourage school administrators and school nurses to develop a relationship with local pediatricians to introduce the student health standardized health form and open a dialogue about other student health issues
- Invite pediatricians to a forum setting to discuss ways to enhance communication between school administrators, school nurses, and pediatricians
- Invite school nurses to attend meetings at local hospitals
- Invite pediatricians to write an article in the school newsletter about child health issues
- Invite pediatricians to attend lunch time meetings to share information with school administrators and school nurses
- Use H1N1 as a way for pediatricians to connect with the local schools
- Use the communication form with local pediatricians and reach out to primary care clinicians, the emergency room, dentists, and other health care professionals
- Host a seminar where school nurses and pediatricians can openly discuss student health and provide a forum for questions and answers
- Invite pediatricians to attend Parent-Teacher Association meetings to talk about general health issues

Additional efforts noted during the evaluation process to improve communication included the following (organized by type of collaborator):

- Review and update the “Emergency Guidelines for Schools” to aid school personnel in taking quick and effective action in the case of sudden illness or injury at school (pediatricians)
- Launch a newsletter article for the school systems (pediatricians)
- Ask a pharmaceutical company to donate supplies for students who are diagnosed with asthma (pediatricians and school nurses)
- Send the chapter newsletter to the Alabama School Nurses Association (chapter)

**Child Health Outcomes**

This project met the overall goal of the AAP Healthy People 2010 grant by developing local blueprints (via a format for focus group and the development of a Physician-School Nurse Communication Form) for collaboration between school nurses and pediatricians. Through the statewide school health survey, each school nurse identified specific school health needs in the community. Each tenet of the Healthy People 2010 leading health indicators was weighted for priority in the local school community. By using this method, effective
educational tools, such as the Physician-School Nurse Communication Form will support specific health needs identified by that community and improve communication between local physicians and school nurses. Furthermore, the project will allow linkages to achieve the current priorities of the Alabama Chapter of the AAP - access to care, obesity, mental health, oral health, and school health.

UNANTICIPATED BARRIERS & LESSONS LEARNED

A number of barriers to delivering health related services to children in the local school system were identified, including:

- Issues with parental consent
- Lack of an adequate number of school nurses
- Problems with state regulations (e.g., for nurse and delegated personnel regarding the administration of medicines)
- Lack of accessibility of nurses at physicians office during school hours

Additionally, nurses and other health care providers reported that they need easy access to pediatricians regarding students with coordinated health plans; directed phone lines (e.g., “press 1 if you are a school nurse”); standing physician orders at beginning of school year for general non-emergency care; and standardized medical authorization and medical health forms.

FUTURE PLANS

The Alabama Chapter of the AAP School Health Committee will follow-up with the school nurses and pediatricians at the beginning of the school year to determine the effectiveness of the Physician-School Nurse Form. All reports and survey documents will be placed on the chapter Web site along with a link to the Alabama Association of School Nurses’ Web site.
PROGRAM SUMMARY

II ARIZONA CHAPTER

Grantee: AAP Arizona Chapter

Program Name: Coordinated Adolescent Mental Health Program (CAMHP)

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PROGRAM DESCRIPTION & GOALS

The Coordinated Adolescent Mental Health Program (CAMHP) will address the overall goal of the HP 2010 grant program to facilitate collaboration between the pediatric health care community, the chapter, and schools in building infrastructure to support preventive health education in the area of depression and suicide. The CAMHP will help eliminate many of the barriers faced by Glendale Union High School District (GUHSD) students when seeking education about depression/suicide and treatment for depression/suicide. The CAMHP will provide a school-based education program, a school-based depression assessment program and a case management process to assure timely and appropriate mental health services for treatment of depression. Through the unique case management model the pediatric primary care provider, mental health provider, and designated school staff will maintain close communication thereby creating a collaborative environment to ensure that each student has success with the treatment plan.

Through this three-pronged approach the CAMHP strives to achieve the following goals:

1) Decrease the number of students at risk for depression and suicide
   a. Provide suicide prevention education for at least 75% of 5,000 GUHSD students
   b. Provide easy access to trained professional school support staff that will assess at least 200 students for signs of depression/suicide

2) Increase use of evidence-based strategies by professional school support staff for identifying and assisting students at-risk for suicide
   a. Contract with agencies to provide GUHSD professional support staff with Depression Assessment and Awareness Training
   b. Provide the Depression Assessment and Awareness Training

3) Increase the number of students, who are identified with depression, that receive appropriate and timely treatment
   a. Provide case management services to ensure identified students receive mental health care
b. Contract with agencies to provide mental health services for at least 40 uninsured students
c. Facilitate collaboration between the school, pediatric primary care, and counseling services providers to ensure adequate communication

The CAMHP will create a model for adolescents to receive the information they need about depression/suicide while providing coordinated care for adolescents with depression.

**COLLABORATION**

The aim of the CAMHP was to implement an evidence-based intervention for the delivery of preventive mental health education, training, and treatment of depression and suicide for faculty and students. The project was designed to facilitate collaboration between pediatric mental healthcare providers and GUHSD schools to provide mental health awareness training to faculty and mental health services to students. In an effort to eliminate barriers faced by GUHSD students when seeking education about and treatment for depression/suicide, a comprehensive approach was designed. The program included teacher education workshops that focused on mental health in adolescents, a school-based cognitive skills building group program for students, and school-based individual counseling for students referred by the school nurse practitioner. Through this three-pronged approach the CAMHP sought to provide the GUHSD students with effective cognitive and behavioral coping skills; increase the use of evidence-based strategies by school staff for identifying and assisting students at risk for depression/suicide; and increase the number of students identified with depression that receive appropriate and timely treatment.

**EVALUATION & MEASUREMENT**

The following evaluation methods were utilized to evaluate the project:

- Conducted pre and post knowledge acquisition survey of support school staff
- Evaluated students at school-based clinics
- Assessed students before, during, and after the program using the Personal Beliefs Scale, Subjective Probability Questionnaire, Beck Youth Inventory II (BYI-II) Self-concept, Depression and Anxiety Subscales, and a Demographic Questionnaire
- Completed a confidential Client Update Form to develop a follow-up plan

**OUTCOMES**

The following briefly summarizes outcomes that occurred as a result of the program:

**Program Outcomes**

- Approximately 800 students attended
- 36 students were referred for evaluation by school professional staff
- 20 students were referred in the first semester of the new school year
- Over 400 students stopped by to learn more about depression; 5 of these students signed up to volunteer for a community mental health agency
- Over 300 professionals attended the in-services at the Depression Assessment and Awareness Trainings at local high schools
- One parent organization invited the psychiatric nurse practitioner volunteer to provide a presentation on mental health issues facing adolescents
• Three local high schools held on-site in-services on recognition of teenage depression and suicide prevention for teaching and professional support staff.
• Students from the leadership team at 2 of the 3 targeted high schools joined the CAMHP Advisory Committee to establish a suicide education plan.
• Two of the 3 high schools held a Depression Awareness Day.
• All of the participating schools provided permission for a mental health advocacy group to talk about depression to all freshmen in their Physical Education class.

Child Health Outcomes
• 71 students received depression/behavioral health screening:
  o Program coordinator and school staff provided students and parents/guardians with assessments, treatment options, and resources.
• 36 students were referred to their high school’s school-based clinic:
  o 6 students were referred for private care.
  o 6 students are being managed medically by school-based clinic staff and taking part in services provided through CAMHP.
• 2 contracts were established to provide counseling services for the project.
• 24 students (8 students/group) participated in skill-building groups.
• 15 students received 6 individual counseling sessions each.

UNANTICIPATED BARRIERS AND LESSONS LEARNED

The following is a list of barriers and lessons learned from this project noted:

• Coordination efforts took more hours than expected, but were essential to the success of the program.
• A great deal of time was spent recruiting students and talking to individual parents; many students were diagnosed with depression for the first time.
• A number of barriers limited student participation (e.g., English as a second language, poverty, depression, parents issues, stigma about mental health).
• As English is a second language for many students and parents, all printed information had to be readily available in other languages, and a translator needed to be available during most sessions.
• Students were eager to participate in the teen suicide prevention education program, but required coaching and supervision.
• Communication between the pediatric primary care provider and the mental health provider needs improving.
• Dedicated hours to CAMHP helped to increase community networking.

Additionally, providing services at school minimized transportation issues but created time consuming scheduling issues and confusing schedules. Although a minimum of weekly reminders were provided to students for sessions, students frequently had to be personally contacted to ensure attendance at sessions. There were also a number of issues with scheduling (e.g., conflicts with state and classroom testing), and organizing a schedule to minimize lost class time was extremely time consuming, but necessary. However, this also created inconsistent counseling session times, which was hard for students, the counseling staff, and the school nurse to track. It was necessary to send frequent reminders and
communication with teachers about the importance of students not missing appointments (without violating student privacy rights), was also very challenging and time-consuming.

Although there were a number of barriers, the biggest accomplishment and lesson learned was “planting the seed” about mental health and the availability of care for mental health concerns.

FUTURE PLANS

The state of Arizona experienced severe financial difficulties this year, resulting in significant cuts in the education and health care budgets. This means there are less dollars available to continue this project and fewer dollars in the community to continue new projects of this nature when more charitable and foundation dollars are being directed to basic needs such as food and shelter. The school-based clinics that serve as the hub for the CAMHP are also at risk of being closed due to the financial cut backs. In normal times, building off the CAMHP success would have been relatively easy and would have led to program expansion, introduction of additional community partners, annual school staff inservices and growth of the student education day.

Funding limitations will not provide this opportunity; however, through CAMHP and the community links developed, additional funding and services have been secured to continue counseling components of the CAMHP. Specifically,

- A local non-profit, Lincoln Gives, has granted Marley House $3,500 to continue services at the nearby high school.
- Several Magellan providers in the nearby community that joined the CAMHP Advisory Committee (People of Color, Jewish Family Services) have welcomed the idea of offering school-based services; discussion is underway.
- Doorways, a private counseling organization, is donating 2 hours a week at Sunnyslope High School (individual counseling). They are also donating 6-7 additional counseling referrals from the clinic this school year.

During the CAMHP, another local school district successfully submitted a school-based mental health grant program. Information from CAMHP has been shared with the program staff including lessons learned and suggestions for the program to successfully work with the medical community. The chapter staff hopes to keep in touch with this new project to see how their program develops and what can be learned from the two programs collectively.
III MARYLAND CHAPTER

Grantee: AAP Maryland Chapter

Program Name: We Are Responsible-Parent Teen Driving Agreement

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PROGRAM DESCRIPTION & GOALS

The We Are Responsible Program was modified from a pre-existing collaboration between Howard County Police Department, Howard County Public High Schools and a local grassroots organization Courtesy on the Road. The program was 5 years old and previously consisted of a PowerPoint presentation of teen driving laws and local crash and fatality statistics with voiceover narration by the school resource officer supervisor. In order for teen students to park on any local Howard County campus, they would have to attend one of the 1 ½ hour sessions offered at any Howard County Public High Schools with one of their parents.

The grant was used to modify the presentation by editing and shortening it to be a video presentation rather than a PowerPoint. New features were added including an introduction by a high school principal, narration of the script by the school resource officer, and actual footage of teens introducing various educational segments. Examples of such segments are the dangers of speed, distracted driving, and the importance of buckling up. Moreover, the Parent Teen Driving Agreement (PTDA) was highlighted by demonstrating a pediatrician implementing the PTDA for parents and their teens.

The goals of the program were as follows:

1) Decrease teen crashes by revising a school presentation aimed at parents and their teens, highlighting the parent/teen driving agreement
2) Increase awareness of the parent/teen driving agreement to pediatricians by area grand rounds presentations

COLLABORATION

Pediatricians from the Maryland Chapter of the AAP (Drs. Rossman and Lichenstein) and national AAP committees (Pediatric Emergency Medicine, Injury, Violence, and Poison Prevention, and School Health) worked with the Howard County Health Department, Howard County Safe Kids, Courtesy on the Road, Howard County Police Department, and
Howard County School System to define the parent/teen driving contract to use, edit the video, plan a schedule, and collect surveys.

EVALUATION/MEASUREMENT

The program was evaluated by surveying parents and teen drivers at the time of the presentation and 6 months later. In addition, electronic surveys were provided to pediatricians who attended grand rounds on the parent teen driving agreement. Finally, Howard County data on teen motor vehicle deaths and traffic related citation counts were reviewed.

OUTCOMES

The following briefly summarizes outcomes that occurred as a result of the program:

Program Outcomes

• A DVD was created that includes an introduction by a high school principal, narration of a script by the school resource officer, and footage of teens introducing educational segments (eg, dangers of speed, distracted driving, and the importance of buckling up)
• 12 area public high schools were provided a copy of the DVD
• Gift cards were provided as an incentive for respondents to complete the initial and follow-up surveys
• Pediatric grand rounds were given to area pediatricians at local hospitals
• PTDAs were distributed to pediatric practices
• 80% of pediatricians said that physicians share at least some role in promoting safe teen driving
• 86% of pediatricians agreed to hand out PTDAs to teen patients

Child Health Outcomes

• 81% of teens signed a PTDA
• 60% of teens said the PTDA would make them a better driver
• 39% of parents set restrictions on their teen’s driving that were not covered in the PTDA
• 89% of parents said that PTDAs make their teens better drivers
• 41% of teens said they would feel safer if all teens signed a PTDA prior to driving

UNANTICIPATED BARRIERS AND LESSONS LEARNED

There were several barriers and lessons learned that were encountered during the project. While all of the groups had a similar goal in decreasing teen crashes, each had different areas of interest. For example, Courtesy on the Road, a grass-roots organization, had financial pressures and changes in their administrative structure, which limited their involvement. They also relied on students to provide the safety driving oriented music video provided by the winner of the Battle of the Bands; however these students were often busy, which made it difficult to get the video completed. Additionally, the police department and school administrators were initially reticent to go on camera to provide messages; however, with encouragement, they were able to overcome their fears. Ultimately, this gave the video more credibility.
As expected, there were also logistical issues in producing the video, but the videographer patiently worked to address these issues. Additionally, each school represented had a number of different personalities; some principals were actively involved and had an authoritarian style demanding PTDA, while others were more interested in getting the students and parents through the program as efficiently as possible. Some smaller schools had parents sitting with their teen while in some larger schools the parents and teens were noticeably seated in separate sections of the auditorium.

Overall, having a student from the school introducing the program or involved in the video would be an improvement in school receptivity. Still, an informal poll of parents and teens after the program showed only positive feedback and comments on how this program was such an improvement from programs in the past. Finally, more feedback from the surveys (parent, teen, pediatrician) is desired.

FUTURE PLANS

The *We are Responsible* program seems to be having some success based on these surveys in changes of some risk behaviors associated with teen driving. Further research is being done into the effect of the program on Howard County teen citation rates as well as crash morbidity and mortality. Possible expansions to the program include more county schools systems within Maryland and physicians’ offices. Getting parents more involved in their child’s driving through the PTDA will hopefully make the roads safer for everyone. As a consequence of this project, the Howard County School System has agreed to fund the cost for updating the presentation as a video and continuing to incorporate educational components on the PTDA. Moreover, there is continued cooperation between pediatricians from the Maryland Chapter of the AAP (Drs. Rossman and Lichenstein) to assist the Howard County Police Department and the school system in producing and updating the video.
PROGRAM SUMMARY

IV UTAH CHAPTER

Grantee: AAP Utah Chapter

Program Name: Caring for Adolescents Through Outreach and Education (CARE)

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PROGRAM DESCRIPTION & GOALS

According to the National Health Interview Survey, 25% of adolescents have not had a health care visit in the past year and 7% do not have a regular source of care. The CARE Program was initiated to increase high-risk adolescents’ access to care by expanding an existing school-based psycho-educational program (BEST program) and developing a network of primary care providers and mental health providers for referrals. A directory of providers willing to accept publicly-insured, privately-insured, and uninsured adolescent patients from local secondary schools was created. The directory was distributed to school counselors, nurses, and administrators.

Few schools provide substance abuse prevention programs specifically designed for youth who are at-risk for using alcohol and other drugs. The Building and Enhancing Skills for Teens (BEST) program was created as collaboration between the Division of General Pediatrics and Department of Educational Psychology at the University of Utah, Granite High School (GHS), and the Utah State Office of Education (USOE) to address this gap in school-based prevention education. The BEST program uses a cognitive-behavioral approach to teach students, in a small group format, important life skills such as problem-solving, decision-making, communication, and stress management as a means to cope with daily stressors instead of resorting to substance use. The BEST program also is designed to become a self-sustaining intervention that can be implemented and facilitated by school counselors or psychologists.

Eighty students participated in the BEST program at GHS during the 2007-2008 and 2008-2009 school years. Feasibility (group attendance, and CARE parent, teacher, and student satisfaction) and effectiveness (drug use, depression, self esteem, and school attendance) measures have been collected. Data continues to be analyzed. The BEST team worked with the USOE to expand this program to other high schools in Utah for the 2009-2010 school year. It was suggested that schools who adopt the BEST program be required to complete the following evaluation measures: student attendance in the groups, site
visits to observe groups and measure adherence to the manual, and a pre- and post-drug use inventory.

COLLABORATION

For the CARE directory, pediatricians and family practitioners in Salt Lake County were identified using the Utah Chapter of the AAP and the American Academy of Family Practice mailing lists. A letter and brochure describing the CARE Program and questionnaire were sent to these providers. Providers responding to the questionnaire were contacted for more information about their practice, particularly the circumstances under which they could accept new patients and barriers to caring for adolescent patients. The resulting directory was distributed to the 5 school districts in Salt Lake County.

During the past two years, strong collaborative relationships have been developed with key stakeholders including the Utah Department of Health, Bureau of Children with Special Health Care Needs; Utah State Office of Education; Valley Mental Health (the mental health provider for children insured by Medicaid in Utah); and the Intermountain Academy of Child and Adolescent Psychiatry (IACAP). Ongoing involvement between the Utah Chapter and key stakeholders include a networking luncheon, a presentation about improving communication between primary care providers and schools by Mandy Allison, MD at a behavioral health conference sponsored by the USOE, and an upcoming presentation about community mental health resources by several stakeholders at the Utah Chapter of the AAP Common Problems in Pediatrics conference.

EVALUATION/MEASUREMENT

The primary measure of improved access to health and mental health care is the number of adolescents without a medical home who are referred by schools to a provider who can offer a medical home. Organized by zip code, a directory of providers in the Salt Lake County area was created, including a map. A referral tracking postcard to evaluate the use of the directory was developed. The postcard requests the following information for each referral: school name, referral date, provider, age/grade of referred student, and reason for referral. Meetings with five public school districts in Salt Lake County have been held to train school personnel in the CARE Program and to distribute the postcards and directories. The directory continues to be evaluated.

OUTCOMES

The following briefly summarizes outcomes that occurred as a result of the program:

Program Outcomes
• Of the 467 primary care providers identified, 161 (35%) responded to the initial questionnaire, and 110 (24%) were committed to participating in the CARE Program
• 51 locations in Salt Lake County are identified in the directory and include 41 family physicians and 69 pediatricians
• Since January 2010, school personnel in all five school districts have been trained in the CARE Program and 200 directories have been distributed
• School personnel have been enthusiastic about the directories and outreach
efforts
• The chapter's annual scientific conference featured a presentation on the pediatrician's role in managing mental health and a panel discussion involving school personnel on available mental health resources
• Increased collaboration occurred between key stakeholders in school health
• Three surveys were conducted to collect baseline data on primary care providers', child psychiatrists', and school districts' experiences, resources, and/or attitudes about providing mental health services for children in Utah

Child Health Outcomes
As of May 24, 2010, the following five referral tracking postcards have been returned:

• A 7th grade student with depression has been referred for treatment and management
• A 12th grade student was referred for untreated chronic health issues and truancy
• A 7 year old student was referred for school problems and possible Asberger's syndrome
• A 13 year old student was referred for “general female health issues”
• An 8th grade student was referred for general gynecological complaints

UNANTICIPATED BARRIERS AND LESSONS LEARNED

Due to decreased enrollment and budget constraints, the Granite District Board of Education elected to close Granite High School after the 2008-09 school year. This school was the program's pilot site. Consequently, the referral resource for adolescents without a medical home was not set-up or advertised as originally planned. The closure of the pilot site and confidentiality issues also limited the ability to evaluate referred adolescents' health care use and outcomes and maintain a database of the needs of referred adolescents as originally planned; however, the CARE directory was able to be completed and distributed to the 5 school districts in Salt Lake County. Additionally, the Referral Tracking Postcard allowed for measurement of the schools' use of the CARE directory; however, this did not allow for measuring whether the referred adolescents actually followed through with the referrals.

FUTURE PLANS

Future plans include outreach to mental health providers regarding collaboration with schools, a presentation by school personnel at the chapter's annual scientific conference, and expansion of efforts to work with schools to improve and evaluate children and adolescents' mental and physical health care use.

If enough Referral Tracking Postcards are returned to indicate that the CARE directory is being used, pediatric residents will be asked to help with efforts to keep the directory updated as part of their advocacy and/or adolescent medicine rotations. Data from the Referral Tracking Postcards will be used to support efforts to obtain future grant funding to update, print, and distribute more directories.
Also, Dr. Allison is a member of the Utah School Health Advisory Committee and the subcommittee on coordinated school health. This group is planning to apply for funding from the Centers for Disease Control and Prevention Division of Adolescent and School Health to improve infrastructure for coordinated school health in Utah. The committee is also pursuing other federal and state-level funding opportunities to support coordinated school health. Dr. Hemond, director of the Teen Mother and Child Program and co-investigator on this grant, has started a Teen Health Clinic one-half day per week at South Main Clinic in Salt Lake City, Utah. This clinic targets high-risk adolescents who are in need of a primary care physician. Psychosocial support is provided by the National Alliance on Mental Illness (NAMI) and interns from the College of Social Work. This clinic has already received referrals from our outreach efforts to schools. Dr. Hemond plans to continue these outreach efforts and expand the services for adolescents at South Main Clinic if they are needed.

Lastly, the CARE program presented an oral abstract during the abstract program at the 2010 AAP National Conference and Exhibition. At that time, Dr. Allison was able to share details about the process and results of the program. It is hoped that other AAP chapters, particularly those in states without a well-developed coordinated school health program or without school-based health centers, can follow the process to create a directory similar to the CARE directory. Chapters can also use or adapt the existing surveys of primary care providers, child psychiatrists, and school districts to collect baseline data in their states or local communities.
PROGRAM SUMMARY

VERMONT CHAPTER

Grantee: AAP Vermont Chapter

Program Name: Working Together for Fit and Healthy Students

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PROGRAM DESCRIPTION & GOALS

The purpose of this project was to connect members of the Vermont Chapter of the AAP and their schools and communities to support health education in the area of obesity prevention and/or treatment in school-aged children. There are many individual projects underway in various communities; however, these often remain uncoordinated and are not based on best practice models.

The Healthy People 2010 objective which the Working Together for Fit and Healthy Students program was designed to address is:

“Increase the proportion of middle, junior high, and senior high schools that provide school health education to prevent health problems in the following areas . . . unhealthy dietary patterns; inadequate physical activity.”

Two possible "tracks" for pediatric involvement were seen as:

1. Working with the individual child with obesity: A particular community may want to collaborate to either help students already identified with obesity by their primary care provider, or the school nurse may want to link a student identified with obesity back to their medical home for treatment. One problem seems to be follow-up for these students after identification - they rarely show up back at the doctor's office. The school nurse could collaborate with the pediatrician by providing weight checks at school, and/or helping to work through a "change plan" with the student.

Prior to the start of this project, the Vermont Department of Health developed a toolkit for pediatric primary care providers: Promoting Healthier Weight in Pediatrics (http://healthvermont.gov/family/fit/documents/healthier-weight_pediatric-toolkit.pdf). This toolkit outlines ways to talk to patients and families about evidence-based nutrition and physical activity changes, and ways to use brief motivational interviewing techniques
with families to encourage lifestyle changes. The toolkit was distributed to all pediatric primary care providers, as well as all school nurses in the state.

2. **Getting involved at the school level:** Some pediatricians may already be doing the above, or may be interested in getting more involved in addition to the above. There may be something already happening at the particular school that the pediatrician could get involved with (eg, joining the Coordinated School Health Council (if one exists), getting involved on the policy level with school foods or recess, teaching a class, or participating in a program such as "Girls on the Run"). The Centers for Disease Control and Prevention guidelines for schools outline what "works" to help kids ([www.cdc.gov/HealthyYouth/KeyStrategies](http://www.cdc.gov/HealthyYouth/KeyStrategies)).

**COLLABORATION**

The actions of this project were designed to address the barriers in Vermont which prevent a fuller impact to decrease obesity in students (eg, lack of coordination, and collaboration between pediatricians and schools, and lack of health professionals’ time to research and implement effective strategies). The chapter initially surveyed all members to determine who was already working with local schools around obesity issues, who was interested in starting to collaborate more with schools, and what the perceived barriers were in working with schools. Six communities across the state expressed an interest in collaborating more with schools around obesity issues.

A facilitator was contracted to coordinate meetings in each community. These meetings provided the initial connection between interested pediatricians (and other pediatric primary care providers) and local school nurses (and other involved school personnel) and helped to distribute and orient all attendees to the *Promoting Healthier Weight in Pediatrics* toolkit.

In each of the 6 communities, pediatric providers (pediatricians, family practice medical doctors, advance practice registered nurses, and physician assistants) were notified of the goals of the meeting and asked if they would be interested in attending and being involved in this ongoing effort. School nurses were contacted to participate and to schedule a meeting room within their school.

The meetings were organized and facilitated from March – April 2009 and included: Barre, Essex Junction, Fair Haven, Milton, Rutland, and Springfield. Each meeting was coordinated by a contracted facilitator. There was a sign-in sheet, a survey to access the communication issues between school nurses and medical doctors, advance practice registered nurses, and physician assistants. A summary report was written after each meeting.

The same agenda was used for each meeting: introductions, purpose/goals of the meeting, district level data, current activities in the schools related to activity/nutrition, role of the pediatric medical home, improvements to coordinate care for kids regarding obesity issues, and ways for schools and medical homes to communicate.

School nurses identified many school activities which were occurring in support of obesity prevention activities. Activities in the schools included the following:
• Nutrition - school gardens, classes on foods and nutrition, healthy snacks, cooking classes, monthly taste test with healthy foods, cooking for life classes, Iron Chef
• Physical activity – walking programs, Girls on the Run, safe routes to school, Wii Fit Program, open gym, classes with the YMCA, Outdoor Club, Mileage Club, Bike to School Club, after school programs
• Assessments & other – BMI’s, fitness grams, Wellness Plans

Some of the challenges experienced by schools included the following:
• Cafeteria foods – large portions, high carbohydrate and high fat, high calorie vitamin water
• Fund raisers - bake sales and candy
• Teachers giving sweets as a reward
• Lack of program funding
• Lack of leadership to change cafeteria food and other school policies
• Minimal requirement for physical education

An important additional challenge that was identified by most communities was the communication between school nurses and providers. One “bonus” outcome that resulted from the community meetings was the discussion of how best to link providers and local school nurses when needed (eg, e-mail, fax, specified times to call).

Finally, at the end of the project timeline, “Mini Grants” were established that the participating communities could apply for, to allow them to move forward in their community with a local project that would sustain the collaboration between primary care providers and schools around the issue of student obesity.

EVALUATION/MEASUREMENT

Formal evaluation tools were not used to evaluate the project, as the main goal was to link pediatricians and other pediatric primary care providers with school nurses to collaborate on childhood obesity issues. What each community chose to do was unique to their needs. All communities were encouraged to use the toolkit (Promoting Healthier Weight in Pediatrics), and/or evidence-based programs through the Centers for Disease Control and Prevention.

OUTCOMES

The following briefly summarizes outcomes that occurred as a result of the program:

Program Outcomes
The initial 6 community meetings had the following attendees: (70) total, including school nurses (31), pediatricians (8) and family practice physicians(3), a doctor of osteopathic medicine (1), pediatric nurse practitioners (3) and physician’s assistant (3), health department school liaisons (11), school health educators (4), and physical education teachers (2).

Child Health Outcomes
The Vermont Department of Health has established the following goal under the Fit & Healthy Vermonters initiative: “halt the increase in the proportion of Vermont youth (grades
8-12) with a BMI for age ≥ 95th percentile to 9%.” Baseline data in 2003 showed the proportion at that time to be 11%; follow-up measurement in 2006 revealed the proportion to be 12%. According to the 2005 *Health Status of Vermonters Appendix*, 10% of youth in grades 9–12 were overweight (BMI >95%); the range in the 12 District Offices was 8–16% (self reported data from the Youth Risk Behavior Survey). This data will continue to be tracked for Vermont students, and will be analyzed by individual school districts to determine if the participating communities made better progress towards the goals.

**UNANTICIPATED BARRIERS**

The biggest barrier was the appearance of H1N1 in the spring of 2009, and the subsequent time, energy, and resources that went into providing H1N1 vaccines at the schools in Fall 2009. Unfortunately, the initiatives of this project were put on hold, and despite being given extra time to complete the project, valuable momentum was lost.

Another barrier was the lack of leadership in many communities who had the time or organizational abilities to move a community along in a project without relying on organization from the outside. This spurred the idea of the “Mini Grants” that were awarded to communities who were ready to move forward and tackle some of the issues identified in their community meeting.

**FUTURE PLANS**

Towards the end of the project timeline, a “Mini-Grant” process was established that was open to the communities that were original participants. The applicants were required to submit projects that involved collaboration among pediatric primary care providers and the local schools, and tackled an issue impacting student obesity. The list below was generated at the community meetings and gives examples of what some groups may wish to work on. To date, several “Mini Grants” have been awarded, and their progress will be followed.

**Communication**

- Involve parents; involve students in planning
- Vermont Department of Health School Liaisons needs to share data and other information relevant to obesity needs to be shared with the school nurses and providers
- Facilitate the use of a HIPAA/FERPA compliant form so that providers and school nurses can discuss students’ health and share specific information
- Establish communication email list for each school region – school nurses, physicians, advance practice registered nurses, physician assistants – in order to communicate school activities and school health policies
- Consider regular school nurses/provider meetings
- Work with town government to communicate and advocate for activities for students
- Recruit a primary care provider to serve on coordinated health teams
Physical activity

- Organized sports only serve a small number of students – need more involvement for all students
- Expand use of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) funds to focus on physical activity fees
- Offer activities which students want to attend – hip hop classes, open gym

Nutrition

- Nutritional leadership needed to improve food offerings and to set school food policy. Many school nurses are frustrated by the inability to impact obesity, influence of food industry, by the school food policies, easy availability of sweets and high fat foods in school
- Policies about bake sales, fund raisers, rewards for students – some schools sell merchandise (eg, magnets, family photo sessions, wrapping paper)
- Prohibit sale of candy and sweets at school
- Cooking classes for parents

Physicians

- Discuss the role of the sports physical versus a full physical
- Discuss role for “district doctor” for a way for nurses to get a ‘consult’ when needed
- Attend and advocate for nutritional and physical activity changes at school board meetings

In-service Education

- Encourage the continuation of Advance Health Education Center (AHEC) in-services for school nurses
- Schools invite physicians to speak to teachers at the opening of each year about students’ health
COUNCIL ON SCHOOL HEALTH

The AAP Council on School Health (COSH) is comprised of more than 200 pediatricians (ie, Fellows) and affiliate members representing various professional disciplines, including nurses, counselors and other allied health professionals who are actively involved in developing, implementing or influencing school health programs or policies or who have an interest in these areas. The council is responsible for policy development, dissemination, implementation, and education and serves as the leading AAP authority addressing issues related to school health. The council addresses a wide range of issues affecting pediatricians and schools, including health and illness management as they relate to school and to the child’s educational potential, as well as the pediatrician’s role in the school setting.

For more information about the Council on School Health or any of the resources noted below, visit the Web site at www.aap.org/sections/schoolhealth/index.cfm or contact Madra Guinn-Jones, MPH, Manager, Committees and Sections, at mjones@aap.org.

PROJECTS

Schooled in Asthma

*Schooled in Asthma* was funded through a 5-year cooperative agreement with the Centers for Disease Control and Prevention (CDC) Division of Adolescent and School Health (DASH). The project was designed to encourage pediatricians to integrate school health concepts with current asthma treatment guidelines. In part, it encouraged the use of Asthma Management Plans as well as increased communication between school personnel and pediatricians.

Various tools and forms were created to obtain an accurate asthma history based on symptoms both at home and school, facilitate communication between school personnel and pediatricians, and provide the patient, parent, and school information about a child's medication program. The tools also provide guidance about what to do when a child's asthma worsens.

For more information about the project, or to access the tools and forms mentioned above, visit www.aap.org/schooledinasthma.

PRINT RESOURCES

*School Health Policy and Practice, 6th Edition*

This AAP manual provides pediatric health care professionals with guidelines for communicating with schools and developing health programs for school-aged children, with a focus on health and illness management as they relate to a child's educational challenges and potential.
Health, Mental Health and Safety Guidelines for Schools
By addressing health, mental health, and safety issues (including transportation and motor vehicle safety), schools can improve students’ academic performance today and contribute to their increased longevity and productivity long after they leave school. *Health, Mental Health and Safety Guidelines for Schools* was developed to inform school health policies and programs and to help those who influence the health and safety of students and school staff while they are in school, on school grounds, on their way to or from school, and involved in school-sponsored activities. This publication is also available online at [www.nationalguidelines.org](http://www.nationalguidelines.org).

Based on the premier AAP publication, the *Red Book*, this helpful guide helps child care and school staff prevent, identify, and respond to the most common childhood infectious diseases. It includes easy-to-read explanations on how infectious diseases spread, strategies for limiting the spread of infection in group settings such as child care centers and schools, guidance about which situations require immediate help, immunization schedules and ready-to-use sample letters and forms for parents or referrals. The guide features more than 50 quick reference sheets on the most common infectious diseases and symptoms that occur in children in group settings. Each sheet provides information about transmission, infection control and exclusion criteria. The guide is written in non-technical language making it easy to use and share.

Managing Chronic Health Needs in Child Care and Schools: A Quick Reference Guide
This guide is designed to help caregivers and teachers face the challenges of caring for children with chronic medical conditions and special health care needs. The health conditions described in this book cover a spectrum of chronic illnesses, acute situations, selected developmental and behavioral problems, and special health care needs, with a special emphasis on children with special health care needs. It provides teachers, administrators, school nurses, and caregivers with ready access to practical information and "what-to-do-when" advice. And it helps health care providers communicate essential information and instructions clearly and time-efficiently. This guide includes information about care plans, medication administration issues, symptom management and emergency planning recommendations while featuring more than 35 quick reference sheets which serve as time-saving problem solvers related to diseases and disorders that caregivers and school staff deal with on a daily basis.

POLICY STATEMENTS/CLINICAL REPORTS

Head Lice
This revised clinical report clarifies current diagnosis and treatment protocols and provides guidance for the management of children with head lice in the school setting. To access the policy online, go to: [http://aappolicy.aappublications.org/cgi/content/full/pediatrics;126/2/392](http://aappolicy.aappublications.org/cgi/content/full/pediatrics;126/2/392).

Honoring Do-Not-Attempt-Resuscitation Requests in School
This policy statement outlines the medical, emotional, and legal issues involved when families have chosen to limit resuscitative efforts. To access the policy online, go to: [http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;125/5/1073?rss=1](http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;125/5/1073?rss=1).

Guidance for the Administration of Medication in School
Many children who take medications require them during the school day. All districts and
schools need to have policies and plans in place for safe, effective, and efficient administration of medications at school. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;124/4/1244.

Disaster Planning for Schools
This statement offers clear guidelines for physicians, schools and communities to collaborate in preparing for a wide array of threats. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;122/4/895.

Medical Emergencies Occurring at School
This statement describes many ways that school and local pediatricians can plan for and be responsive to the student who develops an acute emergency unexpectedly. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;122/4/887.

The Role of the School Nurse in Providing School Health Services
This policy statement describes the role of the school nurse in serving as a team member in providing preventive services, early identification of problems, interventions, and referrals to foster health and educational success. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;121/5/1052.

School Readiness (technical report)
School readiness includes the readiness of the individual child, the school's readiness for children, and the ability of the family and community to support optimal early child development. This report discusses how schools, pediatricians and communities can promote school readiness. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;121/4/e1008.

The Role of Schools in Combating Illicit Substance Abuse
The use of random drug testing on students as a component of drug prevention programs requires additional, more rigorous scientific evaluation. Widespread implementation should await the result of ongoing studies to address the effectiveness of testing and evaluate possible inadvertent harm. If drug testing on students is conducted, it should never be implemented in isolation. A comprehensive assessment and therapeutic management program for the student who tests positive should be in place before any testing is performed. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;120/6/1379.

School Transportation Safety
This policy provides updated information, studies, regulations, and recommendations related to the safe transportation of children to and from school and school related activities. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;120/1/213.

Preventing and Treating Homesickness
Almost all children, adolescents, and adults experience some degree of homesickness when they are apart from familiar people and environments. This statement provides techniques to aid in the prevention of homesickness in the case of a planned separation, such as summer camp, as well as effective treatment strategies in the case of unanticipated or traumatic separation, such as hospitalization. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;119/1/192.
Active Healthy Living: Prevention of Childhood Obesity through Increased Physical Activity
This policy statement reaffirms the AAP support for the efforts of schools to include increased physical activity within the school day. The statement suggests ways schools can meet their goals in physical fitness, and encourages pediatricians to offer their assistance. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;117/5/1834.

Health Appraisal Guidelines for Day Camps and Resident Camps
The American Academy of Pediatrics recommends that specific guidelines be established for pre-camp health appraisals of young people in day and resident camps. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/abstract/pediatrics;115/6/1770.

School-Based Mental Health Services
More than 20% of children and adolescents have some degree of mental health concerns. School-based programs offer the promise of improving access to diagnosis of and treatment for the mental health concerns of children and adolescents. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/6/1839.

Soft Drinks in Schools
School officials and parents need to become well informed about the health implications of vended drinks in school before making a decision about student access to them. A clearly defined, district-wide policy that restricts the sale of soft drinks will safeguard against health problems as a result of overconsumption. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;113/1/152.

Out-of-School Suspension and Expulsion
This policy statement highlights aspects of suspension and expulsion that jeopardize children’s health and safety. Recommendations are targeted at pediatricians, who can help schools address the root causes of behaviors that lead to suspension and expulsion and can advocate for alternative disciplinary policies. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/5/1206.

The Inappropriate Use of School "Readiness" Tests
This policy statement describes how readiness testing can vary greatly and can easily be incorrectly applied and interpreted leading to children being placed into special educational settings inappropriately. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;95/3/437.

Organized Sports for Children and Preadolescents
Recommendations are offered on how pediatricians can help determine a child's readiness to participate, how risks can be minimized, and how child-oriented goals can be maximized. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;107/6/1459.

School Health Centers and Other Integrated School Health Services
This statement offers guidance on the integration of expanded school health services, including school-based and school-linked health centers into community-based health care systems. To
access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics%3b107/1/198.

**Home, Hospital, and Other Non-School-based Instruction for Children and Adolescents Who Are Medically Unable to Attend School**
This statement is provided to assist in planning and evaluation for children to receive non-school-based instruction and to return to school at the earliest possible date. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/5/1154.

**Corporal Punishment in Schools**
The AAP recommends that corporal punishment in schools be abolished in all states by law and that alternative forms of student behavior management be used. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics;106/2/343.

**School Health Assessments**
This statement provides guidance on the scope of in-school health assessments and the roles of the pediatrician, school nurse, school, and community. To access the policy online, go to: http://aappolicy.aappublications.org/cgi/content/full/pediatrics%3b105/4/875.