



# Research Link

By Frank Hernandez, Ph.D.



## ***Health Care Assistance: The Intersection of Health Problems and Learning in High Poverty Schools***

~ by Robert Pena

The health status of school-age children in U.S. public schools is both alarming and difficult to address. Obesity rates among students have skyrocketed and are seen as a crisis in schools and school districts. In fact, obesity rates among school-age children ages 6-11 doubled (from 6.5% to 15.3%) between 1970 and 2000, while obesity rates among adolescents tripled (from 5% to 15%) during the same time period. Furthermore, obesity among Mexican and African-American students is more severe. Finally, those students who come from low-income families are more likely to be overweight than those whose families are above the poverty line (US Centers for Disease Control and Prevention, 2002). Concerned parents, guardians, teachers, principals, and health officials are not sure how to address this severe problem and often have more questions than solutions (National Center for Health Statistics, 2001).

To examine the intersection of student health problems and learning within schools that have a high concentration of low-income students, Pena (2000) in an article entitled *A Study of Health Care Assistance in a Title I School District*, examines how health care in low-income schools functions overall and how school administrators interact with health care providers in their schools.

### **Methods**

To answer these questions, Pena (2000) conducted a qualitative study for which he collected documents, conducted interviews, and observed meetings among building administrators, nurses, health care assistants, a school psychologist, and social workers. Pena (2000) reviewed school health care logs and observed health care providers' reviews of district logs of student visitation to each school health care office. The author also listened and took notes while the previously

mentioned school personnel talked about both the care that school personnel administered and the ways in which school personnel could improve their practice. Pena (2000) also observed meetings that occurred once a month and that involved health care providers, building administrators, and the associate superintendent. In all, Pena (2000) logged 270 hours of observations and interviewed 24 participants who included building administrators, nurses, health care assistants, a school psychologist, and social workers.

### **Findings**

The findings and the discussion are organized into three sections: (1) the community and school environments; (2) student health status and health service use; and (3) school health system. The study was conducted in an elementary public school district that is located in a county which has experienced a 27% population

increase. In one year alone, 6,000 new immigrants moved to this community. At the time of the study, 8,000 students were enrolled in school, ranging from preschool to 8<sup>th</sup> grade. The number of limited-English-proficiency students grew from 1,137 in 1990 to 3,124 in 1996. The number of students who qualified for free or reduced-price meals also increased from 3,168 to 6,136, representing an increase of 94% in six years.

Pena (2000) found that in this low-income district, an average of 34 students per day visited each school's health care provider. Approximately 70% of these students had minor health disorders, such as body aches, head colds, and minor sprains. Of the students receiving assistance from the health care provider, 30% experienced chronic health problems that consisted of congenital heart disease, epilepsy, hemophilia, diabetes, asthma, arthritis, and chronic bowel disease. Overall, students with chronic health disorders made up 16% of the student population in this Title 1 school district. This is considerably higher than the national average of 6% to 10% of school-age students with chronic problems (Office of Women's and Children's Health, 1996). In this Title 1 school district, students who experienced chronic health problems had an average of 17 days absent from school, a figure that is also higher than the national average of 7 days.

Health screening was provided during the registration process for all pre-kindergarten and kindergarten students within this district. This health screening constituted "the primary means for collecting information on the health status, medical histories, and the use of health services [by students in the study's district]" (p. 200). Though the district in the study had early screening, Pena (2000) found that only one out of three students in the district were actually screened:

"District policy does not account for students that have not been screened and allows some whose health files are incomplete or not obtained to participate in school. Each of the health care assistants explained that information describing treatment and the medical history of new students and students arriving from other countries is necessary for providing appropriate health care but that this information is rarely obtained." (p. 200)

In addition, the analyses of the data also revealed that 70% of those students screened had not visited a doctor or dentist in the last 12 months, regardless of insurance coverage. Pena (2000) found that the district had neither adequate resources to collect data on the number of students whose medical histories were undocumented nor sufficient personnel to determine how many students actually experienced minor, chronic, and severe disorders.

Finally, the analyses also indicated that students from low-income families eligible for publicly funded health care services did not use these services.

Regarding the school district health system, Pena (2000) divided these findings into school level and district level. At the school level, the author stated that health care providers seemed prepared to address student health problems; however, the data suggested that the nurse and health assistants were "enormously overworked" (p. 201). The author found that matters such as paperwork, visitations, and other demands for accountability took up most of the providers' work schedules. Furthermore, their extended interactions with students were curbed by time and space constraints. According to the author's observations of interactions between students and health care providers, most providers treated two to three students at one time in their clinics. In fact, some health care providers turned students away after a quick assessment of their health disorders.

At the district level, Pena (2000) found that there were no data that showed whether district students and parents or guardians were aware of the types and the ranges of health care assistance available in the schools. Even school principals were unaware of the full health care that was available to students. These principals learned about their

health clinics through word of mouth, district meetings, and “on a need to know basis.” When discussing student health issues and the school administrators, Pena stated:

“The analyses revealed that none of the administrators identified high-risk behaviors as threats to the students’ health and learning. Administrators did not classify student health problems as minor, chronic, or severe. They also seemed unaware of the varied levels of assistance that the different morbidities required.” (p. 203)

Pena found that none of the principals in the study had received specific training on health care systems and treatment. Furthermore, none of the administrators had an understanding of the training, knowledge, and experience of the nurses and health assistants. While the administrators acknowledged the high number of students treated by the health providers, they declared that district meetings with health care providers constituted the primary means of this knowledge. Finally, Pena (2000) points out that, at the time of the study, administrators “did not associate students’ health status with learning.” For instance, when asked about the barriers to effective health care delivery, one principal stated that his emphasis must be placed on test scores and that before this study, he had not associated health problems with

the ways in which students tested. Another school principal stated, “The failure rates and institutional crises are what we counter, we haven’t really thought about the health crises of our students” (p. 205). Pena (2000) found that a few administrators were actually resistant to increasing their involvement in health care issues:

“I don’t now what they’re asking us to do and how they expect us to do it. I don’t understand the health providers’ language, and I don’t feel they understand what we’re saying and are up against either, and I sort of resent it. I mean, on the one hand, we have to help [the students] learn; on the other, we’re being asked to keep an eye on their health. Something has to give and I know a hell of a lot more about fixing schools than fixing how students feel.” (p. 206)

### **Implications**

This study has important implications for how schools and districts can improve their health care delivery, and recommendations for health care in schools with high numbers of culturally and economically diverse students. First, Pena (2000) points out that federal legislation mandates that public schools provide services to enrolled children who experience health problems and disabilities. Second, the research is clear that the health of children has an impact on their academic learning.

Administrators must understand this connection and work collaboratively with health care providers to maximize the learning of students while addressing student health problems. In fact, health care in public schools “probably starts with administrators and school personnel becoming more aware of the health status of students and continues with their recognizing that health care assistance is not charity. It is a right that students are entitled to by law,” states Pena (2000, p. 209). This is most critical in schools with high levels of low-income students. Indeed, in this study, these particular students were more likely to experience chronic health problems and miss more school days as a result. Clearly, an effective health care database system is needed if schools and school districts are to gather information about the health care access and the health care experiences of students in relation to health care providers and school clinics.

As Iowa schools become more culturally and economically diverse, how will school and district administrators balance the academic and health needs of their students? This article speaks to the important need (1) to conduct health audits at schools and in districts so that health care practices and resources can become more transparent and (2) to improve our understanding of the relationship between health and learning.

**References**

Pena, R. (2000) A study of health care assistance in a title 1 school district. *Educational Administration Quarterly*. 36, 186-215.

National Center for Health Statistics, (2002).

US Centers for Disease Control and Prevention (2002). *Physical activity levels among children aged 9-13 years.*

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