UNITED STATES DEPARTMENT OF EDUCATION

WASHINGTON, D.C. 20202-_____

Dear Invited Observer:

You are cordially invited to observe a meeting sponsored by the Interagency Committee on School Health (ICSH) concerning the relationship of school health and Medicaid. The attached letter was sent to selected school Superintendents, State Title V Directors, and Regional Health Care Financing Administration Administrators.

This meeting, hosted by the Department of Education, will be on Monday, November 14, 1994, from 8:30 a.m. to 4:30 p.m., at the U.S. Department of Education, FOB 10, Barnard Auditorium (Room 2413), 600 Independence Avenue, S.W., Washington, DC.

Please assist us by participating in a meeting that will provide you an opportunity to hear what is happening at the State level. An agenda and list of invitees is enclosed. Please RSVP no later than November 7, 1994, if you plan to attend, have questions, or need additional information by contacting Susan Winingar at (202) 260-0942. Thank you for your consideration.

Sincerely,

Connie Garner, RNC, MSN
Co-Chair, Health Services Subcommittee
Interagency Committee for School Health
U.S. Department of Education

Audrey H. Nora, M.D., MPH
Co-Chair, Health Services Subcommittee
Interagency Committee for School Health
U.S. Department of Health and Human Services

Enclosures

Agenda for Meeting on Reimbursement of School Health Services

DATE:	Monday, November 14, 1994
TIME:	8:30 a.m. to 4:30 p.m.
LOCATION:	U.S. Department of Education - FOB 10 Room 2413 (Barnard Auditorium) 600 Independence Avenue, S.W. Washington, DC 20202

8:30 - 9:00 a.m.	Continental Breakfast
9:00 - 9:30 a.m.	Welcome/Introductions/Workgroup Outcomes
9:30 - 10:30 a.m.	Interagency Update on Key Issues Concerning Comprehensive School Health
10:30 - 10:45 a.m.	Break
10:45 - 12:30 p.m.	Medicaid and Schools: Issues and Implications for Financing Comprehensive School Health Services Moderator: Connie Garner A problem solving session where state Medicaid directors and local superintendents can discuss issues surrounding the impact of Medicaid on school health services.
12:30 - 1:30 p.m.	Lunch (To be provided)
1:30 - 3:00 p.m.	Medicaid: Federal Issues and Answers Moderator: Connie Garner A problem solving session where state Medicaid directors and local superintendents can discuss the role of the Federal government in promoting effective collaboration between education and Medicaid programs.
3:00 - 3:15 p.m.	Break
3:15 - 4:30 p.m.	Summary of the day A synopsis of the days' events and action steps to determine where we go from here.

LIST OF INVITEES
Meeting on Reimbursement of School Health Services

Participants

SUPERINTENDENTS

Michael Flanigan
Superintendent
Wayne County RESA
3500 Van Born Road
Wayne, MI 48184

Paul James
Superintendent
Fort Osage R-1 School District
2101 N. Twyman Road
Independence, MO 64058

Joan Kowal
Superintendent
Volusia County Public Schools
P.O. Box 2118
DeLand, FL 32721

T.C. Mattocks
Superintendent
Idaho Falls School District 91
690 John Adams Parkway
Idaho Falls, ID 83401

James McKimmey
Superintendent
Midland County Intermediate School District
3917 Jefferson Ave.
Midland, MI 48640

Peter Negroni
Superintendent
Springfield Public Schools
195 State Street
Springfield, MA 01103

Bertha Pendleton
Superintendent
San Diego Unified School District
4100 Normal Street
Room 2220
San Diego, CA 92103

Walter Tobin
Superintendent
Orangeburg 5 Public Schools
578 Ellis Ave.
Orangeburg, SC 29115

Robert Watkins
Superintendent
Independence School District 30
1231 South Windsor Street
Independence, MO 64055

Larry Zenke
Superintendent
DuVal County Public Schools
1701 Prudential Drive
Jacksonville, FL 32207

Participants

TITLE V DIRECTORS

Donna Barber, RN, MPH
Chief, Health Program Policy and Development
Family Health Services (HSSH)
Florida Department of Health/Rehab Services
1317 Winewood Boulevard
Tallahassee, FL 32399-0700

Maridee Gregory, M.D.
Chief, California Children's Medical Services Branch
California State Department of Health Services
714 P Street, Room OB8-450
Sacramento, CA 95814

Larry D. Jones, MA, MPH
Deputy Director, Division of Maternal, Child and Family Health
Missouri Department of Health
1730 East Elm Street
P.O. Box 570
Jefferson City, MO 65102

Marie C. Meglen, MS, CNM
Director, Bureau of Maternal and Child Health
South Carolina Department of Health and Environmental Control
Robert Mills Complex
P.O. Box 101106
Columbia, SC 29211

Marcia Panatponi, RD, MBA
Child and Adolescent Health Section Manager
Idaho Department of Health/Welfare
450 West State Street
4th Floor
Boise, ID 83720

Deborah Klein Walker, EdD
Assistant Commissioner
Bureau of Family and Community Health
Massachusetts Department of Public Health
150 Tremont Street, 4th Floor
Boston, MA 02111

Terri D. Wright, MPH
Chief, Bureau of Child Development and Family Services
Michigan Department of Public Health
3423 North Martin Luther King, Jr. Boulevard
P.O. Box 30195
Lansing, MI 48909

Participants

HEALTH CARE FINANCING ADMINISTRATION REGIONAL ADMINISTRATORS

Clarence J. Boone
Regional Administrator
Atlanta Regional Office - HCFA
101 Marietta Street, Suite 701
Atlanta, GA 30323-2711

Nancy J. Dapper
Regional Administrator
Seattle Regional Office - HCFA
2201 Sixth Avenue
Mail Stop RX 40
Seattle, WA 98121-2500

Sidney C. Kaplan
Regional Administrator
Boston Regional Office - HCFA
John F. Kennedy Federal Building
Room 2325
Boston, MA 02203-0003

Michael Piazza
Acting Regional Administrator
San Francisco Regional Office - HCFA
75 Hawthorne Street
4th Floor
San Francisco, CA 94105-3903

Chester C. Stroyny
Regional Administrator
Chicago Regional Office - HCFA
105 West Adams Street
15th Floor
Chicago, IL 60603-6201

Joe L. Tilghman
Regional Administrator
Kansas City Regional Office - HCFA
New Federal Office Building
601 East 12th Street, Room 235
Kansas City, MO 64106-2808

Participants

FEDERAL AND NON-FEDERAL

Debbie Chang
Director, Office of Legislative and Intergovernmental Affairs
Health Care Financing Administration
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
HHH Building, Room 341H
Washington, DC 20201

Connie Garner, RNC, MSN
Office of Special Education and Rehabilitative Services
U.S. Department of Education
Switzer Building, Room 3127
330 C Street, S.W.
Washington, DC 20202

Bruce Hunter
Senior Associate Executive Director
American Association of School Administrators
1801 North Moore Street
Arlington, VA 22209-9988

Mary Jean LeTendre, MA Ed. Admin.
Director, Compensatory Education Programs
U.S. Department of Education
Portals Building, Room 4400
1250 Maryland Avenue, S.W.
Washington, DC 20202

Audrey Nora, M.D., MPH
Director, Maternal and Child Health Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services
Parklawn Building, Room 18A-05
5600 Fishers Lane
Rockville, MD 20857

Thomas Payzant
Assistant Secretary for Elementary and Secondary Education
U.S. Department of Education
Portals, Room 4000
1250 Maryland Avenue, S.W.
Washington, DC 20202-6100

Sally R. Richardson
Director, Medicaid Bureau
Health Care Financing Administration
U.S. Department of Health and Human Services
East High Rise Building, Room 200
6325 Security Boulevard
Baltimore, MD 21207

Bill Sheperdson
Director, School and Community Collaboration Projects
Council of Chief State School Officers
8th Floor
440 First Street, N.W.
Washington, DC 20001

Robert O. Valdez, Ph.D.
Deputy Assistant Secretary for Health, PHS
Director, Office of Interagency Health Policy, HCFA
U.S. Department of Health and Human Services
HHH Building, Room 721H
200 Independence Avenue, S.W.
Washington, DC 20201

Susan Winingar
Education Program Specialist
Office of Elementary and Secondary Education
U.S. Department of Education
Portals Building, Room 4400
Washington, DC 20202-6132

Judy Wurtzel
Office of the Under Secretary
U.S. Department of Education
FOB 10, Room 5164
600 Independence Avenue, S.W.
Washington, DC 20202

Observers

NON-FEDERAL

Donald Beers
Executive Director
South Carolina Association of School Administrators
421 Zimalcrest Drive
Columbia, SC 29210

Ken Crow
Director, Interagency Coordination
Texas Education Agency
William B. Travis Building
1701 North Congress Avenue
Austin, TX 78701-1494

Leila Feister
Policy Studies Associates
1718 Connecticut Avenue, N.W.
Suite 400
Washington, DC 20009

Lynn Groves
Director, Interagency Affairs
Florida Department of Education
Capitol Building, Room 126
Tallahassee, FL 32301

Jane Henderson
Director, Interagency Children and Youth Services
California Department of Education
721 Capitol Mall, 5th Floor
Sacramento, CA 95814

Rick Hutcherson
Missouri Department of Elementary and Secondary Education
Post Office Box 480
Jefferson City, MO 65102

Bill Scott
Director, Division of Student/Family Support Services
Kentucky Department of Education
1703 Capital Plaza Tower
500 Mero Street
Frankfort, KY 40601

Observers

FEDERAL

Tom Ault
Director, Bureau of Policy Development
Health Care Financing Administration
U.S. Department of Health and Human Services
East High Rise Building, Room 100
6325 Security Boulevard
Baltimore, MD 21207

Kathleen A. Buto
Associate Administrator for Policy
Health Care Financing Administration
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
HHH Building, Room 325H
Washington, DC 20201

Richard Chambers
Director, Division of Intergovernmental Affairs
Office of Legislative and Intergovernmental Affairs
Health Care Financing Administration
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
HHH Building, Room 410B
Washington, DC 20201

Joann Gephart, MSN, RN
Division of Maternal, Infant, Child and Adolescent Health
Maternal and Child Health Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services
Parklawn Building, Room 18A-39
5600 Fishers Lane
Rockville, MD 20857

Eric Goplerud
Implementation Director, Division of Policy and Planning
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
Parklawn Building, Room. 12C - 05
5600 Fishers Lane
Rockville, MD 20857

Chris Heldman
Program Analyst
Division of Planning and Policy Implementation
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
Parklawn Building, Room 12C-05
5600 Fishers Lane
Rockville, MD 20857

Debbie Helms
Medicaid Bureau
Health Care Financing Administration
U.S. Department of Health and Human Services
East High Rise Building, Room 233
6325 Security Boulevard
Baltimore, MD 21207

Elaine Holland
Office of Intergovernmental and Intergency Affairs
U.S. Department of Education
FOB 10, Room 6441
600 Maryland Avenue, S.W.
Washington, DC 20202

Cheryl Howard
Chief, Health Education Branch
Office of Prevention, Education and Control
National Heart, Lung and Blood Institute, NIH
U.S. Department of Health and Human Services
9000 Rockville Pike
Building 3, Room 4A18
Bethesda, MD 20892

Joan Hurley
Office of Human Services Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
HHH Building, Room 404E
200 Independence Avenue
Washington, DC 20201

Don Johnson
Director, Medicaid Analysis Division
Office of Legislative and Intergovernmental Affairs
Health Care Financing Administration
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
HHH Building, Room 341H
Washington, DC 20201

Linda Johnston
School Health Analyst
Maternal and Child Health Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services
Parklawn Building, Room 18A-39
5600 Fishers Lane
Rockville, MD 20857

Ernestine M. Jones
Medicaid Bureau, Medicaid Operations Branch
Health Care Financing Administration
U.S. Department of Health and Human Services
East Low Rise Building, Room 2-H-1
6325 Security Boulevard
Baltimore, MD 21207

Evelyn Kappeler
Public Health Analyst
Office of Population Affairs
U.S. Department of Health and Human Services
East-West Towers, North Building
Room 1115
East-West Highway, 5600 Fishers Lane
Rockville, MD 20857

Jennifer Klein
Special Assistant to the President
Executive Office of the President
1600 Pennsylvania Avenue, N.W.
2nd Floor, West Wing
Washington, DC 20500

Terese Klitenic
Medicaid Bureau
Health Care Financing Administration
U.S. Department of Health and Human Services
East High Rise Building, Room 322
6325 Security Boulevard
Baltimore, MD 21207

Lloyd J. Kolbe, Ph.D.
Director, Division of Adolescent and School Health
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
4770 Buford Highway, N.E.
Mail Stop K31
Atlanta, GA 30333

Judith Leonard
Attorney, Office of the General Counsel
U.S. Department of Education
FOB 10, Room 4466
600 Maryland Avenue, S.W.
Washington, DC 20202

Amanda D. Manning, MS, MPA
Associate Administrator, Nutrition Policy Group
U.S. Department of Agriculture
3101 Park Center Drive, Room 802
Alexandria, VA 22302

Jane Martin
Director, School Health Service
Bureau of Primary Health Care
Health Resources and Services Administration
U.S. Department of Health and Human Services
West Towers Building, Room 9-10A2
9th Floor
4350 East West Highway
Rockville, MD 20857

Kristine I. McCoy
Office of Disease Prevention and Health Promotion
Public Health Service
U.S. Department of Health and Human Services
Switzer Building, Room 2132
330 C Street, S.W.
Washington, DC 20201

William Modzeleski
Director, Drug Planning and Outreach Staff
Office of Elementary and Secondary Education
U.S. Department of Education
Portals, Room 4400
1250 Maryland Avenue, S.W.
Washington, DC 20202-6123

Amy Nevel
Office of Health Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services
HHH Building, Room 44ZE
200 Independence Avenue, S.W.
Washington, DC 20201

Sophia Pao
Special Assistant
Office of the Assistant Secretary for Health
Public Health Service
U.S. Department of Health and Human Services
HHH Building, Room 721H
200 Independence Avenue, S.W.
Washington, DC 20201

Linda Sizelove
Branch Chief, Office of Medicaid Policy
Health Care Financing Administration
U.S. Department of Health and Human Services
East High Rise Building, Room 322
6325 Security Boulevard
Baltimore, MD 21207

Elmer Smith
Director, Medicaid Special Programs Initiative Staff
Health Care Financing Administration
U.S. Department of Health and Human Services
East High Rise Building, Room 400
6325 Security Boulevard
Baltimore, MD 21207

Georgeline Sparks
Division of Clinical Preventive Services
Indian Health Services
U.S. Department of Health and Human Services
Parklawn Building, Room 6A-38
5600 Fishers Lane
Rockville, MD 20857

Robert F. St. Peter, M.D.
Coordinator, Children, Adolescent and School Programs
Office of Disease Prevention and Health Promotion
Public Health Service
U.S. Department of Health and Human Services
Switzer Building, Room 2132
330 C Street, S.W.
Washington, DC 20201

Bonnie Strickland, Ph.D.
Habilitative Services Branch
Maternal and Child Health Bureau
Health Resources and Services Administration
U.S. Department of Health and Human Services
Parklawn Building, Room 18A-20
5600 Fishers Lane
Rockville, MD 20857

Mary Vernon, M.D.
Division of Adolescent and School Health
Centers for Disease Control and Prevention
U.S. Department of Health and Human Services
4770 Buford Highway, N.E.
Mailstop K33
Altanta, GA 30341-3742

Nicole A. Walls
Office of Disease Prevention and Health Promotion
Public Health Service
U.S. Department of Health and Human Services
Switzer Building, Room 2132
330 C Street, S.W.
Washington, DC 20201

Susan Weber
Administration on Children Youth and Families
U.S. Department of Health and Human Services
Switzer Building, Room. 2223
330 C Street, S.W.
Washington, DC 20201

Valerie Welsh, MS, MPH
Office of Health Planning and Evaluation
Office of the Assistant Secretary for Health
U.S. Department of Health and Human Services
Switzer Building, Room 2018
330 C. Street, S.W.
Washington, DC 20201

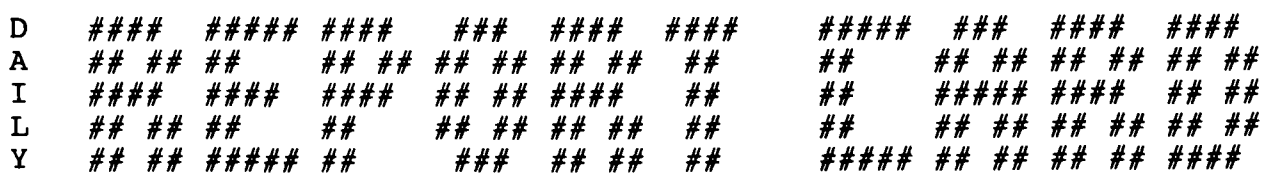
JoAnne Wiggins
Planning and Evaluation Services
U.S. Department of Education
600 Independence Avenue, S.W.
Washington, DC 20202

AGENDA FOR MEETING ON MEDICAID AND SCHOOL HEALTH

DATE:	Monday, November 14, 1994
TIME:	8:30 a.m. to 4:30 p.m.
LOCATION:	U.S. Department of Education Room 2413 (Barnard Auditorium) 600 Independence Ave., S.W. Washington, DC 20202

8:30 - 9:00 a.m.	**Continental Breakfast**
9:00 - 9:30 a.m.	**Welcome/Introductions/Workgroup Outcomes**
9:30 - 10:30 a.m.	**Interagency Update on Key Issues Concerning Comprehensive School Health**
10:30 - 10:45 a.m.	**Break**
10:45 - 12:30 p.m.	**Medicaid and Schools: Issues and Implications for Financing Comprehensive School Health Services** Moderator: Connie Garner A problem solving session where state Medicaid directors and local superintendents can discuss issues surrounding the impact of Medicaid on school health services.
12:30 - 1:30 p.m.	**Lunch (To be provided)**
1:30 - 3:00 p.m.	**Medicaid: Federal Issues and Answers** Moderator: Connie Garner A problem solving session where state Medicaid directors and local superintendents can discuss the role of the Federal Government in promoting effective collaboration between education and Medicaid programs.
3:00 - 3:15 p.m.	**Break**
3:00 - 4:30 p.m.	**Summary of the day** A synopsis of the day's events and action steps to determine where we go from here.

--- Wednesday --- September 21, 1994 --- Vol. 3 --- No. 247 ---



THE NATIONAL UPDATE ON AMERICA'S EDUCATION GOALS
A service of the National Education Goals Panel

"I KNOW WHY THE CAGED BIRD SINGS"

... probably because it is one of the books most frequently challenged by those wanting to censure certain books in public schools. (The author is Maya Angelou). A People for the American Way report documents 462 attempts last year to remove books, films and plays from schools. Fewer than half of censorship attempts are successful, notes the report.

Calif. leads the nation in the most censorship attempts, followed by Texas and Fla. Ark., W.V., and Vt. were free of censorship challenges.

The books most frequently challenged: Steinbeck's "Of Mice and Men;" Salinger's "The Catcher in the Rye;" and Cormier's "The Chocolate War."

BOOK PURGING, RUSSIAN STYLE

Soviet schoolchildren this year for the first time will use textbooks purged of communist propaganda. That's good news for teachers who "winced" when teaching about Leonid Brezhnev (Carpenter, AP/ Miami HERALD, 8/31).

SPOTLIGHT

HEALTH AND INTELLECT

Horace Mann wrote that "on the broad and firm foundation of health alone, can the loftiest and most enduring structures of the intellect be reared." His quote leads off a U.S. DoEd publication on innovative comprehensive school health education programs. (#1)

Many educators and health professionals nationwide are making the connection between health and learning. A recent study conducted by two M.D.s found a link between several common childhood health maladies and a child's repetition of kindergarten or first grade. (#5)

One solution: the creation of school-based health clinics that draw on community support and are housed in middle schools as well as high schools. (#2)

========== QUOTE OF THE DAY ==========

"Teachers have been out there all by themselves for too long." -- Ann Sheetz, director of the School Health Unit for the Mass. Department of Public Health, on student health care. (#2)

supported by the National Education Goals Panel
1850 M Street NW; Washington, D.C. 20036; 202/632-0952

Publisher: Barbara A. Pape

========== TABLE OF CONTENTS ==========

HEALTH AND EDUCATION
SCHOOL HEALTH PROGRAMS: A new paradigm. (#1)
SCHOOLS AND HEALTH CARE: Local models. (#2)
HEALTHY EATING: The debate over school lunch. (#3)
SCHOOL AND HEALTH COLLABORATION: DoEd and HHS. (#4)

RESEARCH NOTES
HEALTH PROBLEMS: One reason children repeat grades. (#5)
CHILDRENS' HEALTH: The environmental factor. (#6)

===== HEALTH AND EDUCATION =====

*1 SCHOOL HEALTH PROGRAMS: A NEW PARADIGM

Innovative programs, practices and information on comprehensive school health education programs are featured in a recent DoEd publication titled "Comprehensive School Health Education Programs." The report includes four papers commissioned for a Nov. 1992 Comprehensive School Health Education Program conference, which focused on strategies and practices for developing, implementing and evaluating school health programs. The papers are: "Research Base for Innovative Practices in School Health Education," by Diane Allensworth, Ph.D. R.N., Kent State U and American School Health Association; "Instituting Innovative Practices in Comprehensive School Health Eduction Programs for Elementary Schools," by Jill English, Southwest Regional Laboratory; "Developing Comprehensive School Health Education Standards for Elementary School Programs," by Lucinda Adams and Betty Holton, Dayton Public Schools; and "A Community-Based School Health System: Parameters for Developing a Comprehensive Student Health Promotion Program," by Dr. Christopher DeGraw, The George Washington U Center for Health Policy Research.

A "new paradigm" for comprehensive school health education emerged from the papers and the conference, according to the publication. For example, shifts in thinking have occurred: from school-based to school-wide, community-wide programs; from a focus on providing health information to a focus on changing health-related attitudes and behaviors; and from a health content instruction model in the classroom to a health promotion model that involves numerous strategies and interdisciplinary team members from the school and community, among others, writes the

report.

The report also notes three themes generated from the conference and papers: comprehensive school health education programs should be driven by the needs of the students; CSHEP should be a coordinated, comprehensive, school- and community-based system of service delivery; and CSHEP should focus on identifying and documenting outcomes.

*2 SCHOOLS AND HEALTH CARE: LOCAL MODELS

The March/April 1994 issue of HIGH STRIDES magazine focuses on health care for students and features several school-based models in urban middle schools.

All Atlanta public school children have available to them school-based health clinics, 87 clinics today compared with only two clinics located in schools four years ago, writes the magazine (Seline). Noble Maseru is credited with the growth of the systems school-based health clinics.

He initially tapped the Medicaid program, which "allows poor families to get an annual or bi-annual check-up for their children," to initially finance the school health programs, according to the magazine. But while families availed themselves of the services when their children were toddlers, they discontinued using the health program as their children grew. "Once the children go to school, the interest to go to a private doctor's office just dropped off," explained Maseru.

Maseru's solution was to bring health care to where the children spent most of their time -- school. "We're getting these students health care and linking the parents, teachers and nurses," he said. Students receive physical exams, blood tests to detect anemia and urine analysis. They also undergo "psycho-social" assessments "to determine how they are interacting with peers and parents," writes the magazine. Outreach workers make home visits to discuss the medical exams with parents and monitor any follow-up treatment.

Student health care in Mass. is part of the state's Department of Public Health's mission (Lewis). Ann Sheetz, director of the department's School Health Unit, works with 36 school districts to "develop model school health programs," according to the magazine. The prevention of tobacco use is a primary goal of the program, which is partly financed through a 25-cent tax on cigarette packs. Funds also are used for public service ads and to upgrade the quality of school health staff. Sheetz: "I was shocked to walk into schools and find, for example, only one person trained for CPR in a school of 2,000 students." She added that "teachers have been out there all by themselves for too long."

Sheetz also is attempting to reach out to community health providers, such as HMOs, which "traditionally have stayed away from schools." And she intends to "inform food service administrators at state and local levels about the nutrition needs of students."

Already, 14 school clinics are open and 21 more are expected, with some in middle schools, according to the magazine.

Mass. also is the lead agency for the federal Model School Health Information System Project, which will integrate data from education and health throughout the New England States.

Other school health programs featured in HIGH STRIDES include: a collaborative effort between the U of Pennsylvania and Philadelphia's John P. Turner Middle school, which boasts a model curriculum that calls on students to "teach their peers, work in hospitals, publish brochures on health topics and lead community health programs;" and the Community Health Education Project housed in the Intermediate School 52, located in a disadvantaged section of Manhattan.

Dr. Aaron Shirley, the first black pediatrician in Miss., explained why health programs should begin in the middle schools, if not sooner. Many problems that become serious for high school students, such as anemia, poor eyesight, dental problems, obesity and teen pregnancies, could have been prevented if detected during the middle school years, he said. But he added that young adolescents mostly need "a place they trust and adults whom they can trust," which is why his clinic staff "do a lot of handholding" because they serve as "surrogate families."

*3 HEALTHY EATING: THE DEBATE OVER SCHOOL LUNCH

Critics of the U.S. Department of Agriculture's reform of its school lunch program warn that the proposal is "too much to swallow" and may cause some schools to drop out of child nutrition programs due to cost (Shogren, L.A. TIMES, 9/8). The debate centers on the approach taken by the U.S.D.A. to limit the amount of fat and sodium in school lunches. (See DRC 9-8-93)

The national Parent Teachers Association, American School Food Service Association and others argue that the U.S.D.A.'s strategy of requiring schools to "analyze the nutritional content of their foods and make sure that over a week students get no more than 30 percent of their calories from fat and no more than 10 percent from saturated fat" is too cumbersome (Greene, The TIMES-PICAYUNE, 9/8). It will force schools that want to comply to purchase expensive computers and software to undertake the nutrient analysis, according to the critics. Instead, the groups recommend that schools use a "modified version of the existing plan that would follow the 'food pyramid,' a program based on the same nutritional guidelines that require cutting fat to 30 percent of calories," writes the paper.

But U.S.D.A. officials maintain that using nutritional data is the only way to insure guidelines are met. "You have to have a mechanism," said Ellen Haas, assistant agriculture secretary for food and consumer services. She added that the department will provide model menus and other assistance to schools.

Meanwhile, Public Voice for Food and Health Policy recently released a study profiling 41 school lunch programs nationwide (multi cites). The advocacy group discovered that these schools already have begun serving healthier meals, despite a 1998 deadline imposed by the U.S.D.A. to improve school lunch programs (Herald Wire Services/Miami HERALD, 8/31). "These case studies show that the creativity, commitment, knowledge and technology to

create healthier lunches already exists from coast to coast," said Mark Epstein, the group's director.

Epstein urged the U.S.D.A. to push up the deadline to the 1996-1997 school year. A BALTO. EVENING SUN editorial agreed. The SUN: "We concur with the group's stance. In fact, this newspaper expressed the same combination of praise and criticism months ago when the U.S. Department of Agriculture went public with its revisions of the school lunch program. We still feel that the decision to allow school districts to phase in the changes over four years is a mistake."

*4 SCHOOL AND HEALTH COLLABORATION: DoEd AND HHS

The U.S. Secretaries of Education and Health and Human Services earlier this year joined forces to confront child health issues. "We know that children who come to school healthy, who have gotten their shots and participated in early childhood programs, are children who are engaged and ready to learn," said Ed Sec Richard Riley. Donna Shalala, Sec of HHS added that "good health for America's children must be a national priority. There is no question that our schools have a key role to play in helping our children begin a lifetime of good health."

Officials from both agencies intend to establish the Interagency Committee on School Health, co-chaired by the assistant secretary for elementary and secondary education and the assistant secretary for health. Also planned is a National Coordinating Committee on School Health, that will unite representatives of major national education and health organizations.

A press release that announced the joint statement of Riley and Shalala also noted that President Clinton's proposed Health Security Act also "would provide major support to children, with an emphasis on prevention as the key to helping children avoid health risks and receive care before an illness reaches an emergency state." (4/7) But health-care reform, which has devolved into a rancorous debate in Congress, is not expected to pass this year.

From the Joint Statement on School Health: "Health and education are joined in fundamental ways with each other and with the destinies of the Nation's children. ... In support of comprehensive school health programs, we affirm the following: America's children face many compelling educational and health and developmental challenges that affect their lives and their futures. ... To help children meet these challenges, education and health must be linked in partnership. ... School health programs support the education process, integrate services for disadvantaged and disabled children, and improve children's health prospects. ... Reforms in health care and in education offer opportunities to forge the partnerships needed for our children in the 1990s. ... Goals 2000 and Healthy People 2000 provide complementary visions that, together, can support our joint efforts in pursuit of a healthier, better educated Nation for the next century."

===== RESEARCH NOTES =====

*5 HEALTH PROBLEMS: ONE REASON CHILDREN REPEAT GRADES

Researchers detected a link between several common childhood health problems and the rising number of children required to repeat kindergarten or first grade (Medical Tribune News Service/The TENNESSEAN, 3/12). A nationwide study of nearly 10,000 children ages 7 to 17 found that 7.6% repeated kindergarten or first grade. U of Rochester in New York researchers revealed that, while a combination of factors contribute to a child's educational difficulties, bedwetting, deafness, low birthweight, exposure to household smoking, male gender and poverty each place children at a higher risk of repeating an early grade, writes the paper.

They also found a link, albeit weaker, between recurrent middle-ear infections, black race and having a young mother and a child's chances of being held back in school. Drs. Robert Byrd and Michael Weitzman, authors of the study, recommend that pediatricians be on "the lookout for such problems to help prevent children from having difficulties in school," reports the paper. Their study was published in the March issue of the journal "Pediatrics."

According to the study, more children are being held back in the early grades. The proportion of 8-year-olds who were in a lower grade than would be expected in 1974 was 17.4% of boys and 12.2% of girls. The percentage rose to 28.1% of boys and 21.7% of girls by 1989, reports the study. An increase in the number of children living in poverty and exposed to violence and pressure placed on schools to demonstrate student improvement may contribute to the escalating number of children held back, write the reports authors. But the study also pointed to health problems: deafness doubled the risk of repeating an early grade; exposure to household smoking increased the risk by 40%; and frequent ear infections made children 20% more likely to repeat an early grade, found the report, writes the paper.

Dr. Barbara Starfield, professor of health policy and pediatrics at Johns Hopkins U School of Medicine in Baltimore, remarked that the findings are not new, but do "suggest that a regular source of coordinated primary care might have an impact on children's education in the early grades," reports THE TENNESSEAN. Starfield added that if the researchers reviewed the type of care the children received, they might have discovered that children with a "more consistent source of care have less risk for repeating a grade than kids with an erratic source of care." The study also validates the argument in favor of improved community health services, noted Starfield.

*6 CHILDRENS' HEALTH: THE ENVIRONMENTAL FACTOR

Scientists must "do more research on the link between the environment and children's diseases," and lawmaker must "review proposed legislation and tolerance levels with children in mind" editorializes USA TODAY (8/22). The editorial came on the heels of the release of a study by the Children's Environmental Health Network, which found, among other things, that children are

developing asthma at a faster rate than adults (Manning, USA TODAY, 8/22).

Children also are exposed to higher pesticide levels than adults because their diets contain larger proportions of pesticide-treated produce, according to the study. And the report noted that 3-4 million preschoolers are reported to have high levels of lead in their blood.

USA TODAY: "It stretches the imagination to think that the higher rates of cancer and spina bifida suffered by children living near toxic-waste sites are just coincidence."

UNITED STATES DEPARTMENT OF EDUCATION

GOALS 2000

Goals 2000: Educate America Act
Legislative Summary

Overview

- The Goals 2000 Act provides resources to states and communities to develop and implement comprehensive education reforms aimed at helping students reach challenging academic and occupational skill standards.

Legislative Review

- On March 23, the House of Representatives approved the final Goals 2000 bill by a bipartisan vote of 306-121. On March 26, the Senate approved Goals 2000 by a bipartisan vote of 63-22.

- The President signed the bill into law March 31, 1994. (Public Law 103-227)

Timetable and Funding

- In 1994, $105 million was appropriated for Goals 2000. First-year funds became available to the states on July 1, 1994. Congress has appropriated $403 million in 1995.

- Funding will be formula-based. For first-year funding, states have been asked to submit an application that will describe how a broad-based citizen panel will develop an action plan to improve their schools. The application will also describe how subgrants will be made for local education improvement and better teacher preservice and professional development programs.

- During the first year, states will use at least 60 percent of their allotted funds to award subgrants to local school districts for the development or implementation of local and individual school improvement efforts, and for better teacher education programs and professional development activities.

- In succeeding years, at least 90 percent of each state's funds will be used to make subgrants for the implementation of the state, local and individual school improvement plans and to support teacher education and professional development.

- During the first year, local districts will use at least 75 percent of the funds they receive to support individual school improvement initiatives. After the first year, districts will pass through at least 85 percent of the funds to schools.

Components of the Goals 2000: Educate America Act

Title I: Setting High Expectations For Our Nation: the National Education Goals

- Formalizes in law the original six National Education Goals. These goals concern: readiness for school; increased school graduation rates; student academic achievement and citizenship; mathematics and science performance; adult literacy; and safe, disciplined, and drug-free schools. The Act adds two new goals that encourage parental participation and better professional development for teachers and principals.

Title II: Public Accountability for Progress Toward the Goals and Development of Challenging, Voluntary, Academic Standards

- Establishes in law the bipartisan National Education Goals Panel, which will: report on the nation's progress toward meeting the goals; build public support for taking actions to meet the goals; and review the voluntarily-submitted national standards and the criteria for certification of these standards developed by the National Education Standards and Improvement Council.

- Creates the National Education Standards and Improvement Council, made up of a bipartisan, broad base of citizens and educators, to examine and certify voluntary national and state standards submitted on a voluntary basis by states and by organizations working on particular academic subjects.

- Authorizes grants to support the development of voluntary assessment systems aligned to state standards, and for the development of <u>model</u> opportunity-to-learn standards.

Title III: Supporting Community and State Efforts to Improve Education

- The central purpose of the Goals 2000 Act is to support, accelerate, and sustain state and local improvement efforts aimed at helping students reach challenging academic and occupational standards.

- Section 318 of the Act specifically prohibits federal mandates, direction and control of education.

Broad-Based Citizen Involvement in State Improvement Efforts

- The Governor and the Chief State School Officer will each appoint half the members of a broad-based panel. This panel will be comprised of teachers, principals, administrators, parents, representatives of business, labor, and higher education, and members of the public, as well as the chair of the state board of education and the chairs of the appropriate authorizing committees of the state legislature.

- States that already have a broad-based panel in place that has made substantial progress in developing a reform plan may request that the Secretary of Education recognize the existing panel.

Comprehensive Improvement Plan Geared to High Standards of Achievement

- The State Planning Panel is responsible for developing a comprehensive reform plan.

- States with reform plans already in place that meet the Act's requirements will not have to develop new plans for Goals 2000. The U.S. Secretary of Education may approve plans, or portions of plans, already adopted by the state.

- In order to receive Goals 2000 funds after the first year, a state has to have an approved plan or have made substantial progress in developing it.

- A peer review process will be used to review the state plans and offer guidance to the State Planning Panel. The U.S. Department of Education also will offer other technical assistance and support by drawing on the expertise of successful educators and leaders from around the nation.

In general, the plans are to address:

- Strategies for the development or adoption of content standards, student performance standards, student assessments, and plans for improving teacher training.

- Strategies to involve parents and the community in helping all students meet challenging state standards and to promote grass-roots, bottom-up involvement in reform.

- Strategies for ensuring that all local educational agencies and schools in the state are involved in developing and implementing needed improvements.

- Strategies for improved management and governance, and for promoting accountability for results, flexibility, site-based management, and other principles of high-performance management.

- Strategies for providing all students an opportunity to learn at higher academic levels.

- Strategies for assisting local educational agencies and schools to meet the needs of school-age students who have dropped out of school.

- Strategies for bringing technology into the classroom to increase learning.

Funds are also available to states to support the development of a state technology plan, to be integrated with the overall reform plan.

Broad-Based Involvement in Local Education Improvement Efforts

- Each local school districts that applies for Goals 2000 funds will be asked to develop a broad consensus regarding a local improvement plan.

- Local districts will encourage and assist schools in developing and implementing reforms that best meet the particular needs of the schools. The local plan would include strategies for ensuring that students meet higher academic standards.

Waivers and Flexibility

- State educational agencies may apply to the U.S. Secretary of Education for waivers of certain requirements of Department of Education programs that impede the implementation of the state or local plans. States may also submit waiver requests on behalf of local school districts and schools.

- The Secretary may select up to six states for participation in an education flexibility demonstration program, which allows the Secretary to delegate his waiver authority to State education agencies.

- The Act specifies certain statutory and regulatory programmatic requirements that may not be waived, including parental involvement and civil rights laws.

Title IV. Support for Increased Parental Involvement

- This title creates parental information and resource centers to increase parents' knowledge and confidence in child-rearing activities and to strengthen partnerships between parents and professionals in meeting the educational needs of children. Parent resource centers will be funded by the U.S. Department of Education beginning in fiscal year 1995.

Title V. National Skill Standards Board

- This title creates a National Skill Standards Board to stimulate the development and adoption of a voluntary national system of occupational skill standards and certification. This Board will serve as a cornerstone of the national strategy to enhance workforce skills. The Board will be responsible for identifying broad clusters of major occupations in the U.S. and facilitating the establishment of voluntary partnerships to develop skill standards for each cluster. The Board will endorse those skill standards

submitted by the partnerships that meet certain statutorily prescribed criteria.

Relationship of Goals 2000 to Other Federal Education Programs

- State participation in all aspects of the Goals 2000 Act is voluntary, and is not a precondition for participation in other Federal programs.

- The Goals 2000 Act is a step toward making the Federal government a better partner a supportive partner in local and state comprehensive improvement efforts aimed at helping all children reach higher standards. The proliferation of many sets of rules and regulations for different federal education programs has often interfered with local school, community or state efforts to improve schools. The Goals 2000 Act is designed to be flexible and supportive of community-based improvements in education.

- Other new and existing education and training programs will fit within the Goals 2000 framework of challenging academic and occupational standards, comprehensive reform, and flexibility at the state and local levels. The aim is to give schools, communities and states the option of coordinating, promoting, and building greater coherence among Federal programs and between Federal programs and state and local education reforms.

- For example, the School-to-Work Opportunities Act will support state and local efforts to build a school-to-work transition system that will help youth acquire the knowledge, skills, abilities, and labor-market information they need to make a smooth transition from school to career-oriented work and to further education and training. Students in these programs could be expected to meet the same academic standards established in states under Goals 2000 and will earn portable, industry-recognized skill certificates that are benchmarked to high-quality standards.

- Similarly, the reauthorization of the Elementary and Secondary Education Act (ESEA) allows states that have developed their own standards and assessments under Goals 2000 to use them for students participating in ESEA programs, thereby providing one set of standards and assessments for states and schools to use for their own reform needs and, at the same time, to meet Federal requirements.

For more information, contact 1-800-USA-Learn.

School Health
PROFESSIONAL
Volume 1, Number 14 July 27, 1994

Schools, Community Health Centers Urged to Link Up

Two federal departments are taking steps to implement a joint statement on school health issued last April by Education Secretary Richard Riley and Secretary of Health and Human Services Donna Shalala (**School Health Professional, 4/27/94**).

Looking for ways to "model" the kind of collaboration they hope to see at the local level, program specialists in the Department of Education and the Bureau of Primary Health Care in HHS are working on a plan to meld the Chapter 1 education program for disadvantaged students with federally funded community health centers located in high poverty areas.

The idea is that both programs serve the same disadvantaged children, and it seems logical that they should establish linkages aimed at improving both health care and education..

But that may be easier said than done. There's no direct geographic relationship between the approximately 15,000 school districts in this country and the approximately 1,500 community health centers currently funded by the federal government.

That makes it hard to know which schools might be able to collaborate with which health centers—a problem the feds are trying to solve by sending introductory letters about the new initiative to local and state Chapter 1 directors and chief state school officers, enclosing a list of community health centers in their states. At the same time, letters are going to clinic directors and State Primary Care Association executive directors, who may know which school districts are in their territories.

The letters will extend an invitation to Chapter 1 schools and BPHC Health Centers to coordinate services, explaining how schools can save money by tapping into an already existing network of health services.

Continued on Page 2

Report Shows Startling Increase in Obesity in U.S.

A report published last week in the *Journal of the American Medical Association* found a startling 31 percent increase in adult obesity since 1980. Thirty-three percent of American adults are now believed to be obese, which is defined as weighing 20 percent more than is optimal for your height and age.

A companion report on children's weight scheduled for release in the next few months is expected to show that at least one-third of American children are seriously overweight, and that lack of physical exercise in schools is one of the reasons for their obesity.

Commenting on the report, Dr. F. Xavier Pi-Sunyer of the division of endocrinology, diabetes, and nutrition at St. Luke's-Roosevelt Hospital said, "The proportion of the population that is obese is incredible. If this was about tuberculosis, it would be called an epidemic."

The rise in percentage of obesity in the adult population is especially surprising, the AMA *Journal* said, because of the emphasis given to weight loss and diet in advertising and media messages in this country.

"The problem with obesity is that once you have it, it is very difficult to treat. What you want to do is prevent it," said Dr. Pi-Sunyer.

IN THIS ISSUE

In the News 3
Violence in U.S. Schools 4
Findings from Evaluated Programs 6
School Health Issues–Higher Education for Paraprofessionals 7
School Health Briefs 8

Schools and Community Centers Urged to Link Up

Continued from Page 1

At the same time, the Bureau of Primary Health Care and the Department of Education say they will develop an "idea book" describing eight or nine sites that are already collaborating in the way they have in mind.

All of this is "down the line a way," they say. They also concede that some problems that have arisen at the federal level—money, for example—will probably come up at the local level, as well. New authorizing legislation for Chapter 1 now making its way through Congress would allow Chapter 1 money to be used for health services, but only as a last resort. The Bureau of Primary Care says community health centers have small budgets for development and expansion, which might make it possible to set up a clinic at a school site.

The two agencies also say they've learned some lessons they'd like to pass on to locals, about collaboration. Don't take differences personally, they advise; work out the vocabulary, so you are both talking about the same things; and try to overcome pride of turf.

The persons managing the collaboration initiative at the federal level are:

- *For the Department of Education—Susan Winingar, Education Program Specialist, U.S. Department of Education, 400 Maryland Ave. SW, Washington DC 20202-6132, telephone (202)260-0942, FAX (202)260-7764.*
- *For the Department of Health and Human Services—Sarah Baily, Public Health Analyst, Public Health Service, 4350 East-West Highway, 9th Floor, Bethesda MD 20814, telephone (301)594-4470, FAX (301)594-2470.*

What Are Chapter 1 and Community Health Centers?

Chapter 1

Most school health professionals are probably familiar with Chapter 1 of the Elementary and Secondary Education Act.

Briefly, Chapter 1 was enacted in 1965 as Title I of the original Elementary and Secondary Education Act. It provides federal funds to states, which distribute it to school districts on a formula based on poverty and other factors, to be used to help educate children who are a grade or more behind in subjects such as reading and arithmetic.

The Chapter 1 mantra is "supplement not supplant," which means the federal money is in addition to and does not replace whatever the school district would have spent on those children.

Generally, Chapter 1 funds have been used to provide "pull-out" programs in which eligible children leave their regular classrooms during specific periods of the day to receive special instruction in math or reading.

The legislation now before Congress discourages such separation and requires that Chapter 1 children be given opportunity to reach the same academic standards expected of other children.

Although Chapter 1 money is supposed to go to schools in areas of poverty, the formula has been tailored over the years in such a way that about 95 percent of school districts receive some Chapter 1 money. Efforts by the Clinton administration to focus the funds on high-poverty schools have failed so far in this session of Congress.

Unlike the other major federal program for children in poverty—Head Start—Chapter 1 programs do not usually have a direct link to health or social services, though some programs have provided them.

Community Health Centers

Like Chapter 1, community health centers had their origin in President Lyndon Johnson's "War on Poverty," in the mid-1960s. Originally managed under the Economic Opportunity Act, the neighborhood health center program was transferred to the Public Health Service in the early 1970s.

Currently, there are community health centers in all of the 50 states, the District of Columbia, and the federal territories. Sixty percent are located in rural areas and 40 percent in high-poverty urban areas.

The Bureau estimates that about 6 million people a year receive primary health care through the centers; 60 percent of the patients have incomes below poverty level. Patients who can afford to pay are charged on a sliding scale, and centers are also expected to make maximum use of revenue sources such as Medicaid, Medicare, and private insurance.

About a third of community health centers have already taken the initiative to start either school-based or school-linked health centers.

In addition, the Bureau of Primary Health Care this year is implementing a first year of a "Healthy Schools, Healthy Communities" program to help homeless children and children who are at high risk for poor health and school failure as a result of poverty. A total of $5.75 million dollars is available for grants to provide health services, health education, and staff development. Under this program, about 12 to 15 new school-based health centers will be established by community-based health care providers who have entered into partnerships with schools and community groups to provide comprehensive primary care to at-risk students.

School Health Professional is published twice monthly, except once in August and December, by The Federal News Services, Inc.
 ISSN 1072-3722. Annual subscription rate, $107.

Publisher: Craig MacKown, The Federal News Services, Inc., P.O. Box 13460, Silver Spring MD 20911-3460
Editor: Virginia Robinson, P.O. Box 1961, Alexandria VA 22313 (703) 548-5948, FAX (703) 683-2466
Business and Circulation Offices: The Federal News Services, Inc., P.O. Box 13460, Silver Spring MD 20911-3460, (301) 608-9322, FAX (301) 608-9057
Accounting Director: Peggy Abrams – Circulation Director: Jane Seeber

Implementing Schoolwide Projects: An Idea Book
Summary

Background

For children in high-poverty schools to meet high standards of performance, their entire instructional program-not just a separate Chapter 1 program-must be substantially improved. High standards, flexibility, school-based staff development, school-family partnerships, and clear accountability can help create the conditions necessary for transforming schools, particularly those that serve high concentrations of poor children. Research demonstrates how schoolwide approaches can be an effective option for high-poverty schools. When the target of change is the entire school, not just the poorest performing children, schools serving even the most disadvantaged can succeed.

Moreover, research has shown that in schools where the majority of students are poor, it makes little sense to attempt to target the program on individual students, to the exclusion of many other needy students. The average performance of all students in high-poverty schools resembles that of Chapter 1 students in low-poverty schools. Where poverty is concentrated, the poverty level of the school itself is an impediment to the performance of all children in school.

At the same time, findings from Chapter 1 studies have identified a need for more assistance in planning, operating, and evaluating schoolwide projects. Many projects initially only reduced class size without making efforts to fundamentally improve instructional practices in schools. Some projects began quickly without adequate planning. Others relied on single measures for evaluation rather than multiple measures of student achievement.

The strategies that successful projects are using--a framework of high standards, comprehensive planning and continuous professional development, flexibility in drawing upon resources, extensive parent involvement and clear accountability for results are those our reauthorization proposal would extend to all Title I (formerly Chapter 1) schoolwide program schools.

This idea book provides information on how successful schoolwide projects have achieved results in high-poverty schools, based on in-depth interviews with administrators and teachers from such projects. The schools represent an array of program options and serve diverse student populations. Profiles of successful schoolwide projects are included in the idea book as well.

On Becoming Successful

Successful schoolwide projects start with an inclusive planning process and a plan that becomes a working document to motivate and guide staff, students and parents towards common challenging goals. Planning should be based on a comprehensive, school-generated needs assessment and parents and teachers should be an integral part of developing and implementing the plan. For example, at Snively Elementary School in Winter Haven, Florida, faculty, parents, and community representatives met frequently for six months to plan the schoolwide project. Teachers rewrote the curriculum to support an interdisciplinary, thematic unit approach and visited parents at home to solicit support for the project.

Schools need to build in adequate time for school staff to learn new roles and to allow time for members of the community, including parents, to accept and support the plan. School staff also need to be involved in developing the plan and need ongoing training and technical support as the school undertakes the changes. Professional development for all staff also needs to be provided in using technology, teaching new content, working positively with parents, and using new teaching methods. The idea book highlights successful strategies schools have used to engage staff and parents.

Successful schoolwide projects reach out to parents and the community in a variety of ways. At Balderas Elementary School in Fresno, California, school-home communications are routinely translated into five languages and followed up with calls to those who cannot read in any language. Two English classes are offered at the school for parents. Each month the school offers a parent workshop given in the languages spoken by school families. Approximately 80 percent of the parents attend. At the parents' request, Balderas also has a monthly open house, during which the school's programs are explained, student guides take visitors on a tour of the building, and parents eat lunch with their children. Balderas has also built strong relationships with the business community. Engineers from several large companies meet with school staff to identify promising technologies and their applications to teaching, and plan ways to install them at the school.

By incorporating the additional resources into the entire school program, schools can change the way they offer instruction throughout the school, extend student learning time, adapt proven program innovations to their school, and provide more focused, intensive staff development. Establishing smaller classes may or may not be a good starting point but is not in and of itself sufficient to bring about far-reaching reforms in the schools. It is also critical that the schoolwide project establish a well-structured, engaging academic program based on helping many more students achieve higher standards. McNair Elementary in North Charleston, South Carolina uses a summer enhancement program for students who scored poorly on district-based tests. The program focuses on the study of energy, space, marine life, and conservation. Francis Scott Key Elementary in Philadelphia adapted Johns Hopkins University's Success for All program to offer a rich array of whole language approaches to teaching. These schools used innovative approaches to improving instruction and learning in their programs.

Successful schoolwide projects use a variety of assessment tools to focus on students' progress. They may use a combination of teacher-designed tests, standardized criterion- and norm-referenced tests, portfolios of students' work, and mastery skills checklists. Teachers also monitor students' reading, and their capacity to demonstrate in writing their understanding of the core content areas of math, science and social studies. The attention paid to academic progress, as well as to monitoring attendance and discipline, provides staff with a fuller picture of student progress. Effective programs recognize that fundamental improvement takes time. Despite high standards and strong academics, students' test scores may waver from year to year and it may take several years to improve the performance of the neediest students.

On Supporting Success

State educational agency staff and school district staff can support the development and continued success of schoolwide projects through providing strong leadership and resources for planning, implementing, and evaluating the success of projects. They can identify and share successful approaches to team building and planning, staff development and technical assistance resources and encourage the formation of networks of schools using similar approaches. Some States have developed guidance on planning for a schoolwide project, with particular attention paid to conducting thorough needs assessments and identifying early on how districts will support schools in their efforts. States have also suggested types of instructional reforms schools may wish to undertake.

Districts can assist schools in developing their schoolwide plans, deciding on components most essential to improving achievement in the school. District staff can also hold training sessions for school teams interested in developing schoolwide projects and can provide information to school teams on other sources of technical assistance and professional development. While providing much more information and assistance on successful schoolwide approaches and planning processes, States and districts need to also provide greater flexibility and make certain their auditing, accreditation, and review procedures compliment, not stifle, successful whole school projects.

Copies of Implementing Schoolwide Projects: An Idea Book are available by writing the Planning and Evaluation Service, U.S. Department of Education, 600 Independence Ave. SW, Rm. 4162, Washington, D.C. 20202.

JOINT STATEMENT ON SCHOOL HEALTH

by

The Secretaries of Education and Health and Human Services

Health and education are joined in fundamental ways with each other and with the destinies of the Nation's children. Because of our national leadership responsibilities for education and health, we have initiated unprecedented cooperative efforts between our Departments. In support of comprehensive school health programs, we affirm the following:

- ***America's children face many compelling educational and health and developmental challenges that affect their lives and their futures.***

  These challenges include poor levels of achievement; unacceptably high drop-out rates; low literacy; violence; drug abuse; preventable injuries; physical and mental illness; developmental disabilities; and sexual activity resulting in sexually transmitted diseases, including HIV, and unintended pregnancy. These facts demand a reassessment of the contributions of education and health programs in safeguarding our children's present lives and preparing them for productive, responsible, and fulfilling futures.

- ***To help children meet these challenges, education and health must be linked in partnership.***

  Schools are the only public institutions that touch nearly every young person in this country. Schools have a unique opportunity to affect the lives of children and their families, but they cannot address all of our children's needs alone. Health, education, and human service programs must be integrated, and schools must have the support of public and private health care providers, communities, and families.

- ***School health programs support the education process, integrate services for disadvantaged and disabled children, and improve children's health prospects.***

  Through school health programs, children and their families can develop the knowledge, attitudes, beliefs, and behaviors necessary to remain healthy and perform well in school. These learning environments enhance safety, nutrition, and disease prevention; encourage exercise and fitness; support healthy physical, mental, and emotional development; promote abstinence and prevent sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended teenage pregnancy; discourage use of illegal drugs, alcohol, and tobacco; and help young people develop problem-solving and decision-making skills.

- ***Reforms in health care and in education offer opportunities to forge the partnerships needed for our children in the 1990s.***

  The benefits of integrated health and education services can be achieved by working together to create a "seamless" network of services, both through the school setting and through linkages with other community resources.

- ***GOALS 2000 and HEALTHY PEOPLE 2000 provide complementary visions that, together, can support our joint efforts in pursuit of a healthier, better educated Nation for the next century.***

  GOALS 2000 challenges us to ensure that all children arrive at school ready to learn; to increase the high school graduation rate; to achieve basic subject matter competencies; to achieve universal adult literacy; and to ensure that school environments are safe, disciplined, and drug free. HEALTHY PEOPLE 2000 challenges us to increase the span of healthy life for the American people, to reduce and finally to eliminate health disparities among population groups, and to ensure access to services for all Americans.

In support of GOALS 2000 and HEALTHY PEOPLE 2000, we have established the Interagency Committee on School Health co-chaired by the Assistant Secretary for Elementary and Secondary Education and the Assistant Secretary for Health, and we have convened the National Coordinating Committee on School Health to bring together representatives of major national education and health organizations to work with us.

We call upon professionals in the fields of education and health and concerned citizens across the Nation to join with us in a renewed effort and a reaffirmation of our mutual responsibility to our Nation's children.

Richard W. Riley
Secretary of Education

Donna E. Shalala
Secretary of Health and Human Services

SCHOOL-BASED HEALTH SERVICES

ISSUES TO BE ADDRESSED BY HEALTH CARE REFORM AND OTHER FEDERAL LEGISLATION

June 28, 1994

A REPORT OF THE SCHOOL HEALTH SERVICES ANALYTIC PROJECT PANEL

Christel Brellochs
Gary Clarke
Beverly Farquhar
Deborah Frazier
David Kaplan
Julia Lear
Susan Lordi
Sarah Shuptrine
Candace Sullivan
Donna Zimmerman

The School Health Services Analytic Project Panel was convened by the U.S. Department of Education and the U.S. Department of Health and Human Services to address important questions concerning issues related to reimbursement for school health services in a changing health care environment. The opinions and recommendations contained in this report are those of the panel and do not necessarily represent the position of the U.S. Department of Education or the U.S. Department of Health and Human Services. Neither the U.S. Department of Education nor the U.S. Department of Health and Human Services endorses any particular product, service, or organization.

SUMMARY

The School Health Services Analytic Project Panel strongly urges that the Health Security Act and other health care reform legislation explicitly recognize the place of school-based health services in the overall health care system. The Panel is unanimous in its view that school health services, including the delivery of primary care services, can play a critical role in the healthy growth and development (and later health and success) of school-age children and youth. It is our belief that states and localities must be given the flexibility to design service delivery systems that recognize local needs and resource capacity. To these ends, we have made a series of recommendations regarding how health care reform can encourage and support appropriate school health services as part of an efficient and effective health care system for children and youth.

Recommendations regarding the delivery of health care services:

- We call for mandating the formation of state and local-level School Health Resource Partnerships to assure that major stakeholders in communities (including all parties involved in caring for school-age children and paying for that care) to come together to assess the needs of school-age children; analyze available resources; and agree on what should be done at the school site for children, who should do it, and who should pay for it.

- We recommend the creation and widespread dissemination and utilization of management information systems and practice management systems for quality assurance and cost effectiveness assurance.

- We propose research and analysis to give us the information we need to create more effective health care systems for school-age children and youth over time.

- We argue that all school-based health centers (SBHCs) that meet Title III requirements should have the same status as SBHCs funded under Title III.

Recommendations regarding services:

- We urge mechanisms be established to finance preventive services including more flexible use of categorical funds and a health insurance set-aside to fund public health programs for school-age children and youth.

- We ask that clinical health services for children with disabilities be included in the basic benefits package for children and youth.

- We call for a packaged capitated approach to pay for a variety of relatively low cost individual and group, age-appropriate therapeutic mental health services (including higher level counseling) to be included in the basic benefits package. More intensive services would be funded under regular provisions of Health Care Reform.

Failure of health care reform to explicitly address school health services could have extremely negative consequences. In some communities, schools and school-based health centers (affiliated with schools, but not generally operated by them) are meeting critical needs in three areas: 1) clinical health services (ranging from screening and immunizations provided by school nurses to primary health care provided by school-based health clinics); 2) clinical, rehabilitative, and specialized physical health care services for students with disabilities (many of which are required by law to be delivered in school sites); and 3) public health services (including outreach where needed and health education).

These services are being provided by a variety of health professionals, (typically under the supervision of a school nurse in general school health programs or a physician and nurse practitioner team in school-based health centers). Or, they may be provided by a multi-disciplinary team that includes a nurse practitioner or physician assistant, a mental health professional, and a physician.

School health programs are organized and paid through a variety of mechanisms and institutions. Increasingly, schools are becoming Medicaid providers, and Medicaid reimbursement is essential to the financial survival of many school health programs. Many of these schools have been billing Medicaid for legally mandated health services for children with disabilities and will face budget crises if they have to substitute education dollars for health dollars. School-based health centers similarly depend on ability to bill Medicaid and other insurers for services provided to students.

Where they exist, school-based health services often demonstrate a value added to the health care system in their community. They both increase young people's access to services and enhance effectiveness of services. Students who do not ordinarily seek needed health care obtain services from school health providers.

Unfortunately, health care reform could have the unanticipated effect of undermining the ability of schools to provide students with needed health services at the very time when education and health agencies recognize such programs to be essential to the health and school success of many young people. With the advent of managed care, health plans will receive Medicaid and other insurance payments currently going to schools unless schools negotiate reimbursement agreements with them.

School health providers that offer efficient and effective quality care for children and

youth should be strong candidates for reimbursement from indemnity insurers and managed care plans for certain preventive and primary services that (for some populations) are best delivered at school sites. However, few school health care providers have the capacity to negotiate reimbursement agreements with the multiple health care plans in which their students are enrolled.

Nor are there sufficient incentives in health care reform proposals to stimulate health care plans to take the initiative in working out agreements with many school health programs. Currently, essential community provider (ECP) status is proposed under the Health Security Act for providers that meet certain criteria, including school-based health centers. Indemnity insurers and managed care providers will be required to reimburse ECPs for covered services. However the ECP designation only affects the minority of school health programs that are primary care providers funded under the Health Security Act. Furthermore, there are limitations to ECP status, as it is only a five year temporary designation.

We make our observations and recommendations with confidence. Together we represent critical stakeholders in health care reform as it affects school-age children -- state health departments, state Medicaid authorities, major health maintenance organizations, state education agencies, local education agencies, the school nursing profession, school health programs, school health programs for children with disabilities, school-based health centers, and education and health policy analysts. In addition, we bring valuable practical experience to bear on actually implementing state, local, and direct health service programs for children and youth.

Our charge did not include addressing the dilemma posed by large numbers of undocumented students. We would note, however, that providing and financing health services to these students is an important future agenda item.

RECOMMENDATIONS

The Panel was charged with addressing important analytical questions related to the school health services component of the Health Security Act. While our recommendations focus on the Health Security Act, they are equally applicable to other health care reform proposals. Specifically, recommendations focus on improving the health care delivery system for school-age children and defining an affordable basic benefits package that meets their needs.

Recommendations related to the health care delivery system

Recommendation #1: Mandate the formation of state and local-level School Health Resource Partnerships to assure that major stakeholders in communities (including all parties involved in caring for school-age children and paying for that care) come together to assess the needs of school-age children; analyze available resources; and agree on what should be done at the school site for children, who should do it, and who should pay for it.

The advent of health care reform (HCR) with its movement towards more universal coverage and managed care brings with it both opportunities and challenges. Actions must be taken now if school-age children are to benefit from these changes. The President's plan proposes a five year transition period between the current system and the emerging HCR system (particularly related to essential community providers). We propose that states take advantage of this transition period to put in place mechanisms that assure the unique needs of school-age children are adequately defined and addressed in emerging health care systems.

Currently, in some communities school health services are meeting critical needs in three areas: 1) clinical health services (ranging from screening and immunizations provided by school nurses to primary health care provided by school-based health clinics), 2) rehabilitative and health services for students with disabilities (many of which are required by law to be delivered in school sites), and 3) public health services (including infection control, outreach, and health education). A number of schools and other school-based health care providers are receiving reimbursement from Medicaid and other third party payers for many of these services.

With health care reform, more students will have health insurance with managed care plans and indemnity insurers, depending on how the states implement health care reform measures. Issues will arise regarding the extent to which public and private

insurers will reimburse schools and other providers to provide students with preventive and primary health services and at what rate. In some instances, services could be duplicative or redundant. There will be a need to sort out redundant services and rationalize the system of child health care in the community. States must take the lead role in assuring that this occurs. Financing of this "rationalized" system would be provided through a combination of indemnity insurance and managed care plans, grants, reallocation of other health funds, and other mechanisms.

It is essential that the onus not be placed on individual schools and school-based health centers (SBHCs) alone to put together a funding package for a full spectrum of school-based health services. In many instances this would require school health services providers to negotiate agreements with multiple indemnity insurance providers and health care plans. Few have the expertise or clout to do this effectively. Furthermore, this is not the most cost effective manner to assure that children's health needs are met through health care reform.

One way to assure the health needs of school-age children are met is for the federal government to require states to assume the role of convener for the various parties responsible for providing and financing health services to children and youth in schools. They could be charged to develop a mechanism whereby localities are encouraged and supported to put together various state and local funding sources (e.g., mental health, substance abuse, indigent funds, tax levy funds, IDEA, etc.) and private funding sources (all health plans serving affected students, etc.) to devise various payment mechanisms that will assure that student preventive and primary health care needs are met efficiently and effectively.

This should create the conditions whereby those who care for children and those who pay for that care work with each other and appropriate regulatory authorities to assure services to school-age children are provided in the most effective manner. If major stakeholders come to the table, decisions regarding various provider and community roles and responsibilities can be reached and implementation issues ironed out in a way that takes into account state and local student health needs and provider capacities.

Specifically, Health Care Reform could include provisions that:

1) A state administrative unit would be responsible for ensuring that a state-level School Health Resources Partnership is organized which brings together insurers; public and private health care providers (including school-based providers); and state officials with responsibilities for health, mental health, education, social services, and other appropriate programs. The purpose of the partnership would be to identify the unmet health care needs of school-age children, identify the most appropriate providers of that care, agree to linkages among the different sites of service and providers of

service, and develop plans for financially supporting the delivery of those services.

Similar partnerships would be established at the local level. Responsibility for organizing the local partnerships would be delegated to a county or other geographic sub-division that is a catchment area for one or more plans. States will develop membership criteria for local partnerships that assure representation from all local school districts, providers of school health services, other pediatric providers and mental health professionals in the community, health care payers, parents, and other community stakeholders. In some instances, the state may ask the local jurisdiction to build on existing health related advisory committees required by Chapter One, Head Start, Migrant Program, and IDEA.

2) The state insurance regulatory agency would require, as a condition of licensing, that insurers must participate in planning for and financing of health services delivered in schools.

3) The education system, the health department, the mental health agency, the social services department, and other agencies that serve school-age children would also participate in planning for and financing of health services delivered in schools.

4) The state will outline functions for the School Health Resources Partnership. These should include:

- Conducting an inventory of the health care needs of school-age children, the services currently available to meet those needs, and the gaps in care that might best be addressed in a school setting. Services to be included are preventive care, primary care, mental health services, rehabilitative services, and services that support public health standards.

- Analyzing the funding sources and levels of support for current services, including a review of insurance status of school-age children.

- Negotiating a menu of services for school-age children (and identifying sources of funding for those services) that takes into account the need for early access, outreach, case coordination, and interventions to reduce risk-taking behaviors. Services should also take into account the need for reducing barriers to enrollment, promoting cost effectiveness, and meeting heath plan requirements.

- Authorizing health care providers to use a variety of personnel to provide health care in schools provided that the health staff have appropriate training and supervision to assure quality and safety.

- Addressing operational issues, e.g., the need for automated data/information

systems that allow efficient communication among various payers and providers.

- Negotiating more efficient payment systems for school-based services, e.g, moving from contracting for reimbursement and fee-for-service claims processing to capitation (that takes into account rate adjustments and more comprehensive services).

- Developing a child health report card for school-age children and reporting to the state on defined child health care utilization and outcome measures.

5) The state will use a variety of authorities and resources to enable members of the School Health Resources Partnerships to participate in health care arrangements. These should include:

- Awarding ECP status to school health care providers (would require indemnity insurance providers and managed care plans to negotiate with providers of school-based health care).

- Defining and supporting the implementation of public health mandates related to school-age children.

- Using a range of public health, mental health, social services, education and other state programs and authorities to meet the health needs of school-age children.

- Identifying the service needs of students with disabilities and assuring that the school-based health services can assist the health plans in meeting their obligation to provide (or cause to be provided) the services that these children need.

6) Federal legislation would explicitly recognize the place of school-based services in the overall health care system through providing ECP status to school health care providers as appropriate and other means. In addition, the federal government would mandate School Health Resource Partnerships and encourage and support state initiatives through a combination of incentives and removal of unnecessary regulatory and other barriers.

Recommendation #2: Create a comprehensive system to monitor the quality and cost effectiveness of program performance.

- School Level. The base for the system should be a management information system which records data on the delivery of health services. The MIS would

document the range of services provided, permit easy billing, and summarize data reated to provider productivity, case management, and high risk behaviors.

While process-oriented MIS are available, outcomes systems (or components of systems) have not been developed. The identification of outcomes measures for school health services need to be developed in concert with the HETUS and HCQUIS monitoring systems being assembled by the National Committee on Quality Assurance and the Health Care Financing Administration.

- Community Level. At the community level, the local School Health Resource Partnership or its designee should draw upon school/clinic-level data as well as other data sources to monitor the extent to which school-based health providers as well as other community providers are achieving community objectives regarding efficient and effective health services.

- State Level. At the state level, there should be uniform reporting requirements that would permit the state-level School Health Resource Partnership or government agencies to create "report cards" or other accountability systems. (Note: Panel members are keenly aware of the importance of sophisticated understanding of reported data. For example, in the case of outreach, compliance data may or may not indicate effective outreach. Middle class areas can have a 90% compliance rate and no outreach, while a poor community may have a 60-70% compliance rate and may be an example of exceptional outreach.) Attention must be paid to qualitative as well as quantitative aspects of data collection and analysis.

Recommendation #3: The federal government in cooperation with the states should commission or conduct analyses that address the following subjects in order to assure that existing school health mandates and programs are necessary and effective, and to provide a basis for developing less expensive, more logical ways to deliver services:

A. Review school health mandates across the country, assess their cost-effectiveness, and make recommendations concerning which mandates might be dropped of shifted to another level of responsibility in the community.

B. Analyze how various states are providing and financing special education and other health services for children with disabilities.

C. Make immediate recommendations regarding provider qualifications and services delivery options to inform Congress as it considers reauthorization of IDEA.

D. As needed, obtain additional information on:

- o the current roles, responsibilities, scope of practice, level of preparation of current school health providers, and the associated costs of school health services,
- o the types and levels of school health services currently being provided,
- o the types and levels of providers offering these services,
- o available labor pools for various types of school health providers,
- o funds currently expended on school health services and their sources,
- o changing requirements for school health services (particularly in light of HSA),
- o implications for changed roles and responsibilities of various school health providers, and
- o alternative, less expensive approaches to providing school health services and clinical, rehabilitative, and specialized physical health services (e.g., roles for paraprofessionals operating under supervision).

E. Document and describe state Medicaid differences in terms of services coverage for children and reimbursement mechanisms being used by Medicaid service providers to recover costs. Also describe regional HCFA variations in authorizing such coverage and reimbursement mechanisms.

F. Consider how the federal government might encourage appropriate school-based health services while not creating barriers to school and community efforts through inappropriate mandates and or regulations. Explore how various government agencies and programs with responsibilities for school-based health services might become positive models of cooperative behavior (as contrasted with turf protection-oriented behavior).

The results of the study or analysis should be the basis of a national initiative to define the school's role in our overall national health care strategy that includes identifying clinical and public health roles to be played by schools.

Some of the above questions may be answered by the Macro International "School Health Policies and Programs Study" and the survey of school nurse administrators being conducted by the University of Colorado.

Recommendation #4: All SBHCs that meet Title III grant requirements should have the same status within the health care financing system as Title III SBHCs

Options for accomplishing this include:

- Creation of "look-alike" status for SBHCs.

- All existing and new SBHCs could be eligible for $1.00 grants under Title III or small scale grants to allow established SBHCs. The former would allow the SBHC to qualify for Title III and Title I benefits at minimal cost to the government. The latter would provide SBHCs with support to "round out" a program as well as qualify them for Title III and Title I benefits.

Recommendations regarding services

Recommendation #5: Establish mechanisms to finance preventive services

Preventive services are essential to the health of young people, yet are seldom reimbursable under health insurance. A combination of strategies should be considered for assuring these services are provided. They include:

- Encouraging more flexible use of new and existing public categorical funds that might support health education and preventive interventions. Such funds include the Maternal and Child Health Block Grant, the High-Risk Youth Demonstration Program, CSAT Adolescent Initiative, the Substance Abuse Block Grant, Critical Regulations Program, the Mental Health Services Block Grant, the Child/Adolescent Service System, Drug Free Schools and Communities, Drop Out Prevention Demonstration, Special Education, Mentoring Program (JJDP, Act 9, 1992), and other federal initiatives.

- Providing a health insurance set aside to finance special preventive programs, including school health programs.

Implicit in this recommendation will be the establishment of standards regarding effective preventive health services.

Recommendation #6: All clinical health services for children with disabilities, including services provided in schools should be included in the basic benefits package.

- The federal government must clarify roles and responsibilities of health and education vis a vis health services for children with disabilities. The IDEA legislation is largely responsible for this problem in that it makes local and state education responsible for providing virtually all health services to children with disabilities, yet pays only about 7% of the cost. This creates a financial hardship for schools and an uncoordinated health service system for children with disabilities (because there is seldom a link between school and other health care providers).

- The HHS Secretary needs to establish standards for long term clinical, rehabilitative, and specialized physical health care services for all children with disabilities with quality assurance provisions. This effort should be undertaken in coordination with the Department of Education.

- Where health care plans provide health services essential to keep children in school, compliance must be monitored to assure parents of children with disabilities that their children are receiving the services they require. For IDEA students, it will be mandatory that health care plans establish connections with schools to assure that students receive the clinical health services they need whether or not such services are essential for them to benefit from special education services.

- The criteria "medically necessary" is not an appropriate method of limiting or regulating services to children with disabilities. Many of these children have need for long term clinical, rehabilitative, and specialized physical health care, eg., speech therapy. OT, PT, RT, private duty nursing, skilled nursing, unlimited home health, and durable medical equipment. Such services need to be available without restrictions as to numbers of visits or other coverage limitations.

  In addition, funding is needed to provide individual and group training and support to parents and other adults who care for children with disabilities outside of school settings. Such funding would not be an entitlement because it would be too difficult to control costs.

Recommendation #7: For children and youth, include mental health services in the basic health care reform benefits package. Also, modify Title III to explicitly include mental health services.

Current HSA provisions are unclear regarding mental health services coverage. In order to assure access to mental health services, we recommend a packaged capitated approach to pay qualified school-based mental health providers to offer students that

need them a variety of relatively low cost individual and group age-appropriate therapeutic mental health services. These include higher level counseling and mental health services of a preventive nature, not just psychotherapy for diagnosed disorders. More intensive services would be funded under regular provisions of Health Care Reform.

A structure is needed so that SBHCs and schools are accountable for the provision of a range of mental health services, and to avoid unnecessary diagnosis and treatment of students to obtain revenue. The current methods for reimbursement of mental health services are treatment driven, which is very limiting for children and youth. Specifically, providers are under pressure to provide students with services that can be reimbursed for relatively easily. This may result in unnecessary and inappropriate labeling of a student and\or providing more costly or less effective services.

QUESTION 1: How should the Health Security Act support the delivery of comprehensive health services in a school setting through school-based health centers within the context of health care reform?

ISSUES

1. What process should be established for SBHCs not funded through Title III of the HSA to become eligible for reimbursement (become an ECP) while assuring quality control?

All SBHCs that meet Title III grant requirements should have the same status as recipients of grant awards under Title III. Options for accomplishing this include:

- o Creation of "look-alike" status for SBHCs

- o All existing and new SBHCs could be eligible for $1.00 grants under Title III or small scale grants to allow established SBHCs. The former would allow the SBHC to qualify for Title III and Title I benefits at minimal cost to the government. The latter would provide SBHCs with support to "round out" a program as well as qualify them for Title III and Title I benefits.

2. What are the relative advantages and disadvantages of possible reimbursement mechanisms -- cost-based, fee-for-service, capitation rates -- in a managed care environment considering issues of quality, confidentiality and cost efficiency?

There is consensus that the form of reimbursement (cost-based, fee-for-service, capitation rate) should be determined at the local level through negotiations with school health care providers, indemnity insurers, and managed care plans.

We don't yet know what reimbursement levels are reasonable for SBHCs as current reimbursement under fee-for-service programs reimburses for diagnosis and treatment only, usually according to the Medicaid or similar fee schedule. Also, we have limited data on program costs in different locations. We need to work towards developing a range of acceptable costs, keeping in mind the importance of cost efficiency.

Advantages/disadvantages of various approaches are:

- Capitation

  Capitation allows greater flexibility and innovation in service delivery and provides a reliable and easy way for health centers to bill for a package of

  services. However, without performance standards and service requirements, capitation may lead to incentives to underserve and not collect important data.

  Capitation involves significant initial administrative time to establish a rate. An advantage of a capitated approach is the ability for SBHC to negotiate a larger package of services for the student enrollees. Confidentiality, however, must be maintained in whatever type of information is submitted for payment.

- Fee-for-Service

  Currently, only a small number of SBHCs bill for services. Notwithstanding, if the revenue potential is great enough and any administrative and legal constraints are removed, the centers will "learn" to bill. Fee-for-service billing is complex and expensive, and involves comprehensive reporting of information. Fee-for-service contains incentives to report and provide billable services, and is treatment-driven. Also, fee-for-service reporting generally does not reflect the broad preventive health and mental health services being provided by SBHCs.

- Cost-Based

  Cost-based reimbursement, such as currently given to federal clinics and federally-qualified health centers, requires more complex accounting and reporting than traditional fee-for-service or capitation options. Most SBHCs are not set up to administer cost-based reimbursement. Furthermore, many schools may have high costs that will make the cost of cost-based reimbursement arrangements with managed care plans prohibitive.

  Cost-based reimbursement discourages cost consciousness by providers, but also may be adjusted by regulators to pay for less than providers actually incur. A real problem with this option is that we do not know what costs ought to be. Notwithstanding, community-based health centers receive cost-based reimbursement and want to maintain it when working with schools.

Health centers and managed care plans could potentially negotiate toward reimbursement of costs in a general capitated rate. This will involve extensive discussions around the types of services to be reimbursed and what constitutes a

reasonable cost.

3. Should there by a standard benefits package provided by all SBHCs? Should there be several "packages" of services?

A SBHC is not a SBHC unless it offers a comprehensive package of preventive and primary health care services, counseling (including mental health and substance abuse counseling), social services, and health education. Service delivery specifics should be determined at the local level through an assessment of the physical and psychosocial needs of children and adolescents and the existing resources in the community.

Different levels or packages of services that exceed the basic comprehensive services package is a local option.

4. How, if at all, can the set of "core services" described in the HSA be more clearly defined in order to facilitate developing a reimbursement mechanism for SBHCs?

Mental health services need to be defined. We recommend a packaged capitated approach to pay for qualified school-based mental health providers to offer students that need them a variety of individual and group age-appropriate therapeutic mental health services (including higher level counseling). Accompanying this should be an accountability system that assures SBHCs do not bill inappropriately simply in order to increase revenues. (See Recommendation #7.)

5. How will the coordination of services and financing for SBHCs be accomplished under a managed care system? Should provisions be made for SBHCs to be reimbursed or otherwise financed to exceed core services? How should regional variation in medical costs and variation in the package of services offered at SBHCs be addressed?

The panel recommends the formation of state and local School Health Resource Partnerships with the responsibility to coordinate health insurance, education, public health, mental health, and other programs and authorities providing school health services. Their charge would be to develop a mechanism whereby localities (with state support) are encouraged to put together various state and local funding sources (e.g., mental health, substance abuse, indigent funds, tax levy funds, Medicaid, IDEA, etc.) and private funding sources (all health plans serving affected students, etc.) to devise various payment mechanisms that will assure student preventive and primary health

care needs are met efficiently and effectively.

This mechanism would bring major stakeholders, including SBHCs, to the table to make decisions regarding various provider and community roles and responsibilities for student health. If a decision is made for SBHCs to exceed core services, arrangements would be made by the various partners to finance such services. Such a mechanism would allow adjustments for regional cost variations and package differences.

Recommendation #1 provides more details on how partnership mechanisms would operate.

6. What can be done to enhance the administrative capacity of SBHCs, especially in the area of efficient billing and collections?

Title III can mandate that SBHCs bill to the extent possible. This is the only way to save valuable flexible Title V and grant dollars. Some SBHCs are better positioned to bill than others. For example, SBHCs with sponsoring agencies that bill (hospitals, acute care providers) know how to bill and have to make it clear to the SBHC that it is expected to bill. Those sponsored by public health departments and schools are less experienced in billing. It is essential that they be provided technical assistance.

An important issue to be addressed regarding billing for adolescent services is assuring appropriate confidentiality. It is essential for states to require the suppression of billing information and statements sent home by insurers on confidential services. This practice currently limits billing in most SBHCs, and forces them to use other grant funds to supplement Medicaid, etc.

What is really required, however, are SBHC practice management systems. Recommendation #2 proposes the creation of a comprehensive system to monitor the quality and cost effectiveness of program performance.

7. Are there steps that could be taken to contain the administrative costs associated with working with numerous health plans?

Recommendation #1 addresses how administrative costs associated with working with numerous health plans can be contained. Specifically, it suggests the formation of School Health Resources Partnerships to assure that major stakeholders in communities (including all parties involved in caring for school-age children and paying for that care) come together to assess the needs of school-age children; analyze available resources; and agree on what should be done at the school site for children, who should do it, and who should pay for it.

8. Similarly, what can be done to contain the executive costs of negotiating with managed care entities or pursuing grant support for non-reimbursable services?

The School Health Resources Partnerships proposed in Recommendation #1 will similarly contain executive costs.

9. If funding for SBHCs is not incorporated in the HSA, yet Congress wants to encourage the development of SBHCs, what options does it have?

- Let Title III stand on its own, with its own legislation.
- Require existing programs to give greater priority to primary care, particularly training and medical education programs.
- Expand and use the National Health Service Corps.
- Encourage Community Health Centers and Rural Health programs to use their grant support to help establish school-based health centers.
- Do more with state health and education departments.
- Change existing categorical programs to encourage establishment of SBHCs, e.g., change Title V and Mental Health requirements.
- Encourage states to examine the possibility of investing Title V block grant funds in school-based health centers as do Louisiana, Colorado, Oregon, New York, and Connecticut.
- Encourage the Agency for Health Care Policy and Research, HHS to focus on aspects of delivering health care at school sites.
- Implement the recommendations of the Office of the Inspector General, HHS on School-Based Health Centers and Managed Care.
- Request that HCFA look at the impact of 1115 waivers of the development of school-based health centers.
- Request a study by the Division of Nursing to examine the impact of various state Nurse Practice Act provisions on staffing school-based health centers.
- Conduct and disseminate a thorough study of funding sources for school-based

health centers, looking especially at state and federal sources.

QUESTION 2: How should the Health Security Act support the delivery of comprehensive health services in school settings beyond supporting school-based health centers?

ISSUES

1. What school health services lend themselves to HSA funding?

The level of school health services offered by schools varies significantly by state, locality, and school population. Services include: 1) clinical health services (ranging from screening and immunizations provided by school nurses to primary health care provided by school-based health clinics, 2) clinical, rehabilitative, and specialized physical health care for students with disabilities, and 3) public health services (including outreach where needed and health education).

Services that lend themselves to HSA funding are clinical services and certain preventive services covered under the basic benefits package such as health screenings and immunizations.

Where schools assume roles for clinical services, it is essential to avoid duplication -- funds going to both schools and health care plans for the same services. This could occur where managed care plans receive prospective reimbursement for preventive and primary care as well as other services. Some of these same services may be being delivered by school-based health care providers, often supported by grants and other appropriations.

It is also essential to assure that there is one responsible party for each health care plan enrollee who is aware of the full range of health needs of the enrolled individual and monitors the individual's health.

2. What services currently covered by Medicaid are unlikely to be covered by HSA?

Some states are currently funding schools for targeted case management and administrative case management, particularly with respect to the developmentally disabled, chronically ill, and homeless. Such services are deemed necessary to the proper and efficient management of the Medicaid system and include outreach, triage, and pre-screening and enrollment. Administration and case management funds are not capitated and education funds provide the required match. In some communities, this frees up local dollars to serve uninsured students or address many otherwise un-

fundable needs of students.

The Health Security Act does not include provisions for reimbursing providers for targeted case management and administrative case management in the basic benefits package. The Health Security Act proposes a wrap-around policy to assure that low income AFDC and SSI-eligible children will not lose services currently available under Medicaid. However, the wrap-around is undefined and may or may not include case management. Furthermore, the wrap-around is apparently limited by budget and also potentially limited by the Secretary's definition of "medically necessary."

In addition, for children with disabilities, some services such as provisions for one-to-one care provided by nurses and paraprofessionals have serious limitations regarding numbers of visits and duration of services. Also, some social and family services allowed under ESPDT under certain circumstances are not included in the HSA.

3. What IDEA services are unlikely to be covered by HSA?

Many IDEA-required services may not be picked up under the HSA. The original HSA eliminated a number of rehabilitative and other services for individuals with disabilities. The current proposal for a wrap-around insurance for low income children and youth would solve some problems. However, even the most recent version is unclear regarding the level and length of rehabilitative services to be provided. It is unclear how well services for the disabled will fare under other health plans.

Other services authorized under IDEA such as family counseling, development of parenting skills, and group support services are unlikely to be provided under HSA.

4. What other school health services are unlikely to be covered by HSA?

Today's vulnerable children and families need a wide range of mental health services ranging from high level counseling to medication for depression. The HSA is not clear about what services are to be covered. The Panel has recommended that mental health services for children and youth be included in the basic benefits package and that Title III be modified to explicitly include mental health services. It proposes a packaged, capitated approach to funding such services (See Recommendation #7).

Many other services provided by school health programs fall under the category of public health functions and are unlikely to be funded under HSA.

5. In the case of services that lend themselves to HSA funding, what mandates,

incentives, and mechanisms might be established to encourage indemnity insurers and managed care providers to reimburse schools for certain health services, establish satellite clinics at or near school sites, and strengthen outreach services by working with schools?

The panel has recommended the formation of state and local School Health Resource Partnerships to address this issue. See Recommendation #1.

Another way to encourage health care plans to work with schools towards mutual aims is for states to require plans to spell out how the plans are to achieve access and other required objectives.

Plans should also be asked how they will address such issues as transportation and interpretative services for patients or services at school sites for children with disabilities. This will provide schools an opportunity to argue that they can help the plan meet its requirements while providing higher quality services at lower cost. To this end, states should be prepared to monitor grievances and compliance with access requirements. Health plans should be reimbursed for higher costs through the HSA's risk adjustment provisions and capitation provisions.

6. What can be done to enhance the administrative capacity of schools, particularly in the area of efficient billing and collections? Similarly what can be done to contain the executive costs of negotiating with managed care entities or pursuing grant support for non-reimbursable services?

Recommendation #1 suggests the formation of School Health Resources Partnerships to assure that major stakeholders in communities (including all parties involved in caring for school-age children and paying for that care) come together to assess the needs of school-age children; analyze available resources; and agree on what should be done at the school site for children, who should do it, and who should pay for it. Arrangements reached may obviate the need for complicated billing systems. In any case, schools will not be required to negotiate separately with multiple health care providers.

7. What school health services currently being supported with federal funding and/or private insurance funding are unlikely to be covered by HSA?

In addition to those discussed in questions 1-4, the HSA could have the unanticipated effect of reducing the incentive of schools to engage in school health services. Specifically, in recent years a number of schools have accepted new roles and responsibilities regarding certain school-based services because they could be

reimbursed for providing these through EPSDT and other mechanisms. If the promise of funding evaporates, so may the motivation to make health services a priority.

Similarly, those schools which have worked out arrangements to become Medicaid providers may see all their efforts in this regard come to naught as other health care providers assume responsibilities for their students, resulting in no guaranteed health services funding for schools. Those schools which have developed good programs may have to abandon them for lack of guaranteed resources to operate them.

8. If funding for certain school health services is not incorporated in HSA, yet Congress wants to expand these services, what options does it have?

Congress and the Executive Branch could reconceptualize school health services by differentiating between clinical and public health services provided by the school. Those clinical services should be paid for under HSA. However, public health services require other funding strategies -- probably a combination of local school district, local health department, federal, and other funds. In Recommendation #5, the panel proposes two possible mechanisms to finance preventive services -- encouraging more flexible use of categorical funds and providing a health insurance set aside to finance special prevention programs.

One action Congress could take would be to encourage the Department of Education and Health and Human Services to take a more collaborative approach to funding of school health programs. Currently, the various federal agencies and programs with responsibilities for school health programs operate with minimal communication and coordination (and sometimes unhealthy competition). There are limited opportunities for federal officials to interact with states and localities that have developed effective school health programs. Thus, some federal policies, programs, and regulations may have the unintended effect of undermining local initiatives.

To date, federal funds have been highly categorical, focusing on specific diseases or health problems. Localities need to be give the flexibility to combine funding streams and use categorical funds to support a more comprehensive and holistic approach to health education and health services. The HSA provides waiver authority that could facilitate this.

To this end, it is important not to enact new requirements or establish new programs that do not support a rational system. For example, it makes little sense to require Chapter I to be a payer of last resort of health screenings if no funds are available for treatment or follow-up. Additional funds for new categorical programs (e.g., demonstration funds for various health education and school health services projects) might be better spent in strengthening the school health service and public health

systems generally. Rather than appropriating "glue money" for new categorically-funded positions in schools, consideration should be given to encourage schools to make systemic changes in existing school positions, e.g., enhancing the school nurse's program manager function.

The federal government has very little information with which to make informed decisions on school health programs. The panel proposes that the federal government, in coordination with the states, conduct analyses to assure that school health mandates and programs are needed and effective and to provide a basis for developing less expensive, more logical ways to deliver services. Moreover, the need for leadership in this area, a well-planned effort in research, and priority setting in workforce development leads to a recommendation that a federal office for school health be established.

9. Does HSA have longer term implications for the content and staffing of school health services, e.g., does the function and preparation of the school nurse, school social worker, school psychologist, and other health professionals need to be redefined?

There is no question that roles and responsibilities of various health personnel need to be rethought in light of the passage of the HSA and changing needs of today's vulnerable children and families. They also need to be rethought in light of technological advances that allow automated records and tape to tape matches (thereby reducing redundant collection of information such as immunization records). This is another priority area for analysis.

10. Does it make sense to fund health services separate from funding "access" to services (case management, identification and referral)? If so, how might funding mechanisms vary?

A basic question is whether we want to view the school as a basic epidemiological unit to fulfill a certain level of public health for children. If so, we need to look at our health care system for children and youth more holistically. Fleshing out the public health component is a major challenge. Doing this will require a multitude of organizations and agencies to come together with health care plans to determine how best to meet the needs of children and youth. Solutions will vary depending upon local conditions and capabilities. Increasing the amount of funding available for preventive services (Recommendation #3) would provide a critical source of funding for public health-type school health services.

It is possible to separate "access" to services from health services. Health

professionals, however, need not be the ones to provide such services. Non-health professionals (including individuals from the community with little formal education) can be extremely effective in motivating families to take advantage of health services and can be highly cost effective.

QUESTION 3: If health related services which are funded by existing federal programs (Medicaid, Title V and IDEA) and across state and local programs are delivered through a managed care model under HCR, is there a need to standardize the definition of "qualified provider"? What standard will be used and how shall it be formulated.

ISSUES

1. What are the current differences in provider credentialing requirements across Federal programs that provide health services in schools?

Professional schools and respective specialist boards set requirements. State licensure boards tend to adopt requirements set by specialist boards. For the most part, federal programs rely on state credentialing requirements. This is true for Medicaid, Title V and IDEA. The frustration that school health care providers experience with different professional requirements from IDEA, Medicaid, and other programs is a state-created problem.

Professionals set their own standards of professional competence through their national organizations. State licensing boards establish licensing requirements for professionals based in large part upon these standards. Licensure requirements for health professionals are rigorous.

In addition to state licensure, state certification is required for some professionals. This is particularly true in the case of education. School nurses and other school employee professionals providing school health services are also certified by the state education agency.

2. Do these differing requirements create barriers to service delivery and/or financial reimbursement for school health services to schools currently providing services? For example, the requirements for "qualified provider" under Medicaid are different that the acceptable standard under IDEA. This discrepancy impacts both contracting and honoring procedural safeguards under IDEA.

Differing state requirements do create barriers, sometimes deliberately. While many school-based health care providers want to receive Medicaid reimbursement for services, many state Medicaid officials are reluctant to encourage Medicaid reimbursement for some of the following reasons:

1) They may not want to incur substantial additional draws on Medicaid resources.

They can avoid this by restricting reimbursement to services provided by specific licensed providers. For example, by restricting mental health service reimbursements to licensed psycho-therapists they have limited financial liability because there are few psycho-therapists practicing in schools. If they were to allow reimbursement for higher level counseling provided by a variety of practitioners, their costs would skyrocket.

2) They may be under pressure from certain interest groups such as physicians or pharmacists who want to protect their turf.

3) They may lack confidence in the quality of care provided by school-based health providers. They may not think they are buying quality or value-needed services when they reimburse schools.

Furthermore, there are inevitable tensions in suggesting that Medicaid should reimburse providers in educational settings when Medicaid generally restricts reimbursement to more intensively prepared professionals. Issues such as who is eligible to write in a medical record and who can be insured for providing health care are complicating factors.

It should be noted that none of these pressures are likely to disappear under Health Care Reform. They will simply be felt by a different set of players.

It also should be noted that where state Medicaid authorities want to reimburse a variety of school-based providers for a variety of services, they can do so (and have in some states). They have three extremely flexible categories of services that can be interpreted to cover most school-based health services -- rehabilitative services, clinical services, and case management (as well as the penumbra EPSDT OBRA '89 mandate).

3. What can be done to help school-based health care providers act to overcome state barriers?

First, governors, state education agencies (SEAs), and others can become far more informed about Medicaid so that they know what is possible under the legislation and what barriers exist to school-based health programs receiving Medicaid reimbursement for services. The Governor's Office, SEA, or other body (alone or in combination) can then take one of a number of tacks.

1) It can approach state Medicaid counterparts to negotiate differences.

2) If its negotiation efforts prove unsuccessful, it can rally political support for its position, e.g., inform and enlist local education agencies (LEAs), public health

agencies, education interest groups, advocacy groups, and other potential allies to urge modifications of Medicaid policies and programs to facilitate reimbursement of school-based health services.

3) It can be part of overall state and local effort to pull together parties with responsibilities for school-based health services to develop an overall response to the health needs of school-age children (see Recommendation #1).

4. What are the implications of conflicting provider qualifications under health care reform as it related to managed care quality standards?

To our knowledge, health care reform will not affect the problem of conflicting provider requirements one way or another. For example, the Health Security Act does not define provider qualifications at the federal level, but relies on performance monitoring and reporting to assure quality of care.

5. If there is a conflict in personnel qualification/certification standards, what are the implications to the institutional capacity or work force necessary to deliver school health services? What is the relationship between personnel qualification/certification standards and the set of "core services" being provided?

There needs to be a mechanism to resolve conflicts locally in a manner to benefit the school-age children population. Similarly, "core services" should only be provided by individuals with training to perform the services. Children's health care needs must come before institutional interests. To this end, considerable local flexibility is required to determine the best way to provide core services to school-age populations with schools being one of a number of potential providers.

6. What are the options for developing a standardized definition of qualified providers that meets existing Federal requirements, the health plan criteria, as well as quality standards established under health care reform?

The panel strongly opposes the federal government setting baseline qualified provider standards for school-based services. The dangers of federal encroachment on state and local flexibility far outweigh the advantages of standardization. Rather, state approved and monitored locally accepted standards of care should govern that take into account local needs, conditions, and resources.

It should be noted that education has a far stronger tradition of local control than does

health. Educators need to understand that they must accept certain state-defined standards if they are to enter the health care domain. School-based health care providers will have to negotiate with indemnity insurers and managed care providers, and other key stakeholders regarding service content, acceptable quality, and quality assurance (see Recommendation #1).

State and local negotiations need to take place to assure standards of care that are equitable for both the managed care plan and the client. Protections can be built in to assure that the health care provider (be it a nurse or a paraprofessional) has the level of training required to perform a specified job. Commonly invoked minimal highest standards are not the best quality assurance mechanism for children's health care. These vary from state to state depending upon the availability of providers and may not meet national professional standards for specialties.

7. What set or sets of "qualified provider" standards are appropriate in a managed care environment? How do we make certain that the standards set in HCR are reasonable enough for some portion of providers to have the opportunity to successfully apply for ECP status, while simultaneously ensuring some level of quality in the services provided?

School-based health programs would benefit from states moving away from the "qualified provider" label to language that permits appropriate services by appropriately prepared personnel. This is a better approach than trying to create new Medicaid or other categories of professional providers at the state level that more resemble school-based health care providers.

As mentioned above, the panel suggests that locally accepted standards of care be used. ECP status should not be conferred on any provider that cannot meet locally accepted standards of care.

UNITED STATES DEPARTMENT OF EDUCATION

PUBLIC AFFAIRS

THE IMPROVING AMERICA'S SCHOOLS ACT OF 1994

Public Law 103-382

The reauthorization of the Elementary and Secondary Education Act of 1965 and related programs*

SUMMARY SHEETS

October 27, 1994

* These summaries include non-ESEA materials.

400 MARYLAND AVE., S.W. WASHINGTON, D.C. 20202-0131
(202) 401-1576

Overview
of Key Provisions in the Act

INTRODUCTION (p.i)

TITLE I OF THE BILL AMENDMENTS TO THE ELEMENTARY AND SECONDARY EDUCATION ACT OF 1965

Title I of ESEA Helping Disadvantaged Children Meet High Standards

p.1 Improving Basic Programs Operated by Local Educational Agencies: Supports local educational agencies (LEAs) in providing high-quality opportunities for students in high-poverty schools to meet the same challenging State content and performance standards already developed for all children (under Goals 2000 or another process). New provisions promote extending learning time in accelerated rather than remedial classes, expand eligibility for schools to operate schoolwide programs that serve all children in high-poverty schools, help achieve effective transitions from preschool to school and from school to work, establish accountability based on results, greatly reduce testing, increase effective parental participation, assure fair and equitable participation of private school students, and support coordination with health and social services.

p.6 Even Start Family Literacy Programs: Strengthens the targeting of services to families most in need and extends eligibility for this intergenerational literacy program to teen parents, who are among the most needy.

p.7 Education of Migratory Children: Helps provide migratory children the same opportunities as other children to meet challenging State performance standards. A more focused program will target efforts on the most mobile children, whose schooling is most likely to be disrupted.

p.8 Education of Neglected and Delinquent Youth: Extends educational services and learning time in State institutions and community-day programs for neglected or delinquent children and youth making the services more comparable to offerings of LEAs. New provisions also encourage smooth transitions to enable participants to continue schooling or to enter the job market upon leaving the institution.

Title II of ESEA Dwight D. Eisenhower Professional Development Program

p.9 Dwight D. Eisenhower Professional Development: Focuses on upgrading the expertise of teachers and other school staff to enable them to teach all children in the core academic subjects set out in challenging State content standards. This title expands the existing Eisenhower Science and Math programs to include other core academic subjects and supports sustained and intensive high-quality professional development focused on achieving high performance standards.

Title III of ESEA Technology for Education

p.10 Technology for Education of All Students: Creates a broad, new authority for challenge grants that support the development and demonstration of technology applications, that help all students achieve challenging content standards, as well as projects that develop better learning tools and resources in the area of literacy, English as a Second Language (ESL), and school-to-work programs.

p.10 Star Schools: Supports partnerships to provide distance-learning services, equipment, and facilities and national leadership activities in this area.

Title IV of ESEA Safe and Drug-Free Schools and Communities

p.11 Safe and Drug-Free Schools and Communities: Expands authority to encompass issues addressed in all of Goal Seven of the National Education Goals to create learning environments that are free of violence and drugs. The legislation calls for comprehensive school and community-wide approaches to making schools and neighborhoods safe and drug-free. The program will provide funds to governors, State and local educational agencies, institutions of higher education, and non-profit entities for a broad range of drug and violence prevention programming.

Title V of ESEA Promoting Equity

p.12 Magnet Schools Assistance: Promotes desegregation through magnet school programs that are part of an approved desegregation plan and that are designed to bring students from different social, economic, ethnic, and racial backgrounds together. New provisions strengthen the focus on minority group isolation and enhance support for magnet school programs that serve a wide range of students, rather than an elite group of students.

p.13 Women's Educational Equity: Supports strategies and newly authorized implementation activities that enhance equal educational access and opportunities for women.

Title VI of ESEA Innovative Education Program Strategies

p.14 Innovative Education Program Strategies: Supports activities that encourage school reform and educational innovation.

Title VII of ESEA Bilingual Education, Language Enhancement, and Language Acquisition Programs

p.15 Bilingual Education, including Immigrant Education: Assists in ensuring that limited English proficient children have the same opportunities to achieve high educational standards as all other children. The program structure and activities are simplified and strengthened to build local capacity for providing high-quality bilingual programs. This title also includes provisions that continue support for LEAs that have had recent, significant increases in immigrant student populations, emphasizing transition services and coordinating the education of immigrants with regular educational services.

Title VIII of ESEA Impact Aid

p.16 Impact Aid: Restructures and simplifies the impact aid formula to focus funding on actual burden imposed by the loss of local revenues.

Title IX of ESEA Indian Education

p.17 Indian Education: Provides Indian children with equal opportunities to learn to challenging State performance standards. Supports professional development and adult education programs.

Title X of ESEA Programs of National Significance

p.18 Fund for the Improvement of Education: Provides national leadership and support for reform efforts, including the development of curriculum and assessment frameworks and other activities to help all students reach high standards, health education, and character education.

p.19 Javits Gifted and Talented Education: Continues support for a national program to help elementary and secondary schools meet the special educational needs of gifted and talented students. The program also supports the existing State and local efforts for the education of those students.

Title X of ESEA (continued)

p.20 Public Charter Schools: Creates a new authority for providing seed money for the development and initial implementation of public charter schools to demonstrate how increasing flexibility within public school systems can produce better results for children.

p.21 Arts in Education: Creates broad new authority to support education reform by strengthening arts education.

p.22 Civic Education: Continues support for a nationwide capability in elementary and secondary schools and private organizations to strengthen civic education.

Title XI of ESEA Coordinated Services

p.23 Allows local educational agencies (LEAs), schools, and consortia of schools to use up to five percent of the funds they receive under ESEA to develop, or to implement or expand, a coordinated service project to increase children's and parent's access to social, health, and education services.

Title XII of ESEA School Facilities Infrastructure Improvement Act

p.24 Addresses the critical need to repair, renovate, or rebuild school facilities in local educational agencies (LEAs) across the country. Grants for school construction assistance will be made to LEAs that demonstrate minimum eligibility for the program and subsequently compete successfully for awards.

Title XIII of ESEA Support and Assistance Programs to Improve Education

p.25 Builds a comprehensive, accessible network of technical assistance to link schools, districts, and States to the Department of Education and to each other for information and assistance about Federal programs and school reform.

Title XIV of ESEA General Provisions

p.26 Provides a general waiver authority for Federal education programs to allow flexibility in return for clear accountability for improving student performance. New provisions authorize consolidated applications and uses of administrative funds. Establishes, for the first time, uniform provisions to provide for the participation of private school students.

TITLE II OF THE BILL AMENDMENTS TO THE GENERAL EDUCATION PROVISIONS ACT

p.27 Updates and streamlines administrative authorities applicable to the Department's programs.

TITLE III OF THE BILL AMENDMENTS TO OTHER ACTS

p.28 Amendment to the Individuals with Disabilities Act (IDEA): Replaces the authority for the Chapter 1 Handicapped program with new provisions in IDEA, in order to serve all children with disabilities.

p.29 Amendments to the Stewart B. McKinney Homeless Assistance Act: Requires a focus on ensuring homeless children's access to high-quality academics that meet State performance standards to which all students are held. Moreover, the amendments encourage the extension of program services to preschool children by clarifying that activities for these children can be funded.

THE IMPROVING AMERICA'S SCHOOLS ACT OF 1994

Introduction

The Improving America's Schools Act of 1994 (IASA), which reauthorizes the Elementary and Secondary Education Act of 1965 (ESEA), marks a watershed in Federal support for education. Under the framework of the Goals 2000: Educate America Act, IASA provides for a comprehensive overhaul of programs governing an $11 billion-a-year investment in education and remakes them in a manner designed to help ensure that *all* children acquire the knowledge and skills they will need in the 21st century.

IASA encourages educators to align various reform efforts and create comprehensive solutions for schools and districts in order to meet students' needs. Schools and districts will receive assistance to improve teaching and learning, through increased support for professional development, comprehensive technical assistance, and technology. The Title I program significantly increases the number of schools eligible to develop schoolwide programs and serve all of their children, allowing educators to use Federal monies for comprehensive education reforms that address the needs of the whole student and the whole school.

The new ESEA also provides resources to help link schools, parents, and communities. The Safe and Drug-Free Schools and Communities Act, Title IV of ESEA, builds on the belief that school-community links are critical to creating environments where all children can reach high standards--school environments that are safe, drug-free, and conducive to learning. In addition, various provisions throughout the bill, including parent-school compacts, encourage increased parental involvement in planning for program development and in sharing responsibility for student performance.

The reauthorized ESEA shifts the focus of Federal education policy from compliance with Federal requirements to emphasis on flexibility to improve teaching and learning coupled with increased accountability for improved student achievement. Indeed, the bill allows grass-roots reform efforts to flourish, without excessive Federal control. Through consolidated applications and plans, reduced testing requirements, and the option to consolidate State and local administrative funds, for example, the bill alleviates paperwork burdens so that educators can focus more time, energy, and resources on better educating children. For the first time, ESEA provides a waiver authority for relief of requirements that are impeding better educational performance and provides a charter school program to demonstrate how increasing flexibility within public school systems can produce better results for children. In addition, it promotes building-level decision-making that will bolster local initiative and partnerships for education reform.

ESEA completes a comprehensive Federal strategy to support State and local school reform efforts. As part of the overall Federal reform agenda, the reauthorized ESEA directly supports States' Goals 2000 frameworks for setting and meeting challenging State standards and will help ensure that *all* students meet those standards.

TITLE I - HELPING DISADVANTAGED CHILDREN MEET HIGH STANDARDS
TITLE I - IMPROVING BASIC PROGRAMS OPERATED BY LEAS
(Formerly CHAPTER 1)

The new Title I has one overriding goal: to improve the teaching and learning of children in high-poverty schools to enable them to meet challenging academic content and performance standards. To accomplish this goal, Title I supports new roles for schools, districts, States, and the Federal government. Schools will decide for themselves how to spend their Title I resources and, in far greater numbers, be able to combine all of their resources to support comprehensive reform through more schoolwide programs; LEAs will play a new, critical role through providing consultation, coordination, and high-quality professional development; States will anchor the program by developing challenging academic standards and linking Title I with their overall school reform efforts; and the Federal government will work to support States, districts, and schools as they strive to make these changes work.

Four overall principles lay the groundwork for these new roles. These principles, and the specific Title I provisions that support each one, are described below.

1. HIGH ACADEMIC STANDARDS-WITH COMPONENTS OF EDUCATION ALIGNED SO THAT EVERYTHING IS WORKING TOGETHER TO HELP CHILDREN REACH THOSE STANDARDS

The new Title I:

- Promotes the alignment of all educational components. Every aspect of the education system—curriculum and instruction, professional development, school leadership, accountability, and school improvement—will be working together to ensure that all children served by Title I attain the challenging standards.

- Requires States, LEAs, and schools to connect their Title I programs with their overall reform efforts, including those developed under the Goals 2000: Educate America Act. The new Title I is designed to support systemic reform efforts at all levels and ensure that the children most in need reap the benefit of those efforts.

- Requires States receiving Title I funds to submit plans demonstrating that they have challenging content standards specifying what children are expected to know and be able to do, and challenging performance standards. To ensure high expectations, States that have already developed standards for all children (under Goals 2000 or another process) will use those standards for Title I, as well. Otherwise, they will develop challenging standards in at least reading and math for children served with Title I funds.

- Requires States to have a set of high-quality State assessments, geared to State content standards, that will be used to determine whether children in Title I schools have met the State's performance standards. If a State has already developed a set of high-quality, State-wide assessments for all children, it will use those assessments for Title I purposes. This will ensure that schools, LEAs, and the State will have assessment information tied to what they expect children to know and be able to do for both accountability and improvement purposes.

2. A FOCUS ON TEACHING AND LEARNING

The new Title I:

- Expands the schoolwide program approach and requires comprehensive instructional reform to enable all children to meet the challenging State standards.
  - -- The law enables many more Title I schools to develop schoolwide programs (about 12,000 more) by lowering the minimum poverty level at which a school can become a schoolwide program from 75 percent to 60 percent poor children in school year 1995-96 and then to 50 percent in subsequent years. Schoolwide programs will be able to combine Title I with other Federal, State and local funds to serve all students in the school. These funds, however, will have to be used for schoolwide reform strategies that increase the amount and quality of learning time and help provide an enriched and accelerated curriculum for all children, according to a comprehensive plan to meet the State's high standards.

  - -- By allowing schools to integrate their programs, strategies, and resources, Title I can become the catalyst to comprehensively reform the entire instructional program provided to children in these schools, rather than merely serve as an add-on to the existing program. A one-year planning period for schools as they develop and implement their plans, and increased technical assistance through school support teams and other mechanisms will further support high-quality reform in schoolwide programs.

- Reforms targeted assistance programs to enable participating children to meet the challenging State standards. Targeted assistance schools (schools that are ineligible or have not opted for a schoolwide approach) will use funds for programs for children who are failing, or most at risk of failing, to meet the State's performance standards. Those programs must give primary consideration to extended-time strategies, be based on what research shows is most effective in teaching and learning, and involve accelerated curricula, effective instructional strategies, strong coordination with the regular program, and highly qualified and trained staff. Title I programs that rely on drill and practice or fail to increase the quality and amount of instructional time will no longer meet the requirements of the law. Like schoolwide program schools, targeted assistance schools must orient their programs toward enabling children served by Title I to meet the challenging State performance standards.

- Strengthens provisions to ensure the equitable participation of students attending private schools. The law clearly states that eligible children attending private schools must receive comparable and equitable educational benefits. The law explains the component steps to ensure timely and meaningful consultation.

- Emphasizes high-quality teaching and professional development. Title I will play a key role in ensuring that teachers, administrators, other school staff, and district-level personnel receive the professional development they need to improve the quality of instruction so as to enable children to meet the State's challenging standards. LEAs will provide high-quality professional development designed by principals, teachers, and other school staff in Title I schools. Professional development also will be a central component of each Title I school. These efforts will be tied to professional development efforts under Title II of the ESEA.

- Ensures Title I funds for the most needy middle and high schools. A requirement that LEAs must serve all schools at any grade level with at least 75 percent poverty before serving schools, including elementary schools below that percentage will ensure participation of the highest-poverty middle and high schools in Title I. Along with offering enriching curriculum and instruction, these schools can use Title I resources for such activities as counseling and mentoring, college and career awareness and preparation, and other services to help prepare students to succeed in college and work.

- Simplifies selection procedures for students with disabilities and students with limited English proficiency to ensure their participation in the program. Students with disabilities and students who are limited English proficient will be eligible for the program on the same basis as other children.

3. FLEXIBILITY TO STIMULATE LOCAL INITIATIVE COUPLED WITH RESPONSIBILITY FOR STUDENT PERFORMANCE

The new Title I:

- Brings Title I decisions down to the school level so that schools, in consultation with their districts, can determine uses of funds in ways that best meet the needs of their students. Each Title I school will work with the district to determine how to use Title I funds in ways that make the most sense for its students. Bringing these decisions down to the school level will help transform Title I from a district-directed "one-size-fits-all" program to a significant resource for schools to use to meet the needs of their children.

- Emphasizes planning as an ongoing process based on the needs of schools and students, not on administrative procedures. For example, plans will be submitted with parental input.

- Provides flexibility by allowing waivers of statutory or regulatory provisions. Title XIV of the reauthorized ESEA allows schools, districts, and States the opportunity to seek waivers of provisions they can demonstrate will impede their reform efforts.

- Develops a new performance-based accountability system using high-quality State assessments.

  -- Each Title I school will be required to demonstrate, based on the State assessment and other measures adequate yearly progress toward attaining the high State performance standards. Schools failing to make adequate progress will be identified for improvement and receive technical assistance. If, after two years in school improvement, the school still fails to make adequate progress, its LEA must, in most instances, take corrective actions, such as instituting alternative governance arrangements or authorizing student transfers to another school. The LEA, however, could take such actions any time after a school is identified for improvement.

  -- Schools exceeding the State's definition of adequate progress for three years will become "Distinguished Schools," with the option to become mentors to other schools and the possibility of receiving monetary awards from their State's Title I funds and other institutional and individual rewards from their district.

  -- School districts also will be held accountable by their SEAs for performance, through mechanisms similar to those established for schools.

  -- Distinguished Educators will be available to assist schools and districts furthest from meeting the State standards, as well as to schoolwide programs schools.

- Requires districts to distribute dollars to schools on the basis of poverty (the total number of poor children in each school), not achievement. This will remove penalties for success that may have previously existed.

4. LINKS AMONG SCHOOLS, PARENTS, AND COMMUNITIES

The new Title I:

- Focuses on increasing parental involvement. The Act emphasizes three components of parental involvement: 1) policy involvement at the school and district level, including parental involvement in developing school-level programs; 2) building capacity for involvement through such means as increased training and enhanced involvement of community-based organizations; and for the first time, 3) shared parent and school responsibility for improved student achievement, embodied in school-parent compacts.

- Strengthen Title I school-community connections to better meet children's needs by fostering integration of Title I with other educational programs and health and social service programs. New provisions 1) ask school districts to coordinate and integrate Title I services with other educational services, including Even Start, Head Start, and school-to-work services and, to the extent feasible and where necessary, with other agencies providing health and social services to children; 2) allow Title I schools to work with the community to provide health, nutrition, and other social services that are not otherwise available to the children being served; and 3) require districts and schools to address the transition needs of children, particularly as they move from pre-school to school.

TITLE I - HELPING DISADVANTAGED CHILDREN MEET HIGH STANDARDS
FORMULA-GRANTS TO LOCAL EDUCATIONAL AGENCIES

Title I funds are intended to help close the achievement gap between high- and low-poverty schools by targeting additional resources to school districts based on their numbers of poor school-age children. The new ESEA law passed by Congress:

- Eliminates Title I funding to the wealthiest school districts by setting a minimum eligibility requirement for school districts of both 10 poor children and 2 percent poverty (with the second requirement beginning with FY 1996 allocations).

- Provides that funds above the 1995 appropriation, beginning in FY 1996, will be allocated through either or both of two new formulas: Targeted Grants and the Education Finance Incentive Program. This change could either increase or decrease the targeting of funds to the highest-poverty school districts, depending on the amount of funds appropriated for these two formulas.

    - Targeted Grants would be allocated through a weighted formula that provides higher per-child amounts for districts with high percentages or numbers of poor children. Furthermore, districts must have at least 5 percent poverty to be eligible for Targeted Grants.

    - The Education Finance Incentive Program would allocate funds to states through a formula based on a count of all children (not just poor children) multiplied by effort and equity factors. This formula would provide higher levels of funding to states that have higher levels of fiscal effort and within-state equalization. States would suballocate these funds to school districts in proportion to other Title I funds.

    - Funds appropriated for Targeted Grants will improve targeting on high-poverty school districts, while funds appropriated for the Education Finance Incentive Program will decrease targeting, with the nation's poorest districts generally receiving below-average increases.

To improve the targeting of funds within districts, the new ESEA law:

- Eliminates the penalty for success caused by allocating funds to schools using numbers of low-achieving children. Instead, allocations would be based on numbers of poor children.

- Sets a minimum amount per poor child that districts must allocate to each school to prevent districts from spreading Chapter 1 funds too thinly among their schools. Each school's allocation per poor child must be at least 125 percent of the district's allocation per poor child; however, this requirement does not apply to districts that serve only schools with poverty rates of 35 percent or more.

- Tightens special school eligibility rules so that districts may serve schools below the district poverty average only if the school has a poverty rate of 35 percent or more.

- Requires districts to serve all schools with poverty rates of 75 percent or more—including middle and high schools—before serving schools under 75 percent poor.

TITLE I - HELPING DISADVANTAGED CHILDREN MEET HIGH STANDARDS
EVEN START FAMILY LITERACY PROGRAMS

Even Start is a family-focused program providing participating families with an integrated program of early childhood education, parenting education, and adult literacy and basic skills instruction. All projects include some home-based instruction and provide for the joint participation of parents and children. Even Start is now primarily a State-administered competitive program in its sixth year of operation. In addition, the Department administers direct discretionary grants to federally recognized Indian tribes and tribal organizations, for migratory families, and to the outlying areas. There are approximately 500 local Even Start programs throughout the nation, with programs operating in every State, Puerto Rico and the District of Columbia.

The new legislation puts a greater emphasis on the family focus of program goals and activities, both in its purpose and through the inclusion of additional family members in appropriate family literacy activities. It also makes more explicit that the purpose of Even Start is to serve families in poverty that also have educational needs.

The new Even Start legislation:

- Revises the statute's statement of purpose to reflect the family focus of Even Start and its targeting on families in poverty.

- Strengthens targeting of services to families most in need by requiring that projects include active recruitment and preparation for participation of these families, giving priority to projects serving families in areas with high concentrations of poverty, and requiring that projects consider, at a minimum, individual levels of adult literacy (or English language proficiency) and poverty in recruiting families most in need.

- Extends eligibility to include teen parents, who are among those most in need of the types of services provided by Even Start.

- Requires local programs to provide services for children at least within a 3-year age range and to operate on a year-round basis.

- Improves the linkages between school and communities by requiring stronger collaboration in the application and implementation process.

- Provides more flexibility to States in the operation and evaluation of the program and to the Department in carrying out technical assistance, evaluation, and program improvement.

TITLE I - HELPING DISADVANTAGED CHILDREN MEET HIGH STANDARDS
EDUCATION OF MIGRATORY CHILDREN

The purpose of the Migrant Education Program (MEP) is to expand, improve, and coordinate educational programs for the children of the nation's migratory farmworkers and fishers. The reauthorization of the ESEA amends the MEP in several substantive ways. In particular, the new statute:

- Clarifies that the program purpose is to address the special educational needs of migratory children in a coordinated, integrated, and efficient way, through high-quality and comprehensive programs, to help them overcome the various barriers to education caused by migrancy, as well as to ensure that such children have the opportunity to meet high content and performance standards, and benefit from State and local systemic reforms.

- Targets the most recently mobile children, who experience the most disruption in schooling, by limiting the population counted, for funding purposes, to those who have moved within the last three years. This is a dramatic change from current law, which allows children to be counted and receive services for up to six years after their last move. The new statute does permit certain types of children who cease to be considered migratory children to continue to be served for certain additional periods, but without generating additional program funding.

- Encourages the formation of consortia of States and other appropriate entities to reduce administrative and other costs for State MEPs and make more funds available for direct services for children.

- Requires that States transfer student records and other data to other States and schools as students migrate. It also eliminates a long-standing provision in prior law that requires continued sole-source awards for a Migrant Student Record Transfer System.

- Establishes a new priority for services for migratory children whose education has been interrupted during the school year, and who are failing, or at risk of failing, to meet their States' content and performance standards.

- Authorizes peer review of State applications.

- Promotes coherent, system-wide educational reform across the MEP, Title I Part A grants, and other relevant grant programs by requiring better integration of these programs' services for migratory children. State and local-level officials who work with the MEP and other relevant programs will develop a joint plan to provide migratory children with access to integrated services.

- Requires that, except when used in schoolwide programs, MEP funds must first be used to provide services that meet the identified needs of migratory children. Identified needs include those resulting from a migratory lifestyle or those not met by other services provided by other programs.

- Broadens the definition of a migratory child to include children who themselves are migratory workers or spouses of migratory workers. The prior statute denied services to youth who were themselves workers or spouses of such workers.

TITLE I - HELPING DISADVANTAGED CHILDREN MEET HIGH STANDARDS PREVENTION AND INTERVENTION PROGRAMS FOR CHILDREN AND YOUTH WHO ARE NEGLECTED, DELINQUENT, OR AT RISK OF DROPPING OUT

The current Chapter 1 Neglected or Delinquent (N or D) program provides financial assistance to State agencies for projects that meet the special educational needs of neglected or delinquent children and youth (under age 21) in State-operated or supported institutions for N or D youth, adult correctional institutions, and community-day programs for N or D children. Funds can also be used for projects that facilitate the transition of children and youth into educational programs or the job market. To address the needs of N or D youth and other at-risk youth more comprehensively, Congress expanded the existing program to provide States with two sources of funding.

1) **The State agency subgrant,** based on the allocations computed under the regular State agency N or D program similar to the current Chapter 1 program:

- Increases the minimum number of instructional hours from 10 a week to 15 for children and youth in adult correctional institutions and 20 in N or D institutions or community-day programs. This will make these programs more comparable to what is offered by school districts, to support incarcerated youth in completing their schooling.

- Authorizes juvenile neglected or delinquent institutions to operate institution-wide education programs using Title I and other Federal and State education funds.

- Authorizes funding for transition services for neglected and delinquent youth following release from an eligible institution or program.

- Requires a designated liaison to coordinate transition activities from the State-operated institutions to locally operated programs.

2) **The local subgrant** that the State makes from funds generated by LEAs, but retained by the State educational agency, under Title I LEA Grants for youths residing in local correctional facilities or attending community-day programs for delinquent children:

- Authorizes SEAs to make competitive subgrants to school districts to conduct programs that provide a wide array of services to meet the special needs of at-risk youth including, for example, coordination of health and social services.

- Authorizes the SEA to reduce or terminate funding after 3 years for projects in LEAs if there is no progress in reducing dropout rates and if juvenile facilities have not demonstrated an increase in the number of youth returning to school, obtaining a high school equivalency certificate, or gaining employment after their release.

The new law also requires LEAs and State agencies to evaluate their programs at least once every 3 years to determine their impact on student achievement, using multiple and appropriate evaluation measures.

TITLE II - DWIGHT D. EISENHOWER PROFESSIONAL DEVELOPMENT PROGRAM

The new Dwight D. Eisenhower Professional Development program will support Federal, State, and local efforts to stimulate and provide the sustained and intensive, high-quality professional development in the core academic subjects that is needed to help students meet challenging State content and student performance standards and thus achieve the National Education Goals. The former Eisenhower Mathematics and Science Education program supported a great deal of professional development that was neither sustained nor intensive. The new Eisenhower Professional Development program will support high-quality professional development to prepare teachers, school staff, and administrators to help all students meet challenging academic standards. The new program:

- Expands Federal assistance for professional development, at the option of State and local educational agencies, to include all core academic subjects. However, the program ensures continued professional development in mathematics and science by requiring that State and local shares of the first $250 million in appropriated funds be devoted to professional development in those subjects.

- Reserves 5 percent of appropriated funds to support national activities, including (but not limited to) providing seed money for organizations to develop the capacity to offer sustained and intensive, high-quality professional development; establishing a national clearinghouse for mathematics and science education; and supporting evaluation of professional development programs and activities. Funds may also support clearinghouses in other academic subjects, professional development institutes, local and national professional networks of teachers and administrators, the development of teaching standards, activities of the National Board for Professional Teaching Standards, and national teacher-training projects in early childhood development and nine core subject areas.

- Requires that State activities be guided by plans for professional development that outline a long-term strategy for providing the sustained and intensive, high-quality professional development needed to improve teaching and learning. Reserves 94 percent of Title II funds for grants to the States, including a total of 1 percent of that amount for grants to the outlying areas and the Bureau of Indian Affairs. Of the total State allotment, 84 percent must go to the State educational agency for grants to local educational agencies. The State educational agency may use up to 5 percent of that amount for State-level activities and State administration. The remaining portion of the State allotment (16 percent) must go to the State agency for higher education for professional development to be provided by institutions of higher education. The State agency for higher education may also use up to 5 percent of its total for administration.

- Requires districts to prepare plans for professional development that reflect the priorities of local schools. Up to 20 percent of the funds received by districts may be spent on district-level activities, with the remainder of funds to be used for professional development of teachers and other staff at individual schools. Local educational agencies must match half of the Eisenhower funds they receive; the entire match may come from a variety of other Federal funds.

- Reserves 1 percent of appropriated funds (up to $3.2 million) for a special professional development demonstration program.

- Applies the Uniform Provisions section of Title XIV to ensure the equitable participation of teachers of children attending private schools.

TITLE III - TECHNOLOGY FOR EDUCATION
TECHNOLOGY FOR EDUCATION OF ALL STUDENTS

Part A is a new authority. It represents a commitment on the part of Congress and the Department to promote the use of educational technology to support school reform and to assist schools in adopting educational uses of technology to enhance curricula, instruction, and administrative support to improve the delivery of educational services and help achieve the National Education Goals. Three programs are funded under Part A:

- National Programs for Technology in Education: Requires the Secretary to develop a National Long-Range Technology Plan that sets out how the Department and other agencies will promote the use of technology to support education reform, and provides a broad authority for Federal Leadership in educational technology through research, development, demonstration, consultation, evaluation, and dissemination activities.

- State and Local Programs for School Technology Resources: Authorizes grants to States to be used for competitive awards to school districts for technology resources--including hardware and software--ongoing professional development for teachers, connection to wide-area networks to acquire access to information and educational programming, and for educational services for adults and families. Resources are to be used to support school reform efforts. The law applies the Uniform Provisions section of Title XIV to competitive awards received by school districts. When the appropriation is less than $62 million, authorizes discretionary National Challenge Grants for Technology in Education to consortia including at least one school district with substantial numbers of poor children. The consortia requirement is intended to link the developers of technologies (and its educational applications) with school districts, so that the practical and effective use of technology in classrooms, including those with many students living in poverty, can be explored and understood. If the total amount available under the State and Local Programs is $62 million or greater, then all of the funds under this section would be distributed to States by formula, except that the Secretary may use funds to meet the five-year commitment to challenge grants awarded in prior years.

- Regional Technical Support and Professional Development: Provides funds for awards to consortia to collaborate with States, provide information to school districts, provide professional development, and disseminate information about resources for educational technology.

STAR SCHOOLS

Star Schools, Part B, supports partnerships to provide distance learning services, equipment, and facilities. Applicants must now demonstrate how they will assist State and local school reform, help meet the National Education Goals, and provide opportunities for students to meet high standards. Many of the current requirements, particularly those for eligibility and for a State-wide or multi-State area of operation, are retained. A new authority for Leadership and Evaluation Activities provides for peer review of applications and activities, evaluation (including a comparison of the effects of differing technologies on learning), and leadership activities.

TITLE IV - SAFE AND DRUG-FREE SCHOOLS AND COMMUNITIES

Title IV of Improving America's Schools Act of 1994, the Safe and Drug-Free Schools and Communities Act, replaces the previously authorized Drug-Free Schools and Communities Act. It authorizes ED to continue the support of school- and community-based drug education and prevention programming and expands the scope of the program to authorize activities designed to prevent youth violence. The program will provide funds to governors, State and local educational agencies, institutions of higher education, and non-profit entities for a broad range of drug and violence prevention programming.

The Safe and Drug-Free Schools and Communities Act (SDFSCA) contains the following important new elements:

- Adds violence prevention as a key element of the programs. The SDFSCA creates a comprehensive Federal effort in support of National Education Goal Seven by expanding authorized program activities to include violence prevention. The bill responds to the crisis of violence in our schools by authorizing activities designed to combat and prevent serious school crime, violence, and discipline problems. Local educational agencies will have the flexibility to design their own programs, which could include comprehensive school safety strategies, coordination with community agencies, implementation of violence prevention activities, such as conflict resolution and peer mediation, and the installation of metal detectors and hiring of security guards (subject to a 20 percent cap).

- Targets resources to where they are most needed. States will receive 50 percent of their funds based on the Title I formula; the other 50 percent will be based on their school-age population. For the first time, States will determine criteria for selecting high-need LEAs and target funds to those districts. The greater of five LEAs or 10 percent of LEAs in the States could be designated as high-need, and States will distribute 30 percent of their LEA funding to those LEAs with the greatest needs. The remaining 70 percent will be distributed to LEAs based on enrollment. State and local grants must provide for equitable services to meet the needs of children enrolled in private schools.

- Increases accountability. States and LEAs will be required to assess needs and measure program outcomes and to use this information to formulate policies and program initiatives. They also will be required to report publicly on progress toward meeting their stated goals and objectives. A new national evaluation system will be established to assess the impact of the Safe and Drug-Free Schools and Communities Act on youth, schools, and communities.

- Links schools and communities. States, including the governors and State educational agencies, and LEAs will continue to be required to show how they plan to use funds to support comprehensive drug prevention programs;, in addition, they will also be required to show how funds will be used to implement violence prevention programs. To encourage community-wide strategies, LEAs will be required to develop their drug and violence prevention plans in cooperation with local government, businesses, parents, medical and law enforcement professionals, and community-based organizations.

- Broadens the range of authorized prevention activities. LEAs will be authorized to implement a broader range of prevention activities. Newly authorized activities include mentoring, comprehensive health education, community service and service learning projects, conflict resolution, peer medication, character education, acquisition of metal detectors, and hiring of security personnel.

TITLE V - PROMOTING EQUITY
MAGNET SCHOOLS ASSISTANCE

The Magnet Schools Assistance Program (MSAP) provides assistance to eligible local educational agencies for the operation of magnet school programs in schools that are part of an approved desegregation plan and that are designed to bring students of different social, economic, ethnic and racial backgrounds together. Eligible desegregation plans may be either required plans (for example, plans ordered by a State or Federal court) or voluntary plans adopted by the local educational agency and approved by the Department of Education.

The reauthorized MSAP contains the following important changes:

- Adds to the purposes of the program. The statute adds two elements to the purpose of the program: one addressing achievement of systemic reforms and providing all students the opportunity to meet challenging State content standard and student performance standards; the second addressing the development and design of innovative educational methods and practices.

- Strengthens the focus on reducing minority group isolation. New applications will require information that describes how the magnet school project will increase interaction among students of different social, economic, ethnic and racial backgrounds. Additionally, flexibility has been added to the manner in which MSAP funds may be used by permitting grant recipients to use funds for instructional activities that are designed to make the special curriculum offered by the magnet school project available to students who are enrolled in the school but who are not enrolled in the magnet school program.

- Enhances support for magnet school programs that serve a wide range of students, rather than an elite group of students. In approving new applications, the Secretary will give priority to applicants that propose to select students to attend magnet schools by methods such as lottery, rather than through academic examination.

- Enhances the quality of magnet programs. A number of steps have been taken in this area. First, the MSAP contains two new priorities to be considered in approving new MSAP applications. Priority will be given to applicants that propose to carry out new or significantly revised magnet schools; and priority will be given to applicants that propose to implement innovative educational approaches that are consistent with approved systemic reform plans, if any, under title III of the Goals 2000: Educate America Act. New applications will also be required to contain a description of the manner and extent to which the magnet school project will increase student achievement in the instructional area(s) offered by the magnet schools. The MSAP also authorizes a longer project period (up to three years) in order to give grantees adequate time to develop and implement new and innovative programs, and provides flexibility in the use of funds by permitting up to 50 percent of the funds awarded in the first year of a project to be used for planning activities.

- Creates "Innovative Programs" grants. A new program is authorized for the conduct of innovative programs that carry out the purpose of the MSAP and involve strategies other than magnet schools (such as neighborhood or community model schools) that are organized around a special emphasis, theme or concept and have extensive parent and community involvement. Up to five percent of the funds appropriated in any fiscal year may be used for Innovate Programs grants.

TITLE V - PROMOTING EQUITY
WOMEN'S EDUCATIONAL EQUITY ACT

The Women's Educational Equity Act (WEEA) was enacted in 1974 to promote educational equity for girls and women, including those who suffer multiple discrimination based on gender and on race, ethnicity, national origin, disability, or age. WEEA also provides funds to help educational agencies and institutions meet the requirements of Title IX of the Education Amendments of 1972.

The reauthorized WEEA:

- Focuses findings on increasing and equalizing women's educational opportunities and tying the programs to systemic reform efforts. For instance, Congress found that since the enactment of Title IX, women and girls have made strides in educational achievement and in obtaining educational opportunities. In addition, because of WEEA funding, more model curriculum and training materials are available for national dissemination. However, Congress also found that teaching and learning practices are still frequently inequitable. Moreover, Federal support should also assist schools and local communities in implementing gender equitable practices tied to systemic reform.

- Authorizes the Secretary to promote gender equity by promoting gender equity policies in all Federal education programs, developing and disseminating gender equity research, and other activities. The Secretary will appoint a Special Assistant for Gender equity to promote gender equity and to advise the Secretary and Deputy Secretary on gender equity issues.

- Expands the scope of WEEA by supporting implementation activities. Implementation programs may include programs to implement policies and practices to comply with Title IX; train school personnel in gender equitable practices; provide leadership training and school-to-work programs to increase opportunities for women; enhance educational and career opportunities for women and girls who suffer from multiple discrimination; help pregnant and parenting teens; introduce gender equitable materials and nondiscriminatory tests; implement policies that address sexual harassment and violence against women; increase educational opportunities for low-income women; improve numbers of women in educational administration; and develop and implement comprehensive equity plans in local schools and communities.

- Funds research to develop innovative training strategies; high-quality, nondiscriminatory assessments; bias-free educational materials; instruments to assess whether educational settings are equitable; replication and integration strategies; sexual harassment policies; programs for low-income women; and guidance and counseling activities to ensure gender equity.

TITLE VI - INNOVATIVE EDUCATION PROGRAM STRATEGIES

The Innovative Education Program Strategies program retains the flexibility of its predecessor, Chapter 2, while supporting activities that encourage school reform and educational innovation.

This newly reauthorized program will:

- Allocate Federal funds, by formula, to SEAs, who will then distribute at least 85 percent of the funds to LEAs with a priority on LEAs located in high-poverty and sparsely populated areas.

- Support a broad range of local activities in eight primary areas: (1) technology related to implementing reform; (2) acquisition and use of instructional and educational materials, including library materials and computer software; (3) promising education reform projects such as magnet schools; (4) programs for at-risk children; (5) literacy programs for students and their parents; (6) programs for gifted and talented children; (7) school reform efforts linked to Goals 2000; and (8) school improvement programs or activities authorized under Title I.

As under Chapter 2, the reauthorized program will also allow Federal support of activities benefitting private elementary and secondary school students. Allowable activities to benefit students in these schools range from the purchase of instructional materials to the professional development of teachers.

TITLE VII - BILINGUAL EDUCATION, LANGUAGE ENHANCEMENT, AND LANGUAGE ACQUISITION PROGRAMS

Title VII is a program to increase the capacity of LEAs and SEAs to provide programs of bilingual education to limited-English proficient (LEP) students. Its purpose is development of full proficiency in English while building achievement in all curricular areas.

The Improving of America's School Act of 1994 reauthorizes Title VII in a new configuration. The reauthorized Title VII strengthens the comprehensive approach of funded programs; streamlines program definitions to enhance flexibility; strengthens the State administrative role; improves research and evaluation; and emphasizes professional development. The new Title VII:

- Establishes four functional discretionary grant categories aligned with the Department's comprehensive educational reform efforts. The restructured programs are (1) three-year development and implementation grants to initiate new programs; (2) two-year enhancement grants to improve existing programs; (3) five-year comprehensive school grants to develop projects integrated with the overall school program; and (4) five-year systemwide improvement grants for district-wide projects that serve all or most LEP students.

- Improves local program evaluations and promotes the use of appropriate assessments linked to instructional practices that build upon the strengths of linguistically and culturally diverse students to help them achieve to high standards. It supports field-initiated research, enhanced national dissemination efforts, and growth in Academic Excellence programs.

- Strengthens the State role by requiring SEAs to review Title VII applications within the context of their State reform plans. The new Title VII promotes partnerships between SEAs, LEAs and other entities for purposes of improving program design, assessment of student performance, and capacity building to meet the educational services of linguistically and culturally diverse students.

- Redesigns and strengthens professional development programs and ensures their integration with broader school curricula and reforms to improve the knowledge base and practices of educational personnel serving linguistically and culturally diverse students.

- Authorizes the Foreign Language Assistance Program as a discretionary grant program to help local educational agencies establish and improve foreign language instruction in elementary and secondary schools. This program aims to develop the foreign language proficiency of our students to face the challenges, as a Nation, of the increasingly competitive global economy.

- Incorporates the Emergency Immigrant Education Act which provides funds to assist in supporting educational services in local educational agencies that experience large increases in their student enrollment due to immigration.

- Incorporates the Uniform Provisions section of Title XIV to provide for the participation of eligible children attending private schools, including timely and meaningful consultation procedures.

TITLE VIII - IMPACT AID

Impact Aid provides financial assistance for local educational agencies in areas affected by Federal activities. Payments are provided to LEAs educating federally connected children, including dependents of active-duty military, and children residing on Indian lands and in low-rent housing. In addition, Impact Aid provides payments to school districts in which the Federal Government has acquired a considerable portion of the district's real property tax base since 1938, thereby depriving the district of a revenue source. The program also provides assistance for school construction in LEAs affected by Federal activities.

The new law makes some important improvements in this program. Among the most significant changes, the statute:

- Alters the distribution of funds under the program of Payments for Federal Property, formerly section 2, by changing the method of estimating the current assessed value of Federal property to make it equivalent to local assessor estimates of "highest and best use" based on adjacent property. The bill also limits payments to the difference between the LEA's maximum and actual Basic Support Payment.

- Changes the formula for Basic Support Payments (formerly section 3 payments) to a distribution based on weighted counts of the federally connected children, combined with a formula that favors LEAs that are most dependent on Impact Aid.

- Eliminates eligibility of "civilian b" children, except for LEAs in which there are both at least 2,000 of such children and those children make up at least 15 percent of the LEA's average daily attendance. Approximately 700 LEAs will cease to be eligible due to this provision, but will receive a hold-harmless payment in the first year.

- Provides separate categorical assistance for certain federally connected children with disabilities, instead of providing supplemental assistance through the basic formula.

- Provides special payments for school districts experiencing sudden and substantial increases in the number of federally connected students as a result of military base realignment.

- Requires the Secretary to use the "disparity standard" to determine whether a State is equalized, and reduces the allowable disparity from 25 percent to 20 percent after three years.

- Replaces the construction authority with a new capital-improvement authority to provide formula assistance to districts: (1) with at least 50 percent children living on Indian lands, (2) with at least 50 percent military dependent children, in which the voters defeated a school construction bond referendum at least twice during fiscal years 1991-1994; (3) that are heavily impacted or coterminous with a federal military installation, or (4) that have experienced a substantial increase in federally connected children.

TITLE IX - INDIAN EDUCATION

Programs authorized under Title IX, Part A support the efforts of local educational agencies, State educational agencies, and Indian tribes and organizations to improve teaching and learning for the Nation's American Indian and Alaska Native children and adults and to meet their special educational and culturally related needs.

The new programs will enable a more coordinated approach to service delivery, stronger accountability systems, and greater flexibility in program design. The programs will promote high standards for all students and build upon Indian culture and the community. The new ESEA:

- Supports efforts to help Indian students achieve to the same high standards expected of all students and promoting comprehensive planning by local school districts to meet the needs of Indian children, by requiring that each LEA or tribe applying for a formula grant develop a comprehensive program for meeting the needs of Indian children, consistent with the State and local improvement plans, if any, approved or being developed under the Goals 2000: Educate America Act. The program must include student performance goals; describe professional development that will be provided; and explain how the district will assess students' progress toward meeting the goals and provide the results of this assessment to the parent committee and the community.

- Promotes more State responsibility for the education of Indian children through State educational agency review of LEA applications for formula grants.

- Authorizes a new Demonstration Grants program, by combining two existing authorities into a program to support projects designed to develop, test, and demonstrate the effectiveness of services and programs for improving educational opportunities and achievement for Indian children.

- Permits LEAs to combine Indian education funds with other State, local, and Federal funds in Title I schoolwide projects.

- Consolidates the functions of the current Indian Education Technical Assistance Centers under the 15 comprehensive regional assistance centers authorized in Title XIII of the reauthorized Act.

- Authorizes a new Professional Development program by consolidating two separate professional development programs into a single authority.

- Requires individuals receiving funding under the Professional Development and Fellowship programs to perform related work following training or to repay all or a part of the cost of training. The service obligation must benefit Indian people.

- Authorizes a new program of research, evaluation, data collection, and related activities, responding to the critical need for Indian education research and evaluation.

TITLE X - PROGRAMS OF NATIONAL SIGNIFICANCE
FUND FOR THE IMPROVEMENT OF EDUCATION

The Fund for the Improvement of Education (FIE), formerly the Fund for Innovation in Education, provides a broad authority to the Secretary to support nationally significant projects to improve education, assist students to meet challenging State content standards, support systemic reform efforts, and contribute to achievement of the National Education Goals. In particular, the Secretary is authorized to use funds for:

- Research and development activities related to challenging State content and student performance standards;
- Development of model strategies for student assessment, professional development, and parent and community involvement;
- Demonstrations at the State and local levels designed to yield significant results, including approaches to public school choice and school-based decision-making;
- Joint activities with other agencies, including activities to improve the transition from preschool to school and school to work and to integrate education, health, and social service activities;
- Studies and evaluations of education reform strategies;
- Identification and recognition of exemplary schools and programs;
- Promoting programs for counseling and mentoring for students, coordinated pupil personnel services, comprehensive school health education, consumer education, competence in foreign languages, metric education, gender equity, reducing excessive student mobility, experiential-based learning, extending the learning experience into student homes by computer, child abuse education and prevention, raising expectations of academic achievement, enabling students to meet higher standards, evaluation of private management organization efforts to reform schools, and testing for the positive effects of prenatal and other counseling provided pregnant students; and
- Six specific program authorities for Elementary School Counseling Demonstration, Partnerships in Character Education Pilot Project, Promoting Scholar-Athlete Competitions, Smaller Learning Communities, National Student and Parent Mock Elections, and Model Projects (in cultural institutions).

TITLE X - PROGRAMS OF NATIONAL SIGNIFICANCE
JACOB K. JAVITS GIFTED AND TALENTED STUDENTS EDUCATION ACT

The new Jacob K. Javits Gifted and Talented Students Education Act continues the purposes of building a nationwide capability in elementary and secondary schools to meet the special educational needs of gifted and talented students, and of supplementing and making more effective the expenditure of State and local funds for the education of gifted and talented students.

- Broadens the purpose. In addition to reaffirming the purposes Stated above, the new Act encourages the development of rich and challenging curricula for all students through the appropriate application and adaptation of materials and instructional methods developed for gifted and talented students. The act authorizes activities encompassing this broader, all-student approach only in the contexts of strengthening the capability of State agencies and institutions of higher education to provide leadership and assistance to local educational agencies and nonprofit schools, programs of technical assistance and information dissemination, and in carrying out research.

- Broadens the research and evaluation authority. Although the Act requires establishment of a National Center for Research and Development in the Education of Gifted and Talented Children and Youth, it provides a general authority (outside the Center) for conducting research and evaluation. The act also limits funds for research, program evaluations, and the National Center to no more than 30 percent of the funds available in any fiscal year.

- Targets resources to where they are most needed, or where they will have the most chance of making an impact. Requires that the Secretary give priority
  - to the identification of and the provision of services to gifted and talented students who may not be identified and served through traditional assessment methods (including economically disadvantaged individuals, individuals of limited-English proficiency, and individuals with disabilities); and
  - to programs and projects designed to develop or improve the capability of schools in an entire State or region.

  Requires that at least one-half of the grants give priority to students who may not be identified and served through traditional methods.

TITLE X - PROGRAMS OF NATIONAL SIGNIFICANCE
PUBLIC CHARTER SCHOOLS

Charter schools are an innovation for improving school and student performance by replacing rules-based governance with goals-based accountability. Public charter schools operate within the public school system, in accordance with State law, but are released from most regulatory requirements in exchange for developing and implementing a plan to achieve better results in student learning.

Eleven States have passed charter schools legislation, allowing a limited number of public schools to sweep away virtually all State rules and regulations--except civil rights, health and safety, and financial audit requirements--in exchange for developing and implementing a plan to achieve better results in student learning.

The Public Charter Schools program will stimulate comprehensive education reform by supporting the development and initial implementation of charter schools. Specifically, this new Federal program will:

- Authorize grants for planning and designing a charter school's educational program, including developing new curriculum, refining desired educational outcomes, securing necessary training for teachers, and reaching out to parents and the community.

- Allow State educational agencies (SEAs) to apply for Charter Schools funds before any other applicant. Other entities, including local educational agencies, may apply for a grant only if an SEA elects not to participate in the program or if the SEA's application is not funded. Applicants would apply for a single grant of up to three years and would work closely with educators, parents, and members of the local community to develop their proposals.

- Require each application to describe the educational results the school will strive to produce. The Department of Education will judge applications from SEAs and other entities separately, but similar selection criteria, such as the following, will be applied: the degree of flexibility afforded by the State to the school, the ambitiousness of the charter school's objectives, and the likelihood that the school will meet its objectives and improve educational results for students.

- Allow an SEA to reserve up to 20 percent of its Charter Schools grant to establish a revolving loan fund. The SEA would make loans to its Charter Schools subgrantees to defray the initial operating costs of the charter school.

- Reserve some funds for an evaluation of the impact of charter schools on student achievement and for other activities that will increase awareness of charter schools and contribute to the success of this program.

TITLE X - PROGRAMS OF NATIONAL SIGNIFICANCE
ARTS IN EDUCATION

With the inclusion of the arts as a core academic subject in the National Education Goals, the Arts in Education program looks to expand its efforts to support the arts as integral to the elementary and secondary curriculum.

This newly reauthorized Federal program will:

- Support a broad range of Federal activities aimed at supporting education reform by strengthening arts education in the school curriculum. These activities include research, model programs, model assessments, and professional development in the arts. Awards will be granted to eligible State educational agencies (SEAs), local educational agencies (LEAs), institutions of higher education (IHEs), and other qualified public and private agencies and organizations.

- Continue Department support for the education programs at the John F. Kennedy Center for the Performing Arts and Very Special Arts, a nonprofit organization promoting the arts for individuals with disabilities.

- Integrate Department efforts with other related agencies and organizations such as the NEA and the National Gallery of Art to ensure nonduplication of effort and to strengthen those efforts through collaboration.

Reauthorization also created a new authority entitled, Cultural Partnerships for At-Risk Children and Youth. These grants, awarded competitively, would be targeted to students enrolled in Title I schools or out-of-school children and youth who are considered at-risk. Funded programs would use the arts to facilitate learning within schools as well as during transition periods from pre-school to school or from school to work.

TITLE X - PROGRAMS OF NATIONAL SIGNIFICANCE
CIVIC EDUCATION

Civic Education consists of two separate programs: (1) Instruction in the History and Principles of Democracy in the United States; and (2) Instruction in Civics, Government, and the Law. Both programs are intended to address the need within our Nation's schools and among our Nation's students for a thorough understanding of the principles that underlie American society. With the inclusion of civics and government as a core academic subject in the National Education Goals, Civic Education will help today's students learn the rights and responsibilities of citizenship.

The Instruction in the History and Principles of Democracy in the United States program provides for a single award to the Center for Civic Education to support and expand its education program about American government entitled "We the People ... The Citizen and the Constitution". This program will:

- Provide instruction on the basic principles of our Nation's democracy, including the history of the Constitution and the Bill of Rights.

- Coordinate simulated congressional hearings within the school and its community. The Center for Civic Education will also sponsor an annual national competition of simulated hearings at the secondary-school level.

The Instruction in Civics, Government, and the Law program, formerly Law-Related Education, awards grants on a competitive basis to SEAs, LEAs, and other public and private organizations, in order to:

- Provide elementary and secondary school students with knowledge and skills pertaining to the law so that they can become more informed and more responsible citizens.

- Sponsor specific activities that teach knowledge of, and respect for, the law such as mock trials, mediation, negotiation, and other nonviolent means of conflict resolution.

- Coordinate learning outside of the classroom through student participation in community service.

TITLE XI - COORDINATED SERVICES

Coordinated Services is designed to address problems that children face outside the classroom that affect their performance in school. The legislation specifies poor nutrition, unsafe living conditions, physical and sexual abuse, family and gang violence, inadequate health care, unemployment, lack of child care, and substance abuse as some of the factors that may impede a child's academic success. This title aims to improve children's and parents' access to social, health, and education services to enable children to achieve in school and to involve parents more fully in their children's education.

Specifically, Coordinated Services:

- Allows local educational agencies (LEAs), schools, and consortia of schools to use up to five percent of the funds they receive under the ESEA to develop, implement, or expand, a coordinated service project.

- Requires eligible LEAs, schools, and consortia that wish to initiate such a project to submit to the Secretary for approval a project development plan, not to exceed one year, or a project implementation or expansion plan.

- Permits funds to be used for activities like hiring a services coordinator, making minor renovations to existing buildings, purchasing basic operating equipment, training teachers and other personnel about the coordinated service project, and improving communications and information-sharing among organizations involved in the project. Funds may not be used to provide directly any health or health-related services.

- Authorizes the Secretary to prohibit an applicant from using its Federal funds for a coordinated services project if the project has not been successful after two years of implementation.

- Requires the Secretaries of Education, Health and Human Services, Labor, Housing and Urban Development, Treasury, and Agriculture, and the Attorney General to identify barriers to successful coordination in their programs and recommend to Congress any legislative or regulatory action to address them. This title authorizes the Secretaries and the Attorney General to use waiver authorities to address the identified barriers, until the necessary legislative or regulatory action is taken.

TITLE XII - SCHOOL FACILITIES INFRASTRUCTURE IMPROVEMENT ACT

This new program is designed to addressed the critical need to repair, renovate, or rebuild school facilities in local educational agencies (LEAs) across the country. Grants for school construction assistance will be made to LEAs that demonstrate their eligibility for the program and compete successfully for awards.

- To be eligible, an LEA must demonstrate that:

  (1) at least 15 percent of the children that reside in the geographic area served by the LEA are eligible to be counted for Title I, or Federal property within the LEA has an assessed value of at least 90 percent of the total assessed value of all real property in the LEA; and

  (2) it has urgent repair, renovation, alteration, and construction needs for its elementary or secondary schools.

- The Secretary will allocate funds among six categories of LEAs, based on size, using criteria that include the relative numbers or percentages of students counted for Title I LEA grants and the relative costs of carrying out the construction activities authorized by this program.

- Awards within each category will be based on the following criteria:

  (1) the number or percentage of children eligible to be counted for Title I;

  (2) the extent to which the LEA lacks the fiscal capacity to undertake the construction project without Federal assistance;

  (3) the threat the condition of the physical plant poses to the safety and well-being of students;

  (4) the demonstrated need for the construction, reconstruction, or renovation based on the condition of the facility;

  (5) the age of the facility to be renovated or replaced; and

  (6) other criteria the Secretary may prescribe.

TITLE XIII - SUPPORT AND ASSISTANCE PROGRAMS TO IMPROVE EDUCATION

Title XIII of the Improving America's School Act of 1994 provides authority for technical assistance to enhance the improvements in teaching and learning achieved through programs authorized in this Act. Its four parts authorize two new technical assistance programs and reauthorize two existing programs.

- Comprehensive Regional Assistance Centers. The Act creates a program of comprehensive, regional technical assistance centers to improve education throughout the Nation. Teachers and other educators will be far better served by this approach than by the current system of dozens of centers that focus only on individual programs in isolation from one another. The law provides for a phase-in of the new system and requires that the current categorical technical assistance centers be funded through 1996.

- National Diffusion Network. The Act continues NDN as a separate program. The reauthorized NDN is broader, less project-centered, and better integrated with other reform efforts, including the new comprehensive regional assistance centers.

- Eisenhower Regional Mathematics and Science Education Consortia. The Act continues the consortia as a separately authorized program.

- Technology-Based Technical Assistance. The Act authorizes the Secretary to take advantage of new technology to provide a broadly accessible technology-based technical assistance service to support ESEA programs.

TITLE XIV - GENERAL PROVISIONS

While the changes in many of the individual programs in the rest of the ESEA will also provide some flexibility, the crosscutting provisions in Title XIV promote program integration, coordination, equal educational opportunity, flexibility, State and local discretion, and efficiency, and improve accountability. Most importantly, this title:

- Allows for consolidation of set-asides for State administrative funds. If the majority of a State educational agency's (SEA's) resources come from non-Federal resources, the SEA will be allowed to consolidate the amounts of administrative funds set aside under individual ESEA formula grant programs such as Title I, Part A of Title II, and Part A of Title IV, to administer all of the funds in question in a coordinated fashion, without the need to keep detailed records. Additionally, the funds can be used for broader purposes such as peer review mechanisms, program coordination, dissemination of data on model programs and practices, and technical assistance. The SEAs may use unneeded administrative funds in one or more of the consolidated programs.

- Allows for consolidation of local administrative funds and authorizes a study of local administrative practices. Within one year of enactment, the SEA, in coordination with LEAs, is required to establish procedures for responding to LEA requests to consolidate such funds.

- Consolidates BIA grants. The Secretary must transfer to the Secretary of the Interior a consolidated amount of funds allocated to the BIA under various ESEA programs in accordance with a consolidated agreement.

- Allows transfer of unneeded program funds and funds for integration of services. An LEA may, with the approval of its SEA, use unneeded funds (up to 5 percent of the total) from one covered program (not including title I) for the purpose of another covered program. Additionally, an LEA may use up to 5 percent of the funds received under ESEA for a coordinated services projects in accordance with Title XI of ESEA.

- Allows consolidated State and local applications (including a single set of assurances) in accordance with procedures and criteria established by the Secretary and the SEA, in coordination with interested parties.

- Establishes that SEAs and LEAs that have already met requirements through their Goals 2000 plans, are not required to separately meet similar ones in ESEA.

- Establishes waiver authority. Since it is impossible to anticipate all of the particular situations in which Federal program requirements might inhibit effective program operations, the Secretary is given waiver authority to address these situations.

- Creates uniform provisions to eliminate confusion and reduce burden in meeting requirements for maintenance of effort and for serving private school children and teachers under various programs.

- Establishes Gun-Free Schools legislation. Beginning one year after the enactment of the Improving America's Schools Act, each SEA receiving ESEA funds must have in effect a State law requiring LEAs to expel from school, for not less than one year, a student who brings a firearm to school. The LEA may modify the expulsion requirement on a case-by-case basis.

- Allows a national evaluation. The Secretary may reserve up to one half of one percent of amounts appropriated for each ESEA program (other than Title I) to conduct a comprehensive program evaluations, studies of program effectiveness, and to report to Congress.

TITLE II - AMENDMENTS TO THE GENERAL EDUCATION PROVISIONS ACT AND DEPARTMENT OF EDUCATION REORGANIZATION ACT

The Improving America's Schools Act (IASA) effects the first comprehensive overhaul of the General Education Provisions Act (GEPA) since the establishment of the Department of Education. GEPA rulemaking and enforcement procedures. *Title II of the IASA amends GEPA to shorten and simplify the* statute, eliminate obsolete and unnecessary provisions, increase flexibility, reduce burden, and enhance program equity. The Department of Education Organization Act (DEOA) is also amended to establish the position of Special Assistant for Gender Equity and to place in the DEOA authority for the Office of Non-Public Education. The GEPA and DEOA contain the following important new elements:

Creates less burdensome administrative provisions:

- **Makes GEPA uniformly applicable** to all Department programs.
- **Converts the responsibility of States to furnish information from an annual to a biennial requirement.**
- **Provides greater flexibility** to the Department to assist projects jointly funded with other Federal agencies, thus promoting inter-agency cooperation and coordination.
- **Streamlines the rulemaking requirements** applicable to the Department to permit the Secretary, when appropriate, to operate the first grant competition of a new or substantially revised program without full rulemaking procedures, thus facilitating the earlier award of grants.
- **Replaces the general requirement that the Department issue regulations within 240 days of enactment** with a similar 360 day requirement, permitting greater priority setting in the development of regulations.
- **Reduces the grantee record retention period** from five to three years.
- **Eases certain restrictions on the availability of records under the Family Educational Rights and Privacy Act.**
- **Affords the Department new opportunities to conserve resources**, for example, by converting the annual evaluation report requirement to a biennial requirement.

Ensures equal opportunity for students and teachers to participate in Department programs by calling upon applicants to address, in their applications, barriers based on gender, race, color, national origin, disability and age.

Establishes disclosure and other responsibilities for organizations that provide, for a fee, honors programs, seminars, or student exchange programs that are directed to secondary students and are offered away from their homes.

Makes conforming and technical amendments to the DEOA. It retains and places in the DEOA a provision (formerly in GEPA) that establishes in the Department an Office of Non-Public Education. It also amends the DEOA to establish in the Department a Special Assistant for Gender Equity to promote, coordinate and evaluate gender equity programs.

TITLE III - AMENDMENTS TO OTHER ACTS
AMENDMENTS TO THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

Children served under the Chapter 1 Handicapped program receive the same kinds of services as those provided under Individuals with Disabilities Education Act (IDEA) programs and have the same rights and procedural safeguards. The Chapter 1 Handicapped program provides funds for services to children with disabilities, from birth through 21 years, who are in State-operated or supported schools or programs, and children who were formerly in such programs or schools but who have transferred to LEA programs. Funds are distributed to States based on child counts weighted by each State's per-pupil expenditure.

Title III, Part A, of the Improving America's Schools Act:

- Replaces the authority for the Chapter 1 Handicapped program with new provisions in the Individuals with Disabilities Education Act (IDEA) in order to serve all children with disabilities under programs authorized by IDEA.

- To ensure that the merger of the programs has no adverse effect, the amendments to IDEA:

  -- Guarantee that for 1995, 1996, and 1997 States will receive no less under the IDEA programs than they received, in total, under IDEA and the Chapter 1 Handicapped programs in 1994; for 1998 and 1999, should the number of children counted decrease, the hold-harmless amount would be reduced based on the percentage by which the number of children had declined from the number counted in 1994.

  -- Require States to give State agencies previously funded under the Chapter 1 Handicapped program the same amount per child that these agencies received in 1994 for each child they served under the Chapter 1 Handicapped program; allows States, at their discretion, to give this amount to LEAs for children who have transferred from State-operated and supported programs.

- Treat State agencies that received Chapter 1 Handicapped funds in 1994 as LEAs, for the purpose of distributing IDEA funds within States for 3- through 21-year-olds.

- Distributes $34,000,000 of the IDEA funds appropriated in 1995 for the Grants for Infants and Families program to States on the basis of the actual number of children being served; distributes the remainder on the basis of population.

TITLE III - AMENDMENTS TO OTHER ACTS
EDUCATION FOR HOMELESS CHILDREN AND YOUTH (McKINNEY ACT)

The Stewart B. McKinney Homeless Assistance Act is intended to ensure that homeless children and youth have access to a free and appropriate public education. The McKinney Act calls on the States to review and revise their laws and policies to eliminate barriers to the enrollment, attendance, and success in school of homeless children and youth and to include homeless students in the mainstream school environment.

Key provisions in the reauthorized statute seek to clarify the legislation, to increase State and local flexibility, and to include the expansion of services to preschool-age children. The reauthorized Elementary and Secondary Education Act (ESEA) and Education for Homeless Children and Youth (Mckinney Act):

- Enables homeless children to achieve to the same standards expected of all children by making those who need services eligible for Title I services regardless of where they attend school.
- Eliminates the focus on remedial education and requires a focus on high-quality academics that meets State performance standards to which all students are held.
- Requires that State plans be reviewed through a peer review.
- Eliminates the requirement to report on counts of homeless children and requires estimates of the number of homeless children and youth in the State and the number receiving assistance under this subtitle.
- Adds a requirement that reliable, valid, and comprehensive information be gathered by State educational agencies (SEAs) on the problems homeless children have gaining access to public preschool programs and elementary and secondary schools.
- Encourages extension of program services to preschool children, by clarifying that activities for these children can be funded.
- Allows before- and after-school services to be provided on public and private property, including sectarian property, where this is constitutionally permissible.
- Requires school districts to abide by a parent's or guardian's request to enroll a homeless child in a particular school to the extent feasible.
- Requires liaisons in districts with subgrants to provide eligible homeless families, children, and youth with educational services including Head-Start, Even Start, and local pre school programs.
- Requires maintenance of fiscal effort by the SEA and LEA.
- Requires coordination with State and local housing agencies responsible for developing the "Comprehensive Housing Strategies."