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Megan L. Rickard
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A Dissertation

entitled

**Public School Superintendents' Perceptions of Schools Assisting Students
in Obtaining Health Insurance**

by

Megan L. Rickard

Submitted to the Graduate Faculty as partial fulfillment of the requirements
for the Doctor of Philosophy Degree in Health Education

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May 2010

An Abstract of
**Public School Superintendents' Perceptions of Schools Assisting Students
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The purpose of this study was to survey public school district superintendents' perceptions of the impact of health insurance status on students' academic success; the role schools should play in assisting students in enrolling in health insurance; and benefits and barriers to assisting students in obtaining public health insurance. Superintendents' basic knowledge of state-funded health insurance, the link between health and learning; and specific school system practices for assisting students in obtaining health insurance were also examined. A total of 800 surveys were sent out to a national stratified random sample of superintendents from public school systems using a four-wave mailing procedure, yielding a response rate of 50.5%.

Only 19% of schools systematically assessed the health insurance status of students. Using Stages of Change theory, 49% of superintendents identified their school districts in the precontemplation stage, and 36% in the action or maintenance stages for helping students obtain health insurance. Current practices identified were making state-

funded health insurance applications/materials available to parents (53%) and school nurses helped parents enroll their children (24%). Three-quarters of superintendents indicated overwhelmingly positive beliefs regarding the effects of health insurance status on students' health and academic outcomes.

The majority of superintendents believed that schools should play a role in helping students obtain health insurance but their specific role was unclear. Superintendents who believed schools should have a role identified more perceived benefits, fewer perceived barriers; and were more likely to have knowledge scores greater than seven (out of eight), be from a rural school, and be in the action or maintenance stages of helping students obtain health insurance.

The perceived benefits identified by more than 80% of superintendents were: to keep students healthier, reduce the number of students with untreated health problems, and reduce school absenteeism and improvement of students' attention/concentration during school. The two most common perceived barriers identified by at least 50% of superintendents were not having enough staff and not having the financial resources. School personnel, public policy makers, and others interested in the health and academic success of students can use the results to support collaboration in getting students enrolled in health insurance.

This dissertation is dedicated to my family and friends for their unconditional love and support over the years. First and foremost to my parents David and Janet Rickard; you have been unwavering in your support of my dreams. You were my first teachers and my biggest fans. You both inspire me to be the best I can be and believe that with hard work, anything is possible. To my family, I am where I am today because of your encouragement, and support. You each played a significant role in building my foundation and have encouraged and supported every one of my choices. Thank you!

And finally to the memory of my grandparents; to Jack and Alice Prescott who believed that education opens minds and doors; and to Evelyn Rickard for modeling throughout her life, independence, understanding and acceptance, three things I hope to pass on to my students. I would like to thank my lifelong friends who supported me throughout this journey: Christina Miller and family, Sarah Monahan, Brian Baker, Jeanette Espinosa, and Amy Sallows. You have been there to listen when I was frustrated, encourage me when I wanted to quit, laugh with me when I needed a break and understood when I was not an attentive friend. I will be forever grateful for your friendships.

Acknowledgements

I would like to thank my dissertation committee. My advisor and committee chair, Dr. James H. Price. Thank you for *always* going above and beyond student expectations, for the time that you dedicate to each student, and for your dependability throughout our journeys. I have enjoyed working with you, and learning from the model you set as a faculty member and health education professional. Dr. Susan K. Telljohann, a master teacher, and supportive friend. I will strive to be the teacher you model in every class. You are the definition of a master teacher and I can only hope to demonstrate the same to my students. Thank you to Dr. Joseph A. Dake for your *constant* encouragement to finish and help with my data analysis; and Dr. Brian N. Fink for the time you spent and your willingness to help. Thank you to the friends that will always be remembered for their kind words of encouragement and support: Joyce Balls, Candice Hendershot, Michele Bryant, James Jeffrey, and Mina Coman. Thank you to the two individuals who inspired me to pursue my doctorate, Dr. Robert Bensley and Dr. Marianne Fraunknecht. Finally, I would like to thank Dr. Debra Boardley, Dr. Timothy Jordan, Dr. Ruthie Kucharewski, Mirella Pardee, Dr. Stephen Roberts, and Mary Jo Seiber who were encouraging and supportive throughout my program. They add to the positive environment, an essential component, making student success in Health Education possible and the University of Toledo a perfect place to learn.

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Chapter 1

INTRODUCTION

This chapter includes the following sections: Epidemiology of Uninsured Children, Health Disparities and the Economically Disadvantaged, Academic Issues for Uninsured Children, Role of Medicaid and Children's Health Insurance Programs in Insuring Children, School's Role in Insuring Children, Statement of Problem, Purpose of Study, Hypotheses, Definition of Terms, Delimitations and Limitations of the Study.

1.1 Epidemiology of Uninsured Children

Despite the success of public insurance programs like Medicaid and the Children's Health Insurance Programs (CHIP), there are still 8.1 million uninsured children in the United States. Children who are eligible for public health insurance coverage, but are not enrolled, constitute about two-thirds of uninsured children in America (Henry J. Kaiser Family Foundation [KFF], 2009j). In spite of a growing economy between 2000 and 2004, employer-sponsored health insurance coverage of children declined at all income levels and has continued with the economic downturn. Although Medicaid and CHIP coverage of children increased during this same time, the offset was mainly for families with income levels below 200% of the federal poverty

level (FPL). The FPL standards vary by the size of the family (Table 1.1). For example, the poverty level for a family of four is \$22,050 (U.S. Government Printing Office, 2009). This coverage increase did not help individuals with income levels above 200% of the FPL (KFF, 2009j).

Table 1.1: 2009 HHS Poverty Guidelines

Persons in family or household	100% Poverty Level			200% Poverty Level		
	48 Contiguous States and D.C.	Alaska	Hawaii	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,830	\$13,530	\$12,460	\$21,660	\$27,060	\$24,920
2	14,570	18,210	16,760	29,140	36,420	33,520
3	18,310	22,890	21,060	36,620	45,780	42,120
4	22,050	27,570	25,360	44,100	55,140	50,720
5	25,790	32,250	29,660	51,580	64,500	59,320
6	29,530	36,930	33,960	59,060	73,860	67,920
7	33,270	41,610	38,260	66,540	83,220	76,520
8	37,010	46,290	42,560	74,020	92,580	85,120

Source: (U.S. Government Printing Office, 2009)

Children without insurance coverage are more likely to be minorities (Table 1.2) and from low-income families. An estimated 7.1 % of non-Hispanic White children compared with 17.9%, 11.2% and 11.5% of Hispanic, African American and Asian children, respectively do not have health insurance coverage. In other words, children of color are far more likely to be uninsured. Poor families (incomes below the FPL) account for 34.8% of uninsured Americans, and families considered near poor (100%-199% FPL) comprise another 29%. Children from poor and near poor families have uninsured rates of 18.1% and 14.8%, respectively, compared to 10.3% for all children (KFF, 2009j).

Table 1.2: Epidemiology of Uninsured Children by Race/Ethnicity

	White only (non-Hispanic)	Black only (non-Hispanic)	Hispanic	Asian/Pacific Islander	American Indian/Alaskan Native
Uninsured (n*)	3.1	1.3	3.1	0.4	0.1
Uninsured (%)	38.5%	15.7%	38.1%	4.7%	1.1%
Rate for same race/ethnicity	7.1%	11.2%	17.9%	11.5%	16.3%

*In millions

Source: Kaiser Family Foundation and Urban Institute Analysis based on Census Bureau's March Supplement to Current Population Survey (KFF, 2009j)

1.2 Health Disparities and the Economically Disadvantaged

Although statistics show the effect racial differences and socioeconomic status have on a child's access to care, a study adjusting for racial differences in health care access, found the lack of health insurance to be an independent predictor of children having a regular source of care (Lieu, Newacheck, & McManus, 1993). Having a regular source of care and continuity of care, is associated with decreased likelihood of hospitalization, shorter average lengths of stay, and decreased emergency department visits (Hsiao & Boulton, 2008).

Healthy People 2010 indicates the need to eliminate health disparities among different segments of the population, including ethnicity and income (U.S. Department of Health and Human Services [USDHHS], 2000). Rates of heart disease, high blood pressure, diabetes, obesity, and depression are higher for African Americans than for whites (USDHHS, 2009a); diabetes, obesity and depression are higher among Hispanics than non-Hispanic whites; and American Indians and Alaska Natives have higher rates of infant death, diabetes, unintentional injuries and suicide when compared with other races

and ethnicities (USDHHS, 2000). These disparities, although assessed in adulthood, usually begin during childhood and adolescence.

Health disparities also exist between people with different levels of income. Those with lower level incomes experience higher rates of illness and death, including heart disease, diabetes, obesity, elevated blood lead levels, and low birth weight (USDHHS, 2000). According to the Key National Indicators for Well-being, poor children reported their health as excellent 71% of the time, compared with 89% of non-poor children (Federal Interagency Forum on Child and Family Statistics, 2005). The National Health Interview Survey found poverty status to be associated with children's health, with 40% of children in poor families compared with 60% of non-poor families reporting excellent health (USDHHS, 2009b). Poor parents are nearly twice as likely to report their child in fair or poor health as non-poor parents (Wood, 2003).

Alarming disparities were found when comparing mortality rates of children eligible for Aid to Families with Dependent Children, a proxy measure of poverty, with those children not eligible. Eligible children were 1.8 times more likely to die from cancer, 3.8 times more likely to die from heart disease, and 4.8 times more likely to die from pneumonia or influenza, as compared to their non-eligible counterparts. Aid eligible children ages 10-14 were 24.2 times more likely to die from pneumonia or influenza than children who were not eligible for aid (Nelson, 1992).

Several researchers examining poverty and health found that poverty had tremendous negative effects on the well-being of children and their access to basic necessities. Diets of lower nutritional value (Fox & Cole, 2004; Nord, Andrews, & Carlson, 2005) and higher rates of physical inactivity (Abernathy, Webster, &

Vermeulen, 2002) were more often found in children living in poor families. These children also suffered more from not only treatable but also preventable conditions like chronic respiratory disease, lead poisoning, and dental disease. Another study examined the effects of poverty on child health and found that poor children had higher rates of hospital admissions, disability days, and death rates with less access to preventive, curative and emergency care (Wood, 2003). The author suggested that the effects on a child's health occur because the poor are affected more frequently by poor nutrition, single-parent families, dysfunctional families and poor housing in addition to their limited access to care. The majority of children who experience lead poisoning are poor and reside in homes with lead levels exceeding the accepted threshold for safety (Levin, et al., 2008).

People with lower income levels also experience less access to medical care. According to Nelson (1992), lack of access to and use of health care services were found to be reasons for the disparities in mortality rates among aid eligible and non-eligible children. Postponement of medical care due to cost was also suggested as a reason for the disparities in mortality rates. Another researcher, Wood encouraged professionals to provide supportive interventions, increasing access to health care, to prevent children from being “caught in a cycle of poverty and despair” (2003, p. 710).

1.3 Academic Issues for Uninsured Children

According to a survey by the American Academy of Pediatrics (1992), teachers reported that 12% of their students had health problems such as asthma, ear infections and vision problems that hindered their academic performance. Learning processes are

interrupted by regular absenteeism (Moonie, Sterling, Figgs, & Castro, 2006), and children with chronic illnesses missed more school days than healthy children (Moonie, Sterling, Figgs, & Castro, 2008; Moonie, Sterling, Figgs, & Castro, 2006; Thies, 1999).

The Council of Chief State School Officers (CCSSO) recognized that children who are distracted or absent due to chronic illness and disease are unable to benefit from even the most effective educational programs available (Council of Chief State School Officers [CCSSO], 2004). The January 2002 report by the National Education Association and the American Federation of Teachers Joint Council identified the lack of health insurance coverage as an issue affecting classroom learning. For students who are sick or have problems with vision or hearing and do not seek treatment for such conditions may find school work unimportant and more difficult. Common childhood illnesses that could be prevented or controlled with routine care are left untreated and become chronic illnesses or lifelong disabilities. In addition to their own struggles, students who do not receive treatment have the potential to spread disease and affect others' learning opportunities (National Educational Association, 2003).

Children in low-income families have higher incidence of problems with vision, hearing and oral health. They are more prone to asthma, resulting in more sleeplessness, irritability and lack of exercise. Low-income children have more lead poisoning and iron-deficiency anemia which both lead to diminished cognitive ability and more behavior problems. If children do not have access to preventive and curative care, the effects of lead poisoning and other preventable conditions may go undetected and untreated (Rothstein, 2004). Rothstein, an analyst with the Economic Policy Institute, says in his book *Class and Schools* that health care is important in reducing academic

disparities. Rothstein (2004) claims asthma symptoms go untreated more often in low-income children so asthmatic children from low-income families are 80% more likely than asthmatic children from middle-class families to miss seven or more days of school a year as a result of their disease.

Children in families with the lowest income were more than twice as likely as children in families with the highest income to have school absences of 11 days or more (Bloom & Cohen, 2007). Eleven or more absences due to illness or injury in the past 12 months was twice as likely to occur in single-mother families as in two-parent families (USDHHS, 2009b).

1.4 Role of Medicaid and Children's Health Insurance Program in Insuring

Children

Medicaid and the CHIP provide coverage for more than one in four children. In 2006, about 29 million children were insured through Medicaid and an additional seven million by CHIP (KFF, 2009j). The Children's Health Insurance Program was established to assist low-income children in obtaining health insurance. This program, together with Medicaid reduced the proportion of low-income uninsured children from 23% in 1997 to 10.3% in 2008 (KFF, 2009j). CHIP targets low-income children who are not eligible for Medicaid, typically from families with incomes from 100% up to 200% of the FPL. The federal government pays a larger portion of the costs to cover a child by CHIP than a child covered by Medicaid. Thus, Medicaid eligible children are not entitled to coverage under CHIP, and if they try to enroll in CHIP are referred back to Medicaid. CHIP, like Medicaid, has federal guidelines and both programs are administered by the

states. States have three options in creating their CHIP programs: expand their Medicaid program, create a separate CHIP program, or use a combination approach (KFF, 2009b).

Services covered by CHIP must provide equivalent coverage to the federal employee health insurance program, a program known to have good benefits. In many cases, Medicaid serves as a safety net for children who need special services not covered by CHIP programs (KFF, 2009e). Studies that examined CHIP programs have shown that children enrolled in CHIP programs had reductions in unmet health care needs and an increase in both preventive and regular sources of care (KFF, 2007a). Increasing parent awareness of eligibility, simplifying enrollment and renewal requirements, and assisting parents in enrollment are all suggestions for further reducing the number of children who are eligible for Medicaid or CHIP but not enrolled.

One of the unintended consequences of CHIP programs has been “crowd out” of privately insured children. In other words, some new CHIP enrollees have dropped employer based health insurance to enroll in CHIP. Substitution of CHIP for private health insurance coverage would increase the cost of CHIP without reducing the number of uninsured children. Most states have laws requiring strategies to prevent crowd out (Sommers, Zuckerman, Dubay, & Kenney, 2007). A study of 10 states accounting for more than 60% of all CHIP enrollment nationwide found that only 28% had private coverage during the 6 months prior to CHIP enrollment. About half of those with private coverage during the prior 6 months lost their coverage involuntarily and would have become uninsured without CHIP. The results of this study found that 7% of new CHIP enrollees met the definition of crowd-out (Sommers, Zuckerman, Dubay, & Kenney, 2007). A study conducted in New York State found similar results with about 7% of

parents reporting one or more reasons that met the definition of crowd out including: 1) cost of other insurance went up and they could not afford it anymore; 2) CHIP costs less; and 3) CHIP has better benefits. Crowd out was greatest among White children and those above 100% of the poverty line (Shone, Lantz, Dick, Chernew, & Szilagyi, 2008).

Although these studies have similar estimates, other studies report crowd out estimates ranging from 8% to 51% (Nogle & Shenkman, 2004; Allison, St. Peter, Huang, & LaClair, 2003; Hughes, Angeles, & Stilling, 2002). Estimates depend on the methods for collection and interpretation. The study in Kansas reporting 51% crowd-out included children eligible for employer sponsored health insurance even though their parents were not enrolled in the program and they were not enrolled in private health insurance the year prior to the study (Allison, St. Peter, Huang, & LaClair, 2003). When those children were not included, crowd out dropped to 22%.

Crowd-out estimates are difficult to determine because affordability is an issue. It is unclear whether parents citing affordability as a reason for lost coverage would find alternative, cheaper insurance plans if CHIP were unavailable. There is variability in estimates because in some studies these children (coverage lost due to affordability) are included, inflating the results. For other parents dissatisfied with their private coverage plans, CHIP could act as a supplement to their insurance (dental and special health care needs) rather than a replacement (Sommers, Zuckerman, Dubay, & Kenney, 2007). The above estimates were calculated before 2003 and due to the economic crises, may be very different today. Employer-sponsored insurance and job loss has increased the number of uninsured children over the past several years requiring CHIP to increase its enrollment (KFF, 2009j).

1.5 School's Role in Insuring Children

Action for Healthy Kids (2004) encourages schools to adopt a comprehensive approach to supporting wellness because if a student is not healthy and ready to learn, quality academic curricula and teachers will not be as effective as they could be otherwise. The school's role is to produce educated individuals who are able to contribute to their community and their own well-being. Case and Paxson (2006) indicate that children in poor health are more likely to drop out of school and achieve lower socioeconomic status as adults. Limited educational attainment significantly limits earning potential (opportunities and wages) and quality of life.

The Council of Chief State School Officers (2004) believes the educational community should work together with the public and private sector to address issues that interfere with student learning and prospects for healthy adulthood. CCSSO's policy statement on health encourages educational communities to support policies that ensure health insurance coverage for all students and staff and ensure leaders understand the connection between health and academic achievement and the importance of these issues being addressed if schools intend to fully meet their educational potential.

1.6 Statement of the Problem

The problem addressed in this study is the lack of health insurance in school children grades K-12. In fiscal year 2008, 8.1 million children were uninsured. However, two-thirds of the uninsured children were eligible for public insurance programs (e.g., Medicaid or CHIP) but not enrolled. Students who are uninsured are more likely to have no usual place of care, delayed care or no care due to costs (USDHHS, 2009b).

Additionally, uninsured students are more likely to receive improper care of childhood illnesses (Covering Kids and Families, 2006), and have more chronic illnesses (Institute of Medicine, 2002).

Healthy children have better attendance, better concentration, more pro-social behaviors, and perform better on academic tests (Association of State and Territorial Health Officials, 2002). Although schools are not required to enroll students in insurance programs, educating and assisting parents in enrolling their child in health insurance programs could benefit the school and the uninsured students. The CCSSO wants to ensure high standards of performance for every child, preparing each one to succeed as a productive member of a democratic society. Their policy statement “calls on our membership and our colleagues to recognize the enormous impact that health has on the academic achievement of our nation’s youth.” (CCSSO, 2004, p. 1).

Many families of uninsured, eligible children are unaware of the availability of programs, do not believe their children are eligible, or face barriers to enrolling and renewing their children in public programs (KFF, 2009i). The Kaiser Commission on Medicaid believes that educating parents and simplifying the enrollment process would significantly decrease the number of uninsured children (KFF, 2009j). Pre-schools and schools could take a more active role and work with state and local health departments to educate and assist parents in enrolling their children in Medicaid and Children’s Health Insurance Programs. Schools could have Medicaid/CHIP employees at their schools during initial fall enrollments to help parents with the enrollment process and insure that all children are covered. Another alternative is that schools could simply have parents complete insurance status forms for their children which are subsequently handed over to

state agencies. A third option would be for school systems to have trained professionals or volunteers who could assist parents in enrolling eligible children. Increasing parent awareness of eligibility, assisting parents in enrollment and simplifying enrollment requirements are all suggestions from the Kaiser Commission on Medicaid. These strategies would reduce the number of children who are eligible for Medicaid or CHIP, but not enrolled. School involvement in health insurance enrollment is likely to decrease the number of uninsured students, childhood illnesses, and absenteeism rates and increase students' academic achievement test scores.

In addition, by having more eligible Medicaid/CHIP children enrolled then schools which provide school based health care could be reimbursed by the state for services rendered. Although schools report the process as complex and complain that only a third of actual costs are reimbursed, they also report a positive financial impact from participation in the program (Michigan Department of Education, 2005).

In this study, school systems, not individual schools, are the focus of the research. Superintendents have the authority to speak for the school system as opposed to individual school personnel. Superintendents make recommendations to school boards regarding policies and practices to be implemented, playing a key role in facilitating or hindering school-based efforts (Winnail & Bartee, 2002). Therefore, it is believed that superintendents are instrumental in school district decisions regarding policies and procedures. Though school administrators may understand school district health issues, it should not be assumed that they understand the connection between student health and student learning (Winnail & Bartee, 2002).

1.7 Purpose of the Study

The purpose of this study was to survey public school district superintendents on their perceptions of the role of schools in assisting students in obtaining state-funded health insurance. The Stages of Change theory was utilized in this study. It is based on the idea that change occurs over time through a series of five stages (readiness and involvement levels). This theory allowed us to assess the superintendents' perceptions of the school system's readiness or level of involvement for (stage) assisting students in obtaining state-funded health insurance. Specific school system practices for assisting uninsured students were also examined. The following superintendent perceptions will be examined: 1) perceived impact of student health insurance status on students' academic success; 2) perceived effects of student health insurance status on students' well-being; 3) perceived role schools should play in assisting uninsured students in obtaining health insurance; and 4) perceived benefits of assisting students in obtaining public health insurance and 5) perceived barriers to assisting students in obtaining public health insurance. In addition to perceptions, public school superintendents' basic knowledge of state-funded health insurance and the link between health and learning were explored.

The lack of health insurance is a problem that affects a large portion of the population, specifically women, children and racial/ethnic minorities. Many individuals from these priority populations are eligible for health insurance but are unaware of their eligibility or unsure of how to apply. This study may provide policymakers, school administrators, health educators and governmental officials with the insight needed to work collaboratively with school systems to ensure school-aged children have health

insurance. Schools that are assisting parents in enrolling their students can provide valuable information that can be shared with other school personnel.

There is considerable research on racial/ethnic health disparities, the lack of health insurance and the impact social inequality has on access to health services. However, there is very limited research in regards to how these issues should be addressed. This study will not solve these issues but will provide insights into one possible solution to reduce the number of uninsured children. Specifically, the following research questions will be addressed:

1. According to the Stages of Change theory, in what stage are school systems with respect to their superintendents' perceptions of schools helping uninsured students obtain state-funded health insurance?
2. What are public school systems' practices for helping uninsured students obtain state-funded health insurance?
3. Do public school superintendents have basic knowledge of state-funded health insurance and the effect of health status on academic outcomes (attendance, attention, graduation)?
4. What are the perceptions of public school superintendents regarding the effects of health insurance status on students' well-being (illness, academic outcomes)?
5. What are the perceptions of public school superintendents regarding the school systems role in helping uninsured students obtain health insurance?
6. What benefits do public school superintendents perceive for schools to help students obtain health insurance?
7. What barriers do public school superintendents perceive for schools to help students obtain health insurance?

1.8 Hypotheses

The following hypotheses will be explored in the current study:

According to the Stages of Change theory, in what stage are school systems with respect to their superintendents' perceptions of schools helping uninsured students obtain state-funded health insurance?

- 1.1 The majority of superintendents do not place their school district in the action or maintenance stage of the Stages of Change theory with regards to schools helping uninsured students obtain state-funded health insurance.
- 1.2 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on whether the school district systematically assesses student health insurance status (yes, no).
- 1.3 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's education level (Bachelor's, Master's or Specialist, Doctorate).
- 1.4 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's race/ethnicity (white, non-white).
- 1.5 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the racial/ethnic composition of the school district (predominately white, non-white).
- 1.6 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).
- 1.7 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students in obtaining health insurance does not differ significantly based on the location of the school district (rural, non-rural).
- 1.8 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's knowledge of state-funded health insurance and the effects of health on academics (high, low).

- 1.9 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's beliefs about the effect of health insurance status on students' well-being (Score 0-24).
- 1.10 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's beliefs about the role of schools in helping students obtain health insurance (high, low).
- 1.11 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.
- 1.12 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.

What are public school systems' practices for helping uninsured students obtain state-funded health insurance?

- 2.1 The majority of superintendents do not report that schools in their school district systematically assess the health insurance status of all students at the beginning of each school year.
- 2.2 The majority of superintendents do not report that schools in their school district help students obtain state-funded health insurance.
- 2.3 The majority of superintendents do not report that their school district received financial support to help students enroll in state-funded health insurance.
- 2.4 The majority of superintendents do not report their school district as providing parents assistance for enrolling their children.

Do public school superintendents have basic knowledge of state-funded health insurance and the effect of health status on academic outcomes (attendance, attention, graduation)?

- 3.1 The majority of superintendents do not have basic knowledge of state-funded health insurance and the effect of health status on academic outcomes.
- 3.2 There is no significant difference in superintendent's knowledge (high, low) by superintendent's education level (bachelor's, master's or specialist, doctorate).

- 3.3 There is no significant difference in superintendent's knowledge (high, low) by superintendent's race/ethnicity (white, non-white).
- 3.4 There is no significant difference in superintendent's knowledge (high, low) by racial/ethnic composition of the school district (predominately white/non-white).
- 3.5 There is no significant difference in superintendent's knowledge (high, low) by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).
- 3.6 There is no significant difference in superintendent's knowledge (high, low) by the location of the school district (rural, non-rural).
- 3.7 There is no significant difference in superintendent's knowledge (high, low) by superintendents' beliefs about the effect of health insurance status on students' wellbeing (0-24).
- 3.8 There is no significant difference in superintendent's knowledge (high, low) by superintendents' beliefs about the role of schools in helping students obtain health insurance (high, low).
- 3.9 There is no significant difference in superintendent's knowledge (high, low) by the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.
- 3.10 There is no significant difference in superintendent's knowledge (high, low) by the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.

What are the perceptions of public school superintendents regarding the effects of health insurance status on students' well-being (illness, academic outcomes)?

- 4.1 The majority of superintendents do not agree that health insurance status affects a students' well-being.
- 4.2 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by superintendent's education level (bachelor's, master's or specialist, doctorate).
- 4.3 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by superintendent's race/ethnicity (white/non-white).
- 4.4 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the racial/ethnic composition of the school district (predominately white/non-white).

- 4.5 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).
- 4.6 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the location of the school district (rural, non-rural).
- 4.7 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the superintendent's beliefs about the role of schools in helping students obtain health insurance (high, low).
- 4.8 There is no relationship between superintendents' perceptions of the effects health insurance status has on students' well-being (0-24) by the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.
- 4.9 There is no relationship between superintendent's perceptions' of the effects health insurance status has on students' well-being (0-24) by the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.

What are the perceptions of public school superintendents regarding the school systems role in helping uninsured students obtain health insurance?

- 5.1 The majority of superintendent's will not agree that the school should have a role in helping students obtain health insurance.
- 5.2 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by superintendent's education level (bachelor's, master's or specialist, doctorate).
- 5.3 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by superintendent's race/ethnicity (white, non-white).
- 5.4 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the racial/ethnic composition of the school district (predominately white/non-white).
- 5.5 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).

- 5.6 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the location of the school district (rural, non-rural).
- 5.7 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.
- 5.8 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.

What benefits do public school superintendents perceive for schools to help students obtain health insurance?

- 6.1 A majority of superintendents will not identify any perceived benefits for schools to help students obtain health insurance.
- 6.2 There is no significant difference in superintendent's number of perceived benefits (0-17) for schools to help students obtain health insurance by the racial/ethnic composition of the school district (predominately white/non-white).
- 6.3 There is no significant difference in superintendent's number of perceived benefits (0-17) for schools to help students obtain health insurance by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).
- 6.4 There is no significant difference in superintendent's number of perceived benefits (0-17) for schools to help students obtain health insurance by the location of the school district (rural, non-rural).
- 6.5 There is no relationship between the number of perceived benefits (0-17) and the number of perceived barriers (0-10) for schools assisting students in obtaining health insurance.

What barriers do public school superintendents perceive for schools to help students obtain health insurance?

- 7.1 A majority of superintendents will not identify any perceived barriers for schools to help students obtain health insurance
- 7.2 There is no significant difference in superintendent's number of perceived barriers (0-10) for schools to help students obtain health insurance by the racial/ethnic composition of the school district (predominately white/non-white).

- 7.3 There is no significant difference in superintendent's number of perceived barriers (0-10) for schools to help students obtain health insurance by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).
- 7.4 There is no significant difference in superintendent's number of perceived barriers (0-10) for schools to help students obtain health insurance by the location of the school district (rural, non-rural).

1.9 Definitions of Terms

Academic Success

Proficiency in Science, Mathematics, English, and Social Studies measured by student grades, scores on proficiency tests, and school completion (graduation) rates.

Action Stage

The stage in which people have made specific overt modification in their behavior within the past six months (Prochaska & DiClemente, 1983). For this study, the action stage will be measured by a school system assisting students in obtaining health insurance at the beginning of the current academic school year.

Barriers

An individual's belief in the potential negative aspects, tangible or psychological, of a particular action which deters an individual from engaging in the recommended behavior (Becker, 1974).

Benefits

An individual's belief in the efficacy of the advised action to reduce risk or seriousness of impact. The potential positive aspects of engaging in or taking action (Becker, 1974).

Child Health Insurance Program

Formerly called SCHIP for State Children's Health Insurance Program. Programs designed to help states provide health insurance for children whose parents do not qualify for Medicaid and cannot afford private health insurance (Sullivan, 2006). These programs include individual state programs which are extensions of Medicaid, combination programs with Medicaid or wholly separate programs from Medicaid.

Children

A child 18 years of age or younger, unless identified by specific ages in the text.

Contemplation Stage

The stage in which people intend to change within the next six months (Prochaska & DiClemente, 1983). For this study, the contemplation stage will be measured by the school systems intent to change within the next year.

Federal Poverty Level

The guidelines used for determining financial eligibility for certain federal programs which includes Medicaid and CHIP.

Health Belief Model (HBM)

A value-expectancy theory used to explain change and maintenance of health related behaviors (Becker, 1974).

Insured

An Individual with continuous health insurance for the entire calendar year.

Low-income

Low-income includes both poor (up to 100% of the federal poverty level) and near-poor (up to 200% of the federal poverty level).

Maintenance Stage

The stage in which people strive to prevent relapse but do not apply change processes as frequently as do people in action, usually measured by a change in overt behavior for less than six months (Prochaska & DiClemente, 1983). For this study, the maintenance stage will be measured by assistance for more than one full academic school year.

Medicaid

Medicaid is a Federal-State matching entitlement program providing medical assistance for individuals and families with low incomes and resources administered by the states (Centers for Medicare & Medicaid Services, 2006).

Multi-generational family

Families with at least three generations in a household, plus families in which adults are caring for children other than their own (KFF, 2009j).

Near Poor

A family's taxable income for the preceding year did not exceed 200% of the Federal Poverty Level but was greater than 100% of the Federal Poverty Level (KFF, 2009j).

Poor

A family's taxable income for the preceding year did not exceed the Federal Poverty Level (KFF, 2009j).

Pre-contemplation Stage

The stage in which people do not intend to take action in the foreseeable future, usually measured as the next six months (Prochaska & DiClemente, 1983). For this study, the pre-contemplation stage will be measured by the school systems intent to change within the next year.

Preparation Stage

The stage in which people intend to take action in the immediate future, usually measured as the next month (Prochaska & DiClemente, 1983). For this study, the preparation stage will be measured by assistance during the current academic school year.

Private Health Insurance

Health insurance coverage provided through an employer or union or purchased by an individual from a private health insurance company (U.S. Census Bureau, 2008).

Public School

An elementary, middle or secondary school supported and administered by state and local governments.

Public Health Insurance

Health insurance coverage funded by federal, state, or local governments (U.S. Census Bureau, 2008).

Relapse

Movement across the stages is fluid, and individuals can regress to an earlier stage if their ambivalence increases or their self-efficacy decreases. Relapse can occur

at any stage, from any stage to another stage (Prochaska & DiClemente, 1983). For this study, relapse will be measured by a school system previously helping students obtain health insurance but no longer do.

Stages of Change

A theory of change in behavior involving progress through a series of six stages (Prochaska & DiClemente, 1983).

Superintendent

An education executive that oversees and manages a school district.

Uninsured

An individual without health insurance coverage for all or part of the calendar year.

1.10 Delimitations

The sample being used requires that the researcher have delimitations that may reduce the external validity of the study. The delimitations of the study include:

1. Only public school superintendents were surveyed so the results may not represent the perceptions of superintendents of private school systems. Private charter, and alternative schools vary widely but the majority function independent from the federal government. Since this study is exploring perceptions regarding federal and state-funded health insurance, it makes sense to exclude schools independent from the federal government. In addition, there are not comprehensive lists of such schools which can lead to sampling errors. Finally,

the student populations of such schools are much smaller than public schools and often they are not characteristic of public school students.

2. Only superintendents who were registered with and listed on their state's Department of Education listserv were included in the sample. If there were public school superintendent's not included in the total sample population, this would affect the external validity of the results. However, since states regularly update their lists this is likely to be rare.
3. The sample was delimited to superintendents in the United States and therefore the results may not be able to be generalized to schools outside of the continental United States.
4. The survey instrument used a closed questions format which did not allow respondents to give their perceptions about concepts not included in the survey. Thus, should key items be missing from the questionnaire this would be a threat to the internal validity of the results.

1.11 Limitations

The limitations of this study include:

1. A cross-sectional survey was used which precludes interpretation of any causality regarding superintendent' perceptions of state-funded health insurance and the insurance activities of their schools.
2. The monothematic nature of the instrument may have placed some superintendents in a mindset that may not be indicative of their true perceptions or

practices. To the extent this was true it would represent a potential threat to the internal validity of the results.

3. The predominantly closed format of the survey is a potential threat to the internal validity of the study. Nearly 11% (n=41) of superintendents wrote in comments. To the extent that the other 90% did not share additional comments, the questionnaire may not have captured all the opinions superintendents wanted to share. Additionally, to the extent that some concepts were not included in the survey, the questionnaire may not have captured the total picture of superintendent perceptions.
4. A school's current role in student acquisition of health insurance was self-reported rather than assessed through direct observation. Characteristic of all survey research, respondents answering in a socially desirable way cannot be ruled out. If this occurred, this would represent a threat to the internal validity of the results.
5. To the extent that the return rate (50.5%) deviated from 100% the greater the potential threat to the external validity of the findings. There were almost as many non-respondents as there were respondents. This may limit the ability to generalize the results to the entire population of public school superintendents. If non-respondents have different perceptions from those who responded, then the results would not represent the perceptions of the total population. National demographic data was not available and there was no representative method, other than making hundreds of phone calls, to detect differences between those who responded and those who did not respond.

During the fourth wave of contact with superintendents some explanations for the lower than expected response rate were identified. When superintendents were contacted by phone to acquire an email or fax number for the fourth contact, the following issues were identified: 1) superintendents reported that they did not open their own mail and had a policy that all surveys were to be discarded; 2) some districts, especially urban school districts had a centralized research office where surveys were sent. Superintendents reported they did not usually receive those surveys; 3) if there was a change in superintendent after the Department of Education website was updated and the survey was addressed to the old superintendent, it was most likely discarded. Although no estimate can be made for how likely it is that these issues affected the response rate in this study, the author felt it necessary to identify potential explanations.

6. There were 11 respondents (2.8%) that did not identify themselves as having experience as an assistant superintendent or superintendent. These individuals were appointed by their superintendent to complete the survey on their behalf. To the extent that their answers are different from superintendents, this would be a threat to internal validity.

Analyses were conducted for Stages of Change with the 11 non-superintendent responses removed. The analyses were the same whether the 11 non-superintendents were included or not. For instance, analyses including the 11 respondents versus analyses not including the responses follows: schools in the action group were more likely to perceive the school to have a role ($\chi^2=12.88$, $df=2$, $p=0.002$) vs. ($\chi^2=13.91$, $df=2$, $p<0.001$); and more likely to systematically

assess health insurance status of students ($\chi^2=29.4$, $df=2$, $p < 0.001$) vs. ($\chi^2=30.3$, $df=2$, $p < 0.001$). Superintendents from the action group answered more knowledge questions correctly when compared with superintendents from the non-action group ($\chi^2=5.83$, $df=2$, $p = 0.054$) vs. ($\chi^2=5.68$, $df=2$, $p = 0.059$). These analyses demonstrate that these 11 respondents are not uniquely different from superintendents and therefore were not removed for data analysis.

7. In recent months CHIP legislation has received considerable mass media attention. This attention in the news may have affected some superintendent's perceptions that they reported in the current questionnaire. If this occurred, this would be a threat to the internal validity of the study.

Chapter 2

REVIEW OF THE LITERATURE

This chapter contains a review of the literature for the following topics: History of Child Health Insurance, Epidemiology of Uninsured Children, Consequences of Being Uninsured, Academic Issues for Unhealthy Children, Sources of Health Insurance for Children, Role of Medicaid and The Children's Health Insurance Program in Insuring Children, Eligible but Uninsured, School's Role in Insuring Children, Health Belief Model, Stages of Change Theory, and Summary.

2.1 History of Child Health Insurance

2.1.1 The Beginning

Child health insurance began with private health insurance. However, in the 1950s medical advances such as antibiotics raised both the value and costs of healthcare. Hospitals charged insurers higher fees to recoup uncompensated care and insurers passed these cost increases on to their customers. Politicians were concerned that this insurance based system could not handle the needs of the high-risk elderly population and worked to ensure elderly, especially poor elderly, health was protected (Engel, 2006). The Kerr

Mills Act of 1960, an amendment to Title I of the Social Security Act, provided federal aid to states for the voluntary establishment of programs to pay for the medical care of economically needy persons over the age of 65 years (Sultz & Young, 2006). However, just like the non-elderly poor, hospitals began rejecting Kerr-Mills patients, and they too missed out on the new advancements of modern medicine (Engel, 2006). The Kerr Mills Act, implemented by 25 states, is considered the forerunner of Medicaid (Sultz & Young, 2006).

President Lyndon Johnson, during the election of 1964, rallied to support the poor, regardless of age declaring a federal “War on Poverty”. During this “War”, Medicare and Medicaid were created to address health care needs of American citizens. Medicare addressed elderly health issues and Medicaid addressed poor health issues, especially poor children and their mothers. Medicaid was considered a “welfare” bill, administered by states through their “Aid to Families with Dependent Children” (AFDC) programs. Although Medicaid was considered a “welfare” bill, no two-parent families, childless couples, or single adults were eligible. The program was for single parent families and children only. Eligibility was based on individual state welfare requirements. The between states variance in eligibility requirements meant that many poor people did not qualify in one state but could be eligible if they had lived in a different state. Additionally, urban poor, nonwhites, rural dwellers and children were considered hard to reach populations and did not benefit as much from the Medicaid program (Engel, 2006).

2.1.2 Medicaid Reform

Many presidents including Nixon, Carter, Reagan and Clinton failed at reforming Medicaid and settled for incremental reforms to fill gaps in coverage of the poor and address budget overruns. Carter, for example, added the Child Health Assessment Program which incorporated poor children with two working parents. However this new program did not address the budget overruns and the number of poor Americans grew faster than the number of people the program enrolled. Reagan lowered payments to healthcare providers and raised eligibility limits. He also insisted that everyone pay something for healthcare to limit overuse of services. As a result, Reagan's reforms lowered the proportion of the poor covered by Medicaid (Engel, 2006).

From 1980 to 1990, Medicaid expenditures grew almost 300% (Sultz & Young, 2006). Although employer-sponsored health coverage increased in the mid and late 1990s, the increase was not enough to offset the declines in Medicaid enrollment that began following welfare reforms in the mid-1990s. During this same period, AFDC was eliminated and replaced with Temporary Assistance to Needy Families (TANF). Many eligible families were not enrolled in Medicaid once the link between welfare assistance and Medicaid was severed by TANF. In spite of these challenges, Medicaid has remained one of the only uncapped entitlement programs in the array of federal-state programs while others have merged into federal block grants which either get reduced or do not receive adequate funding to keep up with inflation (Concannon, 2005).

2.1.3 State Children's Health Insurance Plan

In 1997, Congress approved the State Children's Health Insurance Program (SCHIP), "a program designed to help states provide health insurance for children whose

parents do not qualify for Medicaid and cannot afford private health insurance” (Sullivan, 2006, p. 51). The program, enacted as part of the Balanced Budget Act of 1997 (BBA) had bi-partisan support with authorization for 10 years of nearly \$40 million. As states implemented SCHIP and improved Medicaid enrollment, the number of uninsured declined. Enrollment in both Medicaid and SCHIP increased continually into the 21st century. These increases were due to eligibility qualification increases, improved outreach efforts, and streamlined enrollment systems (KFF, 2009j). By 2001, 4.6 million children had been enrolled in the newly expanded health insurance program and 6 million by the year 2003 (U. S. Government Accountability Office, 2007). However, this trend reversed in 2005. From 2004 to 2006, public coverage rates did not change but employer sponsored health insurance declined resulting in 1 million additional uninsured children in the U.S. (KFF, 2009e). There was a decline of 1.5 million in the number of uninsured from 2006 to 2007 due to a positive fiscal outlook, no changes in employer-sponsored coverage, and more uninsured children (KFF, 2009j).

2.1.4 Medicaid and CHIP Today

Today Medicaid primarily covers four main groups of nonelderly low-income people including children, their parents, pregnant women, and individuals with disabilities but 50% of all Medicaid beneficiaries are children. SCHIP, now known as CHIP, supplements Medicaid by insuring an additional seven million children who are low income but have family incomes too high to qualify for Medicaid. Medicaid covers 25% of all children in the U.S. and 50% of low-income children. Together these programs cover nearly two-thirds (60%) of all poor children and more than 40% of near-

poor children (Schwartz, Howard, Williams, & Cook, 2009). Most states cover children up to 200% of the poverty level through Medicaid or CHIP (KFF, 2009j).

Medicaid and CHIP programs vary by state with each state setting its own type of program, eligibility standards, enrollment procedures and caps, scope and duration of services, and rate of payments to providers. Therefore coverage in neighboring states may vary greatly, further complicating the process for families who relocate to a different state. States must screen for Medicaid eligibility before enrolling children into CHIP. If a child is eligible for Medicaid, then the child is referred back to Medicaid and not enrolled in CHIP. A state's starting point for CHIP eligibility is dependent upon the eligibility levels previously established in its Medicaid program. Under federal Medicaid law, all state Medicaid programs must cover children aged 5 and under if their family incomes are at or below 133 percent of the federal poverty level (FPL) and children aged 6 through 18 if their family incomes are at or below 100 percent of FPL (U.S. Government Accountability Office, 2007). Most states (n=43) and the District of Columbia cover children at or above 200% of the poverty level through Medicaid or CHIP (KFF, 2009j).

Although CHIP and Medicaid are funded by individual states with matching funds from the federal government, the amount varies by state based on the per capita income for each state relative to the national average and the actual amount each state spends that qualifies as matchable. For 2009, the range for Medicaid reimbursement is 56% - 84% (KFF, 2009d) and 65% - 83% for CHIP (KFF, 2009c). Mississippi has the highest reimbursement rate for both Medicaid and CHIP (KFF, 2009c; KFF, 2009d).

2.1.5 Reauthorization of CHIP

Funding for CHIP required reauthorization in 2007. The federal government worked on reauthorization all year beginning with President Bush's veto of a House bill in January and budget in February; ending in December with the CHIP extension bill (S 2499) which maintained previous funding levels through March 2009. Many states supported their programs with roll-over funding of unused portions from prior year allotments. Unused portions from states were redistributed (at the end of three years) to fund states that exceeded their allotments (Park & Broaddus, 2007). However, the President's 2007 budget reduced the amount of time states had to spend allotments from three years to one year making it difficult for states to fund their programs. The congressional budget office projected over 13 billion dollars in shortfalls over the next five years; the President's budget proposal would have covered less than half of the shortfall. The President's budget would have made it impossible for CHIP programs to maintain their current funding or expand programming without additional state funds to cover the shortfalls. CHIP programs would have had to scale back programming by reducing eligibility, capping enrollment, eliminating benefits, increasing beneficiary cost-sharing or cutting payments to providers unless funding was increased (Park & Broaddus, 2007).

In July 2007 both the Senate and the House passed separate CHIP bills with the Senate bill being more conservative, yet still increasing funding. The Senate and House agreed on a compromised bill, the Children's Health Insurance Program Reauthorization Act (CHIPRA), which if enacted into law would have continued to cover 700,000 children who would have lost their coverage. The compromised bill would have also

covered an additional 4 million children, reducing the number of uninsured children by about half. The majority of children (84%) who would have gained coverage under CHIPRA were low-income and currently eligible but not participating. CHIPRA also would have ensured that CHIP funds were sent to the states that needed them by reducing the period states could use CHIP allotments from three years to two years. The unused allotments would be redistributed for performance bonuses which encouraged states to enroll more children who were already eligible for CHIP and Medicaid. This bill targeted those who were eligible but not enrolled by encouraging states, through bonuses and grants, to simplify enrollment procedures and initiate new outreach efforts. The president vetoed the bill and Congress was unable to override the veto (Georgetown University, 2007).

In order to prevent CHIP from expiring on September 30, 2007, Congress extended funding until mid-November 2007, hoping to reach an agreement for reauthorization (KFF, 2007b). Congress was unable to reach an agreement that the President would support. On Saturday, December 29, 2007 the President signed into law the Medicare, Medicaid and CHIP Extension Act of 2007. This extension, until March 31, 2009, maintained the previous level of funding for CHIP at \$5 billion per year with additional funds for projected shortfalls in 2008 and 2009 (Kenney, 2008). Congress vowed at the end of 2007 to get every child covered whether through CHIP expansion or a children's national health care plan.

In December 2007, the Centers for Medicare and Medicaid (CMS) ruled to eliminate federal Medicaid reimbursements to school districts for certain school-based administrative activities and transportation services provided to low-income children with

disabilities. In April of 2008, Congress passed the Protecting Medicaid Safety Net Act (H.R. 5613) which extended the 6-month moratorium on the school-based rule until April 2009 which was signed by President Bush on June 30, 2008. CMS made this rule to save tax payer dollars and because of improper billing by schools deemed waste and abuse (National School Boards Association, 2008).

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 signed into law by President Obama on February 4, 2009 extended and expanded the Children's Health Insurance Program. CHIPRA increased federal funds by \$33 billion over the next four and a half years; expecting to extend coverage to an additional 6.5 million children by 2013. Two-thirds of these children would have been uninsured without these additional funds while the other third are expected to enroll due to efforts to reach new populations. If a state chooses to extend eligibility to children with family incomes above 300% of the federal poverty level (\$66,150 for a family of 4 in 2009), the Medicaid match rate would be used rather than the higher CHIP matching rate. Although CHIPRA did not address the August 17th directive issued under the Bush Administration limiting the state's ability to expand coverage, President Obama withdrew this directive on February 4, 2009 (KFF, 2009a).

CHIPRA does not just extend and expand coverage but improves coverage of low-income children by offering bonus payments to states that exceed enrollment targets of eligible low-income children and providing outreach funds for outreach efforts including translation and interpretation services (KFF, 2009a). These bonuses are intended to encourage enrollment of already eligible low-income children. States with increased enrollment eligibility will have to wait until the third year of implementation

(KFF, 2009g). To be eligible for these bonuses, states will have to implement at least five of the eight policies for application and renewal that promote the enrollment of eligible children. The eight policies are: 1) twelve-month continuous coverage guaranteeing a full 12 months of coverage regardless of changes in financial circumstances; 2) elimination of the asset test/documentation which relieves both families and states of the paperwork burden of documenting assets; 3) eliminating the face-to-face interview at application and renewal helping parents with inflexible jobs and schedules; 4) joint application and renewal forms using the same verification process which will make it less confusing for parents; 5) administrative renewals by verification through other program records and data bases saving parental headache and administrative costs; 6) presumptive eligibility allows organizations in community based organizations and schools to screen children and enroll them into programs; 7) express lane eligibility which allows eligibility to be based on other federal programs like the free and reduced lunch program which would allow organizations like school systems to assist with enrollment; and 8) having premium assistance programs that work in tandem with private health insurance to fill in gaps like dental care (KFF, 2009h). Federal policy makers have made efforts to provide legislation giving the states the tools and resources to greatly increase the number of children insured.

2.2 Epidemiology of Uninsured Children

There is confusion among policymakers as to who should be considered uninsured. When uninsured but eligible individuals seek medical care, usually emergency medical care, they can apply and receive retroactive Medicaid coverage.

Some policymakers view these individuals as insured while other policymakers view them as uninsured because they may have delayed or avoided seeking medical care until it was unavoidable. An additional problem with this conditional coverage is that CHIP funding is going unused while Medicaid is financially overburdened. Informing and assisting individuals of their CHIP eligibility will use these resources more effectively and cut costs associated with emergency department care.

As of 2008, the most recent data available for analysis; 46 million non-elderly people in the United States were uninsured (KFF, 2009j). This means that nearly one in six individuals under age 65 did not have health insurance. Children accounted for about 30% of the non-elderly population but almost 20% of the non-elderly uninsured population. One in ten children in America is uninsured. Adolescents have higher uninsured rates than younger children (11% and 8%, respectively) because of lower Medicaid eligibility rates for older children. Although White children constitute a large percentage of uninsured children, racial/ethnic minorities are disproportionately affected (Table 1.2). While only 7% of White children are uninsured, racial/ethnic minority populations range from 11% to 18% (KFF, 2009j).

Lower education levels are associated with higher uninsured rates, with about 62% of uninsured individuals not graduating from college making it more difficult to get jobs that provide health coverage (KFF, 2009j). As parents' education levels increase, their job opportunities and pay increase which affects their health insurance opportunities. There is a reciprocal relationship between parental education level and a child's health. As a parent's education level increases, the health of their children usually increase (Bloom & Cohen, 2007).

More than two-thirds of uninsured children are from low-income families with incomes at or below 200% of the federal poverty level (Figure 2.1). Even though the majority of uninsured children are poor (incomes less than 100% of the federal poverty level) or near poor (incomes between 100% - 199% of the poverty level), nearly 70% are from working (1 or more full-time workers) families (Schwartz, Howard, Williams, & Cook, 2009). About 43% of the poor and 29% of the near poor do not have health insurance (KFF, 2009j).

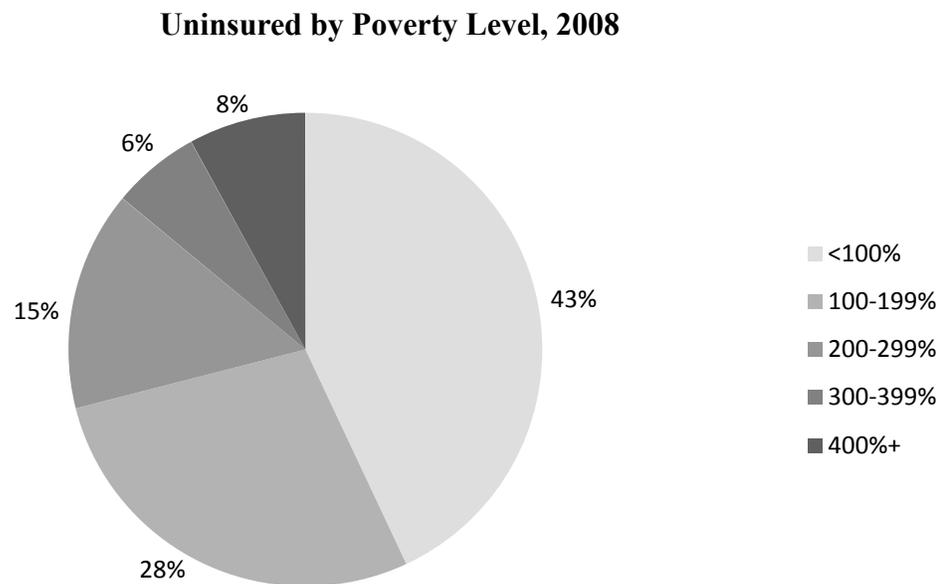


Figure 2.1: Uninsured by Poverty Level, 2008. Source: Kaiser Family Foundation and Urban Institute Analysis based on Census Bureau's March Supplement to Current Population Survey (KFF, 2009j).

Low-income parents tend to have jobs in small businesses, service industries and blue-collar jobs which often do not provide employer-sponsored health insurance. Low-income workers are at the greatest risk of being uninsured and are less able to afford premiums in the non-group market (KFF, 2009j).

Health insurance coverage (Table 2.1) of poor (100% of Federal Poverty Level) and near poor (200% of Federal Poverty Level) children is more likely to be public insurance (64% and 45%) or no insurance (18% and 15%, respectively) compared with children at or above 400% of poverty level (4.2% public and 3% no insurance). Employer-sponsored insurance is less likely for poor (13%) and near poor (35%) children compared with children (87%) above 400% of FPL. Children who live in multigenerational homes are more likely to be uninsured (23%) than children who live with one or two parents, 11% and 8%, respectively (KFF, 2009j).

Table 2.1: Children’s Health Insurance Coverage by Poverty Level, 2008

Poverty Level	Uninsured	Medicaid / Other Public	Employer / Other Private
<100% FPL	18%	66%	16%
100-199% FPL	15%	47%	39%
200-299% FPL	9%	19%	72%
300-399% FPL	5%	11%	84%
400%+ FPL	3%	5%	92%

Source: Kaiser Family Foundation and Urban Institute Analysis based on Census Bureau’s March Supplement to Current Population Survey (KFF, 2009j)

According to the 2008 Current Population Survey, uninsured rates vary by location. The Midwest had the lowest uninsured rate (11.6%) and the South had the highest (18%). The West had an uninsured rate of 17.4% and the Northeast 11.6%. Uninsured rates increased in all regions of the country between 2007 and 2008 except for the South. People living in cities had higher rates of being uninsured than those living in suburbs (Denavas-Walt, Proctor, & Smith, 2009). While some states cover 90% of their

low-income children other states have nearly 30% of their low-income children without insurance. About 40% of the 8.1 million uninsured children live in the Southern States even though fewer than 30% of all children live in the Southern United States (Schwartz, Howard, Williams, & Cook, 2009).

2.3 Consequences of Being Uninsured

Although health insurance status is not an exclusive barrier to health care, the lack of health insurance coverage has been well documented as a major barrier to receiving health care. Having health insurance improves health overall; researchers estimate that a reduction in premature mortality of up to 25% could be achieved if the uninsured were to gain continuous health coverage. The number of excess deaths attributed to being uninsured among adults age 25-64 in 2006 has been estimated to be between 22,000 and 27,000 (Dorn, 2008). The Institute of Medicine reported in 2003 that 18,000 Americans die each year because of a lack of health insurance (Institute of Medicine, 2003). The Urban Institute conducted a follow-up analysis in 2007 and found that between 19,500 and 23,500 Americans, one American every 24 minutes dies as a result of being uninsured (Dorn, 2008). The economic loss to the U.S. economy in 2006 due to poorer health and shorter life spans of the uninsured may have been as high as \$200 billion (Axeen & Carpenter, 2008). Research has shown that health insurance affects utilization rates and utilization rates affect health. Partnership for Prevention reports that increasing utilization of only five preventive (take aspirin daily to prevent heart disease, smokers advised by health professionals to quit smoking, individuals 50 and older were up to date with colorectal screenings and immunized against influenza, and women 40 and older

were screened for breast cancer at least every two years) measures would save 100,000 American lives annually (National Commission on Prevention Priorities, 2007).

2.3.1 Utilization and Health Insurance Status

The lack of health insurance affects health care utilization rates. Health care utilization requires individuals to believe they need care and people with less contact with physicians and other health care providers may not be aware of their undiagnosed conditions or what are recommended screening and preventive services. Delaying or not receiving treatment can lead to more serious illnesses and avoidable health problems (National Commission on Prevention Priorities, 2007). Children with health insurance generally have better health throughout their childhood than uninsured children. Salsberry (2003) found chronic conditions like asthma and ear infections were reported more often among uninsured children. Uninsured children were also more likely to have lower preventive care check-ups for lead, vision, dental and well-visits. Charitable care and the safety net of community clinics and public hospitals do not fully substitute for health insurance. The uninsured are less likely than those with insurance to receive preventive care, receive treatment they need when they do get sick, and are more likely to be hospitalized for conditions that could have been avoided (KFF, 2008; Cohen & Bloom, 2005).

According to the 2007 National Health Insurance Survey, children without insurance are more likely to have no usual place of care, postpone seeking care due to cost, avoid needed care because of cost, and had not seen a physician in the past 2 years. More specifically, about 29% of uninsured children did not have a usual place of health

care compared with 3% and 4% for children with private health insurance and public health insurance, respectively. More than 75% of children with public or private health insurance had seen a doctor in the past 6 months compared with about 50% of uninsured children. About 12% of uninsured children had not had contact with a health professional in more than 2 years (USDHHS, 2009b).

Evaluations of newly enrolled children in insurance programs show that access to health care services improve within the first year of enrollment. Children with asthma who were newly enrolled in New York State's CHIP found improvements in having a usual source of care, unmet health needs, and getting care for asthma problems. Children had fewer asthma-related attacks and medical visits after enrollment in CHIP. Parents of these children reported that asthma care and severity were "better or much better" than prior to enrollment. Most parents reported the improvement was due to insurance coverage or lower costs of medications and medical care (Szilagyi, et al., 2006). Another examination of enrollment into CHIP found California children who had enrolled in programming to have received needed health care services more frequently (Seid, Varni, Cummings, & Schonlau, 2006).

New Jersey's FamilyCare Program reported an increase in health services from 61% to 95% for children who had a primary care provider. General physicals increased from 53% to 96%, dental check-ups from 21% to 75%, and up to date immunizations from 79% to 97%. Immediate access to a doctor increased from 31% to 73% and parents purchasing prescribed medications increased from 27% to 92%. Cost and lack of health insurance were reported by parents as two reasons for not using routine health care services. Ninety-seven percent of parents reported having insurance reduced their

anxiety about their child's health and allowed them to more effectively manage their child's healthcare (Southerland, Hart, & Atkins, 2002). Evaluation of the Alabama Children's Health Insurance Program reported an increase in consistent sources of primary care and routine physicals, improved dental and vision care, an increase in purchases of prescribed medications and a decrease in emergency room visits (Mulvihill, Telfair, Mulvihill, Jackson, Sandlin, & Caldwell, 2000).

Access to health care improves after an uninsured person obtains health insurance; similarly, losing coverage, whether it is private insurance or public, substantially decreases access to care. Those who lose care are 2-3 times more likely than those with insurance to go without care because of cost (Kasper, Giovannini, & Hoffman, 2000). Lack of health care coverage, even for short periods of time, results in decreased access to care. Those who have been uninsured for less than six months are more likely than those with continuous health coverage to report having an unmet need for medical care or a prescription drug in the past year (Haley & Zuckerman, 2003).

In addition to medical care, dental care is also important to a child's health. Nearly 25% of uninsured children have unmet dental needs compared with 7% of publicly insured children and 4% of privately insured children. Thirty-seven percent of uninsured compared with 17% and 13% of Medicaid and private health insurance, respectively, had no dental contact within the past 2 years. African American and Hispanic children are also more likely to have gone without a dental contact in the past 6 months compared with White children (Bloom & Cohen, 2007).

2.3.2 Continuity of Care

Children's health care involves developmental surveillance; the identification of sensory, learning and behavioral disorders; and monitoring for family violence and child abuse (Perrin & Homer, 2007). These issues are difficult to assess without routine care with the same health professional, unlikely at health clinics and emergency rooms. Uninsured children compared with those with public insurance are more likely to use emergency departments (11% and 1%, respectively) as their usual source of care (Salsberry, 2003). Bloom and Cohen (2007) also found uninsured children more likely to use emergency departments than a doctor's office. Among children with public health insurance, only 1% uses the emergency room as their usual source of care compared with 4% of uninsured children. This is a concern because emergency departments do not provide continuity of care for children. Although emergency department care is likely to be high-quality care, emergency departments cannot provide the same preventive, and follow-up care that a primary care physician provides. Routine medical care for children provides continuity of care and record keeping that either prevents or identifies illness early (KFF, 2009j). A review of the literature found that continuity of care with a primary care physician results in a decreased likelihood of hospitalization, emergency department visits, and shorter length of stays when hospitalized (Hsiao & Boult, 2008).

The uninsured are less likely than the insured to have regular outpatient care, so they are more likely to be hospitalized for avoidable health problems and experience declines in their overall health. When they are hospitalized, the uninsured are more likely to receive fewer diagnostic and therapeutic services and are also more likely to die in the hospital than are insured patients (Hadley, 2003; Canto, Rogers, French, Gore, Chandra,

& Barron, 2000). Regardless of a person's insurance coverage, those injured or newly diagnosed with a chronic condition receive similar follow-up care plans, however the uninsured are less likely than the insured to actually obtain all the services that are recommended (Hadley, 2007). Without continuity of care, uninsured children with common childhood illnesses and injuries will not receive the same level of care as their insured counterparts. As a result, they are at higher risk for preventable hospitalizations and for missed diagnoses of serious health conditions (Institute of Medicine, 2002).

2.3.3 Financial Consequences of Being Uninsured

Health insurance affects access to health care as well as the financial well-being of families. Out of pocket medical expenses are more of a burden for uninsured individuals. In 2004, 14% of the uninsured spent more than 10% of their family income on out of pocket health care costs (Banthin, Cunningham, & Bernard, 2008). Another study found that the uninsured paid for more than a third (35%) of their health care costs out of pocket (Hadley, Holahan, Coughlin, & Miller, 2008). Single mother families were more likely than two parent families to have unmet or delayed medical needs due to cost (Bloom & Cohen, 2007).

Barriers, like cost, can have a substantial effect on a person's access to health because individuals may try to limit their health care. Most of the uninsured have few if any savings and assets they can easily use to pay health care costs (Jacobs & Claxton, 2008). For many uninsured, the costs of health insurance and medical care are weighed against equally essential needs. The uninsured are about three times as likely as those with health coverage to live in a household that is having difficulty paying basic monthly expenses like rent, food, and utilities. In addition to spending less on their basic needs,

the uninsured are more likely to have used all of their savings to pay medical bills, dealt with collection agencies, or their credit affected (KFF, 2009j). Medical care for nearly 2 million children went unused because of cost and delayed for another 2.9 million children due to cost.

When the uninsured do receive health care, they may be charged for the full cost of that care, unlike those with group insurance, which can strain family finances and lead to medical debt. Most of the uninsured do not receive health services for free or at a reduced charge. Hospitals frequently charge uninsured patients two to four times what health insurers and public programs actually pay for hospital services (Anderson, 2007). Less than 50% of the uninsured know of a provider in their community who charges less to patients without insurance (Cunningham, Hadley, Kenney, & Davidoff, 2007). Only about 25% of low-income uninsured individuals report that they have received care for free or at reduced rates in the past year (KFF, 2009j). If the uninsured are unable to pay for care upfront and the provider is unable to work out a payment schedule, the uninsured can be turned away (Asplin, et al., 2005).

2.4 Academic Issues for Unhealthy Children

The strain of children being uninsured radiates through the family, causing anxiety, financial difficulties, unmet health care needs, and delay in receiving health care. In addition to the strain on the families, children with anxiety and unmet health care needs are unable to reach their full potential at school. If student health needs of our students are not met, neither the best education nor the best teacher will be able to overcome the discrepancies in education.

The National Education Association (NEA) interviewed the National Association of School Nurses President, Susan Will, who works at an alternative school in St. Paul Minnesota. Will is concerned about the academic success of uninsured children. In her experience, their academics are affected by their health which is affected by their access to care. Will says “I am always dealing with kids who don’t have health insurance. Most states have insurance plans for kids, so the first thing is to try and get the kid into the system. But that child may have to wait four months before it kicks in. And right now, they can’t hear because of a middle ear infection, so they can’t learn.” (National Education Association [NEA], 2007, p.23). And “I’ve had kids show up on Monday morning with broken fingers because a friend’s bike rolled over their hand and cracked their bones, and they didn’t have insurance so they didn’t go to the doctor.” (NEA, 2007, p.23). These are stories expressed from a school nurse who sees every day the impact that health and insurance status have on learning and academic success (NEA, 2007).

The opportunity to attend school is not enough for some children because of the conditions of their childhood. Some children need more help in order to be successful at school. The Educate America Act: Goals 2000 is a bill passed by congress in 1994. It stated in its objectives that children would receive help in meeting their basic needs to help them arrive at school with healthy minds and bodies. Some of the areas addressed in this bill were nutrition, physical activity, and health care. Providing children with these basic needs would help to maintain the mental alertness necessary to learn (U.S. Congress, 1994). Although this effort was focused on pre-school programs, it pointed out the important connection between health care, health and academics. Data from the Early Childhood Longitudinal Study, Kindergarten Class of 1998-1999 demonstrated that a

large number of children entering school had health (31%), cognitive (20%), or social/emotional (31%) problems and a large proportion lagged behind in more than one of these developmental domains (Wertheimer, Croan, Moore, & Hair, 2003). Although this is a very important issue, it should be noted that the children who are past Pre-K, are also in need of help.

There is a limited amount of current research on the effects of health on academics but several studies have found an association between poor health and school absence, special education placement, and diminished academic performance (Newacheck & Stoddard, 1994; King, et al., 2005; Msall, Avery, Tremont, Lima, Rogers, & Hogan, 2003). A review of the literature by Taras and Potts-Datema (2005) found several studies connecting chronic health conditions to poor academic performance. School attendance, academic achievement and cognitive ability and attention were found to be affected by chronic conditions (i.e., diabetes, sickle cell anemia and epilepsy). Another study looked at asthma and school attendance and found that children with asthma were absent from school more often compared to their healthy peers (Moonie, Sterling, Figgs, & Castro, 2006; Silverstein, Mair, Katusic, Wollan, O'Connell, & Yunginger, 2001). Chronically ill adolescents who missed more school because of their illness had lower academic performance compared to those who did not miss school (Breuner, Smith, & Womack, 2004). Chronic health conditions were found to be related to less educational attainment on achievement tests at ages seven and sixteen (Case, Fertig, & Paxson, 2005).

Managing asthma and other chronic illnesses through regular contact with primary care providers could reduce the number of days children are absent from school.

Access to preventive care and having a usual source of care improves the management of chronic conditions by increasing access to medications and treatment. Postponing health care at the early stage of illnesses can lead to chronic illnesses, causing students to be absent more frequently. Preventive, routine care or access to care when needed can reduce days of school missed (U.S. Departments of Education, Agriculture, and Health and Human Services, 2000).

In Santa Clara California the Healthy Kids Program (covering children that don't qualify for Medicaid or CHIP up to 300% of Poverty) found that the proportion of children missing three or more school days in the past month fell from 11% without Healthy Kids to 5% with the program (Programs share lessons learned in improving coverage for children, 2007). Another study in California found newly enrolled children in CHIP reported quality of life improvements such as doing better in school, feeling better physically and getting along better with peers (Seid, Varni, Cummings, & Schonlau, 2006).

An additional health concern for adolescents is mental health. Adolescent mental health issues are frequently preceded by difficulties in academic and social performance. Mental health is often associated with problems in several areas of an adolescent's life and cannot be looked at as only a health or educational concern (Blum, Beuhring, & Rinehart, 2000; Boyce, Essex, Woodward, Measelle, Ablow, & Kupfer, 2002). Frequent school absences for vague and nonspecific physical health problems may be related to underlying emotional and behavior problems in children (Campo, Jansen-McWilliams, Comer, & Kelleher, 1999). Children with frequent, unexplained symptoms of physical

illness that keep them from attending classes are more likely to experience academic difficulties.

In addition to personal costs to the student's future potential and societal contributions, unhealthy children are a financial cost to school districts. Children who miss only one day each month can cost a large school system like New York \$28 million and a Chicago-sized city about \$9 million in state funds (Gonzalez & Berends, 2005). Data from the Finance Project as reported in Action for Healthy Kids (2004), estimated a single day of school absence costs \$9 to \$20 per student.

2.5 Sources of Health Insurance for Children

There are two sources of health insurance for children. Private health insurance which includes employer-sponsored health insurance/group plans and plans purchased by individuals, and public health insurance which includes both Medicaid and CHIP. Figure 2.2 shows children's health insurance coverage by type of insurance. More than half of children are insured through their parent's employer, nearly a third through public health insurance and the rest through private health insurance (KFF, 2009j).

2.5.1 Private Health Insurance - Employer-Sponsored/Group Plans

Employer sponsored health insurance is voluntary; businesses are not required to offer health benefits and employees can choose not to participate. In 2009, less than 60% of businesses (with fewer than 200 employees) offered health benefits to at least some of their employees (KFF, 2009j). Employees that work part-time (less than 35 hours per week) or new employees are often not eligible for insurance while others (38%) do not enroll due to the cost of the employee's share of the insurance premiums (KFF, 2009j).

Sources of Children's Insurance Coverage

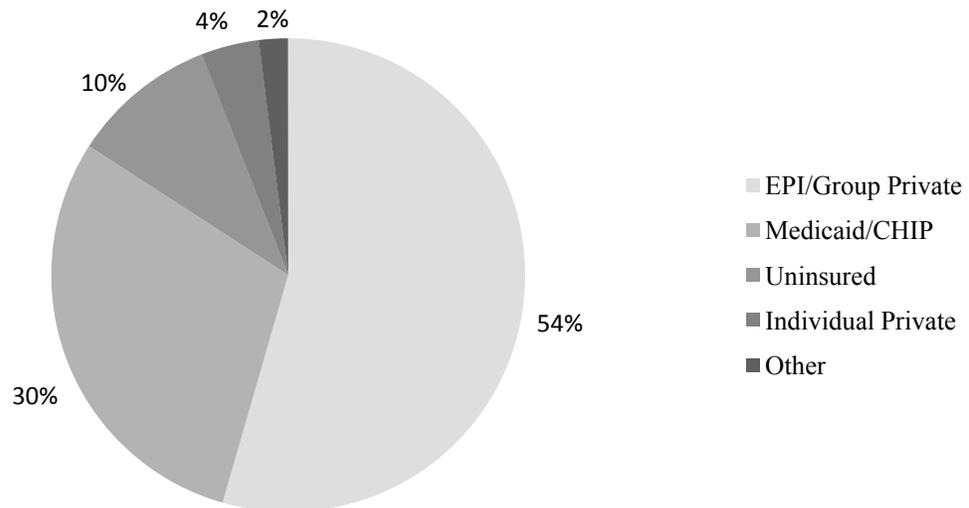


Figure 2.2: Sources of Children's Insurance Coverage. EPI = Employer Private Insurance. Source: Kaiser Family Foundation and Urban Institute Analysis based on Census Bureau's March Supplement to Current Population Survey (KFF, 2009j)

Since 2000, premiums for family coverage have doubled while wages have only increased 19%. In 2009, the annual premium for a family of four was \$13,375 with the family's share of the premium averaging \$3,515 about 16% of the 2009 federal poverty level (\$22,050) for a family of four. The economic downturn in 2001, coupled with rapidly rising health insurance premiums, triggered a prolonged decrease in employer-sponsored coverage which has continued through today (KFF, 2009k; KFF, 2009j).

The economic down turn and rise in unemployment in 2009 will likely continue the downward trend in the number of individuals with employer sponsored health insurance. Declines in the percentage of employers who offered insurance coverage have continued since the turn of the century. These trends were more evident among low-income families with 42% of them having no access to insurance coverage. Of the

58% of low-income employees offered health insurance, 62% choose to enroll (Cunningham, Artiga, & Schwartz, 2008).

2.5.2 Private Health Insurance - Individual Plan

Those who are not eligible for group health insurance through their employer may purchase individual private health insurance on their own. Individual private health insurance plans have premiums that are based on an individual's health risk and depending on their health risk behaviors (smoking) would be more expensive than individuals who have lower risks. They are substantially more expensive than group private plans purchased by employers making it difficult for families to afford this type of coverage. Subsidies do exist for families who purchase individual health plans through the federal tax system but these often do not offset the cost of the premiums. Tax advantages are also available for health savings accounts and flexible spending accounts (KFF, 2009j). However, health savings accounts and flexible spending accounts require parents, often on tight budgets, to make decisions between saving for health care and other basic needs like rent, food and clothing.

2.5.3 Public Health Insurance

Public health insurance includes insurance for the Military including the Veterans Association, Medicare for the elderly, Medicaid and CHIP. However, Medicaid and CHIP are the two main public health insurance programs that directly provide coverage for children. Less than 2% are covered through the other public health insurance programs (KFF, 2009j). Children who do not receive employer sponsored insurance or whose parents cannot afford private individual insurance plans often go without insurance unless they qualify for public health insurance programs like Medicaid or

CHIP. Medicaid and CHIP enrollment have continually increased between 2000 and 2008 for two reasons; an increase in the number of eligible individuals due to the economy and because of increased government enrollment efforts (Holahan & Cook, 2009). These increases helped fill the need for children who lost employer-sponsored coverage. Between 2000 and 2004, employer sponsored health insurance decreased for children by almost 6%, but coverage under Medicaid and CHIP increased by 8% for low-income children (Zuckerman & Cook, 2006). Enrollment hurdles and lack of outreach however, still leave many eligible children uninsured.

About 50% of all Medicaid beneficiaries are children. Medicaid is the largest source of health insurance for children in the U.S., enrolling 29 million children in 2005. CHIP supplements Medicaid by insuring an additional six million children who are low income but whose family incomes are too high to qualify for Medicaid (KFF, 2009j).

2.54 Uncompensated Health Care

Although “uncompensated health care” is not technically a source of health insurance for children, 8.1 million children were receiving care for which health care providers were uncompensated during 2008. Even though the uninsured pay a greater portion of their care out of pocket, two-thirds of the cost will be paid for through federal, state and private funds (Figure 2.3). Health care for the uninsured is often provided through uncompensated care, costing states and the federal governments approximately \$57 billion dollars a year (KFF, 2009j). Although community clinics and physicians see the majority of uninsured patients who receive uncompensated care and are not reimbursed for their efforts, nearly two-thirds of the costs of uncompensated care is reimbursed to hospitals because hospitalization is the most expensive care and the federal

Payment Sources for Uncompensated Care, 2008

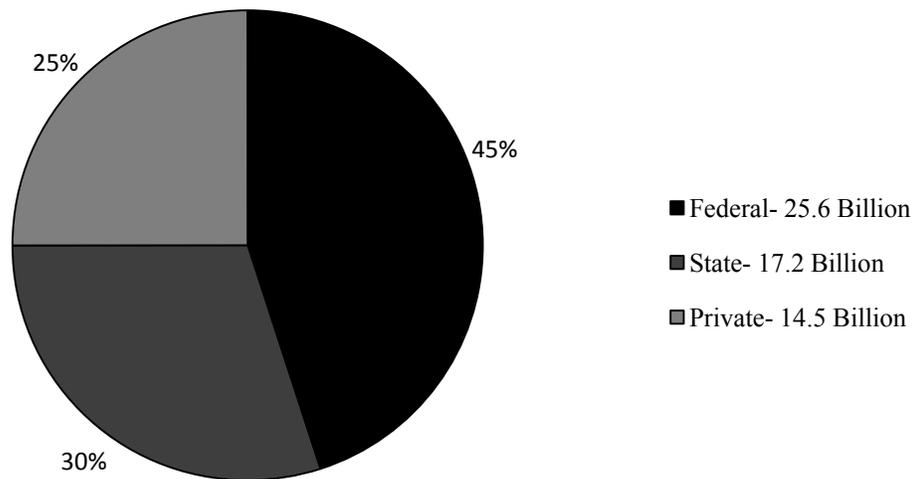


Figure 2.3: Payment Sources for Uncompensated Care, 2008. Source: Kaiser Family Foundation and Urban Institute Analysis based on Census Bureau's March Supplement to Current Population Survey (KFF, 2009j)

government has a component of Medicaid that helps pay for this care (known as disproportionate share hospital) (Hadley, Holahan, Coughlin, & Miller, 2008).

Some communities such as Lucas County in Ohio have created innovative approaches like CareNet to increase access to healthcare for low-income (up to 200% of the federal poverty level) uninsured but are not eligible for public/private coverage. CareNet founders and partners cover administrative expenses only and do not reimburse providers for patient care/services provided. Providers participate as volunteers in providing the needed health services. CareNet coordinates primary, hospital and specialty services and addresses access issues including awareness, coordination, cost and transportation (CareNet, 2008). These types of programs exist in a number of large communities across the United States.

2.6 Role of Medicaid and the Children's Health Insurance Program in Insuring Children

Public health insurance has the same role as other types of insurance, to provide access to health care for individuals. The difference between public insurance and private insurance is the eligible population is covered. Public health insurance programs play a critical role in the U.S. health system because some (Medicaid and CHIP) target low income children who are likely to be uninsured. Public health insurance reduces the number of uninsured children in America, making quality care accessible and affordable to low-income individuals. Since the inception of CHIP in 1997, Medicaid and CHIP have helped reduce the uninsured rate for low-income children by about 33% (KFF, 2007a).

Medicaid and CHIP are managed by states and therefore vary from state to state in program type, eligibility standards, enrollment procedures and caps, scope and duration of services, and rate of payments to providers. Three types of Children's Health Insurance Programs are in existence with 19 states having separate CHIP, 18 states with combined Medicaid and CHIP, and 14 states with Medicaid expansion programs (KFF, 2009b). Massachusetts has the most far-reaching state effort and has implemented a reform plan that provides nearly universal coverage for children. The Southern and Western states tend to have higher uninsured rates reaching 25% in Texas compared with less than 10% in Massachusetts (KFF, 2009j).

Medicaid provides low-income children with a level of access to care that is comparable to that of low-income children with private health insurance coverage. Medicaid pays for physician and hospital visits, screening and treatment, well-child care,

prescription drugs, immunizations, vision care, and dental services. Services covered by separate and expanded CHIPs must provide equivalent coverage “to the benefits provided by the Federal Employee Health Benefits Program Blue Cross/Blue Shield Standard Option; a health benefits plan offered by the state to its own employees; or a plan offered by an HMO with the largest commercial enrollment in the state” (KFF, 2007c, pp. 1-2). Separate CHIP programs however do not have to cover Early and Periodic Screening and Diagnosis and Treatment (EPSDT) services (KFF, 2007c) so in many cases, Medicaid serves as a safety net for children who need special services not covered by CHIP programs (KFF, 2007a).

The Center on Budget and Policy Priorities compared public and private health insurance for children and found public health coverage to be less expensive while providing comparable, in some cases better, access to health care for children (Ku, 2007). Although individuals covered by Medicaid have higher incidence rates of health problems and require more care; public health insurance coverage of children costs about 10% less than private health insurance (Hadley & Holahan, 2003/2004). Administrative cost differences and payment rates to providers are typically lower with public health insurance making the overall costs less (Ku, 2007). Public health insurance costs less for patients too by limiting cost-sharing to 5% of a family’s income unlike private plans that have high levels of cost-sharing making health care unaffordable for many low-income families (Ku & Wachino, 2005).

Research shows that access to care is generally equivalent between public and privately insured children but lower payment rates to providers may reduce timely access to physicians and dentists. Private health insurance benefits vary widely and are typically

less comprehensive than public health insurance with limited coverage of dental, vision, preventive care and prescriptions (Ku, 2007). Medicaid and CHIP play an important role by covering millions of nonelderly low-income people, especially children. However, limits to these public health insurance programs and gaps in employer coverage leave millions of people uninsured and create substantial barriers to obtaining timely and appropriate health care. More than two-thirds of the American public believes the government is not doing enough in providing health insurance to uninsured children. They also believe that families with incomes at 200% of poverty level should be eligible for CHIP (National Public Radio, Kaiser Family Foundation, Harvard School of Public Health, 2007).

2.7 Eligible but Uninsured

Many children who are eligible for public health insurance through CHIP or Medicaid do not participate, often because their parents are unaware of their eligibility or find the application process to be too difficult. There are two reasons why two-thirds of uninsured children are eligible yet uninsured; poor take up or enrollment and disenrollment or dropout (Sommers, 2007). Understanding why so many eligible children are not enrolled is critical to creating effective outreach strategies for increasing enrollment and decreasing disenrollment.

2.7.1 Enrollment

Parents report that awareness about Medicaid and CHIP are lacking, and accessing and applying for the programs are difficult (Haley & Kenney, 2007; Perry & Paradise, 2007; Blumberg, O'Connor, & Kenney, 2005; Brown & Glazer, 2004; Kenney,

Haley, & Tebay, 2003; Salsberry, 2003; Taras, Zuniga de Nuncio, & Pizzola, 2002; Kenney & Haley, 2001). A study of low-income parents with uninsured children with special health care needs found that most (93.5%) parents had heard of either Medicaid or CHIP. However, less than 55% believed that their child was eligible and only 48% believed the application process to be easy (Haley & Kenney, 2007). A study with parents of uninsured children found that although nearly 92% of parents had heard of Medicaid or CHIP, parents did not understand the eligibility requirements. Many parents (43%) believed welfare to be a prerequisite for enrollment. This was a prerequisite when Medicaid was attached to Aid to Families with Dependent Children (AFDC). Over 80% of low-income parents indicated they would enroll their child if they were told their child was eligible, this rate increased to 90% when only poor parents were included (Kenney, Haley, & Tebay, 2003).

An assessment of the National Survey of America's Families revealed that even though nearly 90% of low-income parents had heard about Medicaid and CHIP, only 24% of them inquired about insurance for their children. Those who inquired about health insurance but did not apply gave the following reasons. They believed their child was not eligible (29%) or cited administrative hassles (38%) including language, transportation, or provision of documents as reasons for not applying. The main reasons parents did not inquire about health insurance was that they did not want or need coverage (40%), they did not believe their child was eligible for public health insurance programs (30%), or did not want to deal with administrative hassles (14%). This analysis indicates that there is a need to improve outreach strategies for informing parents about

public health insurance programs and assisting families with enrollment (Kenney & Haley, 2001).

Kenney and Haley (2001) combined the reasons parents gave for not inquiring about or applying for Medicaid and CHIP. Lack of knowledge (program existence, insufficient information about programs or eligibility standards) was the most common reason given by 32% of parents and nearly 10% said administrative hassles. Researchers also found that 22% of parents said Medicaid or CHIP was not needed or wanted. Although the children whose parent's said the program was unneeded or unwanted appeared to be in better health and experienced fewer unmet health needs, a further examination found that they were not receiving recommended levels of preventive care for their age and sex. Only 32% had received well-child care and 51% any dental visits in the past year. In a study by Blumberg, O'Conner, & Kenney (2005), less than 7% of parents said their child did not need insurance.

2.7.2 Disenrollment

Policymakers and program coordinators are devising ways to increase enrollment but rarely look at the issue of dropout. A study was conducted using Current Population Survey (CPS) data from 2000 – 2006 and found that one-third of uninsured children (previously enrolled in public health insurance) remained eligible for public health insurance (5.7% from CHIP, 28.4% from Medicaid) but were dropped from public programs (Sommers, 2007). In the year 2000 and 2001, dropout rates were higher because of the new opportunity for states to have separate CHIP and Medicaid programs, making things more complex and causing individuals to get dropped during the modifications (Sommers, 2005). Budget shortfalls in states are often addressed by

making the renewal process for public health insurance more difficult, increasing premiums or both which also increased dropout rates (Ross & Cox, 2004). With the new 2006 requirement for increased citizenship documentation, there was further exacerbation of the dropout rate (Ross, 2007). In a given year, public health insurance could reduce the number of uninsured children by one-third by simply retaining all enrolled children that have no alternative coverage (Sommers, 2007).

2.8 School's Role in Insuring Children

Closing or substantially narrowing achievement gaps requires combining school improvement with reforms that narrow the vast socioeconomic inequalities in the United States. Richard Rothstein, a research associate at the Economic Policy Institute, believes educators “should insist to every politician who will listen that social and economic reforms are needed to create an environment in which the most effective teaching can take place” (Rothstein, 2004, p. 11). Educators should also be proactive in creating that environment by assisting state agencies in getting school age children insured. In a White House Summit on Early Cognitive Development, Tommy Thompson, then Secretary of Health and Human Services, emphasized the link between children's health and their potential to succeed in school by saying “Health care belongs at the heart of a comprehensive approach toward early learning. One of the best ways we can foster a child's cognitive development is to make certain that a child has access to medical care” (Council of Chief State School Officers [CCSSO], 2004).

Action for Healthy Kids and The Council of Chief State School Officers (CCSSO), national non-profit organizations focusing on adolescent health, academic

success and the school's role in these issues believe that school's have a role to play in health and academic success (Action for Healthy Kids, 2004; CCSSO, 2004). Action for Healthy Kids reports that schools need to address health issues because they have serious implications for learning, health, productivity, economics and equity. They believe that healthy kids make better students and better communities (Action for Healthy Kids, 2008).

The Council of Chief State School Officers has numerous publications addressing the role schools should play in the improvement of child health. The CCSSO believe schools should work with the public and private sector to address issues that interfere with learning and future potential. In 2001, CCSSO gave four suggestions to help schools meet their educational goals, including; 1) communicate and assist families with health insurance issues; 2) coordinate efforts to identify eligible families for health insurance through the School Lunch Program; 3) have school nurses play an active role in outreach and enrollment efforts; and 4) making better efforts through collaboration with state agencies and organizations that address the issues of culture and language to improve communication and outreach. CCSSO believes that these four recommendations will allow schools to more fully meet their educational goals (CCSSO, 2004).

Prior to CHIP, a few states like Florida, Arkansas, New Hampshire, and Texas made efforts to insure their lower-income children through school enrollment-based health insurance (SEBHI) programs. These SEBHI efforts legitimized school involvement as an effective community outreach and enrollment site for public health insurance programs. These early efforts identified the most effective means of conducting outreach, determining eligibility, and enrolling individuals. Some of the

strategies included dispensing literature to parents through, SEBHI program participation in school health fairs, linking eligibility with school lunch programs, and holding enrollment drives (Romund & Farmer, 2000).

Conducting child health insurance outreach at school is a common sense, high-impact strategy for a number of reasons. There are over 50 million school-age children in America who spend the majority of their day in schools, school staff see the problems first hand, schools may already provide health services, and schools are trusted institutions. Screening children for eligibility for free or low-cost health insurance, and then making sure they get enrolled are the first steps toward helping them get needed care. The National Health Education, Health Information Network (HIN) encourages teachers, school administrators, counselors and school nurses to join the Covering Kids National Back to School Effort, a national initiative of The Robert Wood Johnson Foundation working to connect uninsured children to low-cost and free health care coverage programs in all 50 states and the District of Columbia (NEA Health Information Network, no date). Back to school programs include sending home fliers with report cards, in-class activities, fact sheets to educate staff on the consequences of being uninsured, articles for advertising and various other marketing and promotional pieces for working with schools, parents and communities. A review of CHIP outreach initiatives in all 50 states found schools to be States' primary partners for disseminating and educating families about the program. School-based partnerships were often cited as one of the most effective methods of reaching potential enrollees (Williams & Rosenbach, 2007).

In an article by Lear (2007), school based health clinics were identified as a hidden health care system within our communities that are not being utilized to its full potential. Although not all schools have health clinics, most have a counselor, psychologist, social worker or nurse on staff. A collaborative effort between community-based and school-based systems of care is an opportunity for addressing health care issues like immunizations; oral, vision and mental health; and other chronic conditions including obesity, asthma and diabetes. Although the process may be difficult, schools need to do a better job of obtaining care reimbursement from Medicaid and CHIP for services rendered to students.

Currently, federal laws only require services for special needs children as a part of the civil and educational rights of children with disabilities. Expanding required services to all children and to include health services may be helpful in improving health outcomes for school-aged children. School health often competes with the academic agenda because funding for school health is part of the school budget, not the public health budget. State legislatures could direct funds to specific types of school health services or encourage expansion of services through grant initiatives. Although there are challenges to a collaborative effort, neither the school nor the community can ignore the possibly promising health network school based health clinics and on-site staff could provide. Communities need schools to meet its obligations to school-age children and schools need community services to meet their educational needs. Education will improve when children's asthma is controlled; the uninsured are insured; and emotional problems receive early, effective interventions (Lear, 2007).

School staff especially nurses, social workers, and counselors have a potential opportunity to contribute to identifying existing and emerging health needs that affect children's success at school. Among the roles of the school nurse endorsed by the National Association of School Nurses (NASN) are those of promoting student health, providing screening and referral for health conditions and serving as a liaison between the school, family, community, and health care providers (DeSocio & Hootman, 2004). Getting students help by assisting them with enrollment in public health insurance programs will benefit both the children and the schools by improving students' academic success. Lack of health insurance coverage means students will have less preventive medical and dental care, less contact with health professionals and routine care, and more unmet health needs leading to more school absences and lower academic achievement. Schools have an interest in getting children insured because schools need to increase attendance and graduation rates and decrease drop outs.

San Diego city schools superintendent in collaboration with several government agencies created a step by step guide for school districts to promote health insurance for their students (Health Resources and Services Administration, 2000). Some options for school involvement included the following:

- School systems could take a more active role in working with state and local health departments to educate and assist parents in enrolling their children in Medicaid and CHIP.
- School systems could have Medicaid/CHIP employees at their school during initial fall enrollment to help parents with enrolling their children.
- School systems could provide information and application materials to parents.

- School systems could have trained professionals or volunteers that assist parents in completing the application materials and submit materials to state agencies.
- School systems could work collaboratively with state agencies in identifying eligible children through the National School Lunch Program.

Taras, Zuniga de Nuncio & Pizzola (2002), evaluated the cost and feasibility of operating parent outreach, parent education, and application assistance in schools for subsidized child health insurance programs. The project enrolled nearly 1800 children into subsidized health insurance programs in its first two years of operation. On average, families had two children eligible and required about 2 visits to the school to meet with an outreach worker. These meetings and additional telephone calls required less than 5 hours of time per family for successful application. Direct costs were \$45 per child successfully enrolled and an additional \$30 for administrative costs including recruitment of new schools, documentation as well as continuous hiring and training of outreach workers. In addition to application assistance, outreach workers also educated parents on where and when to access health care to improve utilization of health care. The results showed an increase in the number of parents who could identify a primary care physician for their child, and report their child had at least one check up in the past year. Differences in emergency use did not change in year one which was expected to improve by the third year of programming. This outreach effort was successful in improving utilization rates and more importantly reaching parents who had declined to respond to other statewide (non-school) campaigns.

California piloted an Express Lane Eligibility program allowing families to apply for the Medical (Medicaid) and Healthy Families (CHIP) programs at the same time as

the National School Lunch Program. More than 50% of the state's uninsured children were participants in the school lunch program which appeared to be an effective way to identify and enroll eligible children in public health insurance programs. During the first year, 42% of free lunch-eligible children agreed to forwarding their information on for health insurance programs but only 15% consented the second year. Researchers are unsure whether this decrease was because more individuals were already enrolled in programming or because program awareness dwindled during the second year. Another concern was that only 15% of applicants that submitted their application materials were actually enrolled into programming (Cousineau, Wada, & Hogan, 2007). Although evaluation of this Express Lane program was found to be less useful as a broad screening strategy it can be one of many strategies schools use to enroll children in public health insurance programs. Additionally, this Express Lane program did not simplify enrollment procedures for parents, it merely identified potentially eligible children for outreach.

Automatic enrollment procedures that dispense with the need for consumers to complete applications are successful in both employee retirement accounts, Medicare Part B and the National School Lunch Program (NSLP). Although determining eligibility for children is more difficult, automatic enrollment may be an option. This could be done by using government accessible data to determine eligibility and only require completed applications when there is insufficient data. Automatic enrollment would increase the number of children who receive insurance while reducing overhead costs and the number of ineligible children who enroll (Dorn, 2007). This would require eligibility to be based on final income determinations of other means-tested programs

disregarding the differences between the non-health and health programs (e.g., definition of household). This would also require federal matching funds for states to invest in information technology which would allow states to link Medicaid and CHIP eligibility/enrollment data to other databases facilitating automatic enrollment (Kenney & Cook, 2007).

One rural Alabama County used school-based outreach as a vehicle for providing all school children with health insurance. They chose schools because it offered the most effective mode of access to uninsured children. The Bibb County Child Caring Foundation (BCCCF), coordinated access to Medicaid and All-Kids (CHIP) for local children, and offered partial insurance in the County Plan for children without private or public forms of insurance. Three paths were followed toward implementation of this goal. First, teachers distributed surveys on their child's health and health insurance status to parents. These forms permitted children to attend a school-based health fair (1 per year) where they were given an annual physical at the program's expense. Second, after being screened, children with medical conditions were referred to a physician. Third, uninsured children were identified through the surveys, and "common application" forms for insurance were distributed to their caregivers. The caregivers returned the forms and the school submitted them to the appropriate insurer for enrollment. After 6 years of the BCCCF program, most (92%) caregivers reported having health insurance for their school-age children. Although this can be seen as a successful program, most caregivers reported that health providers, rather than the school had helped to enroll their children in health insurance. They may have received information from the school and been prompted to inquire about health insurance because of the school program but due to the

functional literacy of some caregivers, the school based outreach did not help (Lichtenstein, Sharma, & Wheat, 2005). If the school had added a programmatic piece in which assistance for filling out applications was offered, the program would most likely have been more successful.

A study of CHIP directors found the majority (81%) to be working with at least one school district in their state. Many directors perceived the following to be benefits to working with schools: increasing points of access to CHIP eligible youth (74%); assisting CHIP agencies in meeting mandates to cover all CHIP eligible youth (63%); and increasing the ability of state agencies to identify CHIP eligible youth (55%). Although the state directors were willing to work with schools they did report that funding and staff availability as barriers to working with schools. Several directors identified the National School Lunch Program as a potentially effective tool for increasing enrollment but felt there were too many barriers in obtaining the database to be helpful (Price & Rickard, 2009).

2.9 Health Belief Model

The Health Belief Model (HBM) was developed initially in the 1950s by a group of social psychologists in the U.S. Public Health Service to explain the failure of people to participate in programs to prevent or to detect disease (Hochbaum, 1958; Rosenstock, 1960). There are five key components to the Health Belief Model. These components include: perceived susceptibility, perceived severity, cues to action, perceived benefits, and perceived barriers. Within the context of the current study, only the perceived benefits and barriers components of the model were used. Perceived benefits include

beliefs regarding the effectiveness of various actions in reducing the threat. The perceived barriers are the potentially negative aspects of a particular action that may hinder performance of a recommended action (Janz, Champion, & Strecher, 2002).

The HBM is a value expectancy theory, which means that reinforcements and incentives do not influence a person's action directly. The action is indirectly influenced by the person's value of the action and their judgment of the likelihood that it will produce the expected results. After value expectancy concepts were translated to health behavior, the translations included: 1) the desire to avoid illness or to get well, 2) the belief that a specific health action available to a person would prevent illness, 3) further delineation resulted in the individual's estimate of personal susceptibility to and severity of illness and the likelihood of being able to reduce the threat through personal action (Janz, Champion, & Strecher, 2002).

A 1974 issue of the Health Education Monograph devoted an entire issue to the HBM to document whether or not the HBM is successful in assessing people's behavior. This issue analyzed and compiled all the literature relating to the HBM and concluded that there was considerable support for the model in explaining behavior (Becker, 1974). A decade following the 1974 issue of the Monograph, Janz and Becker (1984) conducted an updated review of the HBM. Substantial empirical support for the HBM was provided from the summary results, both from prospective and retrospective studies. The perceived barriers component was the most powerful single predictor among the HBM dimensions.

A more recent meta-analysis of the HBM reviewed 16 studies of the HBM with adults that measured four of the model's dimensions (susceptibility, severity, benefits,

and barriers). Although the authors concluded that the predictive validity of the Health Belief Model is difficult to determine. It is important to note that two components, benefits and barriers, were the most useful components of the Health Belief Model in predicting behaviors and thus provided a justification for their use in the current study (Harrison, Mullen, & Green, 1992).

The perceived barriers and perceived benefits components were used to identify superintendent's perceived benefits and barriers for schools that choose to assist in outreach and enrollment strategies for getting children public health insurance. This information will be critical for the development of effective strategies between Medicaid/CHIP programs and schools to increase health insurance coverage of American children.

2.10 Stages of Change Theory

The Stages of Change Theory is a technique for assessing the readiness of individuals to change a behavior (Prochaska, DiClemente, & Norcross, 1992). The six Stages of Change are precontemplation (no intention to change), contemplation (thinking about changing), preparation (taking steps to change a behavior in the near future), action (recently made a behavioral change), maintenance (have maintained the behavior over an extended period of time), and relapse (use to but no longer engage in the behavior). Relapse can occur during any stage and is when a person has engaged in the behavior previously but no longer engages in the behavior.

The Stages of Change theory has been found to be applicable to a variety of health-related personal behaviors (Prochaska, et al., 1994; Prochaska, 1994). However,

this study utilizes the Stages of Change theory on an institutional level rather than a personal one. Research indicates the Stages of Change theory also works well with assessing stages of organizational change (Price & Oden, 1999; McCarthy, Telljohann, Coventry, & Price, 2005; Price, Yingling, Dake, & Telljohann, 2003).

Stages of Change will be used in the current study to identify the readiness level of schools in assisting public health insurance programs with identifying and enrolling children in programs like Medicaid and CHIP. The questionnaire is unique in its application of the model to organizational rather than personal behavior.

2.11 Summary

Two-thirds of uninsured children are eligible for public health insurance programs. Although increasing eligibility standards will make more of the uninsured eligible and help in reducing drop-out, if we do not increase the number of eligible yet uninsured individuals we will still not significantly reduce the number of uninsured children in America. The eligible uninsured population is largely composed of low-income children and parents who would benefit from increased outreach for Medicaid and CHIP and the adoption of family-friendly enrollment and renewal procedures. Reducing the number of uninsured children requires extensive outreach efforts and simplified enrollment/re-application procedures.

Parents tend to trust schools and the information they provide which is essential in increasing awareness about the insurance programs and getting children enrolled. Schools may be able to diminish the stigma that is often associated with receiving public benefits like they have with school lunch programs. Providing health services and

assistance with enrollment into public health insurance through school-based clinics, school nurses or counselors will increase both health and academic outcomes. Achieving optimal children's health requires partnerships among primary care physicians, parents, dentists, public health professionals, legislators and schools.

Chapter 3

METHODS

This chapter will describe the methods used in this study. The following topics are included in this chapter: Participants, Instrument Structure, Psychometric Properties of the Instrument, Data Collection Procedure, and Data Analysis.

3.1 Participants

The population of interest in this study was superintendents of K-12 public school systems in the United States. A stratified, systematic random sample of school district superintendents was selected from a compilation of superintendents from all 50 State Departments of Education databases to help ensure broad geographic representation. Excluded from the list were superintendents of schools classified as private, special education, vocational or alternative education schools. After removing individuals that failed to meet inclusion criteria, a total of 11,984 superintendents comprised the target population and sampling frame. Stratification was based on the percent of superintendents within each state. The same percent of superintendents was selected from each state's database and comprised the final sample population of 800.

An a priori power analysis, for external validity of the results, demonstrated that the following sample size should be adequate to minimize a Type II error (Price, Dake, Murnan, Dimming, & Akpanudo, 2005). The suggested sample size required for the study was calculated to be 372 respondents based on a 5% sampling error and 50/50 split in responses. Sample size was determined based on setting alpha at .05, the effect size at .20 and 95% power (Price, Dake, Murnan, Dimming, & Akpanudo, 2005). Based on published response rates (44% to 82%) of studies with superintendents, 800 surveys were mailed in the spring of 2009 with the intention of obtaining greater than a 50% response rate (Bredeson & Kose, 2007; Natkin, Cooper, Fusarelli, Alborano, Padilla, & Ghosh, 2002).

3.2 Instrument Structure

This study was conducted using a widely used mail questionnaire approach which is well-suited for measuring attitudes, opinions, behaviors, or characteristics of a population (Creswell, 2005). The questionnaire instrument was a four-page, 40 item survey (Appendix A). The instrument was developed based on a comprehensive review of the literature on the availability of health insurance for children and the relationship between health and academic achievement. The survey was developed to assess the perceptions of superintendents of K-12 public schools in the United States regarding the role of schools in student health insurance. The survey was developed based on the Stages of Change component of the Transtheoretical Model (Prochaska & DiClemente, 1983), and the perceived benefits and perceived barriers components of the Health Belief Model (Becker, 1974).

Stages of Change (SOC) is one of the leading models of behavior change offering a systematic and empirically based approach to conceptualizing and assessing readiness to undertake an activity. The SOC is based on the idea that change occurs over time through a series of five stages. The five stages are: 1) Pre-contemplation in which people do not intend to take action in the foreseeable future; 2) Contemplation is the stage in which people intend to change in the foreseeable future; 3) Preparation is the stage in which people intend to take action in the immediate future; 4) Action is the stage in which people have made specific overt modifications in their lifestyles; and 5) Maintenance is the stage in which people strive to prevent relapse but do not apply change processes as frequently as do people in action. Movement across the stages is fluid, and individuals can relapse to an earlier stage if their ambivalence increases or their self-efficacy decreases (Prochaska & DiClemente, 1983).

The Health Belief Model (HBM) has five constructs including perceived susceptibility, perceived severity, perceived benefits, perceived barriers and cues to action. This model is based on the idea that the five constructs help to determine whether an individual/organization is more or less likely to engage in certain behaviors. The perceived benefits and perceived barriers refer to an individual's perception of the positive outcomes and difficulties associated with a specific action to be taken (Becker, 1974). Since the main interest in the current study was to measure superintendents' perceptions of the school's role in assisting students in obtaining public health insurance, it was most important to focus on the HBM's dimensions of perceived benefits and barriers, the two most potent components of the model.

The survey was a four-page, fold-over booklet style format with six different sections. The first section had eight questions assessing superintendent knowledge of state-funded health insurance (2 questions), the uninsured population (2 questions), and the effects of health status on academic outcomes (4 questions). A sample question regarding the uninsured population was: “Students from low-income: families are more likely than other students to be uninsured”. All of the items in this section were “yes”, “no”, or “not sure” responses to assess the superintendent’s knowledge on these topics.

The second section provided an opportunity for superintendents to identify the perceived benefits (Health Belief Model) to schools assisting uninsured students in obtaining health insurance. Example items were: “Helping uninsured students obtain state-funded health insurance will: reduce the number of students with untreated health problems” and “Helping uninsured students obtain state-funded health insurance will: reduce racial/ethnic disparities in health status”.

The third section contained thirteen items that examined the superintendents’ perceptions of student well-being and the school’s role. Student well-being included each of the following topics: 1) perceived impact of being uninsured on students’ health status; 2) perceived impact of being uninsured on students’ access to medical care; and 3) perceived impact of being uninsured on student’s academic outcomes (attendance, attention, and graduation rates). There were also five questions which assessed superintendents’ perceptions of the role schools should play in assisting uninsured students in obtaining health insurance. A four point Likert-type scale was used to measure the level of respondents’ perceived agreement regarding the various issues. The

items in this section were answered as SA = strongly agree, A = agree, D = disagree, and SD = strongly disagree.

The fourth section of the survey provided an opportunity for superintendents to identify the perceived barriers (Health Belief Model) to schools assisting uninsured students in obtaining health insurance. Example items were: “Our school district does not have enough staff to help students obtain health insurance” and “Personnel in our school district do not know how to help students obtain health insurance”.

The fifth section of the instrument assessed the current practices of school districts. One question asked superintendents to identify their school system’s current level of assistance (Stage of Change) in helping uninsured students obtain public health insurance. Three questions asked about the school districts’ practices in assisting uninsured students in obtaining public health insurance. The first asked superintendents if any of the schools in their district systematically assessed the health insurance status of their students by responding yes or no; the other two questions asked superintendents to identify how their school system was assisting students in obtaining health insurance. These two questions were measured by superintendents checking all the answers that apply to their school district. The final question in this section asked if the school district had received financial support for assisting students with enrollment.

The final section included 10 background and demographic items of the superintendent and the school district. The background and demographic questions assessed for the superintendent were age, sex, race/ethnicity, level of education, and number of years experience. The questions regarding the school included location, racial/ethnic composition, and percent of students receiving free and reduced lunch.

3.3 Psychometric Properties of the Instrument

Face validity of the instrument was established based on a comprehensive review of the literature to ensure the relevant concepts were adequately covered by the survey instrument. Content validity of the instrument was determined by an expert panel (n= 6) review of the instrument. The list of experts is presented in Appendix B and the cover letter requesting their review of the instrument is in Appendix C. Content experts were identified based on their publication record related to the following areas: survey-based research, health insurance and academics, and public insurance programs. The expert panel gave minor suggestions on the wording and layout and the instrument was revised based on those recommendations.

To help establish construct validity, principal axis factoring with subsequent varimax rotation for the knowledge (Questions 1-8), well-being (Questions 10-17), school's role (Questions 18-22), perceived benefits (Questions 9), perceived barriers (Question 10) subscales were performed. This analysis determined whether the items on the survey instrument clustered in their appropriate subscales. The Eigen value of the factor scree plot demonstrated that the instrument consisted of five separate factors. The minimum factor loading for the interpretation, or agreement of correlation of each item with the total pattern of responses was set at the absolute value of .30 (DiLorio, 2005). The factor matrix for the subscales is presented in Table 3.1.

A pilot test of the instrument was completed with a different group (N=24) of superintendents drawn from the original Department of Education databases. These surveys were not included in the data analysis. Individuals participating in the pilot test were asked to complete the survey twice, one week apart. They were sent cover letters

Table 3.1: Factor Matrices for Subscales

Question	Perceived Well-being Factor 1	Perceived Benefits Factor 2	Role of Schools Factor 3	Perceived Barriers Factor 4	Knowledge Factor 5
Knowledge					
Eligibility					
Low-income					.428
Minorities					.378
Enrollment					
Miss School					.755
Attention					.760
Academics					.737
Graduation		-.370			.380
Perceived Well-being					
Usual Source	.643				
Medical Care	.644				
Ill longer	.724				
Ill frequent	.770				
Academics	.802				
Absence	.793				
Attention	.719				
Graduation	.723	-.385			
Role of Schools					
Healthy	.315		.368		
Sole Responsibility			-.400		
Form Access			.621		
Form Assist			.650		
Registration			.680		
Perceived Barriers					
Few students					
Office Space				.559	
# of Staff				.804	
Staff Time				.752	
Know How				.645	
No Role				.421	
Finances				.807	
State Support				.513	
Parents					
Afford increase			.372		

Table 3.1: Factor Matrices for Subscales (continued)

Question	Perceived Well-being Factor 1	Perceived Benefits Factor 2	Role of Schools Factor 3	Perceived Barriers Factor 4	Knowledge Factor 5
Perceived Benefits					
Finances				-.457	
Untreated		.350			
Attention		.461			
Graduate		.663			
Held Back		.613			
Good will		.361			
Health Disparities		.545			
Academic Disparities		.614			
Healthier		.314			
Productivity		.495			
Social Dependence		.537			
Tardiness		.621			
Absenteeism		.592			
Test Scores		.613			
Out of Pocket				-.481	
SBHC		.342		-.589	
Efficiency		.344		-.545	

Accepted loadings of .30 or higher

explaining the purpose of the study and a copy of the instrument. This permitted an assessment of stability-reliability.

Pearson product moment correlation coefficients were conducted on their first and second responses to the instrument to determine the stability reliability of responses to the items. The scores on four of the scales were found to have good stability reliability (Table 3.2): knowledge (Pearson $r=.78$), well-being (Pearson $r=0.96$), and school's role (Pearson $r=0.96$). For the perceived benefits and perceived barriers items, the responses for the pre and post test of each item were compared to determine a percent agreement

score. For each of the subscales, an average percent agreement score was calculated. The perceived benefits had a percent agreement score of 88% and the perceived barriers had a percent agreement score of 80%. Responses for the Stages of Change item, pre and post test were compared to determine a percent agreement score. The percent agreement score for the Stage of Change item was 95%.

Table 5. Reliability of Subscales

Subscale	Stability Reliability	Internal Reliability*
Knowledge ^a	0.78 ^a	0.56
Perceived Well-being ^a	0.96 ^a	0.92
School's Role ^a	0.96 ^a	0.79
Perceived Benefits ^b	0.88 ^b	0.86
Perceived Barriers ^b	0.80 ^b	0.72
Stages of Change ^b	0.95 ^b	NA

^a Pearson product moment correlation coefficients were utilized (N =21-24)

^b Percent Agreement (N =21-24)

*Cronbach alphas were computed on the final sample (N=387)

NA=not applicable

Internal reliability estimates (Table 3.2) were found to be acceptable for the responses on the knowledge (Questions 1-8), well-being (Questions 10-17), and school's role (Questions 18-22) items. The final sample (N=387) was used to assess the internal reliability of these scales. Cronbach's alpha coefficients were found to be .56 for the knowledge scale scores, .92 for the well-being scale scores, .79 for the school's role scale, .86 for perceived benefits, and .72 for perceived barriers. The low internal reliability for the knowledge scale was likely due to the wide variety of ideas being assessed.

3.4 Data Collection Procedure

Once the instrument was developed and the procedures were determined, a proposal was submitted to the University of Toledo Human Subjects Committee. Approval for the study was granted (Appendix D). Participation in this cross-sectional survey was completely voluntary; returning the survey indicated the participant's implied consent to participate in the study. All responses and demographic information was kept confidential.

To help maximize response rates, several survey research techniques were used in this study. The questionnaire characteristics used included developing a questionnaire with a maximum of four pages, printing the questionnaire on colored paper (pastel blue), and placement of the background/demographic questions at the end of the instrument.

Adams and Gale (1982), found that response rates were higher for 3 page surveys, compared to 1 and 5 page surveys. It is estimated that for every page of a survey, the response rate decreases by 0.4% (Burchell & Marsh, 1992). Questionnaire color has been shown to also affect return rates. Mangione (1995) found that colored surveys were less likely to be lost or misplaced, because they stand out. A study conducted by Roberson and Sundstrom (1990) found an 8% increased response rate when the demographics were placed at the end of the instrument.

Other procedural steps taken to maximize response rates included: 1) envelopes and postage, 2) cover letter, and 3) incentives. Outgoing envelopes were personalized, typed and sent with first class postage. A postage-paid return envelope was included for returning the completed survey. Research has shown that the above procedures have

increased response rates (Yammarino, Skinner, & Childers, 1991; Fox, Crask, & Kim, 1988).

The personalized cover letter (Appendix E) was hand-signed in blue ink and informed participants of the deadline and the assurance of confidentiality. McDermott and Sarvela (1999) found evidence that a real, personal signature, in a colored ballpoint pen, shows the researcher's commitment to the study.

An incentive of \$1.00 was included with the first wave of mailing to improve response rates. Several studies have found that providing an incentive increases response rates (James & Bolstein, 1990; Oden & Price, 1999). More specifically, one dollar incentives have consistently been shown to be effective at increasing return rates (Easton, Price, Telljohann, & Boehm, 1997; Fox, Crask, & Kim, 1988; James & Bolstein, 1990). To reduce costs, the return envelope was coded so that respondents who returned questionnaires could be removed from the subsequent mailings. Two weeks following the first wave mailing, an identical second wave was sent to non-respondents with the exception of the \$1.00 incentive (Appendix F). Two weeks after the second wave mailing, a color matched postcard (Appendix G) was sent to all non-respondents urging them to participate. To reach a 50% response rate, a fourth contact was made to non-respondents in states under-represented in the sample. This contact included a phone call to ask for their participation. If contact was made by phone, the survey was sent to the respondent a third time by fax or email (Appendix H). All of these procedures were intended to reduce non-respondent bias and increase the external validity of the results (Dillman, 2000; Edwards, et al., 2007; King, Pealer, & Bernard, 2001).

3.5 Data Analysis

Data analysis was performed using SPSS 17.0 for windows. Descriptive statistics (e.g., frequencies, means, standard deviations, and ranges of scores) were used to describe the characteristics of the respondents including sex, race/ethnicity, age, years of experience, and education level. The location of the respondent's school district, the racial and ethnic composition of the school and the percent of students receiving free and reduced lunch were reported with descriptive statistics. Descriptive statistics helped describe the perceptions of superintendents and the school districts current practices in regards to helping students obtain health insurance.

Independent samples t-tests were employed to identify differences between the dichotomous and continuous variables while one-way ANOVAs identified differences between categorical and continuous variables. The following hypotheses were tested using Independent samples t-tests: 3.7, 3.9, 3.10, 4.2, 4.3, 4.4, 4.5, 4.6, 4.7, 5.7, 5.8, 6.2, 6.3, 6.4, 7.2, 7.3, and 7.4. One way ANOVAS were used to test three hypotheses including 1.9, 1.11, 1.12. Pearson product moment correlations were conducted to determine if a relationship existed between the continuous variables including hypotheses: 4.8, 4.9, and 6.5. To determine the difference between categorical variables, chi-square (χ^2) analyses were conducted on the following hypotheses: 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.10, 3.2, 3.3, 3.4, 3.5, 3.6, 3.8, 5.2, 5.3, 5.4, 5.5, and 5.6. Finally, a multivariate logistic regression was used to determine which variables were most likely to predict a school systems likelihood of helping students obtain health insurance. Additional testing was conducted on the following hypotheses using logistic regression: 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.10, 1.11, 1.12. Because of the number of statistical tests

which were run, the level of significance was set at a more conservative alpha level of 0.01 to reduce the chances of a Type I error.

Chapter Four

RESULTS

The results of this study on superintendent perceptions of the role of schools in students obtaining health insurance are described in the following sections of this chapter: Response Rate, Demographic and Background Characteristics of Respondents, Current School' Practices of School Districts, Basic Knowledge of State-funded Health Insurance and the Effect of Health Status on Academic Outcomes, Health Insurance Status Effects on Students' Well-being, Role of Schools in Helping Students Obtain Health Insurance, Perceived Benefits of Helping Students Obtain Health Insurance, and Perceived Barriers to Helping Students Obtain Health Insurance. These results are then discussed in relation to the hypotheses. The final section of this chapter summarizes the major findings.

4.1 Response Rate

A total of 800 surveys were sent out to a national stratified random sample of superintendents from public school systems. The sample stratification (Table 4.1) was based on the percent of superintendents within each state. The same percentage out of 800 was used to determine how many surveys were to be sent to each state to help ensure broad geographic representation. Twenty-seven surveys were non-deliverable. Thus, 773

Table 4.1: Stratification Results of Superintendent Population by State

State	Superintendent Population	Fraction of Total Population	Sample Population	Fraction of Sample Population
Alabama	133	0.011	5	0.013
Alaska	53	0.004	2	0.005
Arizona	219	0.018	6	0.015
Arkansas	248	0.021	11	0.028
California	58	0.005	4	0.010
Colorado	178	0.015	5	0.013
Connecticut*	154	0.013	0	0.000
Delaware	19	0.002	2	0.005
Florida	68	0.006	2	0.005
Georgia	183	0.015	5	0.013
Hawaii	15	0.001	0	0.000
Idaho	110	0.009	4	0.010
Illinois	857	0.072	28	0.072
Indiana	287	0.024	9	0.023
Iowa	347	0.029	10	0.026
Kansas**	297	0.025	15	0.039
Kentucky	174	0.015	7	0.018
Louisiana	69	0.006	2	0.005
Maine	172	0.014	5	0.013
Maryland	24	0.002	1	0.003
Massachusetts	246	0.021	8	0.021
Michigan	540	0.045	18	0.046
Minnesota	329	0.027	11	0.028
Mississippi	158	0.013	4	0.010
Missouri**	529	0.044	19	0.049
Montana	196	0.016	7	0.018
Nebraska	242	0.020	10	0.026
Nevada	17	0.001	1	0.003
New Hampshire	83	0.007	3	0.008
New Jersey	528	0.044	17	0.044
New Mexico	89	0.007	3	0.008
New York	734	0.061	22	0.056
North Carolina	117	0.010	3	0.008
North Dakota	160	0.013	3	0.008
Ohio	604	0.050	18	0.046
Oklahoma*	539	0.045	14	0.036
Oregon	214	0.018	5	0.013
Pennsylvania**	496	0.041	20	0.051
Rhode Island	36	0.003	2	0.005
South Carolina	87	0.007	1	0.003
South Dakota	160	0.013	4	0.010
Tennessee	136	0.011	3	0.008
Texas*	1033	0.086	29	0.074
Utah	41	0.003	2	0.005
Vermont	58	0.005	3	0.008
Virginia	133	0.011	4	0.010
Washington	285	0.024	11	0.028
West Virginia	55	0.005	3	0.008
Wisconsin*	426	0.036	13	0.033
Wyoming	48	0.004	3	0.008

*Under represented by 1% or more

**Over represented by 1% or more

superintendents received the survey; 390 were returned for a response rate of 50.5% ($390/800-27 = 0.505$). Three returned surveys were incomplete and were not included in data analysis. The sample size of 800 was chosen in an attempt to obtain 372 or more respondents and thus, assure appropriate power. An *a priori* power analysis was completed to determine an approximate number in the sample required to minimize Type II error. The sample was determined by setting alpha at 0.05, the effect size at 0.20, and power at 0.95. The suggested sample size required for the study was calculated to be 372 respondents. The number of surveys returned and used in data analysis exceeded the needed sample size.

4.2 Demographic and Background Characteristics of the Respondents

The demographic and background characteristics of the respondents are presented in Table 4.2. The sample was 74% male and 25% female. The majority of respondents were White (93%) with the remaining being African American (4%) or other (3%). The mean age of respondents was 54.5 (SD=8.0) ranging from 29 to 80 years of age. Respondents reported their highest education level as Doctorate (41%). Eleven respondents (2.8%) did not identify themselves as having experience as an assistant superintendent or superintendent.

According to the Statistical Abstract of the United States, 69% of the total population ages 5-19 was white (U.S. Census Bureau, 2009). This is the cut-off point used in analysis to determine the race/ethnicity of the schools responding. The majority of superintendents (72%) reported their school's race/ethnicity to be 69% or more White. The reported race/ethnicity of the schools was 77% White, 10% Hispanic, 9% African

Table 4.2: Demographic and Background Characteristics of Respondents

Item	N	(%)
<i>Gender</i>		
Female	97	(25)
Male	288	(74)
<i>Race/Ethnicity</i>		
White	358	(93)
African American	16	(4)
Other	10	(3)
<i>Highest Level of Education*</i>		
Bachelors Degree	9	(2)
Masters Degree	102	(26)
Specialist Degree	108	(28)
Doctorate	159	(41)
<i>Location of School District*</i>		
Urban	39	(10)
Suburban	77	(20)
Rural	273	(71)
Item (Range)	M	SD
<i>Age (29-80)</i>	54.5	8.0
<i>Full-time in Educational Position (# of years)</i>		
Teacher (0-36)	9.3	6.3
Vice-Principal/Principal (0-38)	7.6	6.3
Assistant Superintendent/Superintendent (0-38)	9.3	7.7
Other (0-25)	7.6	5.8
<i>Race/Ethnicity of School District (%)</i>		
African American	8.5	19.0
Hispanic	9.6	17.7
White	77.1	27.7
Other (Native American)	4.3	13.2
<i>Students Receiving Free/Reduced Cost Lunch (%)</i>	44.8	22.6

N= 367- 385

* Data may add up to greater than 100% due to multiple responses

American, and 4% other. The majority of respondents who answered other reported their students as Native American Indian. According to the Statistical Abstract of the United States in 2006, public schools were 76% White (U.S. Census Bureau, 2009). The percent of students receiving free and reduced lunch ranged from 0 – 100% with an average of 45% (SD=22.6). Seventy-seven percent of rural schools were predominantly white compared with 64% of urban and suburban schools. Rural schools had higher percentages (47%) of students receiving free and reduced lunch compared to 39% of non-rural schools.

4.3 Current School' Practices of School Districts

Table 4.3 provides information regarding the current practices of schools as reported by the superintendent in regards to assisting students in obtaining state-funded health insurance (e.g., Medicaid or CHIP). Less than one in five (19%) school districts systematically assessed the health insurance status of all students at the beginning of each school year. About 45% of superintendents reported at least one school in their district was helping students obtain health insurance. Using Stages of Change theory (Table 4.4), superintendents were asked to characterize their schools' practice in helping students obtain state-funded health insurance. Nearly half (49%) of superintendents identified their school to be in the precontemplation stage, meaning they had never seriously thought about helping students enroll in state-funded health insurance. Although more than half (63%) of superintendents characterized their schools as not helping students (precontemplation, contemplation, preparation, relapse), 36% reported that their school districts were currently providing assistance (action or maintenance stages) to help

Table 4.3: Current Practices of School Systems

Item	N (%)
Schools systematically assess the health insurance status of all students at the beginning of the year.	73 (19)
Do any schools in your district help students obtain state-funded health insurance?	173 (45)
Has your school district received financial support to help students enroll in state-funded health insurance?	22 (6)
Help Provided by School Districts	
	N (%)
State-funded health insurance applications/materials are available to parents upon request	117 (30)
School nurse helps parents enroll their children	94 (24)
State-funded health insurance applications/materials are given to all parents each school year.	87 (23)
Other school employee helps parents enroll their children during fall Registration	33 (9)
School district uses school lunch enrollment information to identify uninsured students	31 (8)
School based health clinic helps parents enroll their children	17 (4)
School district provides state-funded health insurance program's access to the districts' free and reduced lunch database	16 (4)
Parents complete insurance forms with other school paperwork without assistance and the school submits it to the state	14 (4)
State-funded health insurance program representatives come to the school to enroll students	12 (3)
Other (outside partnerships, no system but nurses assist when needed)	16 (4)
Insurance programs in which schools most commonly assisted	
	N (%)
Separate Children's Health Insurance Program (CHIP)	106 (27)
Medicaid Health Insurance	91 (24)
Medicaid Expansion Health Insurance	27 (7)
Private Health Insurance	19 (5)
Other (local insurance plans, Medicaid/CHIP combination programs, school insurance)	20 (5)
N=379-386	

Table 4.4: School System' Stage of Change

Statement (Stage of Change)	N (%)
Our school district has never seriously thought about helping students enroll (Precontemplation)	189 (49)
Our school district has been talking about whether we should be involved in helping students (Contemplation)	29 (8)
Our school district has made plans to start helping students within the first six months of the new school year (Preparation)	17 (4)
Our school district just started helping students during the current academic school year (Action)	29 (8)
Our school district has been helping students for one full academic school year (Maintenance)	112 (29)
Our school district has helped students in the past, but we no longer do (Relapse)	8 (2)
N=384	

students enroll. Only 22 schools (6%) had received funding for helping students enroll in health insurance programs.

When asked how their schools were helping students obtain state-funded health insurance, 51% of respondents identified one or more activities. Of the superintendents who responded yes to this question, 53% reported that state-funded health insurance applications/materials were available to parents upon request (30%) or to every parent each school year (23%). Approximately one-fourth (24%) of superintendents reported that the school nurse helped parents enroll their children in state-funded health insurance programs. All other forms of assistance were provided by less than one in ten schools.

When asked which health insurance plans their schools helped students enroll, superintendents noted that CHIP (27%) and Medicaid (24%) were the programs receiving the most assistance. Medicaid expansion (7%), private health insurance (5%), and other (5%) program enrollment were not identified as often. Although the Medicaid/CHIP

combination was not provided as an option for respondents, 2% noted the combination program name in “other”.

Due to a low number of responses in some of the stages, data were collapsed into three groups: action group (action or maintenance stages); non-action group (precontemplation, contemplation, or preparation stages); and relapse group (relapse stage). A series of analyses including one-way ANOVAs, and chi-square tests were used to assess if any variables were associated with a school helping or not helping students obtain health insurance. Superintendents from the action group were significantly different than superintendents from the non-action group (Table 4.5). The two groups were different in the following ways: superintendents who reported their districts as helping perceived significantly fewer barriers to doing so ($F(2,367)=14.54, p<0.001$); were more likely to perceive the school to have a role ($\chi^2=12.88, df=2, p=0.002$); and more likely to systematically assess health insurance status of students ($\chi^2=29.4, df=2, p<0.001$). Superintendents from the action group answered more knowledge questions correctly when compared with superintendents from the non-action group ($\chi^2=5.827, df=2, p=0.05$). Although this difference was not significant at the 0.01 level there is practical importance in that increasing knowledge among superintendents may lead to schools taking action. There were no statistically significant differences between schools that use to help (relapse group) and those that currently helped students.

Logistic regression was conducted for the Stage of Change to determine the likelihood of a school system helping students obtain health insurance (action or maintenance stages) by demographic and other selected variables. Four factors were found to predict the likelihood of a school system helping students obtain health

Table 4.5: School System's Stages of Change by Selected Variables

Item	Action Group % Agree	Non-Action Group % Agree	Relapse Group %Agree
Systematically Assessed Student Health Insurance Status **			
Yes	64%	36%	0%
No	30%	67%	3%
Superintendent's Gender			
Male	38%	61%	2%
Female	35%	63%	2%
Superintendent's Education Level			
Doctorate	35%	64%	1%
Bachelor's, Master's, Specialist	39%	59%	2%
Superintendent's Race/Ethnicity			
White	36%	62%	2%
Non-white	42%	58%	0%
Student Population Race/Ethnicity			
≥69% white	36%	62%	2%
<69% white	41%	59%	0%
Free and Reduced Lunch			
≥50%	37%	61%	2%
<50%	37%	61%	2%
School Location			
Rural	35%	63%	2%
Non-rural	40%	58%	2%
Knowledge *			
High	41%	56%	3%
Low	32%	67%	1%
Role of Schools **			
Perceive Role	45%	53%	2%
Do Not Perceive Role	26%	72%	2%
	Action Group M (SD)	Non-Action Group M (SD)	Relapse Group M (SD)
Superintendent's Age (range 29-80)*	55.8 (8.29)	53.6 (7.84)	56.1 (7.20)
Perceived Well-being (range 0-24)	16.6 (4.07)	16.6 (4.39)	15.4 (3.25)
Perceived Benefits (range 0-18)	11.1 (4.08)	10.9 (4.38)	10.5 (4.24)
Perceived Barriers (range 0-11) **	2.6 (2.36)	3.93 (2.23)	3.14 (2.80)

Missing values were excluded from any analysis

*Significant at the 0.05 level, ** Significant at the 0.01 level

Action Group (N=141) includes those in both the action and maintenance stages

Non-Action Group (N=235) includes those in the precontemplation, contemplation, and preparation stages

Relapse Group (N=8)

insurance. School systems that systematically assessed student health insurance status each year were four times more likely to help students obtain health insurance (OR=3.96; 95% CI 2.31-6.80). Superintendents with higher knowledge scores were one and a half times more likely to be from a school district that helped students obtain health insurance (OR=1.54; 95% CI 1.00-2.35). Those who perceived the school to have a role in helping students obtain health insurance were nearly two and a half times more likely to do so (OR=2.40; 95% CI 1.53-3.75). Superintendents who perceived fewer barriers to helping students were two and a half times more likely to be from school districts that helped students obtain health insurance (2.61; 95% CI 1.68-4.04). The results of the crude odds ratios are in Table 4.6.

Multinomial logistic regression with adjusted odds ratios were also conducted to determine the relative contribution of each variable in predicting whether a school helped or did not help students obtain health insurance. This study was exploratory research because there have not been previous studies conducted looking at superintendent perceptions of student health insurance. It is important to maximize the opportunity to reduce as many confounders as possible, therefore all potential key interactive variables were included. The mean scores for age, well-being, perceived role, perceived benefits and perceived barriers were used as cut-off points. The mean scores were used because it would result in approximately equal groups and the differences between the groups would be above and below average. The logical cut-off for education was between a master's or specialist degree and a doctorate. This created groups that were about the same size and had a substantial educational difference between them. The cut-off for years experience was set at 6 years because this would create equal groups; using the

Table 4.6: Odds Ratios for Superintendents In School Systems That Help Students Obtain Health Insurance

Item	Crude OR (95% CI)	Adjusted* OR (95% CI)
Systematically Assessed Student Health Insurance Status		
No	1.00	1.00
Yes	3.96 (2.31, 6.80)	4.58 (2.31, 9.06)
Gender		
Female	1.00	1.00
Male	1.10 (0.68, 1.80)	1.12 (0.58,2.15)
Age		
Younger than 55	1.00	1.00
55 Years of Age or Older	1.48 (0.96, 2.30)	1.46 (0.83, 2.57)
Superintendent Years of Experience		
≥6 years of experience	1.00	1.00
< 6 years experience	1.13 (0.73, 1.75)	1.54 (0.86, 2.76)
Superintendent's Education Level		
Doctorate	1.00	1.00
Bachelor's, Master's, Specialist	1.21 (0.79, 1.86)	1.63 (0.92, 2.88)
Superintendent's Race/Ethnicity		
White	1.00	1.00
Non-white	1.25 (0.56, 2.79)	1.04 (0.34, 3.11)
Student Population's Race/Ethnicity		
≥69% white	1.00	1.00
<69% white	1.21 (0.75, 1.93)	1.31 (0.67, 2.54)
Free and Reduced Lunch		
≥50%	1.00	1.00
<50%	1.00 (0.66, 1.53)	1.09 (0.60, 1.96)
School Location		
Rural	1.00	1.00
Non-rural	1.23 (0.78, 1.93)	1.27 (0.68, 2.37)

Table 4.6: Odds Ratios for Superintendents In School Systems That Help Students Obtain Health Insurance (continued)

Item	Crude OR (95% CI)	Adjusted* OR (95% CI)
Knowledge		
Low (≥ 7)	1.00	1.00
High (< 7)	1.54 (1.00, 2.35)	1.19 (0.70, 2.04)
Perceived Well-being		
Low (≥ 17)	1.00	1.00
High (< 17)	1.02 (0.66, 1.57)	1.43 (0.78, 2.63)
Role of Schools		
Do Not Perceive Role	1.00	1.00
Perceive Role	2.40 (1.53, 3.75)	1.78 (0.97, 3.25)
Perceived Benefits		
High (≥ 11)	1.00	1.00
Low (< 11)	1.02 (0.67, 1.57)	1.09 (0.60, 1.99)
Perceived Barriers		
High (≥ 4)	1.00	1.00
Low (< 4)	2.61 (1.68, 4.04)	2.12 (1.23, 3.63)

*Each adjusted odds ratio was calculated adjusting for all other variables in the table

mean for this variable would have produced widely disparate groups. The same cut-off points for student race/ethnicity ($< 69\%$), free and reduced lunch ($< 50\%$), and level of knowledge (< 7) as I did in the rest of the analyses.

Although four variables were identified in the crude odds ratios that increased the likelihood of a school helping students, when all other variables were controlled for, only two variables remained that increased the odds of a school helping students obtain health insurance. School systems were more likely to help students obtain health insurance if they systematically assessed health insurance status each year and perceived fewer barriers to helping students obtain health insurance. Superintendents from school systems that perceived fewer than four barriers to helping students were more than two

times as likely to have a school that helped students obtain health insurance as those that perceived four or more barriers. School systems that systematically assessed student health insurance were nearly five times as likely to help students obtain insurance as school districts that did not systematically assess students' health insurance status.

Superintendents characterizing their schools as having helped students enroll in the past but were currently not helping (relapse stage) were given the chance to share the reason why their school had changed practices. The following comments were shared:

- None of the above, we have actively given the enrollment materials, but have not helped to fill them out
- Only if asked by parents and it doesn't happen often
- Time. This is a parental responsibility
- Our school nurse still helps some families who need assistance with insurance. At one time we passed out fliers to all students but had very little response.
- Our district distributes forms to assist parents
- We give materials on CHIP and on where they can seek out help if needed.
- Our district does so, on an individual basis determined by health referrals via school nurses
- Information is provided to parents with free/reduced lunch application

4.4 Basic Knowledge of State-funded Health Insurance and the Effect of Health Status on Academic Outcomes

Superintendents were knowledgeable about state-funded health insurance and the effect of health status on student academic outcomes (attendance, attention, graduation)

as indicated by the majority of superintendents answering 63% of the eight basic knowledge questions correctly (M=6.42, SD=1.43). Five of the eight knowledge questions were answered correctly by more than three-quarters of superintendents (Table 4.7). The only item correctly answered by less than half of the superintendents was on the percent of eligible students covered by the state-funded health insurance programs.

Table 4.7: Basic Knowledge of State-funded Health Insurance and the Effects of Health Status on Academic Outcomes

Statement (Answer)	Correct N (%)
The more students miss school, the greater the probability that they will not do well in school. (True)	383 (99)
Students who are not feeling well have more trouble paying attention during classes. (True)	375 (97)
Students who are unhealthy (frequently ill) are more likely to miss school than are healthy children. (True)	367 (95)
Students from low-income families are more likely than other students to be uninsured. (True)	331 (86)
Students who are unhealthy (frequently ill) are less likely to graduate from high school than are healthy children. (True)	316 (82)
Racial and ethnic minority students are more likely than white students to be uninsured. (True)	261 (67)
Children eligible for state-funded public health insurance programs are automatically enrolled by the state. (False)*	256 (66)
State-funded health insurance programs cover 90% or more of eligible children. (False)*	187 (48)

N=384-386

Incorrect and unsure responses were considered to be incorrect

*These items were reverse scored to create a subscale

The average knowledge score of superintendents ($M=6.42$) was used to create two groups of superintendents to assess differences between those who were more informed and those who were not. The cutoff point was rounded up from the average score to increase the likelihood that superintendents in the high knowledge group (≥ 7 correct answers) had a higher than average score (88%) when compared with the score (75%) of the low knowledge group (< 7 correct answers). Superintendents with high knowledge scores ($n=205$), and low knowledge scores ($n=157$) were compared on a variety of variables. The questions in which the correct answers were false answers were reverse coded so that all of the items responses could be added together as a subscale score. Differences in knowledge about health insurance and the effects health status has on academic outcomes were assessed using independent samples t-tests and chi-squares (Table 4.8).

Superintendents who answered 7 or more knowledge questions correctly were more likely to hold the following beliefs: health insurance status has an effect on student' well-being ($t=-5.35$, $df=356$, $p<0.001$) and that schools should play a role in helping students obtain state-funded health insurance ($\chi^2=10.998$, $df=1$, $p=0.001$). This group also perceived more benefits ($M=12.1$, $SD=3.86$) for schools to help students obtain health insurance compared with those who scored lower ($M=9.8$, $SD=4.37$) on the knowledge questions ($t=-5.419$, $df=376$, $p<0.001$). Superintendents with higher knowledge scores were less likely to be from schools with a White student population greater than 69% (48% vs. 63%, $\chi^2=7.234$, $df=1$, $p<0.01$).

Table 4.8: Superintendents’ Knowledge of Health Insurance and Health Status Effects on Academic Outcomes by Selected Variables

Item	Lower Knowledge N (%)	Higher Knowledge N (%)
School System’s Stage of Change		
Action	32%	41%
Non-Action	67%	56%
Relapse	1%	3%
Superintendent’s Gender		
Male	47%	53%
Female	53%	47%
Superintendent’s Education Level		
Doctorate	46%	54%
Bachelor’s, Master’s, Specialist	49%	51%
Superintendent’s Race/Ethnicity		
White	50%	50%
Non-white	31%	69%
Student Population Race/Ethnicity*		
≥69% white	53%	48%
<69% white	37%	63%
Free and Reduced Lunch		
≥50%	48%	52%
<50%	49%	51%
School Location		
Rural	47%	53%
Non-rural	51%	49%
Role of Schools*		
Perceive Role	41%	59%
Do Not Perceive Role	58%	42%
	M (SD)	M (SD)
Superintendent’s Age	54.5 (8.36)	54.6 (7.67)
Perceive Well-being**	15.4 (4.23)	17.7 (3.97)
Perceive Benefits**	9.8 (4.37)	12.1 (3.86)
Perceived Barriers	3.4 (2.36)	3.5 (2.39)

Missing values were excluded from any analysis; potential range 0-8

Data may not add up to 100% due to rounding

Lower knowledge (N=157), and Higher knowledge (N=205)

*Chi-square test was significant at the .01 level

**Independent samples t-test was significant at the .01 level

4.5 Health Insurance Status Effects on Students' Well-being

Superintendents overwhelmingly indicated positive beliefs regarding the effects of health insurance status on students' health and academic outcomes (well-being) (Table 4.9). More than 60% of superintendents agreed with all eight statements about health insurance effects on students' well-being. Nine out of ten superintendents agreed that students without health insurance are less likely to receive needed medical care (94%), have a usual place of care (93%), and more likely to be ill for longer periods (90%) than are children with health insurance.

Table 4.9: Beliefs About Health Insurance Status Effects on Student' Well-being

Statement	Agree N (%)	Disagree N (%)
Students without health insurance are less likely to receive needed medical care than children with health insurance.	364 (94)	22 (6)
Students without health insurance are less likely to have a usual place of medical care than children with health insurance.	359 (93)	25 (7)
Students without health insurance are more likely to be ill for longer periods than children with health insurance.	347 (90)	33 (9)
Students without health insurance are more likely to be ill more frequently than children with health insurance.	303 (78)	75 (19)
Students without health insurance are more likely to miss school than children with health insurance.	296 (77)	80 (21)
Students without health insurance are less likely to do well in school than children with health insurance.	284 (73)	91 (24)
Students without health insurance are less likely to graduate from high school than are children with health insurance.	251 (65)	120 (31)
Students without health insurance are more likely to be distracted (not pay attention) during school.	238 (62)	136 (35)

N=371-386

Agree = strongly agree and agree

Disagree = strongly disagree and disagree

A well-being subscale was created by adding the responses of all 8 well-being items. The range of possible scores was 0-24. The actual range of responses was 0-24 with a mean score of 16.6 (SD=4.2). Higher numbers indicate greater agreement that health insurance status affects the well-being of students. Factors which were statistically significantly different with superintendent's well-being scores were superintendent's education and knowledge level, the perceived role of schools, and perceived number of benefits (Table 4.10). Superintendents with a doctorate had a mean of 17.4 (SD=4.23) compared with 16.1 (SD=4.15) for those holding bachelor's, master's or specialist's degrees ($t=-3.014$, $df=354$, $p<0.01$). Respondents with high well-being scores were more likely to score 7 or higher on the knowledge scale ($t=-5.353$, $df=356$, $p<0.001$) and to hold the belief that school systems should play a role in helping students obtain health insurance ($t=-7.625$, $df=352$, $p<0.001$). A Pearson product moment correlation was conducted and it found a relationship exists between superintendents' beliefs about the effects of health insurance status on student' well-being and the perceived number of benefits for schools helping students obtain health insurance ($r=0.59$, $p<0.001$).

4.6 Role of Schools in Helping Students Obtain Health Insurance

Superintendent' beliefs regarding the role that schools should play in helping students obtain health insurance are indicated in Table 4.11. The majority of superintendents agreed with the following 3 of 5 role items; schools should help students be healthy (92%), schools should provide students' parents with access to state-funded health insurance enrollment forms (74%), and schools should help students enroll in state-funded health insurance when they register for school (52%).

Table 4.10: Perceptions of Health Insurance Status on Students' Well-being by Selected Variables

Item	M (SD)
School System's Stage of Change	
Action	16.6 (4.07)
Non-Action	16.6 (4.39)
Relapse	15.4 (3.25)
Superintendent's Gender	
Male	16.5 (4.62)
Female	17.2 (3.99)
Superintendent's Education Level*	
Doctorate	17.4 (4.23)
Bachelor's, Master's or Specialist Degree	16.1 (4.15)
Superintendent Race/Ethnicity	
White	16.6 (4.11)
Non-White	17.2 (5.84)
Student Population Race/Ethnicity	
≥69% white	16.5 (4.18)
≥69% white	16.9 (4.33)
Free and Reduced Lunch	
≥50%	17.0 (4.55)
>50%	16.3 (3.95)
School Location	
Rural	16.3 (4.33)
Non-Rural	17.3 (3.88)
Knowledge*	
High (7-8)	17.7 (3.97)
Low (<7)	15.4 (4.23)
Role of Schools*	
Perceived Role	18.1 (3.93)
Did Not Perceive Role	14.9 (4.07)
	r
Superintendent's Age	-0.28
Perceived Benefits**	0.59
Perceived Barriers	0.06

N=362

Missing values were excluded from any analysis; potential range 0-24

*Independent samples t-test was significant at the 0.01 level

**Pearson product moment correlation was significant at the 0.01 level

Table 4.11: Role of Schools in Helping Students Obtain Health Insurance

Role of Schools	Agree N (%)	Disagree N (%)
One of the roles of schools should be to help students be healthy.	354 (92)	29 (8)
One of the roles of schools should be to provide students' parents with access to state-funded health insurance enrollment forms.	288 (74)	92 (24)
One of the roles of schools should be to help students enroll in state-funded health insurance when they register for school.	201 (52)	178 (46)
One of the roles of schools should be to assist students' parents with filling out state-funded health insurance enrollment forms.	184 (48)	198 (51)
Obtaining health insurance for students should be the sole responsibility of the parent(s)/guardian(s).*	174 (45)	202 (52)

N=376-383

Agree = strongly agree and agree

Disagree = strongly disagree and disagree

*This item was reverse scored to create the subscale

To analyze the differences between those who agreed and those who disagreed with the school having a role, a school's role subscale was created by adding the responses to the five items (possible range 0-15). Each statement was coded as 3 (Strongly Agree) to 0 (Strongly Disagree) so that higher numbers would indicate the belief that the school should have a role in helping students obtain health insurance. The question about parental responsibility was reverse-scored. The respondents' mean for the school's role subscale was 7.55 (SD=2.43) indicating superintendents agreed somewhat that schools should play a role in helping students obtain health insurance. Two groups were created using the mean, those who believe the schools should have a role (score ≥ 8) and those who did not (score less than 8) to assess differences between the groups on several variables. The differences can be found in Table 4.12.

Table 4.12: Superintendents' Perceptions of School System's Role in Helping Students Obtain Health Insurance by Selected Variables

	Perceive a Role	Do Not Perceive a Role
School System's Stage of Change		
Action	45%	26%
Non-Action	53%	72%
Relapse	2%	2%
Superintendent's Gender		
Male	54%	46%
Female	55%	46%
Superintendent's Education Level		
Doctorate	57%	43%
Bachelor's, Master's, Specialist	53%	47%
Superintendent's Race/Ethnicity		
White	53%	47%
Non-white	71%	29%
Student population Race/Ethnicity		
≥69% white	52%	48%
<69% white	63%	37%
Free and Reduced Lunch		
≥50%	55%	45%
<50%	54%	46%
School Location*		
Rural	50%	50%
Non-rural	64%	36%
Knowledge**		
High (≥7-8)	62%	38%
Low (<7)	45%	55%
	M (SD)	M (SD)
Superintendent's Age***	55.4 (8.00)	53.1 (7.91)
Perceived Well-being***	18.1 (3.83)	14.9 (4.07)
Perceived Benefits***	12.6 (3.62)	9.1 (4.15)
Perceived Barriers***	2.98 (2.40)	3.95 (2.26)

Perceived Role (N=201), Do Not Perceive a Role (N=169)

Missing values were excluded from any analysis

Percents may not add up to 100% due to rounding

*Chi-square test significant at the 0.05 level

**Chi-square test significant at the 0.01 level

***Independent samples t-test was significant at the 0.01 level

Superintendents who believed schools systems should have a role in helping students obtain health insurance identified more perceived benefits ($M=12.6$, $SD=3.62$ vs. 9.1 , $SD=4.15$; $t=-8.534$, $df=362$, $p<0.001$) and fewer perceived barriers ($M=2.98$, $SD=2.39$ vs. $M=3.95$, $SD=2.26$; $t=3.945$, $df=360$, $p<0.001$) to helping with enrollment. This group was also more likely to perceive that health insurance status affects students' well-being ($t=-7.625$, $df=352$, $p<0.001$), have knowledge scores greater than seven ($\chi^2=10.998$, $df=1$, $p=0.001$); and be in the action or maintenance stages of helping students (45% vs. 26%; $\chi^2=15.003$, $df=1$, $p=0.001$) than superintendents who do not believe school systems should play a role in helping students obtain health insurance. Superintendents who perceived schools to have a role in helping students were slightly older than those who did not perceive the school to have a role ($t=-2.72$, $df=351$, $p<0.01$). Although not statistically significant at the 0.01 level, superintendents perceiving the school to have a role in helping students obtain health insurance were less likely to be from non-rural schools (36%) than from rural (50%) schools ($\chi^2=5.760$, $df=1$, $p<0.05$).

4.7 Perceived Benefits of Helping Students Obtain Health Insurance

Respondents were given the opportunity to select which of 17 potential benefits (for schools) they perceived to helping enroll students in state-funded health insurance. At least 50% of superintendents supported 12 of the listed benefits with a mean of 10.99 ($SD = 4.25$) perceived benefits (Table 4.13). The perceived benefits identified by nine out of ten respondents were: keep students healthier (93%), and reduce the number of students with untreated health problems (92%). They were least likely to believe (29%) that helping students obtain health insurance would result in gaining financial support for schools. Three percent of respondents chose the other category and identified additional

Table 4.13: Perceived Benefits of Helping Students Obtain Health Insurance

Benefits	N (%)
Keep students healthier	361 (93)
Reduce the number of students with untreated health problems	356 (92)
Reduce absenteeism rates	336 (87)
Improve affected students' attention/concentration during school	320 (83)
Reduce number of students being held back in school because of unidentified and untreated health problems	275 (71)
Result in families spending less out-of-pocket for health care	270 (70)
Reduce the number of students who drop out of school or fail to Graduate	265 (69)
Increase academic test scores	257 (66)
Increase student's lifelong productivity	253 (65)
Reduce racial/ethnic disparities in health status	242 (63)
Reduce tardiness rates	227 (59)
Be a more efficient method of enrolling a greater number of children in state-funded health insurance programs	213 (55)
Reduce racial/ethnic disparities in academics	191 (49)
Reduce the risk of students' need for social dependence as an adult (receiving public assistance)	178 (46)
Provide schools with the opportunity to have their school-based health care services covered by insurance	162 (42)
Improve a schools' community good will toward the school	158 (41)
Garner financial support for schools	113 (29)
Other (obtain needed professional services and programs, keep schools informed to provide information to parents, increase ability to participate in sports, provide voice for health care and related issues to families)	12 (3)

N= 381

benefits. Additional benefits added in the other category were:

- Helps at-risk students in obtaining needed professional services and programs.
- Keep schools informed and able to provide information to parents. Support a social worker for schools.
- Increase ability for students to participate in sports
- Provide education and a strong voice for health care and related issues for students and families

The number of perceived benefits were found to be statistically significantly different by knowledge, well-being, and the perceived role of schools (Table 4.14). Superintendents who had higher knowledge scores perceived a greater number of benefits to helping students obtain health insurance ($t=-5.419$, $df=376$, $p<0.001$); and to hold the belief that schools should play a role in helping students obtain health insurance ($t=-8.534$, $df=362$, $p<0.001$). A Pearson product moment correlation found a relationship between perceived benefits and perceived well-being ($r=0.59$, $p<0.001$). Although not statistically significant at the .01 level, differences in perceived benefits by school location were found. Superintendents in rural school systems perceived fewer benefits ($M=10.6$, $SD=4.33$) to helping students obtain health insurance than superintendents in urban or suburban ($M=11.8$, $SD=3.95$) settings ($t=-2.48$, $df=376$, $p=0.014$).

4.8 Perceived Barriers to Helping Students Obtain Health Insurance

Respondents were also asked to select perceived barriers to helping students obtain state-funded health insurance from a list of ten potential barriers. The mean number of perceived barriers selected was 3.42 ($SD=2.4$). Two of the ten potential barriers were identified by at least 50% of superintendents (Table 4.15). These primary barriers were not having enough staff (62%) and not having the financial resources (55%). Not having time (46%) or knowing how to help (45%) were selected by nearly half of respondents. The other potential barriers were selected by less than a third of superintendents.

Table 4.14: Superintendents' Perceived Benefits of Helping Students Obtain Health Insurance by Selected Variables

	M (SD)
School System's Stage of Change	
Action	11.1 (4.08)
Non-Action	10.9 (4.38)
Relapse	10.5 (4.24)
Superintendent's Gender	
Male	11.0 (4.24)
Female	11.1 (4.18)
Superintendent's Education Level*	
Doctorate	11.5 (3.89)
Bachelor's, Master's or Specialist Degree	10.7 (4.41)
Superintendent Race/Ethnicity	
White	10.96 (4.19)
Non-White	11.5 (4.99)
Student population Race/Ethnicity	
≥69% white	10.8 (4.15)
<69% white	11.4 (4.39)
Free and Reduced Lunch	
≥50%	11.1 (4.39)
<50%	10.9 (4.16)
School Location*	
Rural	10.6 (4.33)
Non-rural	11.8 (3.95)
Knowledge**	
High (≥7-8)	12.1 (3.86)
Low (<7)	9.8 (4.37)
School's Role	
Perceive a Role	12.6 (3.62)
Do Not Perceive a Role	9.1 (4.15)
	r
Superintendent's Age	0.05
Perceived Well-being ^b	0.59
Perceived Barriers ^b	0.06

N-381

Missing values were excluded from any analysis

* Independent samples t-test was Significant at the 0.05 level

** Independent samples t-test was Significant at the 0.01 level

Table 4.15: Perceived Barriers to Helping Students Obtain Health Insurance

Barriers	N (%)
Our school district does not have enough staff to help students obtain health insurance	241 (62)
Our school district does not have the financial resources to help students obtain health insurance	214 (55)
Personnel in our school district do not have the time to help students obtain health insurance	178 (46)
Personnel in our school district do not know how to help students obtain health insurance	174 (45)
Our school district does not have the office space needed to help with insurance issues	114 (30)
Our school district does not have state support (Medicaid/SCHIP/Health Department) to help uninsured students obtain health insurance	96 (25)
Personnel in our school district do not believe it is the role of schools to be involved in helping students obtain insurance.	83 (21)
The state government cannot afford a significant increase in the numbers of children enrolled in the state-funded health insurance programs.	79 (20)
Few students in our school district are without health insurance	53 (14)
Parents in our school district do not want schools involved in helping students obtain health insurance	31 (8)
Other (economic burden, creates social dependence, resources including funding “unfunded mandates” and time, and not the school’s role)	16 (4)

N= 373

Superintendents were able to write in other barriers to schools helping students obtaining health insurance; about 4% of superintendents did. These additional barriers were grouped by theme:

4.8.1 Economics

- It may be the opposite of reducing the risk of students’ need for social dependence as an adult (receiving public assistance)
- Will create a large economic burden on the state. Will create a dependency on state services, and will create a program that will be politically impossible to terminate.
- State doesn’t provide adequate coverage assistance for nonresidents

4.8.2 Not the school's role

- This is not the mission of an educational system.
- Parents may need help and help should be provided. Must schools be the default provider? Another unfunded mandate?
- We do whatever we can and need to do for our students because we choose to NOT because we have to or are mandated to do so.
- We are willing to have forms but to mandate without funds, give me a break. Let's get the parents involved.
- Parents are too proud to accept our assistance in completing applications.

4.8.3 Resources

- The state cuts school staff and wants us to do more.
- Limited resources and unneeded mandates
- Lack of social workers within district
- Time!!! We have too much to do now. How can we add more?

A Pearson product moment correlation found a relationship between superintendents' age and their number of perceived barriers ($r=-0.2$, $p<0.001$). The number of perceived barriers was statistically different by Stage of Change and the perceived role of schools (Table 4.16). Superintendents that perceived fewer barriers were more likely to be in the action or maintenance stage of helping students enroll in health insurance ($F(2,367)=14.5$, $p<0.001$). Fewer perceived barriers was also associated with a greater belief that schools should play a role in helping students enroll in health insurance ($t=3.945$, $df=360$, $p<0.001$).

Table 4.16: Superintendents' Perceived Barriers to Helping Students Obtain Health Insurance by Selected Variables

	M (SD)
School System's Stage of Change*	
Action	2.59 (2.4)
Non-Action	3.93 (2.2)
Relapse	3.14 (2.8)
Superintendent's Gender	
Male	3.5 (2.41)
Female	3.1 (2.22)
Superintendent's Education Level	
Doctorate	3.3 (2.44)
Bachelor's, Master's or Specialist Degree	3.5 (2.34)
Superintendent Race/Ethnicity	
White	3.4 (2.36)
Non-White	3.7 (2.59)
Student population Race/Ethnicity	
≥69% white	3.4 (2.35)
<69% white	3.5 (2.49)
Free and Reduced Lunch	
≥50%	3.4 (2.31)
<50%	3.5 (2.44)
School Location	
Rural	3.6 (2.44)
Non-rural	3.2 (2.21)
Knowledge	
High (≥7-8)	3.5 (2.39)
Low (<7)	3.4 (2.36)
School's Role**	
Perceive a Role	2.98 (2.39)
Do Not Perceive a Role	3.95 (2.26)
	r
Superintendent's Age***	-0.20
Perceived Well-being	0.06
Perceived Benefits	0.06

N=373

Missing values were excluded from any analysis

*A one-way ANOVA was significant at the 0.01 level

**Independent samples t-test was significant at the 0.01 level

***Pearson product moment correlation test was significant at the 0.01 level

4.9 Additional Comments of Superintendents

At the end of the survey, superintendents were able to write their opinions about this issue; 41 (11%) superintendents gave their opinions. Although all comments were not included, relevant comments to the issue were;

4.9.1 Issues With The System of Insurance and Medical Care

- Our state will treat any student that visits an emergency room – All of our children have the opportunity to seek and receive medical attention
- Many doctors and dentists in our county will not see Medicaid students due to low reimbursement rates. Our nearest dental clinic is 60 miles away and parents can't get there.
- Insurance is not free. Someone pays
- Socialized medicine does not work. In (state), support staff can have free health insurance for \$69 cash. Most take the cash and then complain about no health care. Native Americans get free health care but do not always take it for the children.

4.9.2 Parental Issues

- Parents can create a real barrier in getting qualified students enrolled in health insurance programs, even though it is free!
- Many parents who have insurance do not always get kids the help they need because of the deductibles – students on assistance seemed to have as many or more visits to Drs.
- Sometimes bilingual parents have difficulties.

4.9.3 Not the School's Role and Funding/Mandate Concerns

- All children need medical assistance but why doesn't the parent take care of this. Everyone wants the schools to be responsible for what should be the parents job.
- We want to help any kids that need our help, we will help if asked. However we do not believe it is our role or our job to do that. That is the job of the parents/guardians. We are more than willing to assist or make recommendations.
- I understand why the school is expected to do this, has government ever thought about how many unfunded mandates we have from this state. Parents need to be educated and informed. We do help in some of this because we are small and know the needs of most students.
- Not the schools job. Education is our Job. I feel students do best when healthy. I feel our role as a school is to work with appropriate agencies to make information on health care available to parents and to work with health care agencies via referrals, etc. When we become aware of health care issues which are hindering a student's well being. The key would be additional school nurses as resources in the schools to monitor health needs and work in conjunction with other agencies.
- Schools are already becoming a social agency in regards to the services that we are required to provide. Mandated...but unfunded. It is time for parents to step up to the plate and provide for their children and let schools serve the role for which they are intended...to educate.
- Health Insurance is a very important issue for children. At this time schools are so strapped for resources, it is too much to expect schools to assume this responsibility.

- Should be a “FUNDED MANDATE” if a school has to do it.
- Adding another responsibility for a school district is a challenge.
- Our Healthy Start program got us on track to help with insurance for students, but those funds are now gone. We will have less help for this.
- Should schools be burdened with ever more of society’s responsibilities? If so, they need significantly more funding and staff resources!
- I have a heart for the underprivileged but resent using schools as a means to change society. Government should use other agencies for its social engineering efforts. The poor people who work in these schools are just over worked school teachers who signed on to teach academics. Let the government fully fund personnel whose responsibility would be to assist people in need.

4.9.4 Successes and Suggestions

- The county government provides school nursing and supplies to each school. They are providing health care for students. I do not know how they may be working with health insurance.
- Since 1994, we have been a partner with the Joint Comm. For Children’s Health Care in Everett. This has been an extremely rewarding experience and knowledge base for the school system. We believe that children cannot be successful unless they are healthy. Parents have and still are very happy with this partnership which truly assists everyone. Also, because of the JCCHCE, we have Cambridge Health Alliance now in our community!
- I believe that schools should work collaboratively with the outside agencies. Our area/county has a health department funded medical and dental clinic that meets

many of the needs of our students. They work very closely with the schools in our county to maximize use of taxpayer dollars.

- A social service agency should assist uninsured students. If the public schools are involved, they should partner with an agency that actually completes the forms and more directly assists the families.
- We work to connect parents to programs, as we are a small school. Have seen good results.
- We have 2 school nurses who refer parents to agencies to enroll children in Health Care as we become aware of health concerns. This is a better way to work in conjunction with health agencies.
- We assist parents when we are aware of the need – but don't do it systematically
- We try to help parents with any/all paperwork they request our help with.
- If a parent indicates student is uninsured on free/reduced lunch application, an automatic referral is made to the local hospital district.

4.9.5 More Information, Resources, and Training

- We would be glad to help if we were given more info/help on how to do so. We just need more info on forms, etc.
- We would welcome state support to help connect families with funded insurance.

4.10 Hypothesis Testing

There were 52 hypotheses formulated in Chapter One. The results of analyses are discussed in relation to the null hypotheses. The term majority, as utilized in the hypotheses of this study, is defined as a simple majority, 51% or more of subjects.

Hypotheses 1.1 The majority of superintendents do not place their school district in the action or maintenance stage of the Stages of Change theory with regards to schools helping uninsured students obtain state-funded health insurance.

Only 36% of superintendents placed their school district in either the action stage or maintenance stage of the Stages of Change in regards to schools helping uninsured students obtain health insurance. Thus, the null hypothesis was accepted.

Hypotheses 1.2 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on whether the school district systematically assesses student health insurance status (yes, no).

A chi-square test ($\chi^2=29.40$, $df=2$, $p<0.001$) was used to assess differences in the stage of change school districts were in by whether or not the school district systematically assessed student health insurance status. Results showed that there were differences between schools in the action or maintenance stages and the precontemplation, contemplation or preparation stages. Schools in the action stage (64%) were more likely to also assess student health insurance status than those in the non-action stage (36%).

There were no statistically significant differences between those in action or maintenance stages and those in the relapse stage ($\chi^2=3.89$, $df=1$, $p=0.048$). Thus, the null hypothesis was rejected.

Hypotheses 1.3 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ

significantly based on the superintendent's education level (Bachelor's, Master's or Specialist, versus Doctorate).

A chi-square test ($\chi^2=936$, $df=2$, $p=0.626$) was used to assess differences in the stage of change school districts were in by the superintendent's education level. There were no statistically significant differences in the school district's Stage of Change by the superintendent's education level. Thus, the null hypothesis was accepted.

Hypotheses 1.4 The perceived stage (action, non-action, relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's race/ethnicity (White, Non-White).

A chi-square test ($\chi^2=0.811$, $df=2$, $p=0.667$) was used to assess differences in the Stage of Change school districts were in by the superintendent's race/ethnicity. There were no statistically significant differences in the school district's Stage of Change by the superintendent's race/ethnicity. Thus, the null hypothesis was accepted.

Hypotheses 1.5 The perceived stage (action, non-action, relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the racial/ethnic composition of the school district (predominately white, non-white).

A chi-square test ($\chi^2=2.82$, $df=2$, $p=0.244$) was used to assess differences in the stage of change school districts were in by the racial/ethnic composition of the school district. There were no statistically significant differences in the school district's Stage of Change by the racial/ethnic composition of the school district. Thus, the null hypothesis was accepted.

Hypotheses 1.6 The perceived stage (action, non-action, relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).

A chi-square test ($\chi^2=0.003$, $df=2$, $p=0.998$) was used to assess differences in the Stage of Change school districts were in by the percent of students receiving free and reduced lunch. There were no statistically significant differences in the school district's Stage of Change by the percent of students receiving free and reduced lunch. Thus, the null hypothesis was accepted.

Hypotheses 1.7 The perceived stage (action, non-action, relapse) of a school system in helping uninsured students in obtaining health insurance does not differ significantly based on the location of the school district (rural, non-rural).

A chi-square test ($\chi^2=0.774$, $df=2$, $p=0.679$) was used to assess differences in the Stage of Change school districts were in by location of the school district. There were no statistically significant differences in the school district's Stage of Change by location of the school district. Thus, the null hypothesis was accepted.

Hypotheses 1.8 The perceived stage (action, non-action, relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's knowledge of state-funded health insurance and the effects of health on academics (high, low).

A chi-square test ($\chi^2=5.83$, $df=2$, $p=0.054$) was used to assess differences in the Stage of Change school districts were in by the level of knowledge a superintendent had regarding

state-funded health insurance and the effects of health on academics. There were no statistically significant differences in the school district's Stage of Change by the level of knowledge a superintendent had regarding state-funded health insurance and the effects of health on academics. Thus, the null hypothesis was accepted.

Hypotheses 1.9 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's beliefs about the effect of health insurance status on student's wellbeing (score 0-24).

A one-way ANOVA test ($F(2,357)=0.344$, $p=0.709$) was conducted to assess differences in the Stage of Change school districts were in by beliefs about the effect of health insurance status on student' well-being. There were no statistically significant differences in the school district's Stage of Change by beliefs about the effect of health insurance status on student' well-being. Thus, the null hypothesis was accepted.

Hypotheses 1.10 The perceived stage (action, non-action, relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's beliefs about the role of schools in helping students obtain health insurance (high, low).

A chi-square test ($\chi^2=12.88$, $df=2$, $p=0.002$) was used to assess differences in the Stage of Change school districts were in by superintendent beliefs regarding the role of schools in helping students obtain health insurance. Only 26% of superintendents not in support of a role for schools versus 45% of superintendents in support of a role were from school districts in the action or maintenance stages of Stage of Change. Results showed that there were differences between schools in the action or maintenance stages versus the

precontemplation, contemplation and preparation stages ($\chi^2=12.52$, $df=1$, $p<0.001$).

There were no statistically significant differences between those in action or maintenance stages and those in the relapse stage ($\chi^2=0.98$, $df=1$, $p=0.322$). Thus, the null hypothesis was rejected.

Hypotheses 1.11 The perceived stage (action, non-action, relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.

A one-way ANOVA test ($F(2,375)=0.125$, $p=0.883$) was conducted to assess differences in the Stage of Change school districts were in by perceived number of benefits to schools helping students obtain health insurance. There were no statistically significant differences in the school district's Stage of Change by perceived number of benefits to schools helping students obtain health insurance. Thus, the null hypothesis was accepted.

Hypotheses 1.12 The perceived stage (action, non-action, relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.

A one-way ANOVA test ($F(2, 367)=14.54$, $p<0.001$) was conducted to assess differences in the Stage of Change school districts were in by perceived number of barriers to schools helping students obtain health insurance. Results showed there was a statistically significant difference between schools in the action or maintenance stages and the precontemplation, contemplation and preparation stages ($t=1.34$, $df=361$, $p<0.001$). Schools in the action or maintenance stages perceived fewer barriers to

helping students obtain state-funded health insurance (2.59 vs. 3.93, respectively). There was no statistically significant difference between those in action or maintenance stages and those in the relapse stage ($t=-0.787$, $df=139$, $p=0.670$). Thus, the null hypothesis was rejected.

Hypotheses 2.1 The majority of superintendents do not report that schools in their school district systematically assess the health insurance status of all students at the beginning of each school year.

Less than 20% of superintendents reported that schools in their school district systematically assessed the health insurance status of all students at the beginning of each school year. Thus, the null hypothesis was accepted.

Hypotheses 2.2 The majority of superintendents do not report that schools in their school district help students obtain state-funded health insurance.

Only 45% of superintendents indicated that schools in their school district helped students obtain state-funded health insurance. Thus, the null hypothesis was accepted.

Hypotheses 2.3 The majority of superintendents do not report that their school district received financial support to help students enroll in state-funded health insurance.

Only 6% of school districts had received funding for helping students enroll in health insurance programs. Thus, the null hypothesis was accepted.

Hypotheses 2.4 The majority of superintendents do not report their school district as providing parents assistance for enrolling their children.

Although none of the nine potential activities were identified by the majority of superintendents, a majority of superintendents did identify at least one of the activities.

Two activities that are similar, making application materials available and giving the applications to parents each school year, were chosen by the majority (53%) of superintendents. Thus, the null hypothesis is rejected.

Hypotheses 3.1 The majority of superintendents do not have basic knowledge of state-funded health insurance and the effect of health status on academic outcomes.

Superintendents were knowledgeable about state-funded health insurance and the effect of health status on academic outcomes indicated by the majority of superintendents answering six out of eight basic knowledge questions correctly. On an eight point scale, the mean score was 6.42 (SD=1.43). Three-quarters of the respondents correctly answered five or more knowledge questions. Thus, the null hypothesis was rejected.

Hypotheses 3.2 There is no significant difference in superintendent's knowledge (high, low) by superintendent's education level (bachelor's, master's or specialist, versus doctorate).

A chi-square test ($\chi^2=3.26$, $df=1$, $p=0.568$) was used to assess differences in superintendent's knowledge by superintendent's education level. There were no statistically significant differences between superintendents with high knowledge scores and those with lower knowledge scores by superintendent's education level. Thus, the null hypothesis was accepted.

Hypotheses 3.3 There is no significant difference in superintendent's knowledge (high, low) by superintendent's race/ethnicity (white, non-white).

A chi-square test ($\chi^2=3.48$, $df=1$, $p=0.062$) was used to assess differences in superintendent's knowledge by superintendent's race/ethnicity. There were no

statistically significant differences between superintendents with high knowledge scores and those with lower knowledge scores by superintendent's race/ethnicity. Thus, the null hypothesis was accepted.

Hypotheses 3.4 There is no significant difference in superintendent's knowledge (high, low) by racial/ethnic composition of the school district (predominately white/non-white).

A chi-square test ($\chi^2=7.23$, $df=1$, $p=0.007$) was used to assess differences in superintendent's knowledge by the racial/ethnic composition of the school district.

Superintendents with higher knowledge scores were more likely to be from schools with a non-white student population compared with schools with a white population of 69% or higher (48% vs. 63%, respectively). Thus, the null hypothesis was rejected.

Hypotheses 3.5 There is no significant difference in superintendent's knowledge (high, low) by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).

A chi-square test ($\chi^2=0.019$, $df=1$, $p=0.892$) was used to assess differences in superintendent's knowledge by the school district's percent of students receiving free and reduced lunch. There were no statistically significant differences between superintendents with high knowledge scores and those with lower knowledge scores by the school district's percent of students receiving free and reduced lunch. Thus, the null hypothesis was accepted.

Hypotheses 3.6 There is no significant difference in superintendent's knowledge (high, low) by the location of the school district (rural, non-rural).

A chi-square test ($\chi^2=0.388$, $df=1$, $p=0.533$) was used to assess differences in superintendent's knowledge by the location of the school district. There were no statistically significant differences between superintendents with high knowledge scores and those with lower knowledge scores by the location of the school district. Thus, the null hypothesis was accepted.

Hypotheses 3.7 There is no significant difference in superintendent's knowledge (high, low) by superintendents' beliefs about the effect of health insurance status on students' wellbeing (0-24).

An independent samples t-test ($t=-5.353$, $df=356$, $p<0.001$) was used to assess differences in superintendent's knowledge by superintendent' beliefs about the effect of health insurance status on students' well-being. Superintendents who answered 7 or more knowledge questions correct were more likely to hold the belief that health insurance status has an effect on students' well-being. The average well-being score for those with higher knowledge was 17.7 (SD=3.97) compared with 15.4 (SD=4.23) for superintendents scoring lower on knowledge. Thus, the null hypothesis was rejected.

Hypotheses 3.8 There is no significant difference in superintendent's knowledge (high, low) by superintendents' beliefs about the role of schools in helping students obtain health insurance (high, low).

A chi-square test ($\chi^2=10.998$, $df=1$, $p=0.001$) was used to assess differences in superintendent's knowledge by superintendents' beliefs about the role of schools in helping students obtain health insurance. About 59% of superintendents who answered 7 or more knowledge questions correctly indicated a perceived role for schools in helping

students obtain health insurance compared with only 41% of those having a low knowledge score. Thus, the null hypothesis was rejected.

Hypotheses 3.9 There is no significant difference in superintendent's knowledge (high, low) by the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.

An independent samples t-test ($t=-5.419$, $df=376$, $p<0.001$) was used to assess differences in superintendent's knowledge by the perceived number of benefits identified by superintendents. The higher knowledge group was more likely to perceive a greater number of benefits ($M=12.1$, $SD=3.86$; $M=9.8$, $SD=4.37$) for schools to help students obtain health insurance. Thus the null hypothesis was rejected.

Hypotheses 3.10 There is no significant difference in superintendent's knowledge (high, low) by the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.

An independent samples t-test ($t=-0.404$, $df=367$, $p=0.686$) was used to assess differences in superintendent's knowledge by the superintendent's perceived number of barriers to helping students obtain health insurance. There were no statistically significant differences between superintendents with high knowledge scores and those with lower knowledge scores by the number of perceived barriers identified by superintendents. Thus, the null hypothesis was accepted.

Hypotheses 4.1 The majority of superintendents do not agree that health insurance status affects a students' well-being.

More than 60% of superintendents agreed with all eight statements about health insurance and students' well-being. This indicated that they hold the belief that health insurance does affect a students' well-being. Thus, the null hypothesis is rejected.

Hypotheses 4.2 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by superintendent's education level (bachelor's, master's or specialist, versus doctorate).

An independent samples t-tests ($t=-3.01$, $df=354$, $p=0.003$) were used to assess differences in superintendent's perceptions of the effect health insurance has on student' well-being by the superintendent's education level. Individuals with a doctorate degree ($M=17.4$, $SD=4.23$) compared with those having a bachelor's, master's or specialist degree ($M=16.1$, $SD=4.15$) had higher agreement scores with the effects health insurance has on students' well-being. Thus, the null hypothesis was rejected.

Hypotheses 4.3 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by superintendent's race/ethnicity (white, non-white).

An independent samples t-test ($t=-0.696$, $df=357$, $p=0.487$) was used to assess differences in superintendent's perceptions of the effect health insurance has on student well-being by the superintendent's race/ethnicity. There were no statistically significant differences between superintendent's perceptions' of the effects health insurance status has on student well-being based on the superintendent's race/ethnicity. Thus, the null hypothesis was accepted.

Hypotheses 4.4 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the racial/ethnic composition of the school district (predominately white/non-white).

An independent samples t-test ($t=0.662$, $df=350$, $p=0.509$) was used to assess differences in superintendent's perceptions of the effect health insurance has on student' well-being by the racial composition of the school district. There were no statistically significant differences between superintendents' perceptions of the effects health insurance status has on students' well-being by the student's race/ethnicity. Thus, the null hypothesis was accepted.

Hypotheses 4.5 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).

An independent samples t-test ($t=-1.69$, $df=355$, $p=0.092$) was used to assess differences in superintendent' perceptions of the effect health insurance has on student' well-being by the percent of students receiving free and reduced lunch. There were no statistically significant differences between superintendent' perceptions' of students' well-being by the percent of students receiving free and reduced lunch. Thus, the null hypothesis was accepted.

Hypotheses 4.6 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the location of the school district (rural, non-rural).

An independent samples t-test ($t=-1.93$, $df=357$, $p=0.055$) was used to assess differences in superintendent' perceptions of the effect health insurance has on student' well-being by the school's location. There were no statistically significant differences between superintendent' perceptions' of students' well-being and the location of the school. Thus, the null hypothesis was accepted.

Hypotheses 4.7 There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the superintendents' beliefs about the role of schools in helping students obtain health insurance (high, low).

An independent samples t-test ($t=-7.63$, $df=352$, $p<0.001$) was used to assess differences in superintendent' perceptions of the effect health insurance has on student' well-being by superintendent' beliefs about the role schools should play in helping students obtain health insurance. Superintendents believing that school systems should play a role in helping students obtain health insurance had higher mean scores on the wellness scale ($M=18.1$, $SD=3.83$) compared with those who did not perceive the school to have a role ($M=14.9$, $SD=4.07$). Thus, the null hypothesis was rejected.

Hypotheses 4.8 There is no relationship between superintendents' perceptions of the effects health insurance status has on students' well-being (0-24) by the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.

A Pearson product moment correlation coefficient ($r=0.59$, $p<0.001$) was calculated to determine that a positive relationship existed between superintendent' perceptions of the

effect health insurance has on student' well-being and perceiving there to be more to helping students obtain health insurance. Thus, the null hypothesis was rejected.

Hypotheses 4.9 There is no relationship between superintendents' perceptions' of the effects health insurance status has on students' well-being (0-24) by the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.

A Pearson product moment correlation coefficient ($r=0.06$, $p=0.304$) was calculated to determine there was no relationship between superintendent' perceptions of the effect health insurance has on student' well-being and the perceived number of barriers superintendents identified. Thus, the null hypothesis was accepted.

Hypotheses 5.1 The majority of superintendent's will not agree that the school should have a role in helping students obtain health insurance.

The majority of respondents agreed (48%-92%) with the four questions indicating schools should play a role in helping students obtain health insurance. On a scale of 0-15, zero representing no role and 15 representing a role for schools, superintendent's mean score was 7.55 (SD=2.43). Less than half (45%) believed that obtaining health insurance was the sole responsibility of the parent(s)/guardian(s). Thus, the null hypothesis is rejected.

Hypotheses 5.2 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by superintendent's education level (bachelor's, master's or specialist, versus doctorate).

A chi-square test ($\chi^2=0.445$, $df=1$, $p=0.505$) was used to assess differences in superintendent' perceptions of the school's role in helping students obtain health insurance by the superintendent's education level. There were no statistically significant differences between superintendent' perceptions of the school's role by the superintendent's education level. Thus, the null hypothesis was accepted.

Hypotheses 5.3 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by superintendent's race/ethnicity (white, non-white).

A chi-square test ($\chi^2=2.854$, $df=1$, $p=0.091$) was used to assess differences in superintendent' perceptions of the school's role in helping students obtain health insurance by the superintendent's race/ethnicity. There were no statistically significant differences between superintendent' perceptions of the school's role in helping students obtain health insurance by the superintendent's race/ethnicity. Thus, the null hypothesis was accepted.

Hypotheses 5.4 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the racial/ethnic composition of the school district (predominately white/non-white).

A chi-square test ($\chi^2=3.580$, $df=1$, $p=0.058$) was used to assess differences in superintendent' perceptions of the school's role in helping students obtain health insurance by the racial/ethnic composition of the school. There were no statistically significant differences between superintendent' perceptions of the school's role in

helping students obtain health insurance by the racial/ethnic composition of the school. Thus, the null hypothesis was accepted.

Hypotheses 5.5 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).

A chi-square test ($\chi^2=0.067$, $df=1$, $p=0.796$) was used to assess differences in superintendent' perceptions of the school's role in helping students obtain health insurance by the percent of students receiving free and reduced lunch. There were no statistically significant differences between superintendent' perceptions of the school's role in helping students obtain health insurance by the percent of students receiving free and reduced lunch. Thus, the null hypothesis was accepted.

Hypotheses 5.6 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the location of the school district (rural, non-rural).

A chi-square test ($\chi^2=5.76$, $df=1$, $p=0.016$) was used to assess differences between superintendent' perceptions of the school's role in helping students obtain health insurance and the location of the school district. There were no statistically significant differences in superintendent' perceptions of the schools role in helping students obtain health insurance by the school's location. Thus, the null hypothesis is accepted.

Hypotheses 5.7 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by

the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.

An independent samples t-test ($t=-8.534$, $df=362$, $p<0.001$) was used to assess the differences between superintendent' perceptions of the school's role in helping students obtain health insurance by the perceived number of benefits for schools. Respondents that believed the school should have a role in helping students obtain health insurance identified a greater number of benefits for schools (12.6 vs. 9.12, respectively). Thus, the null hypothesis was rejected.

Hypotheses 5.8 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.

An independent samples t-test ($t=3.945$, $df=360$, $p<0.001$) was used to assess the differences between superintendent' perceptions of the school's role in helping students obtain health insurance by the perceived number of barriers for schools. Respondents that believed the school should have a role in helping students obtain health insurance identified fewer barriers ($M=2.98$, $SD=2.39$) than superintendents who did not believe ($M=3.95$, $SD=2.26$) schools should have a role in helping students. Thus, the null hypothesis was rejected.

Hypotheses 6.1 A majority of superintendents will not identify any perceived benefits for schools to help students obtain health insurance.

Twelve of 17 potential benefits (for schools) were identified by at least half of respondents with a mean of 10.99 ($SD=4.25$). This indicates that superintendents do

perceive there to be benefits for schools that help students obtain health insurance. Thus, the null hypothesis was rejected.

Hypotheses 6.2 There is no significant difference in superintendent's number of perceived benefits (0-18) for schools to help students obtain health insurance by the racial/ethnic composition of the school district (predominately white/non-white).

An independent samples t-test ($t=1.25$, $df=369$, $p=0.213$) was used to assess the differences between the number of perceived benefits for schools by the racial/ethnic composition of the school. There were no statistically significant differences found between the perceived number of benefits for schools helping students obtain health insurance and the racial/ethnic composition of the school. Thus, the null hypothesis was accepted.

Hypotheses 6.3 There is no significant difference in superintendent's number of perceived benefits (0-18) for schools to help students obtain health insurance by the school district's percent of students receiving free and reduced lunch ($<50\%$, $\geq 50\%$).

An independent samples t-test ($t=-0.617$, $df=373$, $p=0.537$) was used to assess the differences between the number of perceived benefits for schools by the percent of students receiving free and reduced lunch. There were no statistically significant differences found between the perceived number of benefits for schools to help students obtain health insurance by the percent of students receiving free and reduced lunch. Thus, the null hypothesis was accepted.

Hypotheses 6.4 There is no significant difference in superintendent's number of perceived benefits (0-18) for schools to help students obtain health insurance by the location of the school district (rural, non-rural).

An independent samples t-test ($t=-2.48$, $df=376$, $p=0.014$) was used to assess the differences between the number of perceived benefits for schools by school location.

There were no statistically significant differences in superintendents' perceived benefits by the school setting. Thus, the null hypothesis was accepted.

Hypotheses 6.5 There is no relationship between the number of perceived benefits (0-18) and the number of perceived barriers (0-11) for schools assisting students in obtaining health insurance.

A Pearson product moment correlation coefficient ($r=0.06$, $p=0.278$) was calculated to determine there is no relationship between the number of perceived benefits and the number of perceived barriers for schools to assist students obtain health insurance. Thus, the null hypothesis was accepted.

Hypotheses 7.1 A majority of superintendents will not identify any perceived barriers for schools to help students obtain health insurance

From ten potential barriers (for schools) to assist students obtain health insurance, only two were identified by at least 50% of respondents. The mean number of barriers identified by superintendents was 3.42 ($SD=2.4$) indicating that superintendents do not perceive many barriers to helping students. Thus, the null hypothesis was accepted.

Hypotheses 7.2 There is no significant difference in superintendent's number of perceived barriers (0-11) for schools to help students obtain health

insurance by the racial/ethnic composition of the school district (predominately white/non-white).

An independent samples t-test ($t=0.144$, $df=361$, $p=0.886$) was used to determine if there were any differences between the number of perceived barriers for schools by the racial/ethnic composition of the school. There were no statistically significant differences found between the perceived number of barriers for schools helping students obtain health insurance by racial/ethnic composition of the school. Thus, the null hypothesis was accepted.

Hypotheses 7.3 There is no significant difference in superintendent's number of perceived barriers (0-11) for schools to help students obtain health insurance by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).

An independent samples t-test ($t=0.461$, $df=367$, $p=0.645$) was used to determine if there were any differences between the number of perceived barriers for schools by the percent of students receiving free and reduced lunch. There were no statistically significant differences found between the perceived number of barriers for schools helping students obtain health insurance by the school's free and reduced lunch percentage. Thus, the null hypothesis was accepted.

Hypotheses 7.4 There is no significant difference in superintendent's number of perceived barriers (0-11) for schools to help students obtain health insurance by the location of the school district (rural, non-rural).

An independent samples t-test ($t=1.482$, $df=368$, $p=0.139$) was used to determine if there were any differences between the number of perceived barriers for schools by the

location of the school district. There were no statistically significant differences found between the perceived number of barriers for schools helping students obtain health insurance by the school's location. Thus, the null hypothesis was accepted.

4.11 Summary

The results of this study suggest that superintendents understand the connections between health status, health insurance status, and academic outcomes but are not directly assisting parents with health insurance enrollment. Although only one in five school districts systematically assessed the health insurance status of their students, the majority of superintendents reported that their school districts made the enrollment forms available to parents to help in getting their children enrolled in state-funded health insurance.

The majority of superintendents were able to correctly answer questions about the uninsured population and the negative academic outcomes of children in poor health; but were less able to correctly answer questions about state-funded health insurance eligibility and enrollment. Knowledge scores differed by the perceived effect health insurance status had on student well-being, by the number of perceived benefits superintendents identified, and how much of a role superintendents thought the school should have in helping parents enroll their children in health insurance programs.

A large number of superintendents agreed that being an uninsured child would have negative impacts on their health status, quality of health care and academic outcomes like attendance, ability to pay attention, and graduation rates. These perceptions became more positive as the superintendent's education and knowledge

increased and by how strong a role they thought the school should play. These individuals also identified greater benefits to helping students obtain health insurance.

The majority of superintendents believed that schools should help students be healthy, provide parents with enrollment forms, and possibly assist with health insurance enrollment when students register for school. However, superintendents were evenly split in their beliefs regarding whether or not the school should assist parents in filling out enrollment forms and the role that parents should play in enrollment. Less than half of superintendents believed it should be the sole responsibility of the parent to enroll their child in health insurance programs. The superintendent's perceived role of schools varied by the superintendents' beliefs about the effect that health insurance has on a student's health, medical care and academic outcomes, and their knowledge of public health insurance and the effects of health status affects on academics. Finally, the more perceived benefits and fewer perceived barriers a superintendent identified, the more superintendents believed the school should play a role in helping students obtain health insurance.

Chapter Five

CONCLUSIONS

This chapter is divided into the following four sections: Summary, Discussion, Implications, and Recommendations for Future Research. The final section offers concluding remarks.

5.1 Summary

This study was completed to determine the following:

1. In what stage are school systems with respect to their superintendents' perceptions of schools helping uninsured students obtain state-funded health insurance?
2. What (if any) are the current public school systems' practices for helping uninsured students obtain state-funded health insurance?
3. Do public school superintendents have basic knowledge of state-funded health insurance and the effect of health status on academic outcomes (attendance, attention, graduation)?
4. What are the perceptions of public school superintendents regarding the effects of health insurance status on students' well-being (illness, academic outcomes)?

5. What are the perceptions of public school superintendents regarding the school systems role in helping uninsured students obtain health insurance?
6. What benefits do public school superintendents perceive for schools to help students obtain health insurance?
7. What barriers do public school superintendents perceive for schools to help students obtain health insurance?

A four-page, 40-item questionnaire was developed to assess current school practices and superintendents' perceptions about the role schools should play in helping students obtain state-funded health insurance; and superintendent knowledge and perceptions regarding the connections between health status, health insurance, and academic outcomes.

The first section of the instrument assessed superintendents' knowledge of state-funded health insurance, the uninsured population, and the effects of health status on academic outcomes. The second section of the instrument provided an opportunity for respondents to identify any benefits to schools that help students obtain state-funded health insurance. The third section of the instrument examined superintendents' perceptions of students' well-being including how health insurance status affects a student's access to medical care, their health status and their academic outcomes. In addition to student well-being, this section also assessed the perceived role schools should have in helping students obtain health insurance. The fourth section identified any barriers to schools superintendents perceived there to be for helping students obtain health insurance. The fifth section of the instrument assessed the current school practices in helping students obtain state-funded health insurance. The following were assessed:

school district's systematic assessment of health insurance status, current assistance in schools in their district, the Stage of Change superintendents perceived their school to be, activities that may assist in student enrollment, reimbursement for enrollment assistance, and for which health insurance programs school districts provided assistance. The final section of the instrument assessed the demographics of both the superintendent and their school district. In addition to the closed format questions, respondents were given several opportunities to provide their opinions about the various issues being examined in the survey. Their complete responses are in Appendix I.

5.2 Accepted Hypotheses

Based on the results of this investigation, the following 33 hypotheses were supported:

Hypotheses 1.1 The majority of superintendents do not place their school district in the action or maintenance stage of the Stages of Change theory with regards to schools helping uninsured students obtain state-funded health insurance.

Hypotheses 1.3 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's education level (Bachelor's, Master's or Specialist, Doctorate).

Hypotheses 1.4 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ

significantly based on the superintendent's race/ethnicity (white, non-white).

Hypotheses 1.5 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the racial/ethnic composition of the school district (predominately white, non-white).

Hypotheses 1.6 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).

Hypotheses 1.7 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students in obtaining health insurance does not differ significantly based on the location of the school district (rural, non-rural).

Hypotheses 1.8 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's knowledge of state-funded health insurance and the effects of health on academics (high, low).

Hypotheses 1.9 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's beliefs about the effect of health insurance status on student's wellbeing (Score 0-24).

- Hypotheses 1.11** The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.
- Hypotheses 2.1** The majority of superintendents do not report that schools in their school district systematically assess the health insurance status of all students at the beginning of each school year.
- Hypotheses 2.2** The majority of superintendents do not report that schools in their school district help students obtain state-funded health insurance.
- Hypotheses 2.3** The majority of superintendents do not report that their school district received financial support to help students enroll in state-funded health insurance.
- Hypotheses 3.2** There is no significant difference in superintendent's knowledge (high, low) by superintendent's education level (bachelor's, master's or specialist, doctorate).
- Hypotheses 3.3** There is no significant difference in superintendent's knowledge (high, low) by superintendent's race/ethnicity (white, non-white).
- Hypotheses 3.5** There is no significant difference in superintendent's knowledge (high, low) by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).
- Hypotheses 3.6** There is no significant difference in superintendent's knowledge (high, low) by the location of the school district (rural, non-rural).

- Hypotheses 3.10** There is no significant difference in superintendent's knowledge (high, low) by the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.
- Hypotheses 4.3** There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by superintendent's race/ethnicity (white, non-white).
- Hypotheses 4.4** There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the racial/ethnic composition of the school district (predominately white/non-white).
- Hypotheses 4.5** There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).
- Hypotheses 4.6** There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the location of the school district (rural, non-rural).
- Hypotheses 4.9** There is no relationship between superintendents' perceptions' of the effects health insurance status has on students' well-being (0-24) by the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.
- Hypotheses 5.2** There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by

superintendent's education level (bachelor's, master's or specialist, doctorate).

Hypotheses 5.3 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by superintendent's race/ethnicity (white, non-white).

Hypotheses 5.4 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the racial/ethnic composition of the school district (predominately white/non-white).

Hypotheses 5.5 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).

Hypotheses 5.6 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the location of the school district (rural, non-rural).

Hypotheses 6.2 There is no significant difference in superintendent's number of perceived benefits (0-17) for schools to help students obtain health insurance by the racial/ethnic composition of the school district (predominately white/non-white).

Hypotheses 6.3 There is no significant difference in superintendent's number of perceived benefits (0-17) for schools to help students obtain health

insurance by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).

Hypotheses 6.4 There is no significant difference in superintendent's number of perceived benefits (0-17) for schools to help students obtain health insurance by the location of the school district (rural, non-rural).

Hypotheses 6.5 There is no relationship between the number of perceived benefits (0-17) and the number of perceived barriers (0-10) for schools assisting students in obtaining health insurance.

Hypotheses 7.1 A majority of superintendents will not identify any perceived barriers for schools to help students obtain health insurance

Hypotheses 7.2 There is no significant difference in superintendent's number of perceived barriers (0-10) for schools to help students obtain health insurance by the racial/ethnic composition of the school district (predominately white/non-white).

Hypotheses 7.3 There is no significant difference in superintendent's number of perceived barriers (0-10) for schools to help students obtain health insurance by the school district's percent of students receiving free and reduced lunch (<50%, ≥50%).

Hypotheses 7.4 There is no significant difference in superintendent's number of perceived barriers (0-10) for schools to help students obtain health insurance by the location of the school district (rural, non-rural).

5.3 Rejected Hypotheses

Based on the results of this investigation, the following 19 hypotheses were rejected:

Hypotheses 1.2 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on whether the school district systematically assesses student health insurance status (yes, no).

Hypotheses 1.10 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's beliefs about the role of schools in helping students obtain health insurance (high, low).

Hypotheses 1.12 The perceived stage (action, non-action, no relapse) of a school system in helping uninsured students obtain health insurance does not differ significantly based on the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.

Hypotheses 2.4 The majority of superintendents do not report their school district as providing parents assistance for enrolling their children.

Hypotheses 3.1 The majority of superintendents do not have basic knowledge of state-funded health insurance and the effect of health status on academic outcomes.

Hypotheses 3.4 There is no significant difference in superintendent's knowledge (high, low) by racial/ethnic composition of the school district (predominately white/non-white).

- Hypotheses 3.7** There is no significant difference in superintendent's knowledge (high, low) by superintendents' beliefs about the effect of health insurance status on students' wellbeing (0-24).
- Hypotheses 3.8** There is no significant difference in superintendent's knowledge (high, low) by superintendents' beliefs about the role of schools in helping students obtain health insurance (high, low).
- Hypotheses 3.9** There is no significant difference in superintendent's knowledge (high, low) by the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.
- Hypotheses 4.1** The majority of superintendents do not agree that health insurance status affects a students' well-being.
- Hypotheses 4.2** There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by superintendent's education level (bachelor's, master's or specialist, doctorate).
- Hypotheses 4.7** There is no significant difference in superintendent' perceptions of the effects health insurance status has on students' well-being (0-24) by the superintendents' beliefs about the role of schools in helping students obtain health insurance (high, low).
- Hypotheses 4.8** There is no relationship between superintendents' perceptions of the effects health insurance status has on students' well-being (0-24) by the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.

Hypotheses 5.1 The majority of superintendent's will not agree that the school should have a role in helping students obtain health insurance.

Hypotheses 5.7 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the superintendent's perceived number of benefits (0-17) to schools helping students obtain health insurance.

Hypotheses 5.8 There is no significant difference in superintendent' perceptions of the schools role in helping students obtain health insurance (high, low) by the superintendent's perceived number of barriers (0-10) to schools helping students obtain health insurance.

Hypotheses 6.1 A majority of superintendents will not identify any perceived benefits for schools to help students obtain health insurance.

5.4 Discussion

This study is significant because it is the first major study to assess superintendents of public school systems in the United States and their perceptions of the affects of health insurance on academic success. This study, along with two others, (Rickard, Hendershot, Khubchandani, Price, & Thompson, 2010; Price & Rickard, 2009) helps to provide a clearer picture of the role of schools as perceived by key personnel in facilitating public health insurance coverage for children. The wide geographical representation of the sample and the fact that the sample was not drawn from a membership list strengthens the external validity of this study's results.

The findings of this study are significant because although a majority of public school superintendents know a link between health and learning exists and believe students without health insurance are less healthy and less successful in school, only one in five public school superintendents reported that schools within their districts assessed health insurance status yearly. Additionally, nearly half of superintendents identified their school system as “never seriously thought about helping students enroll in state-funded health insurance”. If nine out of ten superintendents in this study think keeping students healthy to be a role of schools (92%); and agree that helping students enroll in health insurance programs will keep students healthier (93%) and reduce the number of untreated health problems (92%), why are only a third of school districts currently assisting with enrollment activities?

School personnel may be focused on the immediate issues and short term benefits for students and schools so that larger issues impacting not only health but also student learning and academic outcomes are not being identified. Seeking an upstream approach like helping eligible students obtain health insurance is similar to individuals getting preventive health screenings for cancer. If an individual waits to get a preventive screening until the cancer shows symptoms, they are more likely to have negative outcomes. However, if the cancer is caught in the early stages when treatment will be most effective, they will have better outcomes. Uninsured students should not have to wait until their treatable, acute childhood illnesses become chronic lifelong conditions or risk poor academic outcomes because their parents cannot afford to take them to a doctor. Insured students have increased access to preventive health care, dental care, more contact with health professionals; and fewer unmet health needs (USDHHS, 2009b),

leading to fewer school absences and higher academic achievement (Moonie, Sterling, Figgs, & Castro, 2006; Case, Fertig & Paxon, 2005; U.S. Departments of education, agriculture, and health and human services, 2000). Not graduating from high school will have a lifelong impact on the earning potential of the person and on their future access to health care.

Schools and the professionals working in them are over burdened, and under-appreciated. This was apparent by several comments written on the questionnaire by respondents. Many of them expressed frustration at the expectation that this would become another responsibility of the schools rather than social service organizations and more importantly, parents. It is not suggested that schools should be the sole organization responsible for getting children enrolled in health insurance programs. Because of their position with children, families and communities, schools should be collaborative partners in helping ameliorate the lack of health insurance affecting millions of children.

Collaboration between community organizations, associations advocating for school health, associations training school health professionals, school nurses and student based health clinics, health department personnel, and CHIP agencies could overcome the four resource barriers (limited staff, time, financial resources and know how) to assisting students with public insurance enrollment identified by superintendents, school nurses, and CHIP directors (Rickard, Hendershot, Khubchandani, Price, & Thompson, 2010; Price & Rickard, 2009). Not only would collaboration increase identification of eligible children and reduce the number of uninsured youths but the barriers might seem less formidable.

Superintendents are concerned about the schools budget but only 6% of superintendents reported their school had received financial reimbursement for helping with state-funded health insurance programs. The reauthorization of the Children's Health Insurance Program built in \$100 million available to states to increase enrollment efforts (KFF, 2009a). Collaboration efforts between organizations like the Office of Medicaid, state health departments and schools could reduce the financial barrier identified by more than half of superintendents, nearly half of school nurses and a third of CHIP directors (Rickard, Hendershot, Khubchandani, Price, & Thompson, 2010; Price & Rickard, 2009). This federal money could be used by school systems and community organizations to increase staffing and education of personnel in schools as suggested by the CCSSO in their recommendations to help schools meet their education goals (Council of Chief State School Officers, 2004)

School districts identified as helping parents enroll their children in public health insurance programs perceived fewer barriers to doing so and had higher knowledge scores. This calls for action from school focused organizations like the American School Health Association (ASHA) and the National Association of School Nurses (NASN). Increasing awareness about the issue with school administrators and ensuring that they have correct knowledge will be a step in the right direction. Although superintendents were found to be knowledgeable about the topics explored in the current study, school personnel need to be educated so that they understand the implications of having high percentages of uninsured students in their schools.

About one in four superintendents identified that the school nurse helps students enroll in health insurance which is about 10% less than was reported by school nurses

(Rickard, Hendershot, Khubchandani, Price, & Thompson, 2010). There are at least three potential explanations for this difference. First, some superintendents may not have been aware that their school nurse assisted students with health insurance enrollment and underestimated the activity in their school system. Second, the school superintendents surveyed in this study may be from different schools than the school nurses in the previously referenced study. There are many school districts that do not have a school nurse and therefore superintendents would not have chosen the school nurses option on the questionnaire. And third, if more than one school nurse was randomly selected from the same school system in the previously cited study then the estimates reported in that study could have been inflated compared to the current study results.

The similarity in responses from this study and the previous two studies (Rickard, Hendershot, Khubchandani, Price, & Thompson, 2010; Price & Rickard, 2009) speaks to a form of concurrent validity. The results of this study further support that the lack of resources and knowledge are the accurate issues preventing schools from assisting with public health insurance enrollment. If these are the issues then it is all the more important that there be a coordination of resources. Through adequate education and sharing of staff and financial resources the appropriate groups can overcome these barriers.

It is easy to understand the frustrations expressed toward parents who do not “parent”, but there are several reasons why the majority of individuals with eligible but uninsured children do not enroll their child. First, they may not know that their child is eligible. A telephone survey of parents conducted by the Kaiser Family Foundation found that gaps existed in the awareness about Medicaid and CHIP (KFF, 2009i). Nine

out of ten low-income parents said they would enroll their uninsured child if they were eligible. Some respondents thought that because they had a car, a job and a bank account their child was not eligible. There are also gaps in knowledge among different ethnicities. Hispanic parents were less likely to be aware of Medicaid and CHIP programs (KFF, 2009i) and more likely to be uninsured (KFF, 2009f). Finally, the enrollment and renewal process is not an easy system to navigate, especially for low-income (lower-educated) individuals. These are real barriers for parents and schools could assist them with overcoming those barriers; schools are institutions that parents trust.

This issue of schools assisting with children's health insurance enrollment would be providing a direct benefit to parents as they are the individuals who need to understand eligibility standards, enrollment and renewal procedures. However, students and schools will be the ones who benefit from this service. Ultimately, uninsured children in schools will have less preventive medical and dental care, less contact with health professionals and routine care, and more unmet health needs leading to more school absences and lower academic achievement. Thus, in the end, schools may benefit as much as students by all students being covered by health insurance.

5.5 Implications

Based on the review of related literature and findings of this study, the following suggestions are offered to increase the support for reducing the number of uninsured children.

First, CHIP agencies and schools should pool resources to increase the identification of eligible children and reduce the number of uninsured students. Collaboration efforts not only achieve more than when organizations work solo but will address the barriers to school involvement identified by superintendents, school nurses and CHIP directors (Rickard, Hendershot, Khubchandani, Price, & Thompson, 2010; Price & Rickard, 2009). By collaborating efforts, those organizations with funding could offset the cost for staff time and training, those with extra staff could provide individuals to assist parents, and those with the “know how” could provide the training.

Second, organizations with concern for school health (i.e., ASHA, NASN) should provide continuing education for school personnel including school nurses on how to assist students and parents in enrolling in public health insurance programs (individual assistance and group efforts). School nurses, as trained health professionals, were identified as a logical person to assist with health insurance enrollment. However, schools that do not have school nurses may have other school personnel (teachers, guidance counselors, clerical staff, outside personnel) who could assist with insurance enrollment.

Third, advocacy efforts should use the results from this study to provide information to legislators and school administrators regarding the school’s role in state-funded health insurance enrollment. These efforts could facilitate new ideas and strategies for increasing the efficacy of enrollment efforts. For example, a grassroots effort by a local PTA could facilitate the school board and administration taking action within their school district.

5.6 Recommendations for Future Research

1. Additional research should also be conducted with respect to the school's role in facilitating health insurance enrollment. Possible future research could examine school administrators' (principals, school boards), and parents' support of these ideas. Administrative support is essential to school involvement for schools to help parents enroll their children in health insurance programs.
2. It is recommended that future studies explore schools that facilitate enrollment which could provide additional areas of research including: who (nurses, teachers, counselors, support staff) is handling the insurance enrollment practices, which category of personnel is most cost effective in enrollment or achieves the highest enrollment rates, and what other variables affect health insurance enrollment rates by schools.
3. It may be useful to increase and update the research linking health and learning which can be used to influence decision makers to implement programs and policies that will improve the health of students.
4. Evaluation of successful enrollment efforts should be conducted and widely published to provide support for schools wanting to help students enroll in health insurance programs and to identify existing school roles.
5. Finally, research should be conducted on the effects of health insurance status on academic outcomes. Although we cannot definitively say that health insurance status directly affects academic outcomes, we can speculate that there is a connection because research has found that a student's health is affected by their

health insurance status and their individual health affects their academic outcomes and future potential.

5.7 Conclusions

Few policy issues are as heated as issues surrounding state-funded health insurance. Although two-thirds of uninsured children are eligible for state-funded health insurance, they are not enrolled. To the extent that these results are valid and generalizable, there is support for schools assisting with state-funded health insurance enrollment. Superintendents believe that schools should play a role in this process but the extent of the school's role is still in question. School personnel (health educators, school nurses), public policy makers, health insurance coverage advocates and community organizations can use this research as a resource to collaborate on ideas and resources to increase enrollment efforts. The true challenge becomes how to overcome the identified barriers to schools helping parents enroll children in state-funded health insurance programs.

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APPENDIX A

Uninsured Children in Public Schools Survey Instrument

Uninsured Children in Public Schools

Directions: Please complete each of the following items according to the instructions. Your responses will be confidential. Thank you for your professional courtesy.

State-funded health insurance includes the *Medicaid Program, Medicaid Expansion Program* and/or *Separate State Children’s Health Insurance Programs (SCHIP)*.

Please circle the response which best represents your beliefs regarding each of the following statements.	YES	NO	NOT SURE
1. State-funded health insurance programs cover 90% or more of eligible children.	Y	N	NS
2. Students from low-income families are more likely than other students to be uninsured.	Y	N	NS
3. Racial and ethnic minority students are more likely than white students to be uninsured.	Y	N	NS
4. Children eligible for state-funded public health insurance programs are automatically enrolled by the state.	Y	N	NS
5. Students who are unhealthy (frequently ill) are more likely to miss school than are healthy children.	Y	N	NS
6. Students who are not feeling well have more trouble paying attention during classes.	Y	N	NS
7. The more students miss school, the greater the probability that they will not do well in school.	Y	N	NS
8. Students who are unhealthy (frequently ill) are less likely to graduate from high school than are healthy children.	Y	N	NS

9. Please check **ALL** items below that you feel are **benefits** to schools that help students obtain state-funded health insurance. Helping uninsured students obtain state-funded health insurance will:
- garner financial support for schools.
 - reduce the number of students with untreated health problems.
 - improve affected students’ attention/concentration during school.
 - reduce the number of students who drop out of school or fail to graduate.
 - reduce the number of students being held back in school because of unidentified and untreated health problems.
 - improve a schools’ community good will toward the school.
 - reduce racial/ethnic disparities in health status.
 - reduce racial/ethnic disparities in academics.
 - keep students healthier.
 - increase student’s lifelong productivity.
 - reduce the risk of students’ need for social dependence as an adult (receiving public assistance).
 - reduce tardiness rates.
 - reduce absenteeism rates.
 - increase academic test scores.
 - result in families spending less out-of-pocket for health care.
 - provide schools with the opportunity to have their school-based health care services covered by insurance.
 - be a more efficient method of enrolling a greater number of children in state-funded health insurance programs.
 - Other (please identify) _____

Please circle the response which best represents your beliefs regarding each of the following statements.

	Strongly Agree	Agree	Disagree	Strongly Disagree
10. Students without health insurance are less likely to have a usual place of medical care than children with health insurance.	SA	A	D	SD
11. Students without health insurance are less likely to receive needed medical care than children with health insurance.	SA	A	D	SD
12. Students without health insurance are more likely to be ill for longer periods than children with health insurance.	SA	A	D	SD
13. Students without health insurance are more likely to be ill more frequently than children with health insurance.	SA	A	D	SD
14. Students without health insurance are less likely to do well in school than children with health insurance.	SA	A	D	SD
15. Students without health insurance are more likely to miss school than children with health insurance.	SA	A	D	SD
16. Students without health insurance are more likely to be distracted (not pay attention) during school.	SA	A	D	SD
17. Students without health insurance are less likely to graduate from high school than are children with health insurance.	SA	A	D	SD
18. One of the roles of schools should be to help students be healthy.	SA	A	D	SD
19. Obtaining health insurance for students should be the sole responsibility of the parent(s)/guardian(s).	SA	A	D	SD
20. One of the roles of schools should be to provide students' parents with access to state-funded health insurance enrollment forms.	SA	A	D	SD
21. One of the roles of schools should be to assist students' parents with filling out state-funded health insurance enrollment forms.	SA	A	D	SD
22. One of the roles of schools should be to help students enroll in state-funded health insurance when they register for school.	SA	A	D	SD

23. Please check **ALL** items below that you feel are **barriers** that prevent your school district from helping students obtain health insurance.

- There are **no barriers** that prevent our school district from helping uninsured students.
- Few students in our school district are without health insurance.
- Our school district does not have the office space needed to help with insurance issues.
- Our school district does not enough staff to help students obtain health insurance.
- Personnel in our school district do not have the time to help students obtain health insurance.
- Personnel in our school district do not know how to help students obtain health insurance.
- Personnel in our school district do not believe it is the role of schools to be involved in helping students obtain insurance.
- Our school district does not have the financial resources to help students obtain health insurance.
- Our school district does not have state support (Medicaid/SCHIP/Health Department) to help uninsured students obtain health insurance.
- Parents in our school district do not want schools involved in helping students obtain health insurance.
- The state government cannot afford a significant increase in the numbers of children enrolled in the state-funded health insurance programs.
- Other (please identify) _____

24. Do **any** schools in your school district *systematically* assess the health insurance status of all students at the beginning of each school year? _____ YES _____ NO
25. How many schools are in your school district? _____ elementary _____ middle school _____ high school
26. Do **any** schools in your school district help students obtain state-funded health insurance?
 _____ YES _____ NO
- a. If yes, how many schools help uninsured students at each level?
 _____ elementary _____ middle school _____ high school
27. Which of the following best describes your **school district** with respect to helping students obtain state-funded health insurance? (*Please check only one*)
- _____ Our school district has never seriously thought about helping students enroll.
 _____ Our school district has been talking about whether we should be involved in helping students.
 _____ Our school district has made plans to start helping students within the first six months of the new school year.
 _____ Our school district just started helping students during the current academic school year.
 _____ Our school district has been helping students for one full academic school year.
 _____ Our school district has helped students in the past, but we no longer do. If you no longer help students, why did you stop?

28. How do schools in your **school district** help students obtain state-funded health insurance? (*Please check all that apply*)
- _____ We do not help students obtain state-funded health insurance. [**Please skip to Next Page**]
- _____ State-funded health insurance applications/materials are available to parents upon request.
 _____ State-funded health insurance applications/materials are given to all parents each school year.
 _____ School nurse helps parents enroll their children.
 _____ School based health clinic helps parents enroll their children.
 _____ State-funded health insurance program representatives come to the school to enroll students.
 _____ Other school employee helps parents enroll their children during fall registration.
 _____ Parents complete insurance forms with other school paperwork *without assistance* and the school submits it to the state.
 _____ School district uses school lunch enrollment information to identify uninsured students.
 _____ School district provides state-funded health insurance program's access to the districts' free and reduced lunch database.
 _____ Other _____
29. For which program does your **school district** help with enrollment? (Please check all that apply)
- _____ Medicaid Health Insurance
 _____ Medicaid Expansion Health Insurance
 _____ Separate State Children's Health Insurance Program (SCHIP)
 _____ Private Health Insurance
 _____ Other (Please describe) _____
30. Has your **school district** received financial support to help students enroll in state-funded health insurance?
 _____ YES _____ NO

APPENDIX B

List of Expert Panel Reviewers

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APPENDIX C

Letter to the Expert

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Dear Dr. _____,

This email is to request your expert assistance in reviewing the attached questionnaire on the Child Health Insurance Programs (CHIP). I am a doctoral student at the University of Toledo working with Dr. James H. Price on a national study. We want to survey superintendents from all 50 states regarding their perceptions of working with CHIP to enroll eligible children. This study will be the basis of my dissertation.

Please review the attached questionnaire for the following:

- Are there statements that need to be reworded for clarity? (Please mark the changes on the questionnaire).
- Are there items that need to be deleted? (Please draw a line through them).
- Are there other potentially important items (or response options) that need to be added? (Please feel free to add them.)

My questionnaire contains the following components:

Items 1-7: School district activities related to health insurance

Item 4: School district level of readiness for helping students gain access to public health insurance (Stages of Change)

Items 8-11: Knowledge of health insurance

Items 12-15: Perceptions regarding the link between health insurance status and health

Items 16-19: Perceptions regarding the link between health insurance status and academics

Item 20: Barriers to school districts from helping students obtain health insurance

Items 21-24: Perceptions regarding the link between health and academics

Items 25-29: Perceptions regarding the role schools have in helping students obtain health insurance.

Item 30: Benefits to school districts that help students obtain health insurance

Demographics 1-10: The fourth page consists of 10 demographic items

Please feel free to make the changes and additions in track changes. If you prefer not to use track changes please print a hard copy and fax it to 419-530-4759. Please address it: Attention Megan Rickard. I understand you have a busy schedule and greatly appreciate your time and effort in reviewing my questionnaire. Please feel free to contact us at 517-673-0820 or megan.rickard@utoledo.edu should you have any questions or concerns.

Thank you again, for your time and consideration.

Sincerely,

Megan L. Rickard, MS, CHES
Doctoral Student, Division of Health Education
University of Toledo

APPENDIX D

Human Subjects Approval Letter



The University of Toledo
Department for Human Research Protections
Social, Behavioral & Educational Institutional Review Board
Office of Research, Rm. 2300, University Hall
2801 West Bancroft Street, Mail Stop 944
Toledo, Ohio 43606-3390
Phone: 419-530-2844 Fax: 419-530-2841
(FWA00010686)

To: James H. Price, Ph.D. and Megan Rickard
Department of Public Health and Homeland Security

From: Barbara K. Chesney, PhD., Chair
Wesley A. Bullock Ph.D., Vice Chair

Signed: _____ / _____ **Date:** 02/02/09

Subject: IRB #106325

Protocol Title: *Public School Superintendent's Perceptions of Schools Assisting Students in Obtaining Public Health Insurance*

On 02/02/09, the Protocol listed below was reviewed and approved by the Chair and the Chair Designee of the University of Toledo (UT) **Social Behavioral & Educational** Institutional Review Board (IRB) via the expedited process. You have also been granted a waiver from the requirements of a written consent form. This action will be reported to the committee at its next scheduled meeting.

Items Reviewed:

- IRB Application Requesting Expedited Review
- Invitation Letter (Version Date 02/02/09)
- Survey(s) (Version Date 02/02/09)

This protocol approval is in effect until the expiration date listed below, unless the IRB notifies you otherwise.

Approval Date: 02/02/09 **Expiration Date: 02/01/10**

Number of Subjects Approved: 400

Please read the following attachment detailing Principal Investigator responsibilities.

APPENDIX E

Cover Letter of First Mailing

April 10, 2009

First Name Last Name
Address Line 1
City, State, Zip

Dear Dr. Last Name:

We invite you to participate in this **national** research study entitled “Public School Superintendent’s Perceptions of Schools Assisting Students in Obtaining Public Health Insurance”. You are one of a group of public school superintendents that have been randomly selected to participate in this study examining superintendent’s perceptions of the role schools play in assisting students to obtain public health insurance. Public health insurance includes both Medicaid and the State Children’s Health Insurance Program (SCHIP). The SCHIP program in your state may also be known as “*enter here for each state*”. For superintendents with multiple school districts please choose *one* district to represent.

Enclosed are a survey, a postage-paid return envelope, and a \$1.00 bill. We realize that the \$1 enclosed does not reimburse you for your time, but we hope that you can use it to purchase a bottle of water, cup of coffee, or a soft drink “on us”. The survey will take less than 15 minutes to complete. Please do not write your name or any other personally identifying information on the survey. All of your answers will remain confidential and only group results will be analyzed.

Your refusal to participate in this study will involve no penalty or loss of benefits to which you are otherwise entitled and will not affect your relationship with the University of Toledo. This research has been approved by the University of Toledo Human Subjects Committee. If you have any questions at any time before, during or after your participation you should contact the Project Director, Dr. James H. Price at (419) 530-4180 or by email, JPrice@UTNet.UToledo.Edu. If you have any questions beyond those answered by the research team or your rights as a research subject or research-related injuries, please feel free to contact Chairperson of the SBE Institutional Review Board, Dr. Barbara Chesney, in the Office of Research at (419) 530-2844.

Thank you for your professional courtesy in completing this survey. Your response within the next week would be greatly appreciated!

Thank you again, for your time and consideration.

Sincerely,

Megan L. Rickard, MS, CHES
Doctoral Student
Division of Health Education

James H. Price, Ph.D., MPH
Professor of Public Health
University of Toledo

APPENDIX F

Cover Letter of Second Mailing

April 25, 2009

Superintendent
Address Line 1
Address Line 2
Address Line 3

Dear Dr. _____:

Recently you were mailed a questionnaire on “Public School Superintendent’s Perceptions of Schools Assisting Students in Obtaining Public Health Insurance”. **If you have already returned the questionnaire, thank you very much (please disregard this letter)**. If not, we would greatly appreciate it if you would assist us. You are one of a ***national*** group of public school superintendents that have been randomly selected to participate in this study. For superintendents with multiple school districts please choose ***one*** district to represent. Public health insurance includes both Medicaid and the State Children’s Health Insurance Program (SCHIP). The SCHIP program in your state may also be known as ” *State CHIP Program*”.

The questionnaire will take less than 15 minutes to complete. Please return it in the self-addressed stamped envelope included. We would like to remind you that all responses are confidential. We understand that your time is limited but appreciate your participation. Your participation is very important to the success of our study.

If you have any questions or concerns, please feel free to contact the Project Director, Dr. James H. Price at (419) 530-4180 or by email, JPrice@UTNet.UToledo.Edu. Thank you for your professional courtesy in completing this survey. Your response within the next week would be greatly appreciated!

Thank you again, for your time and consideration.

Sincerely,

Megan L. Rickard, MS, CHES
Doctoral Student
Division of Health Education

James H. Price, Ph.D., MPH
Professor of Public Health
University of Toledo

APPENDIX G

Postcard for Third Mailing

Postcard Reminder

Recently the College of Health Science and Human Services at the University of Toledo mailed you a survey related to Public School Superintendent's Perceptions of Schools Assisting Students in Obtaining Public Health Insurance. If you have completed and returned the survey **THANK YOU** and please disregard this note. If you have not yet had an opportunity to respond, we would appreciate your professional courtesy. The success of this research endeavor depends on an adequate response. Thanks again for your professional courtesy. Please call (517) 673-0820 or email Megan L. Rickard at Megan.Rickard@utoledo.edu if you need an additional copy of the survey.

Sincerely,

Megan L. Rickard, MS, CHES
and
James H. Price, PhD, MPH

APPENDIX H

Email for Fourth Contact

May 15, 2009

Dear Superintendent,

I spoke with your assistant on the phone earlier today about your participation in this national research study entitled “Public School Superintendent’s Perceptions of Schools Assisting Students in Obtaining Public Health Insurance”. You are one of a group of public school superintendents that have been randomly selected to participate in this study. Public health insurance includes both Medicaid and the State Children’s Health Insurance Program (SCHIP). The SCHIP program in your state may also be known as “Medical Assistance Program”. For superintendents with multiple school districts please choose one district to represent.

The survey will take less than 15 minutes to complete. Please do not write your name or any other personally identifying information on the survey. All of your answers will remain confidential and only group results will be analyzed. This research has been approved by the University of Toledo Human Subjects Committee. If you have any questions at any time before, during or after your participation please contact me at 517-673-0820 or by email at mrickar3@utoledo.edu. You can use the return envelopes provided in earlier mailings or fax it back to me at 419-530-4759.

Thank you for your professional courtesy in completing this survey. This will help me in completing my dissertation so your participation is greatly appreciated.

Thank you again, for your time and consideration.

Sincerely,
Megan L. Rickard, MS, CHES
Doctoral Candidate, Division of Health Education
University of Toledo
Fax Number 419-530-4759

APPENDIX I

Qualitative Responses from Superintendents

Page 1: Question 9 “Other” Benefits

- Helps at-risk students in obtaining needed professional services and programs.
- Keep schools informed and able to provide information to parents. Support a social worker for schools.
- It may be the opposite of reducing the risk of students’ need for social dependence as an adult (receiving public assistance)
- “Be a more efficient method” is inappropriate response to the question. More efficient than what?
- This is not the mission of an educational system. (They left 9 blank and put an X through it)
- If tardiness and absenteeism is a result of illness. Many come to school sick and its more attention span for them.
- Increase ability for students to participate in sports
- I am not sure what state insurance covers in Indiana
- Provide education and a strong voice for health care and related issues for students and families.

Page 2: Question 23 “Other” Barriers

- Written in question 9 other: It may be the opposite of reducing the risk of students’ need for social dependence as an adult (receiving public assistance)
- Written in question 9 other: This is not the mission of an educational system.
- The state cuts school staff and wants us to do more.
- Lack of social workers within district
- State doesn’t provide adequate coverage.
- State lacks the vision /will to assure that all children have health care
- Assistance for nonresidents
- Written with benefits but I moved to barriers because it matched one of the answers on page 2, question 23: Will create a large economic burden on the state. Will create a dependency on state services, and will create a program that will be politically impossible to terminate.
- Perhaps the state legislators could do it in their offices.
- Limited resources and unneeded mandates
- Washington Alliance for Health Access WAHA
- I cannot say no barriers but in Vermont there are few.
- Assistance for non-residents
- We are willing to have forms. (MiChild) but to mandate without funds, give me a break. Lets get the parents involved.
- Parents are too proud to accept our assistance in completing applications.
- We have 2 school nurses who refer parents to agencies to enroll children in Health Care as we become aware of health concerns. This is a better way to work in conjunction with health agencies.
- Our district should make the information available to all District students. The guardian of the student should seek the help to enroll their child in an insurance program.
- Parents May need help and help should be provided. Must schools be the default provider? Another unfunded mandate?

- We do whatever we can and need to do for our students because we choose to NOT because we have to or are mandated to do so.
- A state mandated-funded insurance program should be the responsibility to provide families assistance in filling out forms.
- State doesn't provide adequate coverage
- Sometimes bilingual parents have difficulties. Our school system is a partner with a 501c3, the Joint Comm. For Children's Health care in Everett
- Time!!! We have too much to do now. How can we add more?

Page 3 Question 27: Why are they in the relapse stage?

- None of the above
- None of the above, we have actively given the enrollment materials, but have not helped to fill out.
- Only if asked by parents- doesn't happen often
- Time. This is a parental responsibility
- Our school nurse still helps some families who need assistance with insurance. At one time we passed out Healthy Start fliers to all students but had very little response.
- Our district distributes forms to assist parents
- We give student and parent materials on MiChild and on where they can seek out help if needed.
- Our district does so, on an individual basis determined by health referrals via school nurses.
- We help facilitate by providing information via school nurses and other support staff.
- Information provided to parents with free/reduced lunch application
- We do what we can
- We have assisted in providing parents with information and resources that would aid in obtaining insurance for years.
- We have been doing this for several years.

Page 3 Question 28 “Other” Activities

- We hand out chip papers at enrollment
- WAHA
- School nurse provides forms and info
- Our district has a nurse in every building who recommends SCHIP insurance to uninsured families. However, it is not a systematic program to get every student covered.
- School nurse assists identified students in need.
- We will be having a representative of PA CHIP at our kindergarten registration next spring.
- Our district has a Community Outreach Person who assists if needed.
- Help provided upon request
- School nurses help by directing to appropriate agencies
- We have posted fliers or given out information to parents when provided to us by agencies.
- County wide Health First 5 effort with preschool elementary.
- Students/parents receive assistance through Communities In Schools.
- JCCHCE (Joint Comm. For Children’s Health Care in Everett provides outreach enrollment retention and education to parents, children and families. We have had this partnership since 1994.
- Special Education/Medicaid eligibility
- Nurse
- All school staff are involved

Page 3 Question 29 “Other” Insurance programs schools assist with enrollment

- School provided insurance
- Our Kids First
- Mi-Child Combo (MHI & MEHI) for adopted students or those in foster care
- Healthy Kids Mendocino
- VSD

- We refer families to local Health Dept. and Kidcare Health Insurance
- State Plan Combo Program
- Kids Care (not SCHIP)
- IL “All Kids” Combination Ins.
- Kid Care
- School accident coverage only
- Extra curricular health – they purchase
- Hawkeye Children’s Insurance Combo Program
- Group Insurance
- Mi-Child Combo
- Athletic Insurance
- NJ Family Care Combo
- Free and reduced lunch
- Kansas Permanente
- School Accident Insurance
- Commonwealth Care/Choice – Common Care Health Safety Net

Page 3 Question 30: Financial Reimbursement

- No, However the JCCACE has received grants to do this work

Page 4 Additional Comments of Superintendents

At the end of the survey, superintendents were able to write their opinions about this issue; 41 (11%) superintendents gave their opinion.

Issues With The System of Insurance and Medical Care

- Our state will treat any student that visits an emergency room – All of our children have the opportunity to seek and receive medical attention
- Many doctors and dentists in our county will not see Medicaid students due to low reimbursement rates. Our nearest dental clinic is 60 miles. away and parents can’t get there.

- Insurance is not free. Someone pays
- Socialized medicine does not work. In (state), support staff can have free health insurance for \$69 cash. Most take the cash and then complain about no health care. Native Americans get free health care but do not always take it for the children.

Parental Issues

- Parents can create a real barrier in getting qualified students enrolled in health insurance programs, even though it is free!
- Many parents who have insurance do not always get kids the help they need because of the deductibles – students on assistance seemed to have as many or more visits to Drs.
- Sometimes bilingual parents have difficulties.

Not The School's Role and Funding/Mandate Concerns

- All children need medical assistance but why doesn't the parent take care of this. Everyone wants the schools to be responsible for what should be the parents job.
- We want to help any kids that need our help, we will help if asked. However we do not believe it is our role or our job to do that. That is the job of the parents/guardians. We are more than willing to assist or make recommendations.
- I understand why the school is expected to do this, has government ever thought about how many unfunded mandates we have from this state. Parents need to be educated and informed. We do help in some of this because we are small and know the needs of most students.
- Not the schools job. Education is our Job. I feel students do best when healthy. I feel our role as a school is to work with appropriate agencies to make information on health care available to parents and to work with health care agencies via referrals, etc. When we become aware of health care issues which are hindering a student's well being. The key would be additional school nurses as resources in the schools to monitor health needs and work in conjunction with other agencies.

- Schools are already becoming a social agency in regards to the services that we are required to provide. Mandated...but unfunded. It is time for parents to step up to the plate and provide for their children and let schools serve the role for which they are intended...to educate.
- Health Insurance is a very important issue for children. At this time schools are so strapped for resources, it is too much to expect schools to assume this responsibility.
- Should be a “FUNDED MANDATE” if a school has to do it.
- Adding another responsibility for a school district is a challenge.
- Our healthy start program got us on track to help with insurance for students, but those funds are now gone. We will have less help for this.
- Should schools be burdened with ever more of society’s responsibilities? If so, they need significantly more funding and staff resources!
- I have a heart for the underprivileged but resent using schools as a means to change society. Government should use other agencies for its social engineering efforts. The poor people who work in these schools are just over worked school teachers who signed on to teach academics. Let the government fully fund personnel whose responsibility would be to assist people in need.

Successes and Suggestions

- The county government provides school nursing and supplies to each school. They are providing health care for students. I do not know how they may be working with health insurance.
- Since 1994, we have been a partner with the Joint Comm. For Children’s Health Care in Everett. This has been an extremely rewarding experience and knowledge base for the school system. We believe that children cannot be successful unless they are healthy. Parents have and still are very happy with this partnership which truly assists everyone. Also, because of the JCCHCE, we have Cambridge Health Alliance now in our community!

- I believe that schools should work collaboratively with the outside agencies. Our area/county has a health dept funded medical and dental clinic that meets many of the needs of our students. They work very closely with the schools in our county to maximize use of taxpayer dollars.
- A social service agency should assist uninsured students. If the public schools are involved, they should partner with an agency that actually completes the forms and more directly assists the families.
- We work to connect parents to programs, as we are a small school. Have seen good results.
- We have 2 school nurses who refer parents to agencies to enroll children in Health Care as we become aware of health concerns. This is a better way to work in conjunction with health agencies.
- We assist parents when we are aware of the need – but don't do it systematically
- We try to help parents with any/all paperwork they request our help with.
- If a parent indicates student is uninsured on free/reduced lunch application, an automatic referral is made to the local hospital district.

More Information, Resources, and Training

- We would be glad to help if we were given more info/help on how to do so. We just need more info on forms, etc.
- We would welcome state support to help connect families with funded health insurance.

Other comments not included in the results

- ELL 25%
- Survey Questions were quite slanted toward states funding health insurance and school involvement. I believe schools are learning centers and we need to quit trying to “fix” poor parenting or poor government. These are schools.
- Questions 18 – 22 These are thoughts on our answers....
- 18 A role is also for parents

- 19 D not the sole, but the majority
- 20 D not a role, but a go-between
- 21 D not a role, only a courtesy
- 22 D not a role, but a liaison
- Thanks for the dollar – unethical to accept
- Check WAHA 360-383-9202 Ms. Diane Beaman
- Thank you.
- Great survey, I just finished my PhD last week! Good luck to you.
- The wording of the questions seemed a little biased toward schools increasing their role in helping students obtain SCHIP.
- Columbus Junction, IA is a community of 2,000 in a rural setting with urban problems. Our largest employer is Tysons Fresh Meats. To learn more about us, go to: www.Columbus.K12.ia.us
- The way the questions are worded did not offer much room for variance. I would think it would bias your results.
- Questions 5-8 are a little biased? Question 9 is “pointing” survey results to “an end”? Overall survey seems designed to garner data supporting state-funded health insurance for uninsured qualifying students.
- This is a “push poll”. Your thrust is: Schools should expand their mission, vastly in an effort to ensure all students obtain health insurance.
- Good luck!

Page 4 – Other Positions Superintendents have held

3 Social Worker
 3 Guidance Counselor
 2 School Psychologist
 School Nurse
 2 Health Education Services
 3 Health Services Coordinator
 Department Director Central Office
 Department Director District Level
 Central Office
 2 Executive Secretary

4 Administrator
6 Director
Risk Manager
6 Business Manager
School Business Administrator
Dean of Students
At risk coordinator
2 Supervisor
2 Program Director
Director Special Services
Consultant- School Improvement
Director of Human Resource
Human Resource Counselor
Careers Technology Coordinator
Director of the Arts/Gifted
K-12 Curriculum Specialist
6 Curriculum Director/Supervisor
Curriculum Director Intermediate Agency
4 Special Ed Director
Science Coordinator
Teacher's Aide
5 College Professor/Adjunct Professor/University Instructor
College Advisor
Graduate Assistant
2 College B-ball coach
State Education Agency
Private Foundation?
Cabinet Maker

Other individuals appointed by the superintendent to fill out the survey

Health Education Services
State Agency
Health Services Coordinator
Executive Secretary
School Nurse
Office of Research, Evaluation per request of superintendent and director of
accountability
Social Worker
Business Manager
Administrative