Brokering Student Well-Being:
Understanding the Work of School Health Administrators

By

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Dedication

  To my father, who was a visionary school administrator and a committed mentor to many aspiring administrators. Dad, you taught me so much about what our schools could and should be to build a more equitable, just society. You inspired me to serve children as a school nurse and life-long advocate for improved school health programs.

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Abstract

Background: Despite a well-documented need for school health programs (SHPs) among school children who have chronic conditions, require medically complex interventions at school, or experience socio-emotional health issues, there is little school health funding in California. There is limited research on the role of those who manage SHPs.

Purpose and aims: This qualitative study investigated the work of a selected group of school health administrators (SHAs) in California. Study aims were to explore SHA job pathways and responsibilities, the contextual factors influencing their work, and how they get their work done given limited funding for SHPs.

Methods: Thirty in-depth, semi-structured interviews were conducted with SHAs and their staff, supervisors, and deputy SHAs. Interviewees were initially recruited using purposive sampling to reach SHAs from a variety of backgrounds and districts of different sizes and locations throughout California. Snowball sampling was then employed to recruit additional SHAs, as well as staff and supervisors.

Findings: Limited funding and devaluation of SHPs has led to a marginalization of SHAs. As a result of this disempowerment, SHAs' work required double duty: in addition to their daily responsibilities developing and managing district-wide health programs and staff, SHAs had to engage in an array of strategies to broker political support. These brokering strategies included raising awareness of student health needs and the benefits of SHPs, building relationships with decision-makers, and adjusting to working conditions by waiting and devising lower-level workarounds.

Conclusion: This study provides insight into the unique role of SHAs in promoting student

health, and identifies some of the strategies SHAs employ in response to the challenges they face

in their work. Study findings may inform the development of SHA-specific training programs

and more appropriate SHA job descriptions and titles.

Introduction

Having visited many schools and district offices in my work as a school nurse and school health planning consultant, I felt both comfortable and excited to be visiting this district for the first time. I found my way from a rear parking lot into the old district office building, with its high ceilings and wide, echoing halls. After wandering the halls and then asking a friendly passerby, I found the school health administrator's office. She was wrapping up a meeting with one of her staff, so I waited for a few minutes in a large conference room adjoining her office. There were an assortment of file boxes and cabinets along two sides and a large meeting table in the center with at least a dozen chairs surrounding it. Windows filled one wall, from the height of old wooden classroom-style counters, to the ceiling.

When the school health administrator (SHA) invited me into her office, we sat around a small table that barely fit into the small space with a high window at one end. After some small talk and formalities, including reviewing the consent form, we began the interview. The SHA told me about how she came to be in this job. She explained what types of health programs she oversaw and how they were funded, including both district and private grant funding. She also described her ongoing efforts to hire additional, desperately needed school health staff. When asked what a typical day was like for her, this SHA reported that no two days were the same: each day offered a different set of interruptions, challenges, and joys.

Towards the end of the interview, this SHA reflected on how she struggled with getting all of her work done. This, she said, was the biggest challenge of her job: "Time management - the most frustrating part is sometimes feeling like the jack of all trades and the master of none." She also said that she had trouble saying "no" to high-level district leaders who asked her to do things:

I'm like, "Oh, okay, I'll take care of that for you. I know you're very busy," but

managing, learning to say no, learning to know my limits, not being taken advantage of

by higher-ups - because I have great respect for bureaucracy - I'm always like, "Yes, sir,"

and "whatever you need me to do," but I tend to, I think, take on a little bit too much.

That's something I'll work on.

This SHA's "respect for bureaucracy" and interest in pleasing those in authority positions in her

district is part of what drove her to take on more work responsibilities than she could handle. She

felt a need to accommodate important district decision-makers, and did not want to upset them,

even though she already had too much work.

Herein lies the dilemma for many school health administrators. In order to get funding,

hire staff, update policies and procedures, and even operate on school campuses, they must

constantly attempt to get the political support of district "higher ups." Why is this so? What are

the district power structures and other contextual factors that require SHAs to engage in this

"double-duty" of trying to do their work and simultaneously seek approval to do so? How do

SHAs manage to do all this, and what do they think about it?

With limited literature specific to those who manage school health programs (SHPs), I

conceived of this qualitative study to better understand SHAs' perspectives on how they

conceive of their unique work roles, what skills they think are needed to accomplish their jobs,

and what strategies they employ to secure resources for and manage health programs. I also

wanted to compare the views of SHAs and stakeholders (front line school health staff and SHA

supervisors) on SHA responsibilities, skills, and work contexts.

As I delved into the literature on school health programs and how limited school health

funding has been in the United States and California, specifically, I began to wonder: How do

they secure funding in an already underfunded public school environment? Well-known models outline the struggles of mid-level managers, and the idealized potential of cross-sector, collaborative leaders. How do these models apply to SHAs? I wanted to explore this theoretical gap as inhabited by SHAs, who likely strive to bridge health and educational interests as leaders, and yet must also try to secure limited funding resources as mid-level managers. How do SHAs engage in this negotiative, mediating work with a range of school health stakeholders? Given that there are not any formal professional pathways to becoming SHAs, how do those in such roles get there in the first place? Have SHAs formed a sense of professional identity?

With these questions in mind, this study has yielded an in-depth description of what a select group of SHAs do, and how they get their work done, from their and their colleagues' perspectives. The data has also shed light on the core theoretical questions by illustrating how SHAs engaged in brokering strategies with decision-makers for student well-being in the context of marginalizing district power hierarchies. Despite challenges, SHAs and their staff revealed their sustaining, meaningful commitment to the higher purpose of working to improve children's health.

Following a detailed literature review related to school health needs, program models, and leadership among middle managers, chapter 2 delineates the qualitative research methods employed in this study. I conducted 30 semi-structured interviews with SHAs and their deputies, staff, and supervisors from across California. This chapter details the study's design, research questions, sampling procedures, research instruments, and data collection and analysis techniques.

Chapter 3 identifies *who* the SHAs in this study are, and how they became SHAs. This includes an analysis of their professional backgrounds, the pathways they took to become SHAs,

and their current titles and job descriptions. Chapter 4 outlines what SHAs' myriad job responsibilities are, from staff supervision, to policy implementation, to budgeting, to community partnership development.

Chapter 5 investigates the context in which SHAs work, and the structural hierarchy of their districts. This includes districts' organizational charts, chain of command, and the powerful decision-makers with whom SHAs must interface in order to get their work done. Given these political dynamics, chapter 6 describes *how* SHAs get their work done. In order to get political support from district decision-makers such as their supervisors, superintendents, and principals, SHAs employ brokering strategies to negotiate SHP funding, staffing, and equipment needs. These strategies include raising awareness, cultivating powerful allies, and adjusting to work conditions.

Chapter 7 explores *why* SHAs do their work, and what it means to them. Theories related to the meaning of work help illuminate how SHAs believe their work holds a meaningful purpose and significance, and offers a valuable interconnection between them and their staff.

In conclusion, Chapter 8 offers an analytical discussion of study findings, along with study limitations. I also outline research implications including policy recommendations, and my next steps as a researcher, educator, and policy advocate.

The next chapter provides an analysis of literature related to the work of SHAs. This includes an inventory of student health conditions and SHPs in California; an examination of the broader funding and policy context of the state's public education system; an exploration of SHP models and potential SHA job responsibilities, training outcomes, and leadership roles; and an investigation into social constructionist theories related to how, as mid-level managers, SHAs might negotiate boundaries and power relations in their work.

Chapter 1: Literature Review

This study is grounded in four bodies of literature. First, a brief inventory of student health conditions and school health programs (SHPs) in California provides a foundation for understanding the need for SHP staff, including SHAs. Second, the broader context of school health programs may be understood through the historical, sociological, and financing background of K-12 education and SHPs in California. Third, literature defining school health program models and potential SHA job responsibilities, training outcomes, and leadership roles offer frameworks with which to understand some of the challenges and opportunities afforded to SHAs. Fourth, social constructionist theories explore how, as mid-level managers, SHAs negotiate boundaries and power relations in their simultaneous roles as supervisors, staff to district administrators, and representatives of district health services vis-à-vis students and families, principals, and community agencies.

Student Health Needs in California

Children aged 5 -18 spend most of their waking hours at school, making schools an ideal setting for meeting basic health care needs, promoting healthy behaviors, leading public health campaigns, and delivering primary care services. In California, 10.6 percent of children ages 0-17 are estimated to have a special health care need (Lucile Packard Foundation for Children's Health [LPFCH], 2013). This means that at least one million children and youth in California experience one or multiple chronic health conditions, and are considered children with special health care needs (CSHCN) that need to be addressed in school.

A quarter (25.8%) of California's CSHCN have three or more health conditions (LPFCH, 2013). Chronic allergies (41.4%) and asthma (34.9%) are the most common conditions among children and adolescents in California (LPFCH, 2013). The other most common conditions in

California are ADHD (23.1%), developmental delays (18.5%), anxiety problems (14.5%), behavioral/conduct problems (11.5%), and autism spectrum disorder (9.9%) (LPFCH, 2013).

Nationally there are growing numbers of students with chronic conditions that require daily care and occasional emergency interventions, such as insulin-dependent diabetes, peanut allergies at risk for anaphylaxis, and seizure disorders (NASN, 2012). Due to advances in medical technologies, more children born prematurely survive and attend public school; some of these children require complex medical interventions at school such as tracheostomy care (NASN, 2015).

Half of all cases of mental health disorders begin by the age of 14, and approximately 20% of children have a mental health condition (Stagman & Cooper, 2010). Annually, 5 to 9% of school-aged children experience an emotional disturbance so severe that it affects their ability to function at home, in school, or in the community (Substance Abuse and Mental Health Services Administration [SAMSHA], 2012). Added to this, students may experience stress related to bullying, threats of violence, or other forms of trauma at home or school (NASN, 2013).

School health providers deliver supportive assessments and interventions to CSHCN including monitoring their health status, administering needed medications, and developing and overseeing behavioral modifications. In order to provide these services, school health providers must coordinate student services with their primary and specialty care providers, as well as with other school staff. Nearly half of California children with special health care needs do not receive effective care coordination (LPFCH, 2013). Effective care coordination helps reduce school absences among CSHCN; while 8.6% of CSHCN who receive coordination services miss 11 or more days of school in a year, 19% of CSHCN who are not receiving care coordination miss at

least 11 days of school per year (LPFCH, 2013). These data speak to a need for comprehensive school health programs in California.

Meanwhile, only 43% of California's school districts employ school nurses (Baker, Hebbeler, Davis-Alldritt, Anderson, & Knauer, 2015). In lieu of credentialed school nurses, school districts sometimes employ unlicensed personnel, such as health aides, to deliver care. These unlicensed personnel have varied levels of unregulated training, and in some cases are delivering technically complex treatments to CSHCN, such as catheterization, gastrostomy feeding and care, and ostomy care (Baker et al, 2015). In a recent qualitative interview study, researchers found that many districts in California may not be adequately assessing or addressing student health care needs (Knauer, Baker, Hebbeler, & Davis-Alldritt, 2015). Key themes that arose in this study suggest that children not receiving special education services may not have their health needs identified, there are insufficient school health personnel to meet the needs of CSHCN, and requirements for student health data collection and monitoring of health services and outcomes for CSHCN are very limited (Knauer et al, 2015). Study participants also called for an improvement in California schools' ability to support CSHCN (Knauer et al, 2015). All these data indicate that many school-age children require health services at school, and California schools do not currently have the resources to meet student health needs.

Relationship Between Health and Education

Some educational reform efforts in the U.S. and California are calling for expanding physical and emotional health supports for children and teens. Public health and school reform professionals hope that school health programs (SHPs) will yield both health and academic benefits. Research shows that some SHPs have a positive relationship with student health outcomes (Mason-Jones et al., 2012), school assets such as the presence of caring adults, high

behavioral expectations, and opportunities for meaningful participation (Stone, Whitaker, Anyon, & Shields, 2013), and academic indicators, attendance, and dropout rates (Murray, Low, Hollis, Cross, & Davis, 2007; Rosas, Case, & Tholstrup, 2009; Vinciullo & Bradley, 2009).

The level of educational attainment is the social determinant with the strongest influence on health (Freudenberg & Ruglis, 2007). Better-educated people have lower morbidity rates from the most common acute and chronic diseases and longer life expectancy (National Poverty Center, 2007). Conversely, when youth don't finish high school, they suffer "a wide range of negative social, economic, political, health, and criminal justice outcomes, setting them up for a lifetime of further disadvantage" (Ruglis & Freudenberg, 2010, p.1567). Improving health and education outcomes are interdependent because "educated people are healthier people, and healthy students are better learners" (Deutsch, 2000, p.8). While this may be true, what is not yet known is how well this translates into an educational system supportive of health programs and the SHAs who manage them.

School Health Program Context

The work of SHAs is situated in the broader context of public education and school finance policies in California. The following literature review will describe how the U.S. and state educational systems have created a context both inviting and challenging to SHPs and school health administrators.

In the early 20th century, public health doctors, nurses, and dentists volunteered to bring health services into schools to mitigate disease and severe oral health problems (Tyack, 1992). As part of social reform efforts, philanthropic women's clubs provided meals, summer school, and playgrounds (Tyack, 1992). These early efforts led to the institutionalization of school nursing, social work, breakfast and lunch, and summer school programs from the 1920s to 1960s.

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In the 21st century, the goals of most school health programs have remained largely the same, though school nurses increasingly shift their attention from communicable disease to chronic disease, such as diabetes (National Association of School Nurses, 2012).

A renewed focus of some SHPs is contributing to student success in school by improving attendance, student behavior, and school climate. In a recent study with school health and education stakeholders, many interviewees emphasized that SHAs should align the goals and outcomes of SHPs with the interests of district and site administrators – particularly by focusing on improving student attendance (Blackburn, unpublished, June 2014). Chronically absent students, and particularly those from low-income families, are at greater risk for reading below grade level and dropping out of school (Attendance Works, 2014). Improved attendance also increases funding to schools because in California, schools receive per-pupil funding based on the number of students who attend school each day, known as average daily attendance (ADA).

While many point to the "achievement gap" between students who consistently succeed or fail in school, some analysts suggest that while schools do need to better educate inner-city children, educators alone cannot compensate for the effects of poverty and racism (Rothstein, 2004). Similarly, SHPs cannot address systemic inequalities alone. Using multi-sector collaborative approaches such as "collective impact," SHPs may contribute to larger school and community efforts to improve children's health and education (Kania & Kramer, 2011). In the "collective impact" model, leaders from different sectors commit to "a common agenda for solving a specific social problem" (Kania & Kramer, 2011, p. 36).

School nursing, counseling services, school-based health centers, family resource centers, and full-service community schools have helped to re-position schools as community centers serving children's and families' myriad health and social service needs (Warren, 2005). As an

example of this, in 1991 the California Department of Education (CDE) funded the Healthy Start program to improve learning and support families (CDE, 2013). The Healthy Start Planning and Operational grants were intended to ensure that "each child receives the physical, emotional, and intellectual support that he or she needs… to learn well" (CDE, 2013). Each grantee school district or school employed a "Healthy Start Coordinator" who worked with families, schools, and community agencies to develop family resource centers, health programs, and community engagement programs. Though no longer funded, Healthy Start Coordinators created a new model for school health program management and community health partnerships in California.

School health funding.

Despite the relative popularity and high hopes for SHPs, they are often de-funded when budgets are tight. Across the U.S. SHPs have been exclusively funded at the state and local levels, with only a small proportion of special education-related health services receiving federal funding (Libscomb, 2009). SHPs, like other social welfare or safety net programs, are vulnerable to the political economy of state funding. Tyack (1992) suggests that school health and social services are often targeted for retrenchment or elimination because they are "on the periphery of the (educational) system" (p. 26). With budget cuts to both public education and public health, school districts across the U.S. have seen a reduction in school health staff, such as mental health providers (Brener et al, 2007).

California's school financing mechanisms explain some of the difficulty of funding school health services in this state. California's public education system is funded using a "foundation program," otherwise known as a district power equalization approach (Brimley, Garfield, & Verstegen, 2008). This means that state funds are combined with local property tax funds to produce a state-guaranteed minimum per pupil funding level (Brimley et al., 2008). In

California, the state determines the amount of local school revenue generated by a one percent uniform tax rate for all taxable property within each district. Then the state makes a funding allocation to each district based on the difference between the per pupil state funding guarantee and local property tax revenue.

In 1978, Proposition 13 set a limit on the sum of all local property tax rates at 1% of assessed value, and allowed for the state to allocate property tax revenue among local governments (Sonstelie, Brunner, & Ardon, 2000). This revenue limit system continues to today, with some modifications. Some districts – particularly those that are wealthier - may augment their operational budgets with voter-approved parcel taxes, and fund facilities improvements with local school bond dollars (Sonstelie & Richardson, 2001). After the passage of Proposition 13, there was a decline in spending per pupil in California (Sonstelie, Brunner & Ardon, 2000). Compared with the nation as a whole, California spends 9% less per student even though it has more school-age children, children living in poverty, and English language learners (Rose, Sonstelie, Reinhard, & Heng, 2003).

There are two school health-specific funding streams in California: Local Education Agency (LEA) Medi-Cal and School-Based Medi-Cal Administrative Activities (MAA). When school health providers provide specific services to students who are Medi-Cal eligible and qualify for special education, they claim reimbursement from a program called LEA Medi-Cal. LEAs must reinvest the federal reimbursements they receive under this program in health and social services or academic support programs, under guidance from a collaborative committee that assists them in decisions regarding the reinvestment of these revenues (California Department of Health Care Services, 2014). Many districts simply reinvest LEA Medi-Cal revenues in special education services (Consumers Union, 2006).

When school personnel refer students for Medi-Cal-eligible health services, they can count a portion of their time towards School-Based Medi-Cal MAA billing. This billing is done in time studies, rather than a fee-for-service model employed in LEA Medi-Cal (Consumers Union, 2006). Only districts that have large percentages of low-income Medi-Cal eligible students complete MAA time studies and seek reimbursement. Unlike LEA Medi-Cal, MAA revenues are unrestricted, so they are often allocated to districts' general fund, and not reinvested in health programs (Consumers Union, 2006).

Even with these funds, many districts only employ the necessary school health personnel to deliver required services to students who qualify for special education programs. Hiring health staff to serve the broader student population often means choosing to use some of the limited per-pupil state funding allocation (see Figure 1, "base grant" column) for health services staff rather than teachers, administrators, or other educational support staff such as librarians. This is a challenging staffing decision for any district or school principal to make. As a result, California schools employ half as many counselors and support personnel, such as school nurses and social workers, as compared with the U.S. average (Rose et al., 2003). Fifty-seven percent of public school districts in California report having *no* school nurse personnel (Baker et al, 2015).

Local control funding formula.

In 2013, state legislation changed the funding formula to increase funding for higher-need students. The Local Control Funding Formula (LCFF) allocates more funding for targeted students who are low-income, English language learners, or in foster care. LCFF also gives local districts more flexibility in how they spend this additional funding than previously possible with categorical programs. Full implementation of the LCFF will take approximately eight years. The LCFF augments per-student base grants with increased funding for (unduplicated) targeted

students who are low-income, English language learners, or in foster care. The base grant

column in Figure 1 reflects funding allocated per untargeted student, while the other columns

calculate funding per targeted student, depending on the concentration of targeted students in the

district.

Grade Span	Base Grant	K–3 Class Size Reduction and Grades 9-12 Adjustments	Average Assuming 0% Unduplicated FRPM, EL, Foster Youth	Average Assuming 25% Unduplicated FRPM, EL, Foster Youth	Average Assuming 50% Unduplicated FRPM, EL, Foster Youth	Average Assuming 100% Unduplicated FRPM, EL, Foster Youth
K–3	$6,845	$712	$7,557	$7,935	$8,313	$10,769
4–6	$6,947	N/A	$6,947	$7,294	$7,642	$9,899
7–8	$7,154	N/A	$7,154	$7,512	$7,869	$10,194
9–12	$8,289	$216	$8,505	$8,930	$9,355	$12,119

Figure 1. Grade Span Funding at Full LCFF Implementation (California Department of Education, 2014)

By July 1, 2014, all California school districts had to develop a three-year funding plan

called the Local Control and Accountability Plan (LCAP) that described, among other things,

how the district would improve attendance and reduce suspensions, expulsions, and dropout

rates. These are outcomes that may be achieved through academic interventions and a variety of

school nursing, medical, behavioral health, and oral health programs. LCFF also dictated that

local governance teams including school boards, parent and community advisory councils, and

school site councils should develop the LCAP. Some districts allocated a portion of their LCFF

dollars to hire additional school social workers, nurses, and SHAs (Fensterwald, 2014; LCAP

Watch, 2014). In addition, some districts have allocated additional funding to schools based on

their numbers of students who are low-income, English language learners, or in foster care

(LCAP Watch, 2014). These school principals and school site councils may determine how to

spend these additional site dollars in order to improve attendance, reduce suspensions, and reduce drop-out among the targeted students. It remains to be seen whether such sites will allocate funds for school health staff.

Without core funding for SHPs, California school districts are now increasingly relying on community providers to implement health promotion programs, primary medical care, behavioral health services, and even oral health care to their students (California School Health Centers Association, 2013). While district staff still deliver many health services, some are provided by community health organizations with greater financial and human resources. This has contributed to a need for SHAs to establish community partnerships, seek grant funding, develop new models of school health services, and advocate for health programs within under-funded districts. Outside health providers working in schools require formalized partnership agreements and interagency management structures. What we do not know is whether SHAs enjoy enough authority to establish such agreements with community agencies.

School Health Administrator Job Responsibilities and Training

A variety of organizational factors influences the work of SHAs. They must navigate the educational system as central office administrators, which may contrast with their previous role as direct health service providers, especially as school nurses. Research on SHA and public health leadership training institutes has identified possible "boundary-crossing" leadership attributes needed by these professionals, as well as challenges to serving as a SHA given limited funding, training, and organizational support. As described below, theories of collaborative leadership offer models that may serve SHAs as they must garner resources by forming partnerships among diverse individuals and agencies. The following section of the literature review will explore these theories and frameworks as applied to SHAs.

The California Department of Education does not collect or report district or state-level data on how many SHAs there are in California. SHAs are not required to secure a specific school credential to serve in their role, unlike most school administrators and direct service personnel (California Commission on Teacher Credentialing, 2014). It is estimated that 80% of SHAs in the U.S. come from a school nursing background (U.S. Department of Health and Human Services, 2013). Some SHAs have no health background, but are assigned oversight of health services along with other programs, such as special education, afterschool, or even academic programs.

Most SHAs are required to have a school administrative services credential in order to supervise credentialed staff (e.g., school nurses), but others find a way around this. School administration credentialing programs focus on preparing principals to serve as instructional leaders and site administrators. No coursework is required on student health or support services policies, programs, finance, or service/staffing models.

School health program frameworks.

One way of understanding the responsibilities of SHAs is by examining school health program frameworks. Recently, the CDC and the ASCD (formerly known as the Association for Supervision and Curriculum Development) partnered to create a framework for integrating school health and other academic supports known as the Whole School, Whole Community, Whole Child (WSCC) model (CDC, 2014). The WSCC includes the eight components of the coordinated school health (CSH) model, which the CDC has promoted as a framework for integrating health services in schools since 1987 (CDC, 2014). The WSCC combines these eight components with ASCD's whole child framework (CDC, 2014). See a representation of the WSCC model in Figure 2 below. The whole child framework outlines that in order to succeed,

students need to be healthy, safe, engaged, supported, and challenged. The WSCC model integrates community involvement and family engagement with the health-services related components of the coordinated school health model.

The WSCC model suggests that by "coordinating policy, process, and practice" across ten components (in blue section), school health providers and educators will improve both learning and health (CDC, 2014). The "community" (literally) wraps around these components and ideas. While this idealized model rightly highlights the importance of community agency and family engagement (CDC, 2014), it fails to outline how this work will be achieved, and who will lead such collaboration in the school or district. This leads to another theoretical gap: how SHAs might lead school health or WSCC coordination models.

Figure 2. Whole School, Whole Community, Whole Child model (CDC, 2014).

The CDC does suggest that the coordination of SHPs is to be achieved through health councils, and with the support of a "school health coordinator" (CDC, 2011). School health coordinators should perform the following activities: manage health-related policies and practices across the district; convene and facilitate a district school health council; communicate the school health council's decisions and actions to district leadership, school-level health coordinators, staff, students, and parents; ensure consistent implementation of health policies and practices across schools; supervise and provide professional development for school health staff; facilitate collaboration among school health staff; secure funding and other resources to support school health programs; facilitate linkages with community health resources; and coordinate evaluation of policies and practices (CDC, 2011).

It is likely challenging for SHAs to accomplish all these tasks with a diverse set of stakeholders. This highlights the need for SHAs to "communicate a clear vision of the role of health services to school administration and the community," particularly in a time of diminishing resources in schools (Descoteaux, 2001, p. 298). This implies a more political role, whereby SHAs must advocate for SHP funding in terms that speak to the interests of school administrators and diverse community members. A preliminary interview study (Blackburn, unpublished, June 2014) with key informants from education and school health found that the key to securing funding for health programs is tied to SHAs' mastery of a set of "soft" skills and political savvy through which they might garner support from district leadership.

The inter-relationships between the SHA (or school health coordinator), the components of coordinated school health, structures and policies, decision-makers, stakeholders, and community partners have been integrated in a "complementary ecological model" of coordinated school health programs (Figure 3, Lohrmann, 2008). The complementary ecological model

reflects the complexity of interests, providers, and structures that a SHA must coordinate in her role as the district supervisor of students' well being. This model contextualizes the work of SHAs by including the range of systems, agencies, and individuals' interests and bureaucracies SHAs must bridge in order to meet the goal of addressing students' social-emotional and physical health needs.

The complementary ecological model presents family and community involvement as an all-encompassing component that penetrates all of the components of the model, including every team, department, and aspect of school health. The model does not reflect the complex power dynamics and inequalities present across many of the groups and individuals included in the diagram. Instead it diagrams an idealized model for effectively engaging students, families, and communities in establishing and managing relevant school health programs.
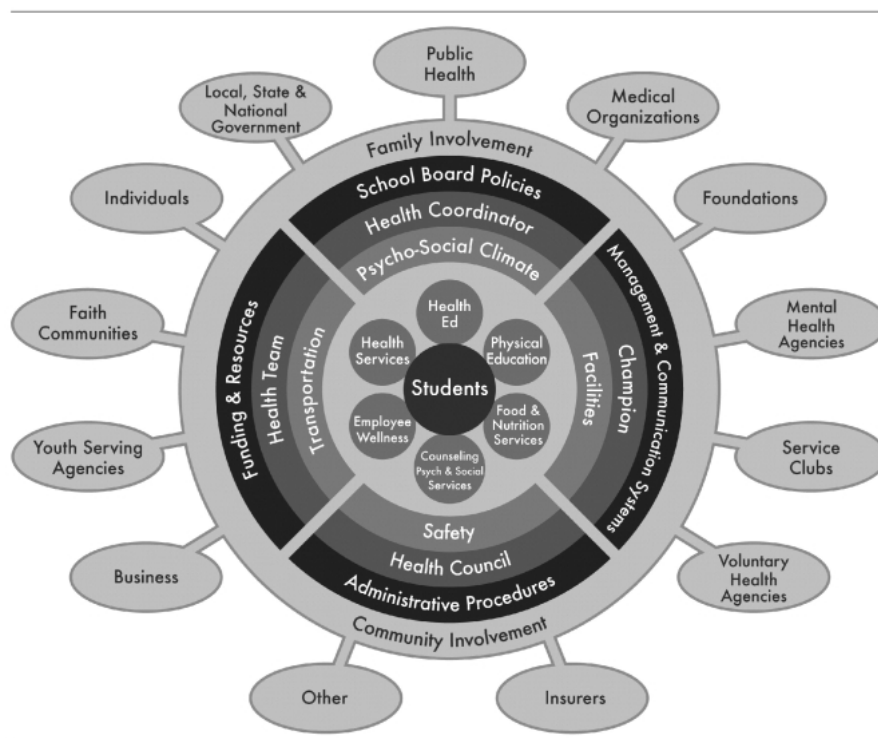

Figure 3. Complementary Ecological Model of Coordinated School Health (Lohrmann, 2008).

Many students and families living in poverty have been forced to live in under-resourced environments, and have been marginalized by the education and health care systems intended to "serve" them. It is a tall challenge for SHAs to overcome so many structural inequalities in their school communities. Employing either the WSCC or ecological model of CSH, it is unclear how SHAs might address the underlying inequalities in their school communities which may have led to community disenfranchisement in the first place.

School health administrator training.

These issues beg the question of how SHAs are prepared for such a challenging set of responsibilities. While 53.7% of surveyed school districts in the U.S. had someone who coordinated their school health program (CDC, 2012), only one in five of these coordinators had received any training specific to their position (Jones et al, 2007). Training to manage SHPs is critical due to the complexity of engaging diverse stakeholders and the competition for inadequate funding resources. Some educational leadership experts suggest that SHPs are challenging to manage successfully (Lindle, 2014). This may be because of inadequate funding, poor SHA or site-level health manager training, or misaligned goals of health providers and educators. Indeed, school health partnerships involve a variety of actors, "each with their own norms, regulations, values, training, and professional behavior" (Lindle, 2014, p. 55). These differences may undermine the ability of "partners" to plan and sustain school health programs, even with a shared interest in student well-being.

The training, norms, and values of SHAs may inform how they partner with community agencies and educators. Phillipo and Blosser (2013) have suggested that school social work (SSW) may not be a subspecialty of social work, or simply social work in a "non-social work setting." Instead, SSW has developed a "professional and organizational infrastructure that, to a

certain degree, diverges from and improvises on these larger fields' practices in order to help practitioners respond to the school setting's unique practice demands and opportunities" (Phillipo & Blosser, 2013, p. 2). Phillipo and Blosser (2013) use *interstitial emergence theory* (Morrill, 2009) to describe the development of the innovative and boundary-spanning practice of SSW. Interstitial emergence theory applied to the context of SHP administration demonstrates how "informal interaction across multiple organizational fields can provide cultural accounts for new formal structures" (Morrill, 2009, p.4). For SHAs, these multiple organizational fields include public health, school health, finance, and public education.

School health administrators are born of and lead the work of interstitial practitioners such as school nurses and school social workers. SHAs work shoulder to shoulder with district managers who started as teachers, and became administrators after completing a school administration credential. Despite the fact that SHAs may share similar managerial responsibilities with their district administrator peers, they often do not share the same paradigm or professional language with educators (Descoteaux, 2001). SHAs' paradigm is aligned with direct health service providers, while most other administrators are focused on adopting new standards for classroom instruction, student assessment and achievement, and education finance.

There is very limited literature on the professional pathways and skills needed to manage school health programs. There have been only a few SHA training programs implemented and studied to date. The American Cancer Society's School Health Coordinator Leadership Institute's participants reported successful application of some of what they learned after completing the Institute, such as developing and sustaining functioning school health councils and conducting school health needs assessments (Ottoson, Streib, Thomas, Rivera, & Stevenson, 2004). In a small group of post-training interviews, "Michiana" School Health Coordinator

Leadership Institute participants defined their success as coordinators as products of collaboration among several groups (DeWitt, Lohrmann, O'Neill & Clark, 2011).

Both of these evaluation studies indicated that after participating in the institutes, school health coordinator activities were not always sustained (Ottoson et al, 2004, DeWitt et al, 2011). There was little follow-through on district health data collection or analysis, and data was not being used to link actions with outcomes at the district level (DeWitt et al, 2011). Many coordinators changed jobs or responsibilities as early as a year after participating in the institute (DeWitt et al, 2011). Institute participants shared similar challenges to performing their coordinator role back in their districts: lack of support, funding, and time (DeWitt et al, 2011).

Similar challenges were reflected in a survey of school health coordinators in a rural state (Wyoming), where 71% of coordinators reported that their job description did not actually include their coordinator responsibilities (Winnail, Bartee, & Kaste, 2005). Most coordinators were primarily employed as health or PE teachers or school nurses, and two-thirds of coordinators said that they spent less than 10% of their time on program coordination (Winnail et al, 2005). Only 31%-47% of coordinators reported "mostly" or "completely" being able to complete their coordinator job skills and competencies (Winnail et al., 2005).

This lack of time, recognition, and skill development may be a barrier to SHAs fully functioning in their leadership role. Some researchers call for the U.S. Department of Education to make a greater investment in SHAs, and decry the lack of training opportunities: "support for training as a school health coordinator… is desperately needed to support human capital development in this crucially important, yet generally overlooked, aspect of school improvement" (Basch, 2011, p.658). Securing funding for a SHA does not necessarily lead to a

well-organized health program, for they also need time, training, and a job description appropriate to their responsibilities (Winnail et al, 2005).

SHAs' roles are similar to those of public health managers insofar as their promotion of children's health requires similar collaboration and partnership. Umble et al (2005) showed that the National Public Health Leadership Institute increased participants' leadership perspectives and confidence, such as instilling an understanding that solving complex problems requires collaboration and partnership. After the training, participants reported an increased number and quality of partnerships within government or with community organizations (Umble et al., 2005). They also reported improved outcomes, such as new interagency policies, procedures, and workgroups (Umble et al, 2005). An evaluation of the Kansas Public Health Leadership Institute demonstrated significant improvement in domains including collaborative leadership, systems thinking, ethics, and crisis communications (Hawley, Romain, Orr, Molgaard, & Kabler, 2011). These training outcomes point to potential skills of value not just to public health leaders, but also to SHAs.

In a recent study conducted in California, the impact of four school districts' wellness coordinators' efforts was evaluated through semi-structured interviews and focus groups with district and school staff, students, parents, wellness committee members, and the wellness coordinators themselves (Westrich, Sanchez, & Strobel, 2015). The researchers found that the wellness coordinators assessed school health needs, connected staff and students with resources, cultivated school site wellness champions, improved communication, and acted in leadership roles (Westrich et al, 2015). As a result of these efforts, the wellness coordinators helped increase awareness of health and wellness, integration of wellness activities, and leveraging of health resources (Westrich et al, 2015). This is an important first study of its kind in California.

While these wellness coordinators were not responsible for managing their districts' school nursing or mental health staff, this study yields insights in the types of coordination processes that school health administrators may also engage in.

Cross-sector and collaborative leadership.

The work of SHAs straddles health and education sectors. As cross-sector leaders, SHAs must master health and education policies, funding, structures, and outcomes. A hallmark of cross-sector leadership is the ability to convene and facilitate cross-disciplinary, cross-departmental and cross-organizational forums (Crosby & Bryson, 2005). SHAs' work requires such collaborative partnerships between education and health providers to leverage public resources. This cross-sector work to meet student health needs may be challenging, given the diverse funding streams and priorities of health and education agencies.

Another aspect of SHA's work is their supervision and support of site-level school health staff. Some leadership models define how to cultivate team members' leadership skills. An *equity-based* approach to cultivating leadership assures that all members' views are respected, and cultivates trust and honesty among team members (Alexander et al, 2001). SHAs could build the leadership capacity of school nurses and social workers by sharing power with them as they work collaboratively to develop health interventions or evaluate program impacts.

SHAs may keep health and educational equity as an organizing principle underlying their engagement with the students and families they serve. SHAs' bridging work should bring together teachers, principles, and health staff to establish shared goals and outcomes to improve student health and educational equity of their students. Leading these interdisciplinary teams, SHAs may develop better systems-thinking approaches as they reflect on the complexities of the interactions between school districts and health agencies.

Cross-sector and collaborative leadership models share similar competencies that could serve SHAs in their complex roles. These skills include facilitating power sharing among various agencies and individuals, analyzing opportunities for collaboration across health and education systems, and building a shared vision for student health and success. These are critical competencies for SHAs who must act as boundary-spanners while they work to define each bounded entity's important contribution to student health and success. By doing this SHAs may be able to secure needed funds and resources from multiple agencies to establish and sustain SHPs. See Figure 4 for a leadership model that applies cross-sector and collaborative leadership concepts to the potential role of school health administrators.

Cross-disciplinary; linking health and education

Cross-departmental; working with principals, instructional services, special education

Cross-organizational; connecting schools and community health agencies

Power-sharing
Teamwork
Vision
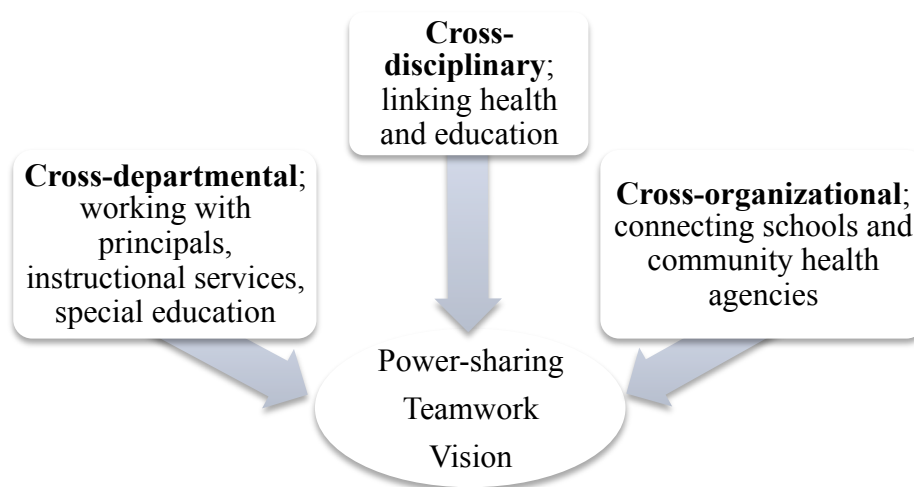
Figure 4 –Model of Cross-Sector Leadership Applied to School Health Administration

This theoretical leadership model offers an idealized view of how SHAs might act as collaborative leaders. SHAs must also negotiate murky professional boundaries and navigate organizational power dynamics to establish functional collaboratives and to secure program funding. The following section explores approaches to understanding this interpersonal level of SHA work.

Negotiating Boundaries and Power Relations

Social constructionist approaches inform an understanding how SHAs might negotiate boundaries and power relations in their myriad roles on a day-to-day basis. Like other mid-level managers, SHAs must address demands from both above and below. SHAs simultaneously supervise direct service personnel; secure buy-in from high-level district administrators; partner with community health and social service agencies; and represent district health services with "clients" including students, families, and principals who decide whether to include and/or help subsidize health programs on their campuses. How do SHAs navigate such complex interpersonal relationships and embedded power structures to accomplish this work?

All organizational actions may be viewed through the theoretical lens of *negotiated order* (Strauss, 1978). Strauss, Fagerhaugh, Suczek, and Wiener (1997) theorize that *negotiative work* occurs when representatives of multiple worlds and organizations are intersecting, such as in the work context of SHAs. Negotiation enters into how both intra- and inter-organizational work "is defined, as well as how to do it, how much of it to do, who is to do it, how to evaluate it, and how and when to reassess it" (Strauss, 1997, p.267). SHAs must constantly negotiate what they do and how they will do it. This is particularly acute given the need for SHAs to relate in different ways with a variety of coworkers and stakeholders.

With a foot placed in both the education and health sectors, and with a tenuous position managing marginalized school health programs, SHAs do not have a well-defined position assigned within the prescribed division of labor of educators and administrators in school districts. The generalized division of labor in school districts includes teachers, who report to site principals, who report to district administrators of curriculum and instruction and school site supervision. Within this hierarchical model focused on classroom instruction, the roles and

responsibilities of SHAs are undefined. This may allow SHAs simultaneous autonomy and constraint in negotiating their unique roles. Literature on mid-level managers in the service sector lends a helpful perspective to understanding this aspect of SHAs' work.

In large organizations, managers must reconcile sometimes contradictory "rationalities or logics of action" held by various members of the hierarchy or clients (Boulton & Houlihan, 2010). SHAs' placement in the management hierarchy of school districts sets up a challenge to respond to differing "logics of action" held by each of the stakeholder groups with whom SHAs work. As SHAs negotiate between front line health service staff, high-level district administrators, and student and family "clients," "what appears to be effective and functional to the strategic level may not appear so to the operational level" (Boulton & Houlihan, 2010, p.383). This suggests that one of the challenges facing SHAs is how to advocate with district administrators for health programs that will truly benefit students and families, and that their front line staff can effectively deliver. At they same time, SHAs must be nimble enough to communicate with each stakeholder group in terms that make sense given the specific "logic of action" of each group.

This may be further complicated when SHAs exercise "operative control" over the provision of school health programs, but do not have access to "allocative control" over strategic resources (Reed, 1991). As a result, SHAs may subject to powerlessness because they are not controlling, but rather reacting to, moment-by-moment demands placed on them by a range of players in their work contexts (Kanter, 1979). Kanter (1979) suggests that when managers don't have access to the necessary resources, information, and support to do their jobs, they may become ineffective, rule-minded, and bossy rather than exercising productive leadership.

Kanter (1979) outlines three "lines of power" explaining the kinds of connections that managers need to be effective: *lines of resource* (outreach reach and influence and the capacity for managers to draw on resources that their own "domain" needs); *lines of information* (being "in the know" and having access to formal and informal flows of information); and *lines of support* (the freedom to act with discretion and exercise judgment and assurance of support from above for their actions). SHAs should have access to these three lines of power in order to practice collaborative and boundary-spanning (rather than rule-bound) leadership. Yet as research on SHA training institutes revealed, once back in their districts, coordinators were challenged by a lack of support, funding, and time (DeWitt et al, 2011). This suggests a potential tension between SHAs as cross-sector, collaborative leaders and their lack of power as mid-level managers is reflected in Figure 5 below.
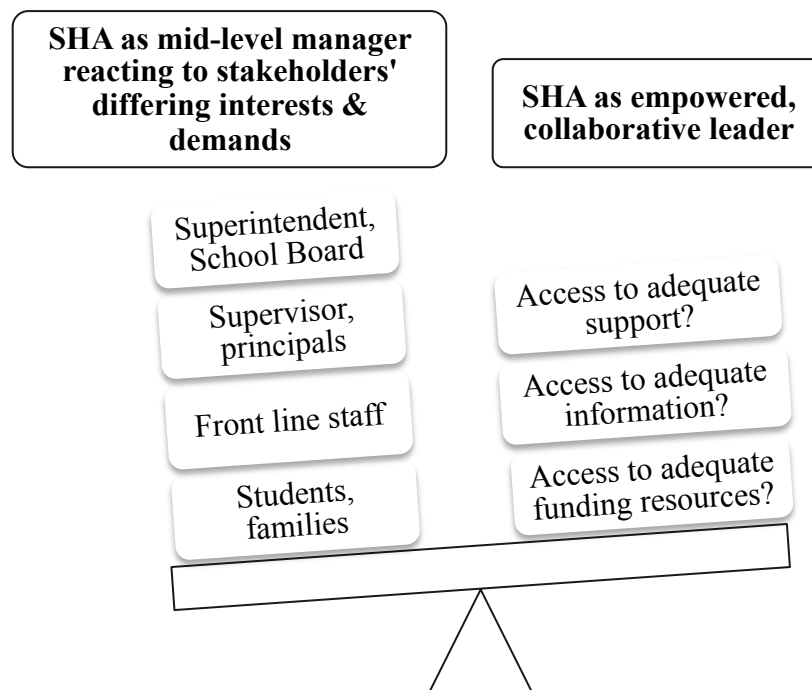

Figure 5 – Model of SHA Autonomy as Leader vs. Powerlessness as Mid-Level Manager

These organizational management theories suggest an interwoven set of challenges faced by SHAs. With potentially inadequate access to information and support, and with operative, but not allocative control over strategic resources, SHAs must somehow negotiate the boundaries of what they do, and how they do it, with a wildly diverse set of stakeholders, each with their own unique "logic of action" vis-à-vis school health programs. SHAs may be alternately frustrated or freed up by these demands, based on how their own rationale or "logic of action" for their role. SHAs' response may also be informed by how they view and enact their leadership role, as they negotiate situational and interpersonal boundaries on a day-to-day basis. SHAs may also employ a variety of communication strategies as they seek to garner the support of a range of stakeholders with different "logics of action."

Macro- and micro- contexts reveal SHAs' potentially complex and challenging job responsibilities. Research on SHA and public health leadership training institutes has identified the "boundary-crossing" leadership competencies they need, as well as challenges to serving as a SHA given limited funding, training, and organizational support. Theories of collaborative and cross-sector leadership offer models that may best serve SHAs as they work to create partnerships with colleagues from education, public health, health care, and social services. Interstitial emergence theory serves as a lens through which to further examine the identities of SHAs as they grow from being school health service providers to being administrators. Adopting a social constructionist approach affords a rich set of theories through which to analyze how SHAs negotiate boundaries, make sense of multiple work logics, and manage power relations in their work with a variety of education and health stakeholders.

Each component of this literature review informs part of the work context of school health administrators. As SHAs must do in their work, this body of literature necessarily

straddles several approaches, interests, and systems. Taken as a whole, we can gaze through this literature review as if through the multiple lenses within a compound lens. Now we can see that students have extensive health needs, our public education system is not currently organized or funded to adequately meet those needs, and school health administrators must act as middle manager-leaders as they negotiate the differing interests and politics of multiple school district stakeholders, towards the ultimate goal of promoting student health.

Chapter 2: Methods

Study Design

This qualitative study with a grounded, social constructionist approach explored stakeholder perspectives by conducting semi-structured interviews with 15 school health administrators (SHAs), 5 of their supervisors and 5 staff, and 5 deputy SHAs. Organizational documents such as organizational charts and job descriptions were reviewed for each participating SHA. In addition, districts' state-mandated Local Control and Accountability Plans (LCAPs) were analyzed to identify whether they included health related goals or funding.

Staff supervised by SHAs such as nurses and social workers shared their perceptions of the roles their SHAs play, and the ways they enact these roles in their school district context. SHAs' supervisors described their perspective on the role and purpose of a SHA, and commented on supportive or challenging structures and contexts for SHA work in the district. Given that deputy SHAs typically work closely with their supervising SHAs on projects or staff training in the central office, they shared unique insights into the daily tasks and struggles that SHAs took on. This data revealed stakeholders' diverse "rationalities or logics of action" and contextualized the views and experiences of SHAs in their organizational setting, particularly how they navigated relationships above and below themselves in the school district hierarchy (Boulton & Houlihan, 2010).

The University of California, Davis Office of Research approved this study on October 30, 2014. It was determined Exempt Category 2, IRB ID 676675-1 (See Appendix D).

Research Questions

This study posed several research questions in order to understand the work of SHAs. The overarching questions explored SHAs' perceptions of their responsibilities, work processes, and leadership skills. I also compared SHAs' views with those of their staff and supervisors.

To understand pathways to becoming SHAs, I asked SHAs about their education, professional background, and how they became SHAs. This line of inquiry allowed me to identify whether SHAs had formed a professional identity. I also explored SHA daily job responsibilities, and how these compared with their job descriptions and placement in their district organizational charts.

Related to SHAs' ability to leverage community and LCFF resources, I investigated how SHAs partnered with community health agencies in order to expand school health programs (SHPs) by bringing community services onto school campuses, and whether SHAs were able to incorporate health programs into their districts' LCAP funding plan.

The final set of research questions studied the interpersonal and organizational context that might inform how SHAs secured resources and support for their SHPs. I explored SHAs' perceptions of influence within districts' power structures and jurisdictional boundaries, and who were their decision-making allies. I investigated the theoretical gap inhabited by SHAs as both mid-level managers and cross-sector leaders, striving to bridge health and educational interests and working to secure limited funding resources as mid-level managers. As I asked about what an average day was like for them, as well as job challenges, I learned how SHAs manage negotiative work with a range of school health stakeholders. Finally, by asking about the greatest joys of their work, I investigated SHAs' meaning-making and purpose in their work.

Sampling

        The sample was recruited via a combination of purposive and snowball sampling. Since each SHA manages different types of health programs and staff, the researcher purposively recruited SHAs working in California who oversaw a variety of programs, including school nursing, behavioral health, health education, and wellness. Two SHAs from smaller districts also provided some direct service as school nurses. Given the variation in programs managed by interviewees, all types of health programs were simply referred to as school health programs (SHPs) for the purposes of this study. Using purposive sampling, participants were intentionally recruited from different professional backgrounds (school nursing, counseling, psychology, teaching, and special education). These are listed in Table 2 in Chapter 3. In order to explore the diversity of perspectives of SHAs working in small, medium and large school districts across a variety of state regions, participants were purposively selected by identifying districts of a variety of sizes, and from northern California, the Central Valley, and Southern California. See Table 1 for a list of number of districts and interviewees in this study by district size and geographic region.

Table 1

Interviewees' District Sizes and Geographic Distribution

District Size	Number of districts represented	Number of interviews
Small (3,000 - 4,000 students)	2	3
Medium (9,000 - 30,000 students)	8	17
Large ($\geq$ 50,000 students)	4	10
Geographic Spread in CA		
Northern	6	14
Central	2	4
Southern	6	12

State, county, and regional school health contacts recommended initial SHA participants. Later, SHAs and their colleagues recommended other interviewees via snowball sampling. The researcher sent each prospective interviewee a recruiting email (see Appendix A).

This study included 15 SHAs, and five "deputy" SHAs from large school districts, where they managed projects under the direction of the SHA. As interviews were scheduled and conducted with SHAs, interviews were requested with some of their supervisors and staff. A total of supervisors and five staff who work with SHAs were interviewed. The staff included mostly school nurses, as well as one school social worker that also served as a site-based health coordinator. A total of 30 interviews were conducted.

Despite efforts to recruit a demographically diverse sample, study participants were very homogenous. This is consistent with the homogeneity found among SHAs and school health staff in California. All of the interviewees were White, except for one African-American and one Latino. Four of the SHAs were male, and the rest were female. All deputies and direct services staff were female. One supervisor was male. Most interviewees appeared to be middle-aged, though actual ages were not collected.

Research Instruments

An interview guide was developed for each of the subsamples (SHAs, supervisors, and staff). Deputies were asked the same questions as staff. The interview questions (see Appendix B) probed interviewees for their ideas on the role of SHAs and potential health and academic outcomes of school health programs, as well as external forces (funding cuts, competing priorities) that may threaten ideal program delivery. These questions were based on the literature review, a California SHA survey conducted by the researcher (unpublished, completed March 2013), a pilot SHA interview conducted by the researcher (unpublished, completed May 2013),

and a key informant interview study conducted by the researcher (unpublished, completed June 2014). As data was collected from interviews and document analysis, the interview topic guide questions were adjusted to better explore or confirm emerging ideas and themes.

Data collection.

Preparation for each interview included a thorough review of documents including SHA and deputy job descriptions and district organizational charts and LCAPs. These documents provided information with which to analyze whether there was alignment between the SHAs' self-reported responsibilities, and those that were codified in writing by the school district. Such documents also helped contextualize an understanding of the external structures, pressures, or supports at play in the SHA's position. The LCAP indicated whether and how school health programs were included as a programmatic intervention for improving student attendance and behavior, and reducing suspensions – all state-mandated priority areas for school districts.

All of the interviews were approximately one hour in length and conducted in-person, at a location convenient to interviewees. Most interviewees elected to have the interview in their office. The interviews were conducted with a commitment to participant-driven inquiry. Participants helped shape the scope and breadth of their interviews and informed subsequent sampling decisions. The interviews were digitally recorded, with field notes recording key impressions and notable points for follow-up. Each interviewee signed a consent form approved by UCD IRB prior to the start of the interview (see Appendix C).

Data analysis.

Using the inductive, emergent methodology often described as grounded theory (Creswell, 2008), the data was interpreted to examine the meaning-making of SHAs regarding their work roles. Data analysis was an iterative process involving ongoing data collection,

writing, coding, analysis, and theme generation (Boellstorff, Nardi, Pierce, & Taylor, 2012; Emerson, Fretz, & Shaw, 2011). Fieldnotes were written during and after the interviews. Interview audio recordings and transcripts were examined for the meaningful and symbolic content of data, such as SHAs' and deputies' views of their roles, district power and authority structures, and how to best secure resources for school health programs. SHA supervisor and staff interview data was analyzed for how they described and prioritized SHA job domains, roles, and contextual factors. Data from interviews with SHAs, their staff and their supervisors and document analysis was triangulated to check for coherence.

Transcribed interview data was organized using the computer-assisted qualitative data analysis software (CAQDAS) program Nvivo. A descriptive category scheme was developed based on the themes that emerged from the interviews. The influences on the SHAs' roles and responsibilities informed a conceptual category scheme. Interview transcripts were coded using a selective approach (Utrecht School of phenomenology), to highlight statements and phrases that seemed essential to understanding the work of SHAs.

As I collected and analyzed data, I practiced reflexive bracketing by working to identify internal assumptions and personal biases to improve the trustworthiness of the data analysis (Gearing, 2004). I kept a reflective journal to explore how my previous experiences working with districts on their SHPs might influence my interpretation of data. This approach allowed me to distinguish between me preconceived notions and the narratives of study participants. I identified how my background and biases influenced my interpretation of what study participants said, since researchers' understanding of study participants' stories is based on a set of assumptions, informed by personal and professional background and training (Gudmunsdottir, 1996). In addition, I received feedback from my dissertation chair that further prompted clearer

explanations of findings and analyses that I might have otherwise failed to explicitly identify because of my knowledge of school health professions and contexts.

Throughout the research process, verification procedures such as methodological coherence, sampling sufficiency, thinking theoretically, and theory development ensured reliability and validity of the study (Morse, Barrett, Mayan, Olson, & Spiers, 2008). By thinking theoretically with both macro and micro perspectives, the researcher altered research questions in order to maintain congruence between the research questions and the components of the method (Morse et al, 2008). Data was collected and analyzed concurrently in order to iteratively identify what was known, and what required further exploration. Sampling was sufficient to lead to data saturation and replication. Despite time and resource limitations of this dissertation research project, depth of inquiry was sustained by verifying major concepts, rather than trying to superficially verify all emerging theories. This array of verification strategies ensured congruence among question formulation, literature, recruitment, data collection strategies, and analysis (Morse et al, 2008).

Chapter 3: Becoming a School Health Administrator

This chapter will identify study participants' backgrounds in direct service and the professional pathways they took to becoming SHAs. In addition, an analysis of SHA job descriptions and titles will provide insights into SHAs' assigned position in school district hierarchies. There is no prescribed path to becoming a school health administrator (SHA). In order to explore the array of professional programs and experiences that have led to serving in this role, SHAs from diverse backgrounds were recruited to participate in this study.

When describing the skills needed to become a SHA, most interviewees harkened back to their initial professional training, such as a nurse, counselor, or teacher. Many SHAs and deputy SHAs started out providing direct student services as school nurses, social workers, counselors, and teachers. Eventually, they moved into an administrative role managing school health programs (SHPs). Most SHAs in this study did get an administrative services credential, but not all. The greatest benefit of this credential was that it allowed SHAs to formally hire, supervise, and evaluate their credentialed staff. Some interviewees felt the credential program gave them valuable insight into the perspectives of principals and other administrators in instructional services.

SHAs and deputies often worked without a job description specific to their role, or with a job description that did not include many of their responsibilities. SHAs found that their positions were placed lower in district's hierarchical organizational charts compared to peers with similar or less responsibilities. Similarly, most SHAs and deputies felt like their titles and lower salaries unfairly meant they had less responsibility than they actually had. How SHAs are titled and placed within their district organizational structures is part of "who" SHAs are.

SHA Backgrounds

SHAs came from diverse backgrounds including nursing, social work, counseling, and teaching. All deputy SHAs were nurses by training, though one of those nurses was a health educator, and then a planner for a community health agency, before becoming a nurse. Four of the staff were school nurses, and one was a school social worker. See Table 2 for all SHA, deputy, and staff participants' primary professional backgrounds, additional expertise, and administrative backgrounds.

Table 2

Interviewees' Professional Backgrounds and Years in Current Role

	SHAs N = 15	Deputies N = 5	Staff N = 5	Supervisors N = 5
Primary Professional Background				
Nursing	7	5	4	1
Social Work or Counseling	4		1	1
Classroom Teacher	4			3
Additional Expertise				
Health Education	2	1		
Special Education	2			
Administrative Background				
Administrative Services Credential	10	1	1	5
Principal/Assistant Principal	4			4
Business Administration (MBA)	1			1
Health Administration	1			
Years in Current Role				
1-5 years	5	3	1	3
6-10 years	6	1	1	2
11 or more years	4	1	3	0

A majority of SHAs (67%) had gotten administrative service credentials after serving in a role related to their primary professional background. One deputy and one staff had administrative credentials as well, and another deputy had started an administrative services credential program.

Direct service.

All interviewees felt that their primary professional training and background was useful to serving as a SHA. They felt that their original direct service work allowed them to understand the issues their staff faced. For example, one staff person said:

> I think it's very important that (our SHA) had a school nurse background because she saw it in the trenches and could take that information with her when she moved up. I think it's critical that they have basic field knowledge and then build on it.

An SHA with experience as a direct service provider could also elicit greater credibility in the eyes of her staff, as a supervisor suggested:

> You need to come up through the ranks in my opinion, and having been a school nurse sometime so that you really get what it's like… as a supervisor of the health clerk, and the health office, and make a call to CPS, and be in on infectious disease investigation with the county health department. I mean those things just prepare you for being somebody who your school nurses will follow.

This supervisor was, herself, originally trained as a nurse, and worked as a school nurse, and then a SHA, before becoming a higher-level administrator of special education in her district. Both of the above quotes employ military metaphors: experience "in the trenches" and coming up "through the ranks." One interpretation of interviewees' use of military metaphors is that they were expressing an internalized district hierarchy.

Codified district hierarchies also informed how some SHAs felt that direct service providers or classroom teachers should work their way up to administrative roles. For instance, one classroom teacher who became a health education resource teacher, and later a SHA, felt that others should follow a similar path:

I think having school experience as a teacher or some sort of facilitator, coordinator

position in a school where you help people organize things, like a Title I coordinator or a

Curriculum Resource Teacher, which is like the principal's right hand where if the

principal is absent, that person is designated to be the principal... That sort of leadership

position in a school would prepare you for this. A nurse would be great if she had the

broad-based understanding of programs and if she was willing to stretch her mind to

encompass the work that needs to be done around programs and not just services. A nurse

would be great but that's not the whole package with this particular district.

By describing such a professional path, this SHA may be justifying her own experience, and

defending against a potential suggestion that a nurse should occupy her role. Her defensiveness

is not unwarranted, as her predecessor was a school nurse by training. All school nurse

interviewees felt that anyone who supervises school nurses should also be a nurse, so that the

SHA would understand the clinical aspects of their work. The above quote also references the

scope of SHAs' work, specifically developing a broad array of school health programs (SHPs),

not just supervising school nursing practice.

This professional affinity is not unique to school nurses. A supervisor who was a teacher

and principal before becoming a central office administrator shared this sentiment about her

SHA:

I love the fact that she was an educator first and had the opportunity of knowing what it's

like to be at the school site working with the kids first and foremost. In her capacity, I

think, or in that role's capacity, it's always beneficial to know not just the medical side of

things, too - like how do those two things work together - because it's not only managing

instruction and education and from that level, it's also knowing the depths of how to

service the kids medically and having the right RNs in place and health clerks and all

that. You have to have a management style that services educators, administrators,

medically-trained professionals.

This interviewee saw a link between having served as a teacher, or managing instruction, and

being able to manage health programs in schools. SHAs and deputies did not identify

understanding classroom instruction as central to their scope of work. However, study

participants did reiterate a need for SHAs to develop a communication style adapted to a variety

of stakeholders, including teachers, administrators, and health providers.

Another supervisor who had a background in business was very pleased that her SHA

shared a similar background, in addition to being a nurse:

She has an MBA and I have an MBA. It's just like we are in totally different worlds but

we both have an MBA. I think it's awesome because that really gives her that fiscal

component. She understands the finances. She understands how a grant works. She

understands staffing and how we pay for it - that kind of stuff - as well as the health piece

of it.

This supervisor highlighted critical job skills that SHAs need to master in addition to their

clinical expertise: budget development, fiscal analysis, and configuring staffing according to

available funding sources. She also provided insight into how important it is for her that her SHA

is similar to her in some way. This ability for supervisors to relate to their SHAs may impact

how well SHAs can secure support for SHPs. In another district, a supervisor said that school-

level experience is essential to understanding the district's mission:

School experience is hugely important because as an organization, it has the whole

mission that we do, the whole - what's the primary goals of education, and you can't lose

track of that. Our mission, I always have said, is twofold. It's to educate students and to

graduate them and to keep them safe. The safety part of it is physical, mental. We keep

them safe so that they can learn and access (education).

This interviewee's statement reflects how educators typically view SHPs. In many public

educators' eyes, the value of SHPs is in how well such programs keep students safe and healthy

so they can learn. This idea informs how SHAs garner educators' support for SHPs.

Pathways to Becoming School Health Administrators

Many interviewees followed a pathway from site-level work as school nurses,

psychologists, or social workers into their central office SHA positions. Several of these study

participants became SHAs because they were encouraged to apply. For instance, one SHA was

asked to apply for his job after the superintendent saw him give a talk on promoting equity in

schools. Some SHAs got their jobs because of pre-existing relationships with district

administrators. For example, one SHA said that a couple years after her boss moved to a new,

larger school district, he asked her to apply for the SHA position in his new district.

This position came open and I was recruited. My boss who I have currently, he and I

worked together in (another district) and so he and I would stay in contact and talk about

different things in my position in (that district) versus what was going on here in this

district with the leadership that was here within the department. He would always talk

with me about "would you do it this way?" or "how would you recommend that we do

that?"

This SHA's supervisor valued her expertise so greatly that he "brought" her to work with him in

his district. Other SHAs and deputies were also strongly encouraged to apply for their positions.

One deputy described how her school nurse peers asked that she serve as their deputy SHA:

"We think you would do this really, really well. We would like you to consider. We don't

have a lead nurse role but that's what we're going to the union to press for. If we could

get that, we think that you would do really well at it."

She was elected by her peers to serve in the deputy SHA role, before they had even created such

a role. Another SHA was reticent to apply for the SHA position in her district, where she was

working as a school nurse. She said she did not want to apply because "I viewed myself as being

a good clinical nurse and I loved it." A professor from her school nurse credential program

strongly encouraged her to apply because of her previous hospital management experience:

"Well, you know that God gave us gifts and then he expects us to use them." So it kind of

pushed me into talking to my boss and saying maybe I might be interested. So the

superintendent at the time called me and he said, "Let's go talk." I went and talked with

him, had coffee, and he gave me the position.

This SHA expressed no regrets that she had taken the job as a SHA. She was concerned that she

did not currently have any school nurses who were interested in growing into this role when she

retired, however.

Four SHAs described a different pathway to becoming a SHA. They went from the

classroom into administrative positions, such as school principals, eventually leading to

becoming their district's SHA. For example, one SHA felt his growth into the role was "natural:"

It was basically a natural progression from my role in the district, starting just in the

classroom and working in a couple different positions… A special ed teacher and

intervention teacher and then rolled into administration from site level and the district

level for special education, and then just becoming more involved in the tentacles of

where special ed touches, that became health services and other various tentacles that

come out of special ed and supporting students. I was strongly encouraged to apply for it

when our previous administrator of health services left.

This interviewee outlines a pathway more typical of how schoolteachers grow into site

administrators (principals or vice-principals), and in some cases, central office administrators.

Some interviewees did not plan on becoming SHAs because they did not have a

background in school nursing. For instance, one SHA did not even consider applying until they

opened the position to people who were not nurses:

The position was open and they went through our whole recruitment cycle. I didn't even

think about doing it. They went through a whole recruitment cycle and did not find an

appropriate match and then they opened it up again and opened it up to people who didn't

have an RN degree. I applied and was interviewed and got the job.

This happened in three SHAs' districts: positions previously held by administrators with a

background in nursing could not be filled, as no qualified nurses applied. The districts then

removed the nursing requirement, and hired SHAs who came from other types of backgrounds.

SHAs who did not having a nursing background felt like nursing expertise was not required to

complete their job responsibilities. However, they indicated that the school nurses in their district

desired clinical support from a nurse. All of these SHAs who supervised school nurses but did

not have a nursing background created part-time deputy roles for school nurses. These deputies

served as a resource to their school nurses for complex clinical interventions, interpretation of

health-related education laws, and issues related to school nursing and licensed vocational

nursing (LVN) practice.

Administrative services credential.

As was seen in Table 2, many SHAs' professional pathway included getting an administrative services credential. This credential is required by the California Commission on Teacher Credentialing in order to evaluate credentialed staff such as school nurses and counselors who hold a pupil personnel services credential (PPSC). The ability to formally supervise and evaluate credentialed staff was the reason for most SHAs' pursuit of the administrative credential. Traditionally, the administrative services credential helps prepare principals and central office administrators in charge of instructional programs. Credential programs do not provide training specific to SHP management, though they do include some information about special education requirements.

Those SHAs who had the administrative credential felt that going through the credentialing program had some value beyond being able to evaluate their staff. In particular, they thought the program provided them helpful insight into the work of other district administrators. Several interviewees said that getting the administrative credential helped them better communicate with educators because they could better understand teachers' and principals' perspectives. As one SHA said, " I learned their language and I think that was important. I think you have to be able to speak their language, not just nursing language." This SHA provided insight into how credentialing programs may help SHAs acculturate to district administrative roles.

Many SHAs attributed their administrative credential program with helping them understand the broader public education system. One supervisor who had a background as a nurse and SHA felt that the administrative program opened her eyes to all the factors involved in running a district, and why certain decisions were made:

As a provider sometimes you don't understand how higher decisions are made, you don't

understand, you just get frustrated because something's in your way or a barrier's there

that you don't - it seems so easy to remove - but when you get the opportunity to get an

administrative credential you start looking at budget, and unions, and labor, and laws and

things that impact the running of the district, and it helps you see how your department,

which many feel is a little unique, really fits in to the whole.

This interviewee identified some of the key issues that SHAs need to know how to address, such

as how to work with unions and labor laws. This indicates that administrative credentialing

programs may serve to socialize SHAs so that they are willing to assume an assigned role within

the district bureaucracy.

Despite getting the administrative credential, one interviewee with a nursing background

found that administrators and educators did not truly respect her. Instead, they placed the greatest

importance on having been a classroom teacher, rather than a health service provider:

I learned a lot and I'll go ahead and say this on tape, but it's a lesson that was unexpected:

how much educators value a superintendent - or even an executive director, or deputy

superintendent, assistant sup - how much educators value a leader who has been in the

classroom. I appreciate that now. At first I was a little resentful because I've done so

much work to try and learn their craft, and learn to speak their language, and that kind of

thing. In many people's mind, you just never become that credible leader. So it's kind of

the side B of it, but that happened, and it is true, and it's a cultural thing, and looking back

I probably had some of that even in my cohort in class, nobody said anything but I can

look back and think maybe people were thinking we're (SHP staff) a little out of place,

but nonetheless I had a great experience and really learned what I needed to learn at that

time. I was using the EdD to maybe launch into a higher level leadership in education,

but learned the reality was that sometimes people didn't think a person outside of the

teaching profession belonged in educational leadership.

This interviewee clearly felt hurt by this experience. Her discomfort was evident when she

prefaced her story with "I'll go ahead and say this on tape." She still felt the program was helpful

and she did go on to serve as a SHA, and later a principal for students with special needs. Her

statements, however, reflect a deeper insight: school administrators' professional culture is

founded on starting out as a classroom teacher, and then serving as an administrator of

educational programs. SHAs do not fit that mold. This contributes to the marginalization of

SHAs, as they are not able to fully join the world of school administrators.

Despite the potential downsides of having to get an administrative services credential,

SHAs did report one more positive aspect of having the credential: they were more likely to

secure an administrative title, as opposed to a "lead nurse" title, and a higher salary. Titles and

related job descriptions provide key information about who SHAs are in the context of their

district hierarchies.

Titles and Position Descriptions

There was no standardization of SHA titles across school districts in this study. Table 3

lists the titles of SHAs and deputies. These titles range from those typically assigned to a direct

service provider (e.g., "School Nurse") to a "Director" within the district's organizational chart.

This lack of standardization reflects how undefined the SHA role is within school districts'

organizational structure. The different titles of study participants also reflect how varied SHAs'

jobs can be. Some oversaw health services, others managed support services such as behavioral

health, and a few supervised both physical and emotional health programs. Some SHAs' job

titles reflected a broader scope of responsibility, such as wellness programs or special education.

Table 3

School Health Administrator and Deputy Titles

SHA Titles
Coordinator, Health Programs
Director, Student Support Services
Lead Nurse
Director, Student Health Services
Director of Student Support Services
Program Manager
Chairperson, Health Services
Coordinator, Health and Prevention
Health Services Director
Mental Health Program Administrator
Lead Nurse
School Nurse
Program Manager, Nursing and Wellness
Director, Integrated Health and Support Services
Coordinator of Health Programs
Deputy SHA Titles
Business Operations Manager I
School Nurse
School Nurse
Lead Nurse/School Nurse
Special Projects Nurse

When approached for an interview, some study participants did not feel that they should

participate because their titles were not administrative. Regardless of title, these "lead" and

"school" nurses functioned in roles very similar to their peers who had more managerial-

sounding titles. Unfortunately, the lack of an administrative title seemed to undermine some

SHAs' professional self-worth.

Study participants' job descriptions, like their titles, seemed to reflect more on their district's organizational chart and administrative naming conventions that the actual work of SHAs. Several interviewees were working under a job description that did not include many of their responsibilities, such as developing policies and procedures, or grantwriting. Other SHAs were working without any job description at all. For example, one SHA joked about her lack of a job description:

> What I do now as a program administrator, there isn't a job description. People really don't know. I have good job security. No one knows what I do. [Laughter] So I can do whatever I want. No, I can't do whatever I want. Nobody wants this job. So I'm good.

Not having a job description may require SHAs to define their own role. A few interviewees had grown into a role that they created for themselves over time, and didn't exist previously. Working without an appropriate job description or title may undermine SHAs' authority. This may also perpetuate SHAs not being adequately titled, empowered, or compensated within their districts' organizational structure. In addition, there may be no institutional record of everything the SHA did when she or he leaves the position.

Several interviewees commented on the inequity in how SHAs are titled and placed in their district organizational chart compared to other central office administrators. For example, one SHA felt frustrated with her lack of administrative authority, which was reflected in both her title and her inability to evaluate credentialed staff:

> Because how dare I discipline a fellow (nurse), they're like my peers, I'm not there. I may be called the Health Services Chair but that really means pretty little really. They may think I have more power but in the essence when you look at the union structure, I'm on the same basis that they have.

Due to a lack of authority in the district's structure, this SHA was at the same level with her

school nurse colleagues because she did not have an administrative credential or an

administrative title. As a result of her frustration, she was working to upgrade her title and job

description.

Interestingly, several other SHAs were working to upgrade their title and job description,

because they felt it did not accurately represent the nature of their work in SHP planning, fiscal

management, or staff training and supervision. Two SHAs had been collecting SHA job

descriptions from other districts, and were planning to pull all the best elements from these into a

new position description for themselves. Their hope was that with a more representative job

description and title, they would have more authority and a better salary. A few SHAs were

specifically attempting to change their title from "program manager" or "coordinator" to

"director." One SHA compared herself to someone else in her district who was a director:

> Most of the other departments - even the director of counseling and guidance, she doesn't
>
> supervise, directly supervise the number of staff that I do, and counselors all report to the
>
> principal on site, and she provides the structure and guidance and the professional
>
> development, but realistically they all report to the principal - where for me, as a
>
> centralized model, everybody does truly directly report to me. So, that would be one
>
> reason why my title is going to be changed and that's something again bureaucratically
>
> within the district that doesn't make a whole lot of sense to me, like you almost have to
>
> have a certain number of people to move up the ladder as far as title goes.

Though this SHA had to directly manage almost 200 people, her title was at a "program

manager" level. She supervised more people than other central office administrators who had a

"director" title. One of this SHA's deputies felt this unfair and explained, "I look at her and I

think, 'She works hard and her department is big and it's impacting, but she's just a program manager. She's not a higher director level which is interesting.'" This deputy's awareness of the inequity in how her SHA was titled and salaried within her district made her feel like the district did not value the SHAs' work. This deputy also felt like her own compensation was too low. She felt that she should be paid more than a school nurse, which she was not.

A few interviewees were accepting of the inequity in their title, job description, and even salary. One SHA who had a "coordinator" title was the only administrator working at her level of the organizational chart who did not have a "director" title, but she did not consider it a problem. In another district, the health services "coordinator" position was eliminated during a period of budget cuts, and replaced with a "lead nurse" position. This meant less pay and a lower position on the organizational chart, but the SHA in the role had the same responsibilities as her "coordinator" predecessor, who was now her supervisor. This supervisor explained: "The lead nurse has done everything I would have done as a coordinator. She has carried on without the administrative title." The lead nurse was accepting of the fact that she was not afforded better compensation or authority in her title:

> I don't worry about it. I really don't. They've been really, really generous at the time when I was just a lead nurse and I didn't have anything so I just got paid my salary. I used to work a lot of extra days and I didn't get paid for any of them. Then in the middle of this huge budget thing, they made me a NOSA (nurse on special assignment) and that's when I got the 10 extra days and the 5% (pay increase). It was really unusual because everybody was being cut at that time. So it was a way of them saying, "we do appreciate what you do every single day."

This SHA felt gratitude that she was compensated for at least some of the extra days she worked, as well as a modest pay increase. Given the context of budget cuts across public schools in California, and elimination of SHP staff positions, this SHA was happy for the recognition she got for her work.

Another SHA had a similar feeling; she was happy to get paid a little extra: "I get this stipend for being the Medi-Cal MAA coordinator and it breaks down to an extra hour a day. I work - the contract is six and a half hours - same as the teachers - and I work seven and a half." In a larger district, a deputy SHA was compensated for her lead nurse role through a small stipend as well. In neither case was the stipend appropriate to the role of deputy or SHA.

Several other deputies and SHAs in this study expressed dissatisfaction with their salaries, which were sometimes based on the salary of a school nurse (the same salary schedule as teachers), with a small stipend of an additional $1,000 - $2,000 a year. This is an extreme case of salary inequity compared to other central office administrators. By not paying SHAs or their deputies salaries commensurate with the salaries of administrators and deputies who work in instructional services, school districts are sending a clear message: we do not value school health programs as much as instructional services. This was demoralizing to some SHAs and deputies in this study. The SHAs and deputies who were not bothered by pay inequity said they did the work for other reasons. For instance, some said they did the work because they cared about children's welfare, or out of a personal commitment to their staff.

An additional problem that SHAs in large districts have reported facing is difficulty getting approval and funding for deputy positions. For instance, one SHA had a nurse who was supporting her in a deputy role for several years, but without any change in title or compensation. When the SHA finally got approval to employ an official deputy, human resources (HR) would

not give her a title specific to health services, and instead gave her a generic "business operations manager" title and job description. The SHA was reassured that at least the deputy would be compensated as a manager. Her next step was to formulate a new, health-related deputy job description that the school board would approve. One of her staff said that finally getting a deputy role was important because the SHA had too much on her plate:

> She was being pulled umpteen ways to Sunday and not very efficient. So, being able to delegate one whole body of managing personnel on a day-to-day basis, to cover the LVNs, to cover the procedures and absences and that kind of thing, it was really important. That person also does a lot of the in-service training and that kind of thing. It took a long time for the district to realize that every other director has assistants, hello?

This staff person identified how unfair it was that all the other large department directors were afforded assistant directors, but not the SHA. Not giving SHAs sufficient and appropriate staff support reflects a disregard of the importance and scope of SHP work. SHPs are marginalized when they are inadequately staffed because SHAs and direct service providers cannot complete their job responsibilities.

In this chapter we have seen that SHAs come from a variety of backgrounds and follow diverse professional pathways, and yet all assume oversight of SHPs in their districts. As we explored SHA titles and position descriptions, some SHAs expressed that they did not feel they were fairly compensated or titled for the work they performed. Some interviewees noted that their position was inappropriately placed on their district organizational chart, given the breadth and depth of their responsibilities. In order to deepen our understanding of the above concerns, the following chapter will outline the nature and scope of SHAs' job responsibilities.

Chapter 4: School Health Administrators' Scope of Work

Daily responsibilities offer one lens through which to view how SHAs work to ensure student health. This chapter will outline the primary areas of SHAs' scope of work. These include providing health guidance; supervising staff; ensuring student safety and adequate staffing levels; developing and implementing policies, procedures, and programs; conducting billing and grant writing; and partnering with community health agencies.

SHAs and deputies described their workdays as extremely varied. They simply did not have a "typical day" because even if they came to work with a plan of what they wanted to accomplish, they often had to respond to student health or staffing crises instead. Many of their work tasks centered on ensuring students' immediate health needs were met through appropriate staffing and service provision. They were also called upon to interpret and provide clinical guidance regarding school health program (SHP) requirements as outlined by education code, health-related special education services as defined by IDEA (Individuals with Disabilities Education Act), and specific policies required by local school boards. Related to this, interviewees described their ongoing efforts to develop new policies and procedures for SHPs.

SHAs also hired, trained, and supervised health services staff. Who they supervised and the nature of their support to these staff depended on staffing structures in the district. In addition to certificated staff such as school nurses, limited funding for SHPs led to hiring more unlicensed personnel (e.g., licensed vocational nurses [LVNs], health aides) to deliver health services. SHAs' supervision of staff was indirect, because all health services staff worked out at one or more school sites. SHAs may make periodic visits to specific staff or targeted schools, but most of their time is spent working at the district offices.

SHAs also spent time every day trying to maximize their funding streams. Some of them oversaw Medicaid Administrative Activities (MAA) billing and/or Medi-Cal (special education) billing for health services. Most of them were also either developing or reporting on grants from local foundations. Typically grant work was not conducted in isolation; one or more community agencies were key partners in writing grant proposals or delivering grant-funded services. SHAs also described the importance of establishing and sustaining community health agency partnerships. These agencies' services were needed because districts do not have the funding to offer such programs themselves.

Providing Health Guidance

SHAs said that every day, they fielded calls from health staff, principals, school site staff, other administrators, and parents about student health conditions, procedures, and policies. Typically school staff and administrators wanted to know how to handle communicable disease, an emergency, or parents' concerns. As one SHA said:

> I'm constantly on call for anything that goes on. So I get principals that call, nurses
>
> that call, and health clerks that call, and administrators here that call and something is
>
> going on, or something is blowing up, or we've got an issue with the child, or we
>
> need to get some help with this. So a lot of it has to do with – it's really health triage,
>
> if that makes any sense. So you're constantly dealing with different grade levels,
>
> different teachers.

As this quote suggests, SHAs with a nursing background work to educate and reassure school personnel about a variety of issues. A combination of local, state, and federal education and public health laws inform SHAs' health guidance to staff, administrators, and families.

Interviewees who had a behavioral health background described being called upon to guide schools' responses to student misbehavior or mental health crises. One SHA told a story of a call she got from a teacher, who was very concerned that a student was going to hurt herself, and she did not know what to do. The teacher told the SHA that the student said:

She was planning to jump off her apartment building, and she'd most likely do it this afternoon after school when she got home. It was like, "Yes, we don't need one of my people coming out. We need to have the PET team come out and hospitalize this kid." So, that does happen. We probably get anywhere from five to maybe 10, eight to 10 crisis calls a week. This week, there'll probably be a little bit more, usually before the holidays, because kids know they're going to be home for a whole week.

This scenario required the SHA's judgment about whether to call upon one of her staff, or a different mental health provider to respond to this situation. In this case, she knew that the County PET (psychiatric emergency team) should be called in. This SHA went on to explain that afterwards, one of her social work case managers would facilitate a "return to school" meeting, and provide ongoing support and case management for the student.

This same SHA said that many of her calls, particularly from principals, were for minor behavioral problems. For instance, she said:

Many times I'll get calls about behaviors, the little guys, the little kindergarten or first graders. I get lots of calls about them. I think that's hysterical, that the principals are chasing after them. It's like, "Really? You're running after them as you're calling me? Okay. What is it you think I'm going to do differently that you haven't done yet? [Laughter]" Number one, I wouldn't chase them because how fun, you have your principal chasing you [Laughter].

This SHA was frequently called upon to provide "live" guidance to principals on how to more appropriately respond to student misbehavior.

Those SHAs who also oversaw social services received calls for emergency help for a family. As one SHA explained:

> I've had a principal call me Friday afternoon going, "I have a mom in front of me, dad just left, there's no food in the home and I know the food banks don't open until Tuesday". So I was like, "Okay. Send them on over."

This SHA kept a small food pantry in her offices, along with other essentials like clothes and toiletries. This example illustrates how SHAs are called upon to help take care of basic needs for students and families, in addition to complex health issues.

Meeting the overall educational requirements under IDEA is typically the responsibility of the district's manager of special education services. The physical health assessment and intervention components of special education are the responsibility of the SHA, or in the absence of a SHA, the school nurse/s. In smaller districts that participated in this study, the same person oversaw both special education and health services. In addition, SHAs had to interpret the complex state education laws or codes (often referred to by interviewees as "ed code") that govern SHPs along with all public education programs in the state. These codes provide policies guiding how districts should manage everything from required health screenings, to sexual health education, to what training is required for school employees who administer insulin to students. Education codes and special education requirements drive SHAs and school personnel to focus on preventing liability.

Several SHAs emphasized the importance of understanding special education compliance and education codes. As one interviewee described it:

There's a huge piece of this job that's compliance-driven… knowing what you can and

you can't do, and what you need in order to provide supports to a student legally, and

what you can and can't ask someone to do at a school site, and what you would like to

happen and what you would like to push through, but knowing that you might need to do

things a little different to make sure that you're in compliance with how it's supposed to

work.

This SHA has outlined just how complex school health laws are, and how subtle their

interpretation and implementation can be. These laws impact staff training and supervision as

well as overall service guidelines for districts. Several SHAs referred to some tension between

themselves and their district's special education services. They felt that special education staff

and administrators were just focused on providing the minimum amount of services to students

that were eligible for special education. By contrast, SHAs were working to ensure the health of

the entire district population.

A different SHA was displeased with what she perceived to be an over-emphasis on the

legalities of school nursing practice. She found school nurses' and some of her staff's fear of

lawsuits inappropriate:

Why are the legalities of everything more important than the work? Why does everybody

want to focus on that? Focus on our license and lawsuits and this and that when - if

you're doing your job, do you even have to worry about that? I've been a nurse for over

25 years. I've been mentioned in lawsuits but my work has always been impeccable so

why am I worried? I never have been worried…"The district carries liability insurance on

every one of you. If you want to carry an additional policy on yourself, by all means, but

if you are doing things, by district practice and protocol, you're never going to have a

problem." That should never be a question.

While this SHA felt that so long as her staff followed district procedures and standards of care,

which were informed by school health-related laws, they should be well protected, not all

interviewees thought it so clear-cut. Another SHA indicated that conflicting laws created

confusion, especially when she was training staff:

We work under our BRN licensure but we work under Ed Code, we work under regs.

There are all these layers of things and they don't all – it's not clear. This one says this

and this one says this and it's not clear who has the authority in this particular situation,

so how do you train people about those things when it's all muddied?

This SHA implies that there is not consistency across all governing laws, licensing standards,

and other policies. This exemplifies one of the daily challenges SHAs faced: making meaning of

complex, and occasionally conflicting school health laws and practice guidelines on a case-by-

case basis.

Supervising Staff

Interviewees described how SHAs provided clinical guidance and support to their staff as

well. One deputy SHA explained the type of calls she gets from staff vary:

I had a call from a nurse, actually yesterday, because she had a student with diabetes that was

really high (blood sugar) with a pump and she was confused about the orders so she had

called me specifically to help her interpret orders. Sometimes it's real clinical, sometimes it's

more just, "I need to share this because I need to share this."

Both SHAs' and their deputies' support is important because, unlike in hospital- or clinic-based

work, staff work alone at school sites. All the interviewees described staff supervision as

somewhat challenging due to the highly independent nature of school health providers' work. School health staff independently conduct student health assessments, make determinations of services or interventions needed by students, and develop student health care or behavioral health plans. As one deputy explained, direct service providers worked at multiple school sites where they were rarely supervised:

> School nursing is interesting in that it's very - I won't say isolated, but you work sort of in satellites, if that makes any sense. I mean there's kind of this center hub that's health services and then you go out and you do your thing, but you're doing it alone unless you call somebody else, and nobody else knows what we're doing. That makes it a little bit harder as far a trying to train somebody because nobody sees what everybody is doing in a daily basis.

According to interviewees, supervising new school nurses and LVNs was more complicated because they could not be with them at all times, to assess their readiness for independence in a variety of tasks. One SHA felt both pleasure and overwhelm at her district's recent hiring of several school nurses:

> It's like herding cats so you've got 10 more cats you've got to keep an eye on. Then the idea is just to keep it so that it's consistent across all schools as you don't have somebody who's the rogue nurse out there doing something that nobody else is doing. Their security lies in the fact that they're following the protocol and the standards of the department in the district.

This SHA indicated that new staff needed to understand that they must follow district clinical practice standards in order to keep their jobs. The risk of a nurse not following district health

policies or protocols, however, could create even more stress for an SHA, who is responsible for her staff's performance.

Many interviewees said the most effective way to manage staff autonomy was to provide training and support, but not to try to oversee individual assessments or interventions that staff conducts. Staff said they appreciated being treated with respect by their SHA. SHAs echoed that, describing most of their staff as highly competent providers that operate well without supervision. One school nurse pointed out that the staff helps each other out: "We all work collaboratively and we cover each other when needed but we're district nurses because we provide care for the whole district. We're not just limited to our own sites." In this way, some staff and SHAs had created a system for ensuring that all students' needs were met across the district.

Some interviewees indicated a need for SHAs to stay connected with day-to-day student health issues. Without knowing what student health issues their staff had to address, SHAs would not be able to prioritize which policies, procedures, or staff training they should direct their attention to. As one deputy SHA warned:

> I think out of sight, out of mind. If you're not there every day dealing with the number of kids that come into the office on that end and then the number of IEPs that you have to get done, if you're not there experiencing that all the time, it's easy to mentally know it, but you don't physically know it. It's not as high - I may in my mind have a priority on what I want to work on to help, but maybe that isn't the reality of what's important at this time, this school year. I think that's important. That's how you support your staff.

In order for SHAs to negotiate for additional health staff time or positions, they need to know how long it takes for a staff person to provide each type of health service or intervention. One staff person felt a responsibility for helping to define appropriate workloads:

> As nurses, it's our responsibility also then to figure out the needs. That's why we try and collect information within our computer system so that at the end of the year we can say, "This took this much nursing time," not health tech time, not parent time, but actual – we went and gave the insulin.

In this case, the SHA engaged her nursing staff in gathering data on how much time they spent providing certain types of services, such as assessing students' blood sugar levels and administering insulin, or training staff at multiple schools on when and how to administer an EpiPen or Diastat (for seizures). Measuring and recording the time school nurses spend on required health services is one way to prevent exploitation of their labor. One way for SHAs to keep their staff from being overworked and unhappy is for SHAs to try to broker additional funding to develop more appropriate staffing patterns.

How much SHAs engaged their staff in decision-making or advising SHPs varied. One SHA of a larger school district created a school nursing governance council, and another established a nurse leadership team. Some interviewees created regional staff teams or content-focused committees. SHAs reported engaging staff in these committees for a variety of reasons. The purpose of staff involvement might include drawing on staff expertise to plan trainings for school personnel, or to develop a new health education program, or to create staffing assignments for the coming year. Engaging staff in making staffing assignments entails defining how many and which schools each staff person will provide services to. This might help staff understand how complicated making staffing assignments is, but it also might help the SHA feel

less responsible for assignments. In this way, SHAs may deflect some of the frustration their staff may have with them. Feelings of responsibility for staff discontent may be particularly difficult for SHAs who cannot access additional money to hire more staff.

Responding to staff complaints of being overworked may be challenging for SHAs whose professional identity is the same as their staff's. One SHA felt that SHAs still needed to be clear in their roles as managers, and not as colleagues, even if they can relate to their staff's issues:

> (SHAs) need to know what it means to be a manager, that sometimes you're asking people for their opinion and their opinion's going to impact your decision, and sometimes you need to know that you're going to make that decision regardless of what they want. So it's like knowing what it means to be a manager and some of the challenges and being able to own it when you're talking to your staff. That's separation… You can understand what they want, what they need, but you can't be one of them anymore. You have to be separate from them… when you're a manager, you're looking at things a little differently. You're looking at the big picture, you're understanding what all the different demands are, so you have to figure out how to frame what you want, how to talk to certain people, how to build alliances, and I think if you're overly aligned with your own people, their scope is much narrower. So this is what they think about and you're representing them, but you're representing them in a much bigger system, so you've got to figure that out. You've got to understand what their priorities are and match them.

This quote reveals that SHAs must engage in "boundary work" to separate from their staff, and simultaneously represent staff interests. Striking this balance is key for mid-level managers who must address the needs of their staff and those "above" them in the power hierarchy. SHAs' work to establish jurisdictional boundaries between themselves and their staff might prove

particularly challenging when the SHA's professional identity is the same as their school health provider staff (e.g., school nurses), and their most recent role was as a direct health service provider. This could make it difficult for SHAs to distance themselves from the staff they supervise. Identity aside, SHAs must engage in ongoing *negotiative work* as they define what their role is, and what work they do vis-à-vis a variety of coworkers (Strauss, 1997).

For SHAs, establishing boundaries between themselves and their staff might afford them some emotional distance when their staff have problems with other site staff, principals, and even parents. One school nurse said she liked how her SHA "stands up" for her staff when they received complaints from parents or principals:

> If there is ever like some kind of a complaint at the district - a parent feels that their child didn't receive the right care in the health office for whatever the reason is - she will talk to you and ask you what happened. It's non-accusatory. It's a, "I just want to know what happened so that I can respond appropriately to the family. So that I understand, I can mediate." So she's got kind of a – it's positive. It's not punitive. She listens to you if you have something that's going on that you need to run by her or if there are issues even here with the staffing. For example a few years ago we had an assistant principal that was difficult to work with…but seeing as I was brand new to this school, I didn't know, and I made sure that all of my emails or my communications with the assistant principal I would cc (the SHA) on those because I needed her support - and I didn't want her to hear a different story.

Other interviewees echoed the same sentiment about the support they received from their SHA. One said that her SHA helped explain to administrators and parents "why district protocols or policies are the way they are." By lending their support to staff when dealing with principals, in

particular, SHAs made staff feel like the district was backing their clinical or procedural judgment. Another school nurse shared an example: "She'll say to administrators, 'It's inappropriate for you to ask my nurse to transport in a private vehicle.'" In this example, the SHA also delineated a jurisdictional boundary between what the principal might ask for, and what the school nurse should provide.

Given the myriad tasks SHAs are in charge of, some have delegated components of health services staff training and supervisory responsibilities to deputy SHAs. This was true in all of the large districts from which I recruited participants. One SHA explained that she expected her deputies "to deal with those type of site level issues until it gets to the point where obviously I need to step in or come in and meet with them." If a principal requested a meeting with the SHA, she said that she would bring the deputy SHA to the meeting as well. Not until there was staff disciplinary action would the SHA would become more involved and work closely with the deputy to monitor the staff person's performance improvement plan. This approach could help build the capacity of deputy SHAs.

All districts from which study participants were recruited were addressing inadequate school health funding and staffing by hiring less expensive licensed vocational nurses (LVNs), and unlicensed health assistants (also called health techs, clerks, or aides). In some cases, LVNs provided a majority of ongoing care to students who required insulin, tracheostomy care, or other health interventions during the day. This allowed school nurses to conduct activities that required a registered nurse, such as student health assessments for special education, care coordination with students and families, or staff training. In other districts, there were no LVNs, so school nurses needed to provide all this care. Health aides provided limited first aid, triage, and

managed students who were sick with minor illness (e.g., colds) at school. They did not provide treatments, and mostly communicated with families.

In another district, a deputy SHA said that she was trying to get her SHA to understand that "part of me getting out there and seeing the LVNs and kind of managing the LVNs, I can go back and report to her and say, 'Hey, this is what's happening at this site' or, 'we probably really need to look at this situation'." This gave the SHA a connection to site-level care, when the SHA did not have time to oversee the work of several LVNs in her large district.

Figure 6. Types of School Health Staff Supervisory Structures
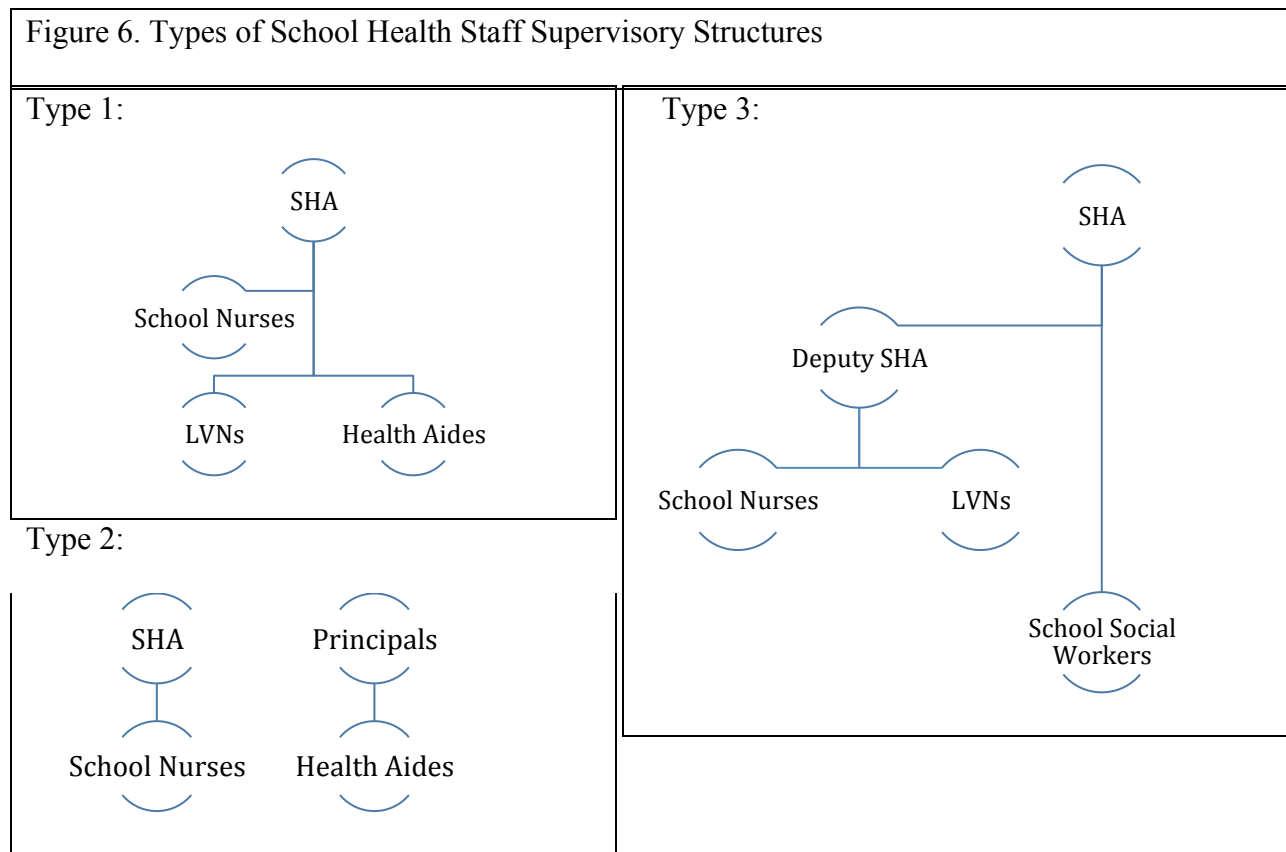
Figure 6 illustrates examples of the different types of staffing arrangements that SHAs oversaw. In Type 1, SHAs supervised school nurses, who in turn provided clinical supervision of LVNs and health aides. Most SHAs in this type of arrangement provided formal evaluation of LVNs and health aides. In Type 2, SHAs supervised school nurses, and principals supervised health aides. In most districts with this arrangement, SHAs had to train and monitor health aides to provide more clinical procedures, such as catheterizing a student. In Type 3, the SHA had a deputy who provided clinical support to school nurses, LVNs and health aides. The SHA still formally evaluated all these staff, in addition to the school social workers. These are not pure models, as most districts in this study had some mix of Type 1, 2, or 3. There were also two SHAs who provided direct school nursing services as well as staff and programmatic oversight. There were three SHAs who did not oversee school nurses at all, and instead supervised behavioral health staff. One of these SHAs was from a small district where he did oversee an LVN.

All interviewees with a background in nursing felt that only nurses should supervise school nurses because only a nurse could understand the work of school nurses, and provide related clinical guidance. However, as seen in Table 2, only 47% of SHAs were nurses. Most of the non-nurse SHAs arranged for one of their nurses to serve as a part-time "lead nurse" in addition to their site-level duties. Some of the deputies were paid a small stipend out of the SHAs' budget. Others received the same salary as their school nurse colleagues. These deputies provided training and guidance specific to school nursing clinical practice and the work of health aides and LVNs. Some deputies also helped their SHAs with billing, grant writing, and other

projects. One of the deputy SHA interviewees was in the lead nurse role for just 0.4 FTE. Her SHA supervisor described the arrangement in her district:

> The school nurses that I work with are very independent. One of our school nurses is currently serving as a lead nurse…40% (of her time) she goes around and supports the other school nurses because I'm not a nurse…She is doing much more of the working with the nurses at the sites and the health techs.

This SHA simultaneously recognized the independence of the school nurses, and acknowledged their need for clinical support. As such, this SHA was delineating a jurisdictional boundary where she did not address clinical issues; these were within the deputy's purview. This SHA's part-time deputy felt that the nurses needed a full-time nurse administrator to turn to with clinical issues.

Some SHAs supervised and evaluated their LVNs and health aides, while others did not. When the SHA was not a nurse, school nurse staff supervised the LVNs. In one district, someone in the special education department who had an administrative credential evaluated the LVNs, but they were trained and supervised by the school nurses. In many cases, there was confusion about who was in charge of the health aides. Principals sometimes did the hiring, supervision, and evaluation of their health aides, as seen in Figure 6, Type 2. In those districts, SHAs and school nurses were very displeased with the situation, and felt that health aides should be part of the health services department. In one district, principals even evaluated school nurses, because their SHA did not have an administrative credential, and couldn't legally evaluate credentialed staff.

This variety of health staff supervisory structures reflects who has power over whom in district staffing and administrative hierarchies. SHAs were clear that they felt that they should

have the power to hire, supervise, and evaluate all health staff within their health services departments. This was not the case, however, when districts decided to give principals this power instead, and they were able to hire and supervise health staff, regardless of whether the principals understood the qualifications or outcomes required of SHP staff.

Ensuring Student Safety and Staffing Levels

SHAs and deputies who were in charge of mandated health services spent the first part of each morning figuring out how they would get staff coverage for every student with special health care needs. Inevitably, they said, one or more health aide, LVN, or nurse would not be a work, so they had to figure out how to move staff around school sites to ensure students' health needs were met. As one SHA put it: "Staffing schools comes first. So the first thing I do when I get here is: who's absent, who's not absent, and do I need coverage for diabetics." Insulin administration wasn't the only type of immediate care needed. Trained staff also needed to care for medical fragile students with complex procedural or medication regimens, such as tracheostomy care, tube feedings, or anti-seizure medications. Several SHAs said they also contracted with outside nursing agencies for "substitute" nurses or LVNs to fill staffing gaps.

Ensuring appropriate health services delivery went beyond finding coverage for staffing gaps. Many interviewees described their efforts to establish appropriate staffing patterns that would afford 100% health staff coverage of every school in the district. This was not yet possible for most interviewees. One SHA describe how she was making improvements:

> Now we have 100 schools that are missing one to two days of coverage. So, before it was... those 90 schools went five days with no coverage. So, we need 20 more staff, whether they be nurses or health techs or a combination, to have 100% coverage in all of our schools five days a week.

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While many SHAs said they preferred to employ licensed health staff, they had to compromise and hire health techs to fill in staffing gaps. Two SHAs had huge charts on their office walls that showed which RNs, LVNs, and health aides they had at which schools. Their daily work entailed moving those staff around schools like knights across a chessboard.

Policies, Procedures, and Program Development

Part of SHAs' work entailed researching changing education codes and laws, and ensuring that district policies and procedures respond accordingly. Most recently, SHAs have had to implement new laws and recommend district procedures related to new requirements for stock Epi-Pens (and personnel to administer them) at every school, comprehensive sexual health education, and the administration of prescription medications including insulin and Diastat (for seizures). As one SHA conveyed, the challenge is not only creating protocols to implement policies, but also educating decision-makers in the district about those policies: "You need to stay up with the government policy, and being able to find ways to work with the people within the district so they're aware of rewriting policy, and keeping board policy up to date and communicated properly." In particular, this involved getting school board and administrator buy-in, at both the central office and site level.

Part of how interviewees worked to create new school policies, or update existing policies, was to present at school board meetings. For instance, this deputy SHA described presenting to the board late one evening on new laws governing bathroom and gym locker room access for transgender students:

Well it was this whole process, this thing with transgenders and the bathrooms and rather than just focusing on that, it's the whole thing: how do we support our kids that have something different going on in their lives, which can be our transgender kids, can be our

openly gay kids, can be our pregnant and parenting kids. So let's not just label each one

but what is the process for any of these kids to get the support that they need? This is

what Ed Code says is available to them, are we providing it?

This is an example of how SHAs outlined guiding education laws to foster a safe and supportive

environment for all students. SHAs are often responsible for helping establish an environment

where all students, regardless of health condition, sexual orientation, gender identity, or other

"conditions" such as pregnancy, feel protected from harassment, bullying, or violence. SHAs

must describe state health and safety laws to school board members, administrators, and school

personnel, and develop a set of procedures to implement these laws.

One SHA described doing work to change board policy so that they would not send

students home for head lice or nits (eggs). She started by giving the superintendent the data on

why their current "no nit" policy was not research-based. Then, she made a presentation to

principals, to educate them and build their buy-in, before taking it to the school board.

Another SHA worked for two years to get a mandated wellness policy passed. She first

engaged staff, principals, students, and teachers in helping define what they wanted the wellness

policy to include. Then, she invited a range of community members to help, including university,

business and health service partners. The SHA formed subcommittees to further refine the policy

and related framework, and to help plan how the policy would be implemented and evaluated.

Finally, the SHA met with the superintendent for guidance as to how to organize what pieces

would be included in the policy, and what would be included in a longer framework. This

example highlights how much of their own effort, as well as stakeholder engagement, many

SHAs must rally to develop and implement health policies for their districts.

In addition to health mandates, SHAs identified a set of responsibilities related to developing comprehensive health promotion and early intervention programs. In addition to finding funding for health promotion programs, SHAs said they experienced difficulty getting district personnel to see the need for preventive health programs. One SHA explained her problems getting social-emotional health programs in place:

> I think there're so many competing priorities that they don't see this as an integral part to getting to their outcomes and I think that our business - our social, emotional and health - has not done a terrific job with the research showing the connections, the correlation between early intervention and success.

This statement reflects a need for SHAs to present research demonstrating the outcomes of any health or wellness program they want for students. This suggests that SHAs must spend time researching programs to demonstrate their impact, along with securing funding (typically foundation grants), staffing, and buy-in from the sites where the programs will be implemented.

Interviewees also described having to justify which schools would receive wellness programs. Some SHAs structured program allocation based on student needs and distribution of resources. As one supervisor said of her SHA's decision-making regarding implementation of a program that promotes physical activity and a safe environment without bullying:

> It's not just one school you service and settle. She has that very keenly a part of what she does - that it's all kids, but it's data driven - and the schools that are getting the Peaceful Playgrounds are definitely the schools that have highest BMIs. You know we want these kids to live a great healthy life and so if that's where we have to go, then that's where we have to go. It's not just on a whim she'd pull them out of a hat. There's a reason behind it and everything she does, it's always validated, whether it's research that she has or it's

evidence that she has seen or it's the outcomes of exams or whatever they may be. It's

definitely thoughtful and deliberate based on the facts.

This story highlights not only the work SHAs do to ensure that the school health programs

(SHPs) they promote are research-based, but also the time they must spend collecting data on

student need, and then distributing resources accordingly.

Budgeting and Billing

All study participants reported that SHAs need to know how to manage budgets. Their

budgets included multiple sources, including Medi-Cal reimbursements, revenues from Medicaid

Administrative Activities (MAA) billing, funds provided by district special education

departments, general purpose funds, and private foundation grants. In some interviewees'

districts, principals used site dollars to pay for or increase site health provider time. MAA billing

required collecting "time studies" and coordination across all schools serving a largely low-

income population. Medi-Cal billing required school health providers to complete detailed claim

forms. In addition, SHAs had to negotiate for, and then report on, all special education and

general purpose fund dollars they received.

SHAs described making budget requests that were frequently denied, whether for

salaries, equipment, or other expenses. One SHA expressed her frustration with budget decision-

making:

We also need some business sense or something to understand how decisions are made in

the district. You got to have a whole lot of patience when you have to continue to have

the hope for the future. You don't get it (funding) a lot of times.

Most SHAs echoed this sentiment: the struggle for SHP funding was the most challenging part of the job. One staff member said her SHA spends the greater part of her day trying to get money for SHPs:

> She's always looking for money. [Laughter] I think a big part of what she does is money and keeping us afloat. That's something she talks about a lot - grant money, getting money from the schools, or getting money from the district. This year, I think, was one of the first times the district has actually committed funding - like it didn't come from somebody else who had cast off money. Usually we're like, "We got lucky because Special Ed had an extra this."

The fact that this staff person knew so much about her SHA's financial struggles indicates just how pervasive the problem was: all health services providers not only had to attend to their work serving students, they also worried about how it would be paid for.

Even when district funds were available, SHAs felt that the budget process was very slow, and unresponsive to student health needs. For example, one SHA explained:

> The budget thing is huge, I think. From a budget and a staffing outlook, you have to know that it does drive things, and it drives decision-making where you really wish you could do things different two weeks from now, but you know that that decision has to be put off probably for three months in order to work it through the system in order to make budget and staffing work for it.

According to this SHA, budgeting sometimes drove staffing and programming needs, rather than the other way around. A different SHA described creating a proposal to justify having district nurses do tuberculosis (TB) screening, rather than paying employees to get TB tests elsewhere:

When I wanted to propose to the district that we would take over tuberculosis screening -

we could do it cheaper and better, take it over from paying all of our employees to go get

it - I needed to have a business plan, because otherwise I wouldn't have really even

known how to talk about it. So I know how to do business plans. I know how to do

evaluation of financial data.

This SHA clearly felt confident in her budgeting skills, but still had to spend time creating a

business plan in order to demonstrate future cost-savings to the district. Developing the plan also

helped her figure out how to present the idea to decision-makers.

Some SHAs said they weren't given adequate or timely information from their fiscal

services departments regarding their budgets. One SHA had been told that while her department

would get additional money as a result of the district's LCAP (Local Control and Accountability

Plan) and LCFF (Local Control Funding Formula), the monies wouldn't come until the following

year. She found out after the fact that she already had this money placed in her budget:

They did give me something but I didn't really know it because Budget (department) isn't

great at telling me things. The board member that is constantly in here and giving me

things to do, came in and she goes, "You were given LCAP money and you didn't spend

it. See?" She pointed – "I could show you. It's somewhere around here."…I'm like really

good at budget. That's one of my strong suits. I'm like, "I didn't even know I had that

money." She is just like, "Well, they gave you $68,000.00 or something."

Despite this SHA's self-identified skills in budgeting, she did not realize she had been allocated

additional district dollars because the budget department had not informed her. She said given

the lateness of finding this out, she had to request a roll-over to the following school year, so she

could still use the funds.

One school nurse had recently taken on a part-time deputy role to provide support to other nurses in her district. When asked what she would like to know about other school nurses serving in a capacity similar to hers, she described her frustration at not being prepared to understand how to manage budgets.

> When I took on the resource (nurse role), right away I went to our secretary… I said, "I need this. I need this," and I looked at this budget thing that they gave me and I didn't understand it. I'm pretty good at math. I just didn't even understand it.

This speaks to the need for budget training for new SHAs or deputies, or those who hope to grow into such roles. According to other interviewees, part of this budget training should include how to extend existing dollars to safely serve as many students as possible. One deputy described her SHA's efforts to expand health providers' reach to more schools:

> For several years we were trying to expand our licensed coverage at school sites. So when nurses retired we would convert those FTE to LVNs, because we could convert one RN position to two LVN positions, to expand our coverage because of the emergency medication and school laws like for lorazepam and insulin. But we're to the point now that we cannot operate on fewer RNs because they've added another middle school, they've added programs…Nobody wants to give up any of their budget, but they want us to do their preschool special ed assessments and – [Laughter] so (our SHA) is trying to get across and has documented all the charter schools that they contract with, all the added responsibilities that health services has been given, but not any additional RN staff.

There were increasing demands placed on health staff, and yet no additional funds allocated to pay for more staff. This story reveals the strain SHAs, their deputies, and site staff were under to ensure safe care is provided to all students in need. The SHA and deputy were forced to trade

highly trained school nurses for less-educated, and less expensive LVNs. This suggests that SHAs are making risk assessments while engaged in the staffing and budgeting process, in order to provide the best possible SHPs within given budget constraints.

Grant Development and Reporting

Due to budget constraints, all SHAs described looking for grant funding to cover existing costs or expand their SHPs. SHAs said they were applying for or had received grants for everything from equipment for a school health center, to improving school nutrition programs, to providing asthma education. Securing grant funds required regularly searching for grants and developing proposals. Some SHAs said getting grant funding had become more competitive, so they had to take care to demonstrate student needs if they hoped to apply.

Some SHAs worked with community agencies, such as their local public health departments, to apply for grants. Other SHAs said they cultivated relationships with potential funders so they would be better positioned for grants when they came along. For example, one SHA said a grant program officer she had been working with awhile "lets me know when grants are coming or different things. She always frontloads me with what they're looking for so I know how to fit what we're doing." The information provided by the grantmaker allowed the SHA to try to align her SHPs with what the foundation was interested in funding.

Once SHAs receive grants, they have to ensure all grant "deliverables" are being met, and write detailed reports. One SHA described how she works daily to implement and gather data regarding grant activities. She said the funders "are really on top of me." She went on to explain:

Today, I have a conference call at 2:00 with (the funder) to check my measurements and

Wellness Policy implementation - more physical activity, healthier options, healthy fund-

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raising. Staff wellness is a part of the grant and what am I doing to help people be

healthy, it's constant. It's like every single day. It's a ton of stuff.

In addition to all her other supervisory, staffing, fiscal, and policy-related responsibilities, this

SHA was in charge of a foundation wellness grant that required daily oversight. This grant, like

many that SHAs oversee, also required work with community health agency partners.

Partnering with Community Agencies

Almost all study participants talked about how SHAs developed partnerships with

community agencies to better serve students' health needs. Community agencies provided

services on school campuses or in nearby facilities that school districts didn't have the funding or

capacity to provide. For example, across the districts from which participants were recruited for

this study, community agencies provided student mental health services, dental screenings,

primary medical care, and physical recreation activities. When asked what skills a SHA in her

position needs, one SHA said: "it's somebody who has that willingness to collaborate with

community agencies because that's something you have to do daily and be able to bring people

together and talk about the needs of the community." Interviewees listed an array of community

agencies they worked with, including non-profits, primary care providers, specialty providers

such as endocrinologists, institutions of higher education, community gardens, county behavioral

health departments, and even local businesses. Some of these agencies provided daily services to

students on school campuses; others were more remotely involved in supporting student health.

Some SHAs sought after community agencies as they developed new programs. This

would build program buy-in, and serve to engage agencies as potential providers of a component

of the new program. For instance, one SHA invited multiple agencies to help her develop a new

district wellness policy:

We started inviting community partners - university, our university partners, our business

partners, our service partners to the table to say, okay, well you as a community have a

voice in that, right? We had parents at the table, high school kids at the table, district staff

at the table, district principals, teachers - but we didn't have the community piece

realistically involved.

As a result of this community engagement, two grant-making organizations also joined the

wellness policy planning, and decided to invest in piloting the new policy at several schools.

Some SHAs described using their personal and social connections to help bring

community resources into the district. One SHA shared that her husband is an endocrinologist,

and he helped her by first talking to some of the insulin pump vendors and asking if they'd be

interested in providing information to his wife's school district. She then contacted the vendors,

and arranged for them to provide training for school nurses:

I kind of let them know what's going on in our district and how we deal with students

with diabetes and how we would really like the benefit of some of their education that

they could give us, and kind of brokered it along that way. So I've done a little fluff and

buff and begged, but most of the time they're very, very nice and very willing to come

and educate. We, in turn, end up educating them as far as how it's different at home and

why it's different during the school, why we can only do certain things or we have to

have things set up certain ways.

This deputy's use of the word "begged" suggests a power imbalance between the for-profit

insulin pump vendors and the deputy. The deputy "brokered" the vendors' training, with "fluff

and buff," implying that she made the vendors feel important in order to get them to deliver the

training. The deputy SHA did not feel empowered in relation to the vendors, and had to use her

husband's connections to talk to them. For profit agencies selling something like insulin pumps have no incentive to talk with school nurses, who are not buyers of their products. However, this deputy felt that the training was useful, and that the school nurses taught the vendors something as well.

Some SHAs found that community agencies did not share their focus on serving students. Another deputy SHA spoke about how in her contracts with school-based health center provider agencies, she has learned to require that they prioritize students:

> It's got to be mutually beneficial and has to be a benefit to our kids. For example, we have some school-based health centers that are on our sites and of course, in the contracts we supply utilities and we give the rent free, but they're seeing mostly community members. Well, that's not okay. That's not integrated. "No, our kids get priority in your schedule or why are we doing any of these for you?" It's a turnaround of "what benefit are you going to provide to the district? We're not just here for your disposal, for your use."

This deputy had learned from past experiences that some community agencies wanted the school clinic space to serve more lucrative community members, and not necessarily students. Finding shared goals and operational agreements that serve both schools and community agencies can be challenging. SHAs and deputies are still motivated to try to work these arrangements out, because community agencies have access to more and different funding streams to provide health services for their students.

Several SHAs talked about their willingness to broker community-school health and wellness partnerships, even when it was not related to work that SHA was specifically responsible for. As one SHA said, "I do a lot of meetings and a lot of connecting people with

resources." "Connecting" was a natural role for SHAs. While they might not be in a position to create formal agreements with community agencies, SHAs seemed happy to serve as liaisons who could ensure that the right district people and processes were connected to form partnerships with community organizations. One SHA did not seem upset that she was not a decision-maker as she described her connecting role:

> I'm not doing gardens in schools, but if they need something, I frequently will get the call to help them connect to the right person in the district. So although I may not be the person – but I do that. I welcome those calls, I like to connect people. It doesn't have to be in my world, so those meetings are an opportunity to just connect with different people and see what are the new initiatives going on… When you're in a place for long enough and you earn a reputation and respect, you can go to meetings and you can nicely ensure the people are going to do what they need to be doing. So I use a little bit of my power to make sure that things are moving properly within the system. I do it in a very friendly way. I mean, I got a "thank you" from someone today who just said that "I'm so glad you were there because you were able to…" Things get stuck in big systems.

This quote illustrates that SHAs' work as brokers is recognized both inside and outside the district. With their knowledge of district processes and community agencies, SHAs are in an ideal position to serve as a bridge. This SHA felt that she had the power to help move a potential partner's request through the right channels. This SHA also shared something that other interviewees echoed: taking the time to attend community agency meetings provided important information about new and potential community health partnerships. Some SHAs invested time in serving on other agencies' boards or committees, because later they could call on those agencies to support their SHPs.

This chapter has accounted for many of the day-to-day activities that SHAs were responsible for. Their job requirements varied individually, based on the types of programs and staff they oversaw, and whether they had deputy or other support staff. Half of the SHAs and deputies in this study said they simply had more work than they could complete. For example, one SHA said that for over a year she had been trying to demonstrate that she simply did not have enough hours in the day to do all her work:

> I did pie charts and showed how many days in a contract and all the different components and the different things that I do and I broke it down into percentages because I pretty much have a lot of data that I can show with my calendar how many hours it takes to do certain events or projects and I go, "Look, it would take me a year to do all of this stuff," and I only have 188 days in the calendar and the administrators just look puzzled like, "No, you're just not time managing well basically."

Despite the evidence of an unmanageable workload provided by the SHA, the administrators in the district did not agree to increase funding to make her a year-round employee, or to hire another school nurse to help her. This SHA said she was so frustrated that she was thinking about leaving her position. In a different district, another interviewee was upset over how a previous, part-time deputy had done so much work that it was unsustainable for her and she quit:

> When the nurse had that 10% time (as lead nurse), she was responsible for our budget. She was responsible for our hiring and terminating. She was responsible for all evaluations over nurses and health techs for 10% time… she really did us a disservice when she was here because she really did – she did more than two people's positions.

This staff person was upset that the previous deputy SHA set an unrealistic precedent that no one else could follow in that role, unless they worked full-time. Some SHAs recognized their

tendency to overwork. One explained that she often did not get to sit down and work on things like policies, procedures, budgeting tasks, and grant reports until after 5 p.m., when others' demands on her ceased, so she would often stay in the office until 7 or 8 p.m. at night.

When SHAs or deputies agree to overwork, they risk perpetuating a system in which other SHAs are expected to do too much with too few staffing and financial resources. Some SHAs' willingness to overwork could be a gendered response to marginalization that allows for exploitation. Most SHAs in this study came from "feminized" helping professions, particularly nursing. As caretakers by training, SHAs who find themselves in a marginalized position may be more accepting of a lower salary, less authority, and working extra hours. The district organizational context can also define SHAs' workload. The next chapter will identify how school districts' institutional power structures and individual politics impact whether, and how SHAs can accomplish their myriad responsibilities.

Chapter 5: School District Power Structures

Multiple institutional, legal, and political factors influenced the work of school health administrators (SHAs). This chapter will share interviewees' descriptions of how school district power structures shaped what they do, and how they needed to work with key decision-makers, including the superintendent, school board, their supervisor, executive cabinet members, and principals. Examples of how SHAs, their staff, and their supervisors described the context in which they work illustrate how SHAs and their colleagues reproduce district power structures.

SHAs operated in an organizational structure in which they often did not have the authority to make funding, hiring, or policy decisions. SHAs described how the school board, superintendent, and his or her executive cabinet held ultimate decision-making authority regarding school health program resource allocation. The cabinet was made up of the superintendent and the highest level of district directors or associate superintendents, and rarely included the SHA. State education code and federal special education laws dictated some of the programs and services SHAs were accountable for. School board members determined which school health policies and procedures were approved at the local level. School principals served as gatekeepers to site-based health services, and in some cases, to the hiring and evaluation of site health staff.

Study participants described why and how SHAs had to carefully navigate their school districts' organizational structures. Every time SHAs or deputies wanted funding, additional staff, or a policy or procedural change for their school health program (SHP), they had to seek the approval of district decision-makers. SHAs also described ongoing efforts to secure political support for SHPs as the greatest challenge to getting their work done. As one supervisor said:

Making sure that that voice (for school health programs) is heard through the LCAP and

the new LCFF funding and as districts are always saying, "How do we best meet our

mission?" So I would say that getting that voice out of what our support people can do

and maybe increasing that amount of support - as everybody's vying for that - I think it is

a difficult thing to do with the financial structure…the most challenging thing is to keep

that voice heard.

This supervisor raised several central themes that emerged from other study participants: SHAs

are the lone "voice" for SHPs in their districts, the financial structure of school districts does not

allocate funding to SHPs beyond what is mandated under special education, and SHAs must

repeatedly try to negotiate for funding that others are competing for.

SHAs were also clearly identified as middle-level managers within their districts by all

interviewees. This posed a challenge to SHAs and deputies, because they were not empowered to

make decisions without approval "from above" within their district hierarchies. As one staff

person aptly described the difficulties her SHA must deal with in her daily work:

Middle management is really difficult because you're not the *boss* boss. You have bosses

to answer to and then you have staff and I think I'm not sure what's worse: the staff or

the bosses, but you get no happy cushion in there at all like you're – I mean there's some

– I mean I know she's satisfied in some way otherwise she'd have been gone by now. So

I think there is a lot of job satisfaction that she gets and I know the staff do appreciate her

and I know that the administrators appreciate her but I think it's really tough to be in the

middle because you hear the griping of the nurses. You hear the griping of the directors

and the superintendents, and I think it's really difficult.

SHAs' middle-management position, caught between their supervisors "above" them and staff "below" them in their districts' hierarchy, informs how they accomplish key responsibilities on a daily basis.

Most SHAs said in order to make any decision, they first must get approval by their supervisor and health services department, and then the "executive cabinet" made up of "the top leaders of the district." Most decisions were made at the cabinet level, which includes the superintendent. If needed, the superintendent would take issues to the school board for their approval. In some cases, SHA supervisors are at the cabinet level. Two SHAs from smaller districts who participated in this study were at the cabinet level themselves.

District Organizational Charts

Organizational charts are one way that school districts establish power structures and related internal hierarchies. These hierarchies serve to formalize and reinforce who has power, and how much authority each individual role has. Districts create their own organizational charts and systems of designating central office administrator titles. See Figure 7 for the typical hierarchy outlined in school districts' organizational chart. One SHA described her large district's organizational chart, and some of its inequities:

> It's program managers, directors, executive directors, chief superintendent – well, area superintendent, superintendent - and then there's classifications. You have your area superintendent. They're over all the principals (who) are all over instruction. We have a superintendent, and then the chief of staff, and then we have a chief of operations, and the chief of HR, the chief of student services, and then under them are then executive directors but some of the executive directors oversee nobody directly. They just support

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various programs and/or schools or whatever. Then we have the executive director for

special education and she has over five or six, I mean, thousand people.

This district may have more layers of management than smaller school districts, but all districts

in the study sample followed the same pattern of establishing a hierarchical system of naming

high-level administrators. Each title is associated with more influence the closer they get to the

superintendent. The administrators who oversee curriculum and instruction as well as special

education typically have a higher place in the organizational chart than SHAs. The organizational

chart serves to reinforce administrators' professional identity and amount of authority. Most

SHAs did not feel that their placement in the organizational chart gave them enough authority

given their scope of work was at least as large, if not larger, than their administrator colleagues

who were placed higher in the chart.

Figure 7 – Typical School District Organizational Chart
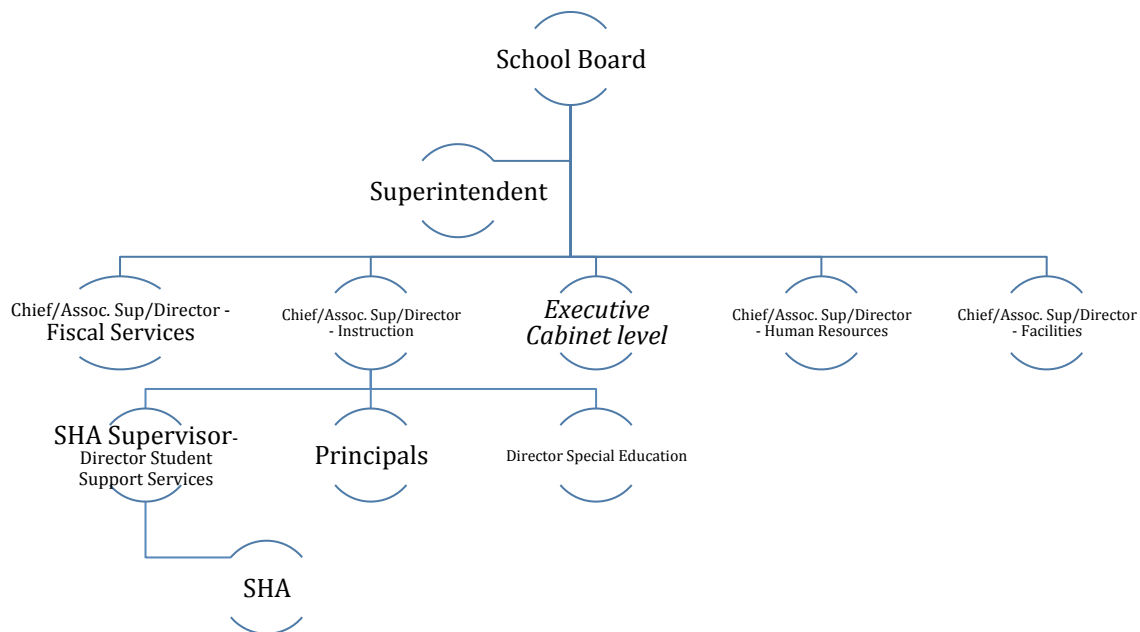
District organizational charts frequently change. Four interviewees' supervisors were changing at the time of the interview. One SHA described his predecessor's movement across different departments:

The way things kind of move in any school district…she was in special ed for a period of time under health services, but along the way I think during that 20 years she did jump back and forth between special ed and pupil personnel. I think it's just whether the psychologist are under special ed or pupil personnel that they get bumped back and forth. The counselors sometimes get bumped back and forth, the nurses sometimes get bumped. It's just how the wind blows and how the tides change with education and what's happening in the district and who can supervise who.

Power shifts each time a new superintendent is hired, and when other high-level administrators change or shift their own staff. This reorganization could mean that SHAs without an appropriate title or job description would have to try to re-establish their authority and scope of work with each new administrative peer or person above them in the hierarchy.

Chain of Command

Interviewees described their district hierarchy as very formal. A request by a SHA would have to follow a specific chain of command in order to be approved. Supervisors described how all decisions and paperwork related to budgeting and personnel would need to go through them, and possibly on to higher-level decision-makers. As one supervisor explained:

Some of it, her (the SHA) and I can talk about and I can approve it. There are some things I have to go to cabinet and the cabinet will just decide. Then some things go to the superintendent, some things go to the board. It all depends on what the situation is. There are lots of different things. Usually, if it affects the classroom, that's usually cabinet for

the most part. If it's a staffing issue, sometimes that's the cabinet, sometimes that's the superintendent. It depends on what the staffing need is, the "whys." If it's a Special Ed issue or it's an IEP-driven kind of thing, then it's almost we just have to do it. We have to figure out how to make it work… If it's just, say additional staffing or additional services that we want or an additional program, a new program, those will probably go to the board for the most part. Day-to-day stuff, flu clinics, that kind of stuff, her (the SHA) and I can just do.

This supervisor has delineated what types of decisions need to be made at which level of the district hierarchy. Special education needs are always approved because the federal government mandates related services through the Individuals with Disabilities Education Act (IDEA). Interestingly, the supervisor did not mention any operational or programmatic decisions that the SHA could make on her own. Instead, the supervisor's statement suggests that she does not think her SHA has adequate authority to make these decisions. This supervisor reflects her buy-in to the status quo, a situation that does not afford the SHA any decision-making authority at all.

In some cases, interviewees described circumstances in which SHAs were allowed to speak to cabinet members directly, so long as the SHA first went to her supervisor, and the supervisor was present at the cabinet meeting. One supervisor said: "Most times when her and I meet, she'll kind of give me a synopsis on what she needs and I'll take it to cabinet. There have been instances where she has been invited to cabinet." Most SHAs were only allowed access to this higher level of decision-makers if they needed to provide a more detailed explanation of the request than their supervisor could provide. Most study participants indicated that they would not challenge their district hierarchical decision-making structures.

Interviewees described how it was important to move all health proposals through prescribed channels before taking them to the superintendent and school board. One SHA said that by following this process, "they have not taken things to the board that will be shut down…It doesn't get to the board unless it's been vetted pretty carefully." The same SHA said that the executive cabinet would first identify and address any potentially controversial issues before a health proposal goes to the school board for a vote.

Central Office Decision-Makers

The school board.

School boards, or boards of education, are the locally elected governing bodies of school districts. Board members tend to be focused on issues of importance to their neighborhood constituents. Members may also have political interests beyond their role on the school board, such as in city politics, or local businesses. Some school board members are easily influenced by their (appointed) superintendent, others less so. The superintendent attends all school board meetings. One SHA described the dynamics of the board and superintendent depends on who's on the board at any given time: "The synergy of the people sitting on the board, they tend to get themselves worked up together. You can have a board that's quite antagonistic and we've had that. I've seen the board change over the years." So individual board member attitudes and decision-making may be impacted by their group dynamics, and vice-versa.

Interviewees described school board members as generally supportive of the idea of SHPs, but also said that they are dealing with competing interests and funding priorities. Like other district decision-makers, their priorities typically do not include SHPs. Instead, they often prioritize fiscal solvency and academic achievement in their districts. Interviewees spoke of

some school board members who were very politically conservative, and did not believe that school districts should be providing physical or socio-emotional health services.

The superintendent.

Most interviewees identified the superintendent as the individual who had the most influence on how much funding SHPs received at any given time. If the superintendent saw the need for more expansive SHPs, they were awarded more funding and positions. If not, then staff would likely be laid off, particularly when there were statewide or district budget cuts. One SHA explained that she'd been able to hire school nurses because of the explicit support of her superintendent: "When nurses have retired we've been able to fill those positions because the superintendent has designated nursing as critical to the organization. So anytime anybody leaves I'm able to fill (the position), whether it's a health tech or nurse." When the superintendent named school nursing as "critical" to the district, it seemed that potential barriers fell away.

Another SHA echoed this experience. She said the key to her success has been the trust her superintendent has in her:

> You have to have a superintendent that trusts you and trusts that – I mean I think that's the critical thing, a very supportive school board and a superintendent that doesn't watch your every move and say, "Yes, you can" or "No, you can't" - and that's what we've been blessed to have. Our superintendent is retiring in June. We're not really happy about that but she's been the superintendent for – this is her 14th year - and she really believes in the whole child and understands that health is a really important component. I have not been limited and said, "No, you can only do this and you can only do that." If I find opportunities, I go out there and get involved in them and then try to bring resources back to the district.

This SHA did not feel micromanaged by her superintendent or the school board. She was allowed to explore and bring in more health resources as a result. Clearly the SHA did not have institutionalized authority, though. Instead, it was predicated on the support of that one individual - the superintendent – who was preparing to retire. Therefore, the SHA and her staff were "not happy" about the departure of their key supporter.

One SHA tried for years to get support from district leaders to start a school-based health center (SBHC). Eventually the superintendent became an advocate for the SBHC, and then it happened:

> It had to come from the top down and so, to get it, because if I were to put it out there, there are so many steps and people don't get it. With health, they just don't get it in the district. Even if I went to exec cabinet, which I have, they just don't get it until he makes, says, "This is what we need," …and "I've got the buy-in, and I've got – I can pull in programs and do it all."

This reveals the "top-down" influence of the superintendent on cabinet members and their decision-making, and the SHA's relative lack of authority and control. The SHA's analysis of how decision-makers in the district "just don't get" the need for SHPs in her district reflects, once again, how marginalized SHPs are.

The impact of superintendent turnover.

Many interviewees expressed frustration with frequent superintendent turnover in their districts. Because each new superintendent tended to make his/her own appointments to senior administrative positions, these positions became more political. This led to increased power of the superintendent, who had control of executive cabinet. In some districts, it also meant that the

SHA's supervisor changed. For example, one SHA reflected on how she had four different supervisors in one year:

> We've had a lot of transition here. So when our superintendent left, then you had my previous supervisor boss. She left and part of her reason for leaving was probably, she didn't know – well when new superintendents come in, they clean the house - so that was her fear and she left. Then I was moved over to chief of staff. She left, same reason, and then I was with the interim superintendent. She left, and then I was with the chief of schools. She stayed and her title changed, so four different people in one year. The last person, first she was chief of schools and now she's deputy superintendent, so she's just below the superintendent. He didn't bring any new people, he just changed some of the structure.

This reveals how disruptive it can be for SHAs each time there is a new superintendent. One SHA described how superintendent turnover actually made her fear for her own job:

> We tend to have a large turnover here as well, which has led to much of some delays in my programs going through because we tend to have upper management turnover. I'm on my fourth superintendent. We had three new chiefs hired last week. Chief of academics, chief of facilities, chief of finance, all were let go or moved on because the sup wants to bring in his – we just got a new sup. He was here as a chief and was promoted to sup… So all of a sudden, people start disappearing and I'm like, "Ooh, wow." So I've been sitting here like strapped in and going, "I'm going to get fired."

While this SHA did not end up getting fired, all the disruption led to increased anxiety, as well as delays in getting SHP actions taken by the new administrators "above" her. She also explained

that the turnover led to worsening communications so that she often did not learn about key changes that impacted SHPs or staff until after the fact.

The risks inherent in superintendent turnover are very real to SHAs. Several SHAs described how previous or current superintendents did or did not see the value of SHPs, and acted accordingly to either eliminate SHP staff, or support hiring more SHPs. One example of this was shared by a SHA in a large district:

> There was a superintendent that came in that did not see the worth of school nurses, and I think he gave the directive to the special ed director at that time to cut. Our current superintendent is not of that mindset and so folks are coming back. We're bringing things back to support students.

SHAs have to learn how to assess the mindset of each consecutive superintendent, do whatever possible to build that individual's support, and then try to ride the changing political tide and the interests of administrators that the superintendent brings with him/her.

Executive cabinet.

Budget decisions were made at the level of the school board, superintendent, and executive cabinet. The executive cabinet did not typically include the SHA. While composition was not identical across districts in this study, interviewees said their cabinet typically included assistant superintendents or directors of instructional services, human resources, special education, fiscal or business services, facilities, and the superintendent. See Figure 7 for an example of where the cabinet was placed in the organizational chart. Sometimes the district's attorney and "public information officer" were also part of cabinet. Most SHAs only got access to the cabinet through their supervisor, or their supervisor's supervisor.

Several interviewees highlighted how important it was for SHAs to get access to the cabinet through whatever means possible. Even site staff recognized the importance of getting representation in cabinet, as one emphasized: "You have to have someone at that higher cabinet level who understands the cause and who's championing the cause, or really believes in it and buys it." The only way to get SHP requests thoughtfully considered within cabinet was to get a cabinet member to champion the issue.

Not being a part of the district's executive cabinet means not participating in decision-making related to SHP funding. As one SHA plainly stated: "I don't manage how we're funded but they do that at the district. What I manage is just people and then maybe supplies or whatever is going on at the sites." Study participants outlined how most key decisions were made at the cabinet level, including funding for staffing or equipment, and who would supervise and evaluate which SHP staff. For example, one staff person was surprised to find out from her SHA that executive cabinet had made a decision that their health services division would no longer oversee health techs. Instead, health techs would be supervised and evaluated by principals. The staff person described finding out about this from her SHA:

> "Now we'll have the health techs back, right?" She was like, "No. I don't think we'll
> ever get that back in-house." I'm like, "That's us. We need to have that back. It shouldn't
> be out there." "No, that was an executive cabinet decision." Because we have our
> superintendent and then our board, our school board, and then executive cabinet which is
> a combination but also brings in the attorney and different things and they meet. I guess
> executive cabinet made that decision.

This conversation conveys an acceptance of the cabinet's authority, even though the interviewee did not think the cabinet's decision was appropriate. It does not seem that the SHA had any

power to challenge cabinet decisions, despite the fact that no rationale was provided for the decision to have principals supervise the district's health assistants.

SHAs highlighted how SHPs were often not at the forefront of their cabinet's interests. This could be because SHPs are not considered or funded as a central component of districts' services for students. Instead, SHAs said the executive cabinet's focus was on instructional or other budgetary issues, which stalled decision-making regarding SHPs. One deputy expressed her frustration with what was happening in response to a request for more SHP staff:

> Our assistant superintendent is taking that forward to the cabinet, which are the district level leadership, and then cabinet goes to board for things that they approve or they give us the go ahead… So anyway, but we have to do all the prep, all the justification, set everything up so that (the SHA's supervisor) has the information to present to cabinet - and sometimes she'll have (the SHA) there so that she can also answer questions. So it's a very cumbersome process. And then if there's a problem with some other entry, then they get all the attention and then we're kicked to the backburner again.

When other cabinet agenda items get moved to the forefront, SHP issues lose their opportunity to even be heard at cabinet meetings. Despite this, SHAs must prepare justifications for additional staffing, and give their supervisors the information, just in case they can actually present the request to cabinet. Other interviewees expressed frustration with not receiving needed information that was only shared within cabinet. One SHA said she was not invited to cabinet meetings, and as a result "I just get bypassed in some of the lines of communication because I don't sit on these – the cabinet meetings." All this reflects how higher-level district administrators and cabinet processes disregard the importance of SHA requests and the programs

they oversee. Cabinet meetings serve to reinforce the power of cabinet members, to the exclusion of SHAs.

Another SHA expressed irritation with not being able to secure a date for an outside expert to train district administrators about students' experiences of trauma, and how it could impact their learning:

> I need a date…I can't figure it out and I have to ask. I've asked (my immediate supervisor), I've asked (my higher level supervisor), I've asked everybody and say, "All I need is a damn day, okay?" [Laughter] but I don't know if it's more about "this is instructional services, so we're holding on to that. We're not sure if we want this person for the whole day." I don't like to go there. I'd like to think that it's just "we don't know," okay, and if they would just say, "We don't know," I'd be fine with it but I do need - in order to get this person to commit - I need a day in June. That's all I'm asking for. So those are the frustrating pieces about my job and I don't know if it's just way above my paid grade or I don't have enough clout to get that information. I'm not in the circle and I don't want to be in the circle really, but for those things I do [Laughter].

While this SHA may not have been able to get the date because cabinet members were not prioritizing her request, she was worried it was because they did not want to give administrator time for a training on trauma. The SHA was also clear that she did not typically mind being outside of "the circle" of district decision-makers. In this case, however, she felt totally impotent to do something as simple as schedule a workshop. This, again, reinforces the concept that district decision-makers are exercising their control by ignoring the requests of SHAs, thus reinforcing the marginalization of SHPs.

Only two of the SHA interviewees were part of the executive cabinet. They were both male, worked in smaller school districts that had fewer levels of leadership, and reported directly to the superintendent. They may have been a part of cabinet because their districts were smaller, or because they were given more authority as men. It is important to note that two other male SHAs from larger districts were not part of cabinet. Another possible reason for these two SHAs being allowed in cabinet is that they both oversaw other programs that may have been considered more "important" than SHPs: disciplinary programs and special education.

One of these SHAs also managed student suspensions, expulsions and other disciplinary issues in the district, in addition to mental health programs. Even though he was part of cabinet, he said that he had a very limited budget:

> Typical of most student support services departments, my budget is not large. So when I need money for something extra, I have to go beg and then somebody somehow will help me out whether it's (the superintendent) telling me go talk to somebody about general fund or another director having some extra money in their program…I'll just wait and then when it's my turn I'll chime in to let people know "this is what I need a piece of the money for." It's not the most comfortable thing. I would like to just have a robust budget so I don't have to say anything or ask anyone for anything but that's not the case.

Despite being part of cabinet, this SHA still suffered from inadequate funds allocated to his programs. This speaks to structural funding inequalities in public education that cannot be "fixed" simply by SHAs having a seat at the cabinet's decision-making table. At the same time, this interviewee said that other directors *would* share money with him when he asked: "Yes. They know I'm broke. They know my budget. Yes. It's happened several times." A possible

explanation for this is that as a member of cabinet, this SHA was able to secure needed funds more easily because he enjoyed a closer, collegial relationship with cabinet members.

The other SHA who was a member of cabinet oversaw the district's special education program, in addition to health and mental health services. He said that when he needed funding for health or support services programs or staff, he worked directly with the superintendent and HR. He said they were very supportive, in large part because he was also in charge of legally-mandated special education services:

> They've always been very supportive. I think because our primary service is special education and they know that program is not driven by funds. I mean, it is and it isn't. If the students need it, we have to provide it by law. If I ask for an aide, they'll give me an aide, an extra teacher. So I think that mentality is already there. It's already established.
>
> So when I ask for health, it's the same thing, whatever the students need.

The federal government mandates special education services, so this SHA enjoyed a higher level of funding and programmatic support than other study participants. This SHA was also from a very small district, with few health staff employed in-house. Many of his SHP providers were from county agencies that had other funding sources to cover staff time.

One SHA had recently been allowed to participate in "extended cabinet" which included more middle-management administrators like her. One of her staff said she thought it was "super important" that her SHA got to participate in this extended cabinet because:

> There's not a lot she can do without support and the backing of the higher ups to really look at that as a system of care issue…looking at the way things are structured for kids. I know those are people's jobs, and it's power and control. There are probably other things I don't even understand. It's always been that way. So, there's that institutional arthritis

thing. [Laughter] Like we can't look at it now so I imagine those are some of the barriers that exist for her, but I think that's why it's important for her to go to those meetings and I'm sure it takes a ton of time. I'm sure she might want to like - not go, [Laughter] but I think it's so important because it does trickle down into how we work together and how we play together and how things – we ultimately benefit our kids.

This staff person identified how important it is for SHAs be able to make improvements to the SHP at a systems-level. Even though participating in "extended" cabinet was likely time consuming, this was the only way for her SHA to be able to more directly negotiate for SHP funding.

Several SHAs expressed a desire to be at a level within the district's hierarchy where they had a seat within cabinet. This would get district administrators to better understand student health needs. One SHA said getting "the voice" for SHPs heard in cabinet was important, as it:

Keeps us in the forefront, reminds them of what the health issues are, keeps that whole child in their forefront because I think a lot of times - and I think right now we're there - the academic piece and the score piece and all that tends to consume them. I think that voice needs to be there.

This interviewee emphasized how marginalized SHPs are. Without someone speaking up for student health, other priorities take the attention of cabinet members. One supervisor who was in charge of all student supports for her large district thought that SHAs, or their representatives, should have a seat within cabinet:

I think that - should that position maybe have its own seat in the cabinet? I would say yes. In our structure it's being served through the education services. So I think it's fine. It's well-positioned. I'm not thinking I need to particularly be there but I do believe that

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whole voice needs to be at the cabinet. Maybe our assistant sup maybe could use maybe

one other voice right there supporting that, another assistant sup there but as long as that

voice gets heard.

This supervisor, who acted as a higher-level SHA in some respects, thought that it did not matter

who it was in cabinet, so long as "the voice" of SHPs was being represented at the cabinet level.

Given the few numbers SHAs in this study who participated in cabinet, it is difficult to determine

how influential it is to have SHAs or another SHP representative in cabinet.

Getting approval of SHP proposals from cabinet is not always an end in itself, as there

are other bureaucratic processes that cabinet members must put in motion. Once SHAs get

funding approvals, then they have to fight to actually get the promised funds to implement new

policy, or hire new staff, or buy needed equipment. As one SHA put it:

That's another part of my job, is lobbying for this money, and getting the money they

said they were going to give me. So communication is not the strongest part of this

district…Communication is really challenging around here because I'm like, "Why didn't

you tell me that?" I seem to go home in the evenings, like, "God, I wish they had told me

that."

This SHA described a situation in which she was not getting access to needed information

related to her budget.

The district's fiscal services department (sometimes called "business services") is an

important gatekeeper inside and outside of cabinet. This department is in charge of all district

departments' accounting functions. For example, one SHA observed: "They establish our

budgets for us. That's challenging because while they say that the program drives the budget, it's

really the budget is going to drive the program as far as what they'll allow you to have." In this way, the fiscal services department may also drive SHP programming to some extent.

The director or "chief" of fiscal services also wields a great deal of power in allocating funds to SHPs. One SHA said that her district eliminated health tech positions without even telling her. She said this decision was made by HR and the district's fiscal officer, "who basically runs this district." Several interviewees made this observation about the power of fiscal services, and that department's chief. One supervisor said that a decision about funding SHPs was not hers to make, and instead "it resides with the chief financial officer or the chief superintendent." An SHA found that the greatest challenge he faced in his job was:

> Working through the bureaucracy, working with business services and human resources.
> I think this may be the same challenge that a lot of school sites have, just trying to get
> things through the system in place. There are various rules and interpretations of those
> rules, various gatekeepers along the way. While the district has good intentions around
> customer service in flattening the organization and removing some of those barriers, they
> still persist. It's almost like once you connect - get that door way opened, that one closes.

HR and business services act as gatekeepers to the financial resources that SHAs need. In addition to securing the promise of funding, SHAs must actually get the funds by navigating structural barriers. This entails getting the support of the individuals who uphold those bureaucratic systems.

SHA supervisors.

The first step for getting anything approved was for SHAs to get the buy-in from their supervisor. For instance, one SHA depicted the process of attempting to secure funding for more school nurses:

I'm supposed to go through my supervisor so, and she's the one that I have to convince

that I need what I need, and then… we would go to executive cabinet… and then in

fiscal… just get them to agree and do a (budget) input on that.

This SHA's use of language reveals some of her resentments: she is "supposed" to go through

her supervisor who she has to "convince" that she actually needs additional SHP staffing. All

SHAs described similar work to convince their supervisor of SHP program needs. As a deputy

SHA said: "You have to be prepared to tell them why and to show them why, but they're really

good at taking all that and running with it." Deputy SHAs also had to secure the buy-in of their

SHA as well. One deputy described how and from whom she could solicit support:

My first step is to go to (SHA's name). He is actually an outstanding advocate for health

services. If I can make a really good case to him, he has taken it and run with it and

gotten us to whomever we needed to be presenting our case to. (The SHA's supervisor) is

frequently involved and she's also an incredible advocate for health services. Above that,

I wouldn't approach anyone independently.

This deputy felt that her SHA (who was not a nurse) would help her secure needed approvals, but

only if she could make a good enough case for what she needed. She was also very clear about

the need to follow the chain of command, which did allow her the ability to approach the SHA's

supervisor directly. These processes clearly reflect district power structures, which marginalize

SHAs, and empower their supervisors and cabinet members to make decisions related to SHPs.

Once their supervisors bought into the SHA's request or proposal, most SHAs found their

supervisors good at taking it forward for approval as appropriate. Supervisors' comments

reflected a similar willingness to move proposals forward, so long as they were always consulted

first by the SHA. For example, one supervisor explained his pivotal role in district decision-making related to SHPs:

> I'm kind of her liaison between the district office and her. She'll let me know what her
> needs are and then I'll go talk to the appropriate people in the district office about that…
> She will call me up and say, "I need to order these materials," and I will tell her that if we
> have it in our budget, go ahead get a purchase order and get it over to me. I will sign it
> and then I'll do the leg work from there. She just needs to let me know what it is she
> needs and I'll do everything I can to find it. There's always a way.

This supervisor is reinforcing his control of the SHAs' access to higher-level decision-making and resources. His comments also seem to reflect a certain self-aggrandizement in terms of his power to get the SHA what she requested.

Supervisors cannot always "deliver" on SHAs' requests, however. Some interviewees indicated that SHAs' supervisors are also caught between what the SHA wants, and competing district priorities. As one staff person explained:

> The way it's supposed to work is the district sup that's over our department should be
> working with the health services, but there are imperatives above that person as to how
> much money is going to be allocated to our department, and then you have to negotiate
> and document and beg.

This suggests that both the SHA and the SHA's supervisor are vulnerable to the greater decision-making authority of the superintendent and school board.

Bureaucratic Barriers

Educational employees' unions.

Another bureaucratic gatekeeper mentioned by most interviewees was the certificated (credentialed) employees' union. This union traditionally represents the interests of classroom teachers, not those of credentialed school health staff. Even when funding was available for health services staff or SHAs, the union would sometimes create barriers to hiring staff, or to giving them appropriate titles or wages. The union's structures did not acknowledge the different roles played by other certificated personnel such as school nurses.

Some interviewees tried getting the union to advocate for a minimum nurse-to-student ratio, because their school nurses were responsible for far more students than the recommended minimum ratio of one school nurse to 750 students (U.S. Department of Health and Human Services [USDHHS], 2014). A couple interviewees had been successful. One deputy who was ultimately successful in getting the union to support school nurse ratios explained that when she and her school nurse colleagues began their efforts, the union had no idea about school nurse work issues:

> The union really did not even understand at all, worse than the district, what school nurses did - even though we're part of the thing - but there were only 20 of us versus the thousands of teachers. But we got very vocal and they established the joint committee and I sat in along with the joint committee as lead nurse. We've educated the union people as to what we do, why we do it, how we do it, what time it takes to do it.

In order to get union support for SHP personnel, SHAs, deputies, and staff must invest considerable time in educating union leaders. A SHA who is the sole school nurse for her rural

school district described her unsuccessful experience trying to get the union to advocate for a school nurse-to-student ratio:

> I went to the teacher's union and said, "I want you to negotiate into the contract caps - numbers for nurses. I want you to do something for nursing. You need to. It needs to be addressed." I don't think they want it. See, that's the problem with me not being able to be there and you have your team of teacher negotiators, but they don't understand. Again, I'm alone. They don't even understand what they're fighting for and they can't articulate it. Sometimes I don't even think I can. Nothing happened. All of the things that were a benefit in a new contract were related to teachers, nothing for nurses.

This SHA was overwhelmed by the amount of effort she would need to put into getting the union to support her. Going it "alone" she could not get the union to advocate for more nursing staff.

Some SHAs felt that the union did not always have the best interests of the students in mind when they were representing credentialed staff. For instance, one SHA was clear that while she did not agree with everything going on in the district, she still disagreed with their union representative:

> It's not that I believe in everything that the district says is right. I mean I have a brain. I can think for myself. I'm a nurse by trade. I don't change that just because I'm in a leadership role, but there are going to be times that he and I disagree because he's looking at it through the eyes of adults and I'm looking at it through the eyes of children, and he can tell me all he wants that children are realistically the big picture, but I know that just based on actions and statements that that's not the case.

This SHA asserted herself as a nurse who could think for herself, and always represented the best interests of students. This SHA found that the union leadership did not share in her focus on

students' well being. Instead, the union was more preoccupied with the needs of their constituents, and particularly classroom teachers.

Another issue with the union has to do with staff supervision. The union holds fast to certificated employees' contracts, which require someone with an administrative services credential supervise them. This has led to situations where SHAs without an administrative credential cannot supervise or evaluate their health staff, and instead a school principal might do so. This is also very frustrating for SHAs who do not have the authority to hire SHP staff. SHAs also may not be able to fire negligent or dangerous SHP staff because of overzealous union protections, or a principal who knows little about health services standards of care.

Interdepartmental silos.

Several interviewees identified bureaucratically sanctioned "silos" that exist between school health programs (SHPs) and other departments. This was particularly difficult when SHAs tried working with other departments that had greater power within school districts, such as special education and (guidance) counseling services. Many SHAs expressed frustration in their negotiations with special education departments. They felt that special education directors only had the interests of those students who qualified for special education in mind, while SHAs faced the challenge of meeting all students' needs. SHAs also resented the relatively generous funding special education departments enjoyed, while the SHAs struggled to keep minimal staff employed. One SHA shared an example of her frustration working with special education, and their lack of a plan employing the RTI (response to intervention) model:

> I think that there're bureaucratic barriers that they set up these hierarchies so you really can't talk to people, and school districts are really good at creating silos. I mean just unbelievable. At the last board meeting, a perfect example: special ed, we're very

disproportionate in our students in special ed, really, really bad, so the board came back

and said "Well, what are you doing? Like in RTI model, what are you doing?" Well, this

particular chief put the kibosh on the RTI model when she came almost five years ago,

four years ago. So the district as a system, special ed as a system, doesn't have that in

place. Certain schools do. My department does that, then we work off this (RTI) model.

So she was given charge to come up with a plan, and I know that if I don't go to my boss

to say "She needs to include us in this conversation. We are out at the sites. We are doing

RTI." If I don't do that, I promise you, she'll come up with a plan by herself with her

small little cadre and not look at the big picture of who all needs to be included to make

sure it's a real, solid, comprehensive plan. It takes time and it takes a certain level of

being okay with spending those meetings, sitting at the table and hashing it out.

Sometimes it's easier for someone to go in their office and come up with a freaking plan

and say "Here it is," but you have no input along the way, so it's very silo-based, it's not

reaching out to those who are doing the work.

This SHA's story exemplifies how departmental silos foster inefficiencies in how programs are

developed, and how the planning process may not include people who have expertise, such as

this SHA and her site staff. In addition, this SHA was not empowered to bridge the identified

silo, but had to ask her supervisor to step in and try to remediate it instead.

SHAs and deputies found that lack of cooperation across departments was pervasive. One

deputy expressed her frustration with not getting a welcome response to an effort to look for

grant funds for expanding counseling and mental health programs:

I think that's a challenge working some of the other departments. There's a lot of

bureaucracy and a little "well it has always been done that way." That happens here a lot.

Trying to change mindsets - like I know (my SHA) struggles working with the other

departments and student services – the other leadership. I have experienced that first hand

myself lately because I'll go to them and I'll be like, "Oh, I want to support this or how

can I help Counseling and Guidance?"

This deputy found that the counseling department was threatened by her attempt to link school

nursing, wellness, and counseling efforts. If SHAs and deputies were more empowered within

districts hierarchies, they might find greater ease in their efforts to form partnerships with other

departments that hold more authority in the district. Individuals who believe that maintaining

departmental boundaries will afford them greater power, however, will still reproduce

jurisdictional silos within their districts.

Location of SHAs' offices.

One of the ways that district hierarchies are established is by carefully allocating where

administrators' offices are located. The offices of some SHAs and deputies were not in the main

district offices that housed other central office administrators. Distancing SHAs and their day-to-

day work further marginalizes health services. One SHA said that her predecessor had a falling

out with the (then) superintendent, so the SHA's office was moved to another location where the

district had some offices. When the current SHA took the job, she told her boss "if I'm going to

be here and you are expecting this level of change then I need to be here in the district office."

The SHA's supervisor moved her office into the main district administrative building, and gave

her adjoining offices for some of her deputy SHAs and regional coordinators. The SHA felt that

being in the central office elevated the visibility of SHPs:

Moving into this space has allowed me to bring in more people so now that people that

work here at the ed center can actually see truly what our department is kind of all about,

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right, when they stop by or when we do things, because I try and do things within the

building for people to kind of have a better idea of what nursing services and wellness

are, and what that realistically should be for kids and staff.

This SHA was able to educate other central office administrators by inviting them in to her

physical offices to learn more about her programs and staff. As the popular saying goes, "out of

sight, out of mind," so SHPs will simply be more visible to cabinet members and the

superintendent if their offices are proximal to their SHAs' offices.

One SHA's supervisor wanted to move her to a school site where they were starting a

health magnet high school, far from the district office. She described her conversation with her

supervisor:

I said, "Well, that school site is just a portion of who I am as a school nurse. My direct

responsibility is to the whole district. I'm better suited to be where I am because I have to

access the special education files quite frequently and all the staff here quite frequently,"

and I said, "I don't think that would logistically make sense for me."

This SHA prevailed, and remained in the central office, just down the hall from both the

superintendent and the special education department. This allowed her greater visibility and

access to key decision-makers in her district.

Physical separation of their office led to lack of communication for some interviewees.

For example, one SHA complained that she is often left out of important district

communications, for a variety of reasons:

I have no idea - because they're lame; because they don't think about me; because I'm on

a wing that separated from the main sup's wing, which is down that way; because I'm

good at what I do and I think they just think, "Oh, she'll figure it out." I don't know, but

if I complain, I feel like I'll get fired or that they don't want a complainer around here.

They don't want anybody who complains. They want, be happy and get it done. They

told me that from the beginning.

One of the reasons she listed was being physically apart from the superintendent's offices. She

also worried that she could not complain about being left out, for fear of being fired; she was told

when she started her job that she couldn't complain. This is a very difficult position to be in,

when SHAs feel like they do not have access to the resources, support, *or* information they need

to do their jobs. This reflects a lack of access to the lines of power necessary for SHAs to be

effective managers (Kanter, 1979).

Principals and School Site Power

School principals are also power brokers in the structural hierarchy of districts. They

control everything that goes on at their schools, and they report to central office administrators

who have more authority than SHAs. Principals hold reign over student instruction and academic

achievement, and therefore are highly respected by district decision-makers such as

superintendents and school board members. Principals serve as gatekeepers to SHAs' access to

students and teachers, they control site-based funding, and in some districts, they hire, supervise,

and evaluate site-based health staff. One supervisor explained why her district's SHA needs the

support of principals to succeed:

She really needs to be supported by them because really she's not going to be able to

have the access to the kids. She's not going to be able to provide some of those services

without their buy-in, without them understanding at least a little bit of it, so they

understand the benefit to the kids. I don't think she could do as much as she's been able

to do without that, that piece. I think that's the first thing that a school health

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administrator would need… If the principal doesn't know what you're doing, doesn't

believe in what you're doing, they're not going to allow you in. Yes. You've got to win

them over first.

In this study, interviewees identified the importance of getting principals to allow access to

students, or to allocate funding for SHP staff and services.

Many interviewees felt that principals devalued the work of SHP staff. Some did not

think that SHPs were even necessary, as one SHA said, "Some of our principals still see student

services as the touchy feely part of the district and that we really don't need them." Another SHA

explained that some principals did not understand the nature of school nurses' work:

Principals tend to look at the nurses as the first aid person, which the least of our job. It's

important but you can have anybody do a first aid. But to write up reports and do

education and do evaluations and assessments and drug assessments and vision –

whatever it is, you have to have a higher level of understanding and ability.

This interviewee felt that some principals did not understand what school nurses can offer, as

opposed to an unlicensed health aide. Some interviewees said the reason principals think SHPs

are only first aid is that they do not want to provide first aid themselves, nor do they want their

school secretaries or other staff to do so. Similarly, some principals only wanted social work

services so that they wouldn't have to deal with students with behavioral problems. Another

SHA described this type of situation:

They've been an administrator for 25 or 30 years and they just don't see schools as being

- the social work aspect - that having any place in schools. It wouldn't matter what I say,

you know what I mean, but they want the services because they don't want to deal with

them (students), like they don't want to have to man the health office, so they want the

services but they just don't want to be bothered.

This makes it sound like principals do want some basic health services provided, but they do not

want to have to think about it. One SHA explained this type of attitude:

Sometimes, they're busy with the academics as they should be, but I think they don't

think about other things because they just want no complaints. They want to get through

the day and I don't know if they really get it that IEP that was for tomorrow that the nurse

wrote up an initial assessment and evaluation and blah, blah, blah as an example. I don't

know if they really get that, but some do. Some just want things to go smoothly, and how

do things go smoothly? If there's a nurse or health assistant in the office and their

secretary doesn't have to go back there and do it. Because once they're complaining, then

their life is harder. It's not everybody, but a few.

This quote reinforces the idea that principals do not understand the complexity of what school

nurses do, such as IEP (individualized education plan) health assessment and planning.

Principals do have a lot of responsibility, and the pressure on them is real. Oftentimes, principals

are reassigned or fired when student achievement at their school does not improve after a couple

of years. So, it is understandable that they are focused on teaching and learning, and motivated

out of a desire to make sure things "go smoothly."

Site staff funding and supervision.

In some districts, principals had to spend school site dollars to have health services staff

at their sites. Some principals would elect to hire a health aide rather than a school nurse,

because nursing time is more expensive. Similarly, principals could use some of their budget to

pay for additional social worker or counseling time. One interviewee who served as a site

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coordinator of health and social services on campus found it very uncomfortable to have to always please the principal, but felt she needed to do so to continue to be funded:

> Part of the strange dynamic of this job is that I'm dependent on them (site administration) funding me. So, how much do you say no to, like you've got to keep them happy because I want to him to still spend $100,000 a year on our services so that we're here for the kids. Yes, there's a personal motivation - I want a job - but really I know we do a lot of good work. I think that just like hits me because I feel this responsibility to keep the center open, too. So, I need to keep him happy. I want to meet their expectations and demands, but sometimes it's getting really hard so you feel like you're - can I say this? Sometimes I feel like I'm a prostitute or something. [Laughter] Whoring myself for a budget. [Laughter] We joke about it and it's really dark humor. It's sick, but it's a reality and we all feel that. So, me being able to set the expectation for what it is that we can do and what we can't.

Even this site-level staff person struggled with how to establish boundaries with her principal, given that principal funded some of her and another social worker's time. This reflects a pervasive power imbalance between principals and SHP staff and SHAs.

In most districts, school nurses and LVNs were evaluated by their SHA, but principals did the supervision and evaluation of health assistants. In a few cases, principals evaluated LVNs too, and in one district, principals even evaluated the school nurses at their sites. Regardless, the SHA and nursing staff were still responsible for training the LVNs and health assistants to provide specialized health care procedures, like performing suctioning on a student with a tracheostomy, or assisting a student with her catheterization. In all cases, SHP staff were "guests" on the principal's school campus. As such, staff also needed to form and sustain a good

working relationship with each school principal, so that he or she would allow them to continue to work at that school site.

In most districts, classroom teachers delivered state-mandated health education programs. SHAs needed to collaborate with these teachers, and by extension, school principals, to implement such programs. As one deputy in charge of health education for her district explained:

It's teachers, classroom teachers who implement prevention programs, Project Alert. We have had some other ones in the past that we're not doing right now. Classroom teachers, and they are being supervised by their site administrators, their principals or vice principals. We just kind of make sure that the funding is there, the programs are in place, the training has taken place and we're there for support and follow up.

This is another example of how important principals are to getting access to students and teachers.

While SHAs work to promote student physical and emotional well-being, they operate within their district structural hierarchy. This means SHAs follow a prescribed chain of command and do not directly question the authority of those in positions "above" them in the hierarchy. As a result, SHAs must find non-confrontational approaches to building the support of district power brokers. The next chapter outlines the strategies SHAs employed to get needed resources for their staff, and for the students they served.

Chapter 6: How School Health Administrators Get their Work Done

In order to complete their daily job responsibilities within the hierarchical structure of their districts, participating SHAs outlined an array of strategies they employed to get school health program (SHP) funding, staffing, equipment, or policies in place. SHAs' work to get political and funding support was, by their accounts, as time-consuming as their "regular" job responsibilities. This chapter will illustrate how SHAs devoted significant energy to brokering support from allies, negotiating, making a financial case for SHPs, and demonstrating how they are preventing liability.

SHAs had to weave tailored interpersonal approaches into every interaction they had with administrators and other district decision-makers. When asked what skills were needed to serve as a SHA, the overwhelming response from interviewees was that SHAs needed communication and "people" skills to garner SHP resources. SHAs also employed these skills to try to support and protect their staff from being laid off.

SHAs and deputies said they put considerable effort into carefully adapting their communication strategies for each stakeholder group they worked with. In this way, SHAs' work was not just intellectual; it also required emotional effort and regulation. This can lead to physical and emotional exhaustion, which may be felt more acutely by SHAs who must dedicate so much energy to "how" they work with district decision-makers. The constant effort that SHAs had to put into *how* they conducted each work interaction was frustrating for some SHAs. This chapter will illustrate how SHAs' work to "sell" school health programs to a variety of decision-making "clients" is a form of emotional labor (Hochschild, 1983).

Brokering Strategies

In order to get their work done, SHAs described a range of strategies they employed to broker the support of powerful district decision-makers. This additional layer of work involved employing "soft" interpersonal skills, honing requests so that they aligned with other district priorities, and carefully building the support of decision-makers. A supervisor pointed out that SHAs need "people skills because you work with so many different people in a school district setting, so many different personalities." SHAs also worked to frame their request for funding or support in terms that aligned with decision-makers' interests. As one SHA said, part of being effective as an SHA is "knowing how to advocate for the right thing - so having your talking points is critical, and making sure that those talking points are consistent with the vision and mission of the organization." This required SHAs to assess the current political environment, and then adjust their strategies to better "sell" them in the context of more powerful administrators' interests.

SHAs tried to get decision-makers' support through three main strategies: 1) raising awareness of student health needs and the benefits of SHPs; 2) cultivating powerful allies, and 3) adjusting to working conditions. These three main strategies with exemplar quotes are summarized in Table 4.

Table 4

School Health Administrators' Strategies for Seeking Political Support for Health Programs

Strategy	Exemplar Quote
Raising Awareness	"She really makes sure that they understand what we do, what we can provide, and how important it is to the kids and families." – Staff person
	"(I'm) helping to bring back the notion that 'Oh, did you know that school nurses help to improve school attendance because children that are healthy tend to go to school and do better when they're at school?'" –SHA

	"Our superintendent sees our department as a liability prevention piece. So she values health programs a lot. She sees a lot of what we do as insurance." – Deputy SHA
	"We do a lot of LEA billing. Of course they value revenue so they're very happy about revenue. So she (SHA) shows 'Look at what we do. Look at what we bring in.'" – Staff
Cultivating Powerful Allies	"All my nurses know, my best gift is when they come up against the brick wall, they come and we talk and I look in my rolodex and I figure out how to break down the wall." – SHA
	"So having somebody that's able to advocate and promote and connect is important." – SHA
	"(The principal) had to work with an AED which we had trained him to do…I was able to support him through that. It was pretty traumatic for him. He saw the need to have input from the health program people at that point." – SHA
Adjusting to Working Conditions	"If I always ask for permission to do things, we would get nothing done, so I've taken a lot of liberty in my job to seek out opportunities and just do it, bring money in, bring supports in and do it." – SHA
	"When the moment comes, you have to have all your homework done to be ready to step in and make suggestions but you also have to be really patient." – SHA

It is important to note that 22 of the 30 interviewees repeatedly used the term "advocate" or "advocacy" to describe their SHAs' work to get support for SHPs. While the term "advocate" often connotes empowerment, this is not so for SHAs, who are clearly marginalized due to the funding and administrative structures of school districts. When study participants said that SHAs acted as "advocates," they could be reacting to SHAs lack of access to the resources needed to run their SHPs; therefore, SHAs must engage in educating and relationship-building strategies to get political support. Examples of how SHAs tried to get buy-in for SHPs are outlined below.

Raising awareness.

There are several ways that SHAs described their efforts to raise the awareness of other administrators, principals, and even school board members. These approaches included providing education on how SHP staff address student health needs; linking health to attendance

and academic outcomes, preventing liability, or financial benefits; and taking advantage of emotional responses to traumatic health events in schools.

As they provided this education, SHAs described how they had to tailor their communications for each decision-making group and individual they worked with. As one interviewee put it, SHAs "need to know how to communicate with everybody - students, parents, folks they work with, higher up." Interviewees shared examples of how they employed a range of deferential communication skills, such listening, diplomacy, and tact. As one deputy SHA said: "I think you need a little bit of salesmanship because you're doing a lot of persuading." This implies that SHAs not only need to be gentle in their communications, but also more proactively "selling" their SHP ideas or needs.

One SHA described how being a health and physical education teacher really helped her prepare for her current job as an SHA, because it helped her develop helpful communication skills. Her perspective was that in order to be effective, SHAs must be assertive, and not shy. This helped with public speaking, such as presenting at a school board meeting, as well as running a staff meeting or networking with community agencies:

> Being a schoolteacher was great, and I taught PE too for years. Yes, (it gives you) the big voice. You have to be like, "Sit down." [Laughter] You know, "it's my turn to talk." You know how it is being a classroom teacher. [Laughter]…I think somebody who isn't shy, who has an admin credential, who has some speaking abilities and really good communication techniques and can work with the non-profits in the public.

This SHA employed public speaking skills when presenting the case for SHPs with a variety of school district and community audiences. She said she prepared extensively for every presentation she had to make. As a result, she said, "People are always very impressed with my

confidence and my ability to effectively communicate and articulate the goals and mission and the importance of the programs." This reflects how SHAs need to develop a variety of communication skills for convincing both individuals and groups, such as at a school board meeting.

Another SHA felt that treating people with respect was most important to building support. He explained, "I have my admin credential, but - I think it's the people skills, really, even though I have the credential. A credential is not going to change the way you treat people. So it's always treating people with respect." This SHA emphasized that getting an administrative credential did not give SHAs the critical skills they needed to be successful. Instead, being an SHA was about how he treated people, and how he sought to raise the awareness of important decision-makers. Throughout this chapter, interviewees' stories highlight how employing highly honed communication and interpersonal skills was required for SHAs to get their work done.

Providing education on how SHP staff address student health needs.

Interviewees said that SHAs needed to convey to others the breadth and depth students' health services needs. This was often the first step in securing support for SHPs. Several interviewees also described an ongoing process of trying to demonstrate the value of specific health interventions. One SHA said this was one of the most challenging aspects of her job: "Helping folks to understand what it is a school nurse does and how it helps improve the overall wellness of children, their ability to attend school and stay in school, that's been tough." Because of how marginalized SHPs are, SHAs constantly need to outline the benefits of SHPs. Another example of this was described by a deputy who relied on her SHA to educate others on student health needs in special education Individualized Education Plan (IEP) meetings. The

deputy shared her worry about a student who used a wheelchair, and had gained 50 pounds over four months:

> As a school nurse, I'm very concerned about her weight - that's going to impact her whole life. In the education piece, they're more concerned about educating her and academically where she is. Having a boss, a nurse administrator in there, she can help facilitate the nurse voice in the IEP meeting.

This deputy trusted her SHA to "facilitate" or educate others to establish an IEP that would include services to support the broader interests of students' overall well-being, and not just academic issues.

SHAs also spoke of increasing the visibility of their staff and programs to improve administrators' understanding of their value. For example, one SHA was working to make her district's nurse practitioner more visible by having her float across multiple sites rather than work from one school clinic, and also administer staff TB tests. The SHA was also going to have all the school nurses trained as CPR instructors, so they could train school staff in CPR rather than paying for outside classes. She also thought that the district would realize that school nurses were "cost effective." This included persuading instructional services administrators as well as principals.

Another way that SHAs increased their visibility was by networking, reaching out, and being a presence in the schools. This helped SHAs build relationships with district administrators, and increase awareness of student health needs and programs. One interviewee shared how she volunteered to participate in the district's strategic planning process:

It's imperative that I participate…because once again, that's our opportunity to make sure

that everybody remembers that if they don't have healthy children sitting in those seats,

those children are not going to learn to their full abilities. I make myself very visible.

This deputy SHA took extra time to participate in a voluntary planning process to promote the

importance of SHPs in helping students succeed. Multiple interviewees talked about joining

committees within the district to build relationships and support for SHPs.

One SHA had been trying to get district buy-in for socio-emotional support services at

schools for nine years. Some administrators and principals didn't see a need for socio-emotional

support services for their students. The SHA described having to repeatedly work to get school

staff and administrators to understand student health needs: "it's really getting them to come to

that realization and it's taken nine years [Laughter] to knock on that door and keep – well, I've

been pounding on it for a while to really get them to see that." Even supervisors and staff saw the

need for SHAs to repeatedly educate district decision-makers on the need for health programs.

As one supervisor said, SHAs need:

> …good communication, verbal, written. [Laughter] Saying it again and saying it again
>
> kind of a thing…keeping it on the forefront of everything that's going on out there, not
>
> letting it get buried: "We've got these kids. We're getting more and more of them. We
>
> can't forget them", that kind of thing. She's got to get that advocacy piece.

The marginalized position of SHPs requires SHAs to be persistent in their negotiations for

student health resources.

SHAs also have to be tenacious in their efforts to get higher-level administrators to make

a decision in support of SHPs. One deputy in a large district described how the SHA has to

devote time to move the decision-making process along:

We're told these are the different people that have to be involved in it, and yet they're not

doing anything. And (our SHA) has other things that she's trying to get done. So unless

she comes back around and says "when are we meeting on this again?" it's not going to

be done, or something's going to be pushed through that's not adequate.

This example speaks to the ongoing "educating" work SHAs must do, in addition to completing

their myriad job responsibilities.

A component of SHAs' work involves educating school staff and administrators about

how different students need varying levels of care, depending on their health conditions. One

SHA said she spent time getting others to understand that "most kids need this kind of support, a

few need this kind of support, and a very few need all the stuff - I think is a real benefit for the

district to understand." Other SHAs said they needed to educate district administrators about the

conditions in which their students were growing up, and how that impacted their school success.

For example, one SHA said that their SHPs needed to address student experiences of trauma:

The research is pretty clear that children need to be ready to come to school. They need

access to health, substance abuse programs, not for just them but for their family. A lot of

our children are in homes where they're involved in a lot of trauma within the

community, so being able to address those needs.

In coordinating care with families and primary care providers, SHP staff and SHAs described

becoming familiar with the struggles of families in their communities. Many of these

interviewees expressed an interest in serving the health needs of both students and their families.

One staff person described how hard her SHA worked to convince school personnel and

administrators of the value of school nursing:

We fight and claw for all that. Well, she fights and she really has to explain how important nursing is to principals, to teachers, to the board, to district personnel, to the superintendents. She really makes sure that they understand what we do, what we can provide and how important it is to the kids and families. I don't think if it were not for her efforts and nurse skills and diplomacy and tact that we'd have five nurses, because many other districts have maybe one nurse with a couple LVNs…I think that we need to have a voice but we need to do it with grace so we don't turn people off because we're this little satellite. Even though we're part of the Teachers' Union, we're this tiny little satellite of five people and what we do is under the radar most of the time. The time when everybody knows it is if there's a serious injury on campus and then they'd want us for help, but what they don't see are the hundreds of student study team meetings, 504 meetings, IEPs that we prepare for, the hundreds of calls that we make to parents, referrals to community agencies, trying to get kids insurance, I mean just a lot of work that we do that's behind the scenes so that the kid can show up in class at the desk, but they don't see it. They don't see what we do. That's why I think it's so important that she have the skills that she has so she can keep us in their minds without being aggressive or pushy or demanding.

This staff person has tied her SHAs' interpersonal skills to her ability to secure funding for school nurse positions. She described her SHA as demonstrating grace, diplomacy, and tact as she went about her work. This suggests that her SHA put considerable emotional effort into how she presented herself as she tried to get support for SHPs, so as not to appear too "demanding." The emotional labor of SHAs as they present themselves in a favorable, nonthreatening manner to administrators is an important theme in this study.

Linking health to attendance and academic outcomes.

Interviewees said they recognized that the central work of schools was to educate students. As one deputy stated: "We're in a setting where their main purpose is to educate people. So health sometimes is not right out there front and center, but (my SHA) knows and believes and advocates that if a child doesn't have health, then they can't learn." This deputy felt confident that her SHA was making the case for the link between SHPs and student learning. Given the focus on academic achievement, one SHA identified the difficulty the cabinet and superintendent might have in allocating funding to SHPs:

> It still doesn't ease the hard choices that senior leadership needs to make as to how we're going to spend our dollars, because ultimately the bottom line is we need to increase student achievement. We need to increase attendance at school so we get the full amount of our ADA dollars and we need to increase our graduation rate.

Part of how districts (and in some cases, schools) are funded is based on ADA, or average daily attendance. In order to help increase district funding and improve academic outcomes, SHAs tried to make the link between SHPs and students' ability to attend school. One SHA felt that his district leadership recognized that health issues could present a barrier to learning:

> Now with the leadership that's in place at the district office level, I think everyone is definitely on that page of supporting students across the board, not just driving home the academic side of things, but seeing the whole child and looking out for those things that are impacting their learning. I think folks have realized that kids are not going to be able to learn if they have these huge obstacles to getting to school or being hungry in the morning or having some other issue. That's important for a school site to recognize and

to be able to support that student before any learning's going to take place and it's just

going to be a wasted day probably in that kid's life.

One strategy SHAs may use to get political support for SHPs is to outline how health services,

and even nutrition programs, remove barriers to students getting to school and being able to

learn.

Another SHA felt that increased state funding allocations under the Local Control

Funding Formula (LCFF) could foster better support programs for students from low-income

families:

> That funding has helped to move things in a direction that we believe is going to begin to
>
> address some of those basic needs that are preventing students from being able to
>
> participate fully in the educational experience and the instructional piece. So we kind of
>
> see that as a way to support the overall mission of the district. So helping to bring back
>
> the notion that "Oh, did you know that school nurses help to improve school attendance
>
> because children that are healthy tend to go to school and do better when they're at
>
> school?" So working on those kinds of conversations towards the overall mission.

The LCFF requires districts to outline how they will reduce chronic absenteeism, and then

provide reports on related outcomes. This SHA was using this new focus, or "overall mission" of

reducing absenteeism as a way to garner support for his SHPs.

Other interviewees used a focus on improving attendance to make the case for their

funding request. For example, one SHA was using projected improved attendance to ask for

money for needed equipment:

> I'm a little nervous about it because I'm going to be asking for some money, because I'm
>
> going to say that in order to continue making assessments on our students to successfully

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– how am I going to say this? - "In order to have a successful assessment of students

because we were keeping them healthy, to stay at school, we need to have updated

equipment and this is what it costs." It's not very much money… $16,000.00 is a drop in

the bucket.

This SHA seemed nervous about asking for this funding, and was actually rehearsing how she

would make her request during the interview.

Some interviewees found some difficulty linking specific health or mental health

interventions directly to academic improvements. One SHA described the complexity of

associations between socio-emotional supports and academic performance:

That's the problem because there're so many intervening variables, so it's very, very

different. It's not like "I'm going to give you these math problems, I'm now going to test

you and if you don't have a lot of problems, you're going to be okay." The majority is

going to be fine, but when it comes to health and mental health, you can't always claim

that what you're doing is making an impact on the academic. It's a tough one, but in

communities of poverty where you now have generations of poverty, we're not talking

one or two; we're talking three and four and five now. Just the whole functioning of the

family in the community needs so much support and they don't see it. That's probably

been my biggest challenge.

This SHA was referring to how administrators did not understand the pervasive impact of

multigenerational poverty on children's health and academic performance. When SHAs cannot

demonstrate that their interventions are improving academic outcomes, some will refocus on a

more immediate, short-term outcome they can ensure: preventing districts' legal liability for a

failure to provide needed health services to students.

Preventing liability.

Several interviewees suggested that many district decision-makers, including the superintendent and school board, are most interested in SHPs preventing district liability for failing to provide needed acute or emergency care. As one staff person said, "I don't really believe that the budget people or the superintendent, particularly, are invested in us, except that if it didn't work, then there'd be consequences." This could mean that not meeting student health needs could have legal ramifications or lead to harmful circumstances for students. This statement also reflects an "out of sight, out of mind" attitude towards the work of SHAs and their staff.

A school nurse outlined examples of the types of liability that administrators are worried about:

> Well I think they just don't want to have any emergencies. [Laughter] I mean I think everybody's nervous when something happens that's really catastrophic in a school. Whether a child gets really injured or – so I think knowing that there's staffing at the school that can respond in the emergency quickly so that it doesn't become worse like anaphylaxis or diabetic crises or seizures which are the big things that people gets scared about in the schools. I think they just want to make sure that the students are safe. Then after that – then I think after that they would like to see them be more healthy, but I think primarily they want that safety because that's a liability obviously.

If SHAs can frame SHP needs in terms of preventing liability, then they may more readily secure the support of key administrators in the district.

One deputy explained that her superintendent's expressed interest in SHPs was that they guard against potential liability:

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Our superintendent sees our department as a liability prevention piece. So she values

health programs a lot. She sees a lot of what we do as insurance. So that's good. She does

have a lot of - she certainly has a lot of power over us.

This deputy felt comfortable with her assigned role in preventing liability, and also recognized

the absolute authority of her superintendent in determining SHP funding. In the same district, the

SHA's supervisor reiterated the importance of liability prevention for her, other cabinet

members, the board, and the superintendent:

I think their main concern is one, liability. I think that's huge. Every once in a while,

things come out in the news which causes concern, causes questions about, "Are we

doing this? How are we doing it? How are we addressing it?" kind of thing. I think that's

probably their top priority. It's making sure that there is no situation in any of our schools

that could create a liability…risk management is also one of my divisions. Yes. I'm

always kind of asking that question. "What's the risk to the district? Is there any risk?

How do we make sure that there isn't?" That's usually one of the big questions.

The SHA in the same district described how she responded to what her superintendent said to a

group of nurses: "She said, 'Ladies, this is all about preventing liability' and I say – 'as school

nurses, we call that excellent nursing care'." This SHA acted as a translator between her

superintendent and school nursing staff, demonstrating her ability to understand and speak to

both educators' and health providers' interests. These quotes from one district provide insight

into how SHAs and their staff have aligned their approach for getting political support with

district decision-makers' priorities.

In a different district, a staff person spoke with admiration for how her SHA promoted

student safety despite pushback from administrators:

She's very firm when something is not safe and saying, "This is not safe and I'm not

going to support it." I think she gets a lot of flak because of it. The people in this school

district that are respectable respect her but there are a lot of people who slide by and

someone like her makes their life difficult because she holds herself accountable, she

holds the nurses accountable, and she holds the administration accountable in a very

delicate way.

According to the staff person, her SHA was "delicately" modeling accountability for student

health and safety with administrators. This implies the SHA had to use non-confrontational

interpersonal techniques in order to not threaten administrators or put them on the defensive. In a

different district, a staff member said that in addition to providing staff and parent testimony, her

SHA worked to point out the value of their health programs. She said that district administrators

knew that "when things are stable in health programs, they don't get that many complaints at the

district and things run pretty smoothly." This relates to how SHPs can prevent liability as well.

In another district, a deputy SHA said that SHPs were ignored by the district unless there

was some type of high-profile student health problem: "We're the redheaded stepchild

[Laughter] until there's a problem." This joke reflects a perception that SHPs are neglected or

unwanted until they are needed to prevent district liability for failing to provide a safe learning

environment for all students. Several interviewees said that preventing liability and promoting

student safety was central to their work, in addition to being a good way to make the case for

their staff's value. In one case, an SHA demonstrated how school social workers were

identifying students potentially at risk for suicide:

I know she's used our data and she used it last night. She said this year alone we've done over a hundred suicide assessments and you see [Laughter] the look…on a few of their faces. It is what gets people's attention.

Other SHAs described situations where they fought school board decisions on student health issues that would lead to potential liability. For example, this SHA took a position against a board decision even when though she experienced political pressure not to question the board:

We had a very charged school board and one of the school board members who was a physician wanted to have policy that said that high school-aged students could carry medication on their person, anything, and that we didn't have to monitor it. I was very against that and I was called into the superintendent's office and told, "You know, you need to go along with what the school board wants." I said, "No, I won't because here's the bottom line, I'm an advocate for kids and if I align myself in that position, then when I look at what policy he's trying to pass, it's not in the best interest of the whole population. I don't agree. So, I would not be doing my due diligence if I don't fight against this."

In this situation, the superintendent tried to use his power over the SHA to get her to acquiesce to the school board's authority. However, the SHA would not back down from her position. She took a student "advocacy" stance to back up her position that this was not a safe policy.

As part of the Local Control Funding Formula (LCFF) that determines school district funding, districts must show an improvement of suspension and expulsion rates. One SHA was able to use this mandate, along with a written endorsement within education code, to promote restorative justice programs in schools:

In the 2012-2013 education code booklet, as an alternative to suspension, they listed restorative justice as an option. Now, I was already steeped in the conversation. When I saw that I said, "There it is. Now I can say it's an ed code." So from that point forward nobody could say anything. I've been saying it but now it's an ed code as an option, not a mandatory option but as a list of options. Instead of suspending or even expelling, you can refer a student to a restorative justice program. So I will look of additional selling pieces and then come back and present that information.

This SHA explained how he was gathering evidence for the restorative justice program he had been trying to implement. Restorative justice programs require that all parties involved in a case of student bullying, fighting, or other misbehavior come together to determine how to make amends for the student wrongdoing. This type of program can improve safety and reduce liability by decreasing "revengeful" acts and restoring peace.

Many SHAs emphasized the importance of approach school boards in the right manner, with the right message. For example, one SHA did not like how nurses in her district used liability-related scare tactics with the board before her arrival:

Some of the nurses that were here had really backed themselves into a corner to realistically say - because of the layoffs that they had been experiencing for the last seven years before I got here - to principals and to the board of education, "if you don't vote to keep us then kids will die." I just don't think that's a good way of trying to do anything.

This SHA felt that being negative or threatening made school board members defensive, rather than supportive. While SHAs might use data to demonstrate the potential outcomes of SHPs, they must also take care not to make school board members uncomfortable because this would alienate them from SHAs.

Other interviewees suggested that asking for funding for SHPs or staffing to prevent health liabilities did not always work. One staff person complained about the risk of staff layoffs in her district, despite their efforts to outline potential liabilities to district decision-makers:

> Nobody wants to have a kid commit suicide. Everybody wants to say we're "the whole child" but then you don't fund us. [Laughter] Same with nursing - you don't want that kid to die with a bee sting, you know, but you want to make sure that the staff is trained on [Epipen] and who does that? It's the nurse - or your diabetic (student). So, I find that very frustrating in the district. They like to talk the talk, but not necessarily walk it with where they put the money.

The statement reveals frustration on the part of school health staff when decision-makers say they support SHPs, and then fail to fund them. As a result of not being able to make the case for SHPs by preventing liability, some SHAs have looked for different strategies to get funding. One of these strategies relates to demonstrating SHP cost savings or efficiencies.

Making a financial case.

There is limited funding for SHPs in California, largely because they are not mandated. This has led to a marginalization of student health and support services, and an emphasis on classroom education. As one SHA explained, lack of funding has marginalized SHPs:

> Funding for nursing, it's a big one. Because we're always sitting in the back as the kind of like the little step kids. We're not mandated and we've heard that how many times but I learned early, too. It's not about being touchy feely, "Oh, the nurse saved the child." You know that's all great but if you can't help with a little bit of funding, it's going to end – and that's reality….Helping people is great but it's not just about that anymore.

That was hard for me because I'm an older one so I just want to do good things but that's

not going to cut it.

This SHA emphasized how important it is to make the case for SHPs by showing how they

increase revenues. One of the ways that SHAs and their staff can increase revenues is by

conducting billing for all health-related special education services. This Local Education Agency

(LEA) Medi-Cal billing, is also sometimes referred to simply as "LEA" billing. One staff person

indicated how important it was for her SHA to show that revenue to other district administrators:

We do a lot of LEA billing. So they see the revenue that comes in. Of course they value

revenue so they're very happy about revenue. So she kind of shows: "Look at what we

do. Look at what we bring in."

As mentioned in Chapter 4, SHAs devote a considerable amount of time to conducting billing for

both LEA and MAA (Medi-Cal Administrative Activities).

In addition to demonstrating billing revenues, SHAs need to demonstrate cost efficiencies

or savings when proposing new SHPs. For example, one SHA was able to get district approval to

purchase a new, comprehensive health curriculum because she was able to demonstrate financial

savings over the long term:

It was the financial case. Yes, absolutely and that took about a year because they knew

the curriculum. They had seen the curriculum and they were aware of it and really like it.

So they got that it was a really good thing but they were struggling with the financial.

It is not always possible for SHAs to make the financial case for a new or existing SHP. A

supervisor in different district acknowledged how difficult it was for SHAs to make the case for

SHPs given financial constraints: "Making sure that we are providing enough services to take

care of our kids, to take care of their needs, and somehow do it fiscally responsible. Easier said

than done." Some SHAs were able to make the case for additional LVNs by using a financial case because their salaries were lower than school nurses. As one staff person said:

I think that's part of the reason why we're able to finally get more LVNs is that - just dollars and cents and liability factored in. They just had to understand that in the real world, outside of school districts, you couldn't expect somebody to take on that big a caseload. I have almost 2,000 kids I'm responsible for, at three elementary schools.

This school nurse indicated that what made the case for increasing funding was the cost savings of hiring LVNs instead of nurses to provide needed health services.

In another district, the SHA suggested that part of how SHAs can make the case for funding SHP staff or equipment is by building trust with decision-makers over time:

I think it's been relationship building along the way. I just don't go and say I need additional funding and just say, "I need $20,000.00 to purchase this or that." I think you have to be very, very creative in this position to be able to use moneys and to move moneys to do things for staff…if you do that and you do that enough - and I think people who are above me see that that is the general rule of being creative and trying to use various budgets to support your varying programs - that when you do take that request forward, they know that I just can't do it any other way. You have to have a lot of data to back it up…if I were to go in and ask for new vision screeners, it would be "Here are the grade levels we have to do it. Here's how many students are in those grade levels. Here's how it's been operating in the past. Here's the team approach that we've taken to vision-screen. This is why we can get it done in this amount of time. This is why we don't have to contract out and pay someone else to do it for us and why it makes more sense for us to do it ourselves."

It appears this SHA created an entire business plan outlining all requirements, staffing, supplies, and time in order to get approval for new vision screening equipment. She also had to provide a cost comparison with the alternative: contracting with a company to provide vision screening.

Some SHAs also described how they leveraged community agency resources to better serve students and families. For instance, school-based health centers run by outside agencies that do their own billing and require no district funding enjoy a lot of support in some of the districts in this study. As one SHA explained, "It's a good leveraging of resources. It helps to take some of the burden off of the school districts and helps to connect families to the resources that are available in the community." SHAs play an essential brokering role as they find community agencies that are willing to bring health programs onto school campuses. There is no one else who knows student health needs and existing SHP gaps as well as SHAs.

SHAs might also make the case for district funding by looking for "matching" private or public grants. As one supervisor pointed out, some grants require districts to match at least some of the funding they invest, in order to sustain the program after the grant period:

> What support do they give their health programs from an executive leadership position, how are those programs supported, how are they communicated? Are there district matches for certain things so there's that investment level? If there are companies willing to give sometimes $700,000.00, is the district willing to match it because this is what the potential gain would be? … What are you willing to put into it because what you put into it is what you get out of it?

This supervisor, who was new to her central office administrator role, posed these questions in the context of what school districts should consider regarding their SHPs. She seemed to indicate that districts' executive leadership need to invest more in their SHPs in order to get better student

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health outcomes. Using potential grant funding (or a business donation) might be one way that SHAs can get the district to match promised funds. Cultivating such a financial agreement would require that SHAs invest time into planning the SHP, applying for the grant, as well as securing administrative approvals and funding.

Taking advantage of emotional responses.

In a few school districts, administrators' emotional response to student, staff, or family tragedies created an opportunity for SHAs to expand their SHPs. One SHA had been working for years to try to get AEDs in the schools. She worked with the head of the district's safety programs who shared the SHA's desire to get AEDs in the school. Even with a grant they were unable to afford the expensive AEDs, and district leadership and principals didn't want the cost to come from their budgets. Unfortunately, it took a coach dying from a heart attack at a high school sporting event to get the AEDs paid for. Within weeks, every school and district building had AEDs. The district's deputy SHA felt that it was a combination of a fear of liability and an emotional response that motivated district leadership to finally pay for the AEDs.

In a different district, the SHA described trying to get principals and teachers to have an emotional reaction to data related to disproportionality in student suspensions:

I can go into a school today and say "You know, African-American students make up 50% of suspensions," and people will go "Oh, okay." …. There's no emotional response and I believe that even from a leadership perspective, nothing changes until it hits you emotionally. If you could look at the data and go "okay" and turn the page, nothing's about to happen with that but if you look at the data and you're almost about to cry, [laughter] then you're more apt to get busy on trying to implement things. Even if it's

only within your classroom but there has to be an emotional response of outrage to the

data before action can take place.

This SHA believed that until educators felt how unfair it was that African-American students

were disproportionately suspended, they wouldn't make their discipline practices more equitable.

Another SHA told a story about how for the first couple years on the job, she could never

get into the largest high school to deliver staff trainings, or expand services. She felt that it took

an emotional experience that principal had with a staff member having a heart attack to make

him reach out to the SHA. Ever since, she had not problems with that principal:

He had an incident where one of the adults in his school had a heart attack. He was

required to care for that person - he and that other person were there alone. He had to

work with an AED which we had trained him to do and the relationship took a turn for

the better [Laughter] because of that incident. I was able to support him through that. It

was pretty traumatic for him. He saw the need to have input from the health program

people at that point…. Again, it's all really about building those relationships, taking a

moment when you can and going with it and not being kind of afraid to do that because I

think I was initially.

This SHA said that she used to be nervous about calling principals and asking for access to

students or teachers to implement a program. Then one of her faculty in her administrative

services credential program helped her examine the power structure in the district:

It's an authority issue. As nurses, we find ourselves being sort of handmaidens. I mean, I

graduated from nursing school in the '80s. We used to open doors for physicians. We

used to wear little white outfits with hats. I think I've always had sort of a respect but also

a feeling of being subordinate to physicians and sort of transfer it over to being this big

honcho (principal) with five secretaries and responsible for 2,500 students every day.

This SHA shared her insight into how she reacted to the authority given that principal by the

district power structure. She felt more comfortable calling and making requests of principals

thereafter. It is unclear whether using administrators' emotional experiences as an opportunity to

build a trusting relationship with them actually changes the codified power dynamic in the

district. It seems like SHAs' relationships with specific relationships with administrators become

an exception to the rule, in which SHAs are still disempowered by district authority structures.

One SHA described how she had to work with a new board member who was

conservative, and did not understand the needs of students living in poverty:

This is a person who's really, really, really, really politically conservative, really, really

family values type of person. I think in her job as a board member in a school district,

she's going to have to understand the needs of a lot of children that she hasn't ever

thought about. Those who live in a tent by the river. I know that that's what I can help her

understand - that every child does not have a middle class family with food, and shelter,

and medical care, and clothing, and opportunities to go to college. That she has to

represent all of them in the decisions that she makes.

This SHA accepted her role educating school board members who did not have an understanding

of some children's health needs. Teaching multiple board members how to be compassionate

with some students' and families' needs seems like an onerous task that the SHA should not be

solely responsible for.

Some SHAs described situations in which school staff, administrators, and the board felt

uncomfortable thinking about student health issues, especially mental health problems such as

depression. One staff member said that when her SHA recently presented at a school board meeting she shared information about how many children had significant mental health diagnoses, and the impact of their conditions on their graduation rates. The staff member said school board members and administrators who were there looked really uncomfortable: "It's like, 'Put that in the closest.' Maybe it's too close to home or there's still so much myth about it, there's so much stigma." She said she saw this other times with staff at her school site. If hearing about student mental health conditions makes administrators uncomfortable, then SHAs must modify how they describe student health needs, so as not to alienate those they are trying to persuade.

Cultivating powerful allies.

SHAs put considerable effort into cultivating the political, funding, or staffing support of key allies. In order to get what they needed for school health programs (SHPs) and staff, participating SHAs cultivated relationships with individuals who held the power to make supportive decisions or allocate resources. Decision-makers such as their supervisor, cabinet members, superintendent, and school board members were the types of allies SHAs needed.

Oftentimes, getting support required that SHAs find common ground with individuals whose interests might be different than their own. As one SHA said: "You have to be able to be willing to listen to people who are fighting just as hard for things you don't believe in to really understand it from their perspective to come to some type of common ground." Another SHA described the importance of understanding others' perspectives in order to identify a strategy to engage them as allies:

> I think it's really important to understand just different perspectives of things. I think that
> you really understand where people are coming from so you can meet them where they're

at…I think understanding where people come from with their values and what they think

- because I mean there are times when I know that I'm not going to get someone to

understand why I think this is so important and you have to give that up. You have to go

to where – you have to find those people who you do connect with and your allies.

This SHA recommended finding shared interests with some district administrators to cultivate

their support, and letting go of convincing everyone. This strategy could help SHAs conserve

their energy by only investing it in likely allies.

Another SHA referred numerous times to the importance of her "rolodex," all the

contacts for the relationships she had built over the years. In order to help her staff, she said

would call up key allies in the district to negotiate a resolution to problems staff encountered:

Everybody in my department knows, all my nurses know, my best gift is when they come

up against the brick wall, they come and we talk and I look in my rolodex and I figure out

how to break down the wall.

This SHA carefully built relationships with administrator allies with whom she could broker a

solution to staff's day-to-day work issues.

As evidenced in the last chapter, SHAs typically work as middle managers of a

marginalized department within their district. Because of this, SHAs often did not hold the power

to get what was needed for or requested by their staff. This was also true when brokering

community agency partnerships. One SHA said she used her knowledge of the district's

structural processes to help others get access to those who could make needed decisions:

I sort of teasingly call myself a midwig, not a bigwig and so when people – because

people are always saying, "Well, why can't you get this – can you help us get this

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through?" I say, "Well, clearly, you need to understand that I'm a midwig, not a bigwig

so I can't do it but I can help you navigate to get to who needs to make that decision."

This SHA's joking title for herself reveals her lack of power as a middle manager in the district

hierarchy. This example also identifies one of the brokering strategies that SHAs frequently

alluded to throughout the interviews, though not always by using "brokering" terminology.

Another SHA talked about helping a local university get access to students, as part of a

grant to serve foster youth: "It's really important in the terms of the grant that they're able to

connect with that population. So having somebody that's able to advocate and promote and

connect is important." This SHAs' use of language, such as "promote" and "connect" could be

interpreted as a type of brokering, whereby the SHA helped shepherd an agreement so the

university could serve foster youth in the district.

One deputy talked about how she came to accept that she didn't have power to make

things happen, and instead could broker deals to improve student health:

I actually have a couple of times run across an instance where "Man, I wish I had more

power because I need a big stick" - discussing things with my husband who is a manager

level also. He said, "No, nobody really carries a big stick." That's really true. I thought

about it and I thought "Well, that's true." I have to try and cajole people with my charm

and that kind of a manner rather than the title or whatever. That's very, very, very true. I

do refuse the mid-level. I tell people "I have no title. I have nothing different, but let's

talk."

This deputy was reflecting on her powerlessness to make decisions and her lack of authority as a

middle manager, given her title was still "school nurse." She seemed resigned to trying to use her

interpersonal skills to negotiate agreements instead. The following sections will illustrate how

SHAs and deputies used their interpersonal and negotiating skills to get resources for SHPs with powerful decision-makers.

School health administrator supervisors.

SHAs' supervisors are key gatekeepers to other district decision-makers. Some SHAs described how they cultivated their supervisor's support for school health programs (SHPs). One SHA shared an example of how his supervisor provided him access to other district decision-makers:

> He's effective in the way that he goes about bringing things forward and helping people - he's just like "Hey, research shows that it makes a difference." He's very good at helping bring people along and then creating opportunities for us to present to the principals and other groups. So I think he's been a big ally. He's quiet about his work. He's not going out there carrying big banners.

This SHA appreciated his supervisor's low-key style as an ally who helped him get access to principals at times. This may help explain his supervisor's success, insofar as he was non-confrontational with other district power brokers. In addition, other interviewees described the importance of using "data" and other forms of evidence to build support for their SHP proposals.

Some SHAs felt a lack of support and understanding from their supervisors. For example, one SHA did not have success getting her supervisor's buy in, and felt that her supervisor made unreasonable demands on her:

> She has a lot of knee jerk requests that I try to accommodate as much as possible but when I can't, it takes a lot of explanation and time to explain why, that I'm not just digging in my heels in a power struggle, that there is a reason for my practice. I try not to keep bringing up my experience or the other situations that have gone well. I'm trying

very hard to let her be my boss, but it's a struggle…It's not an intentional, "Nurses are

not anything I care about," but her understanding of our role and our level of expertise is

developing.

This SHA's supervisor was not a nurse, and the SHA felt that her supervisor did not respect her

as such. Because of her background in school nursing, rather than "regular" educational

leadership, the SHA had to justify each request she made of her supervisor. The SHA also

carefully navigated how she responded to her supervisor's requests, because the SHA could not

afford to alienate this important gatekeeper.

The superintendent.

All SHAs in this study described how important it was for them to build a supportive

relationship with their district superintendent. For example, one supervisor suggested that SHAs

must anticipate what their superintendent will ask related to any given funding or policy request.

Then, they can prepare the supervisor so he/she has all the information needed to respond to the

superintendent's questions. In this way, SHAs might be continually working to get their

supervisor's support, and the superintendent's support.

One SHA was in the process of creating a data report for the superintendent, who wanted

to identify how community partners could provide needed services in the district:

His big things are asthma and vision…but right now he wants to know by region what are

the medical needs that nurses are dealing with with kids just to show all we're doing for

kids for medical, taking care of them a lot.

When asked why the superintendent cared so much about asthma and vision, this SHA replied:

"I've heard him say it, 'If they can't see and they can't breathe, they can't learn,' and so he wants

to make sure that's taken care of." The SHA needed to quickly respond to superintendent

requests for data, in order to garner his support for SHPs. This exemplifies how attuned SHAs must be to opportunities to get superintendent support.

Another strategy to build trust with the superintendent was that when interviewees had to bring a SHP problem to the superintendent, they simultaneously presented a solution. For instance one SHA said that her superintendent was:

> …a person who expects you, as the leader of your department, to bring in issues, to have a suggestion on how to solve those issues and not to bring in a problem and dump them, dump the problem on her… So I think the relationship of having the trust comes from doing what you're supposed to do, being really faithful to that and to being a part of the answer to a problem rather than more of a problem.

This superintendent clearly outlined her expectations to the SHA, who heeded her directive. This SHA accepted that her job responsibilities involved identifying problems, and providing related solutions appropriate to the district's vision and funding streams. That could be difficult for SHAs who do not have access to needed information, resources, or authority. Another SHA said he rarely even brought problems to his superintendent: "I don't want stuff to leave me and have to get to the superintendent. He has enough stuff to worry about already. So I try to fix things on this level." He was trying to protect his superintendent from additional worries and also trying to avoid disappointing or frustrating the superintendent. This SHA also distinguished his "level" in the district hierarchy from his superintendent's higher level of authority.

Superintendents often act as spokespeople for key district issues. One SHA used this to his advantage. He had arranged for his superintendent to speak with him at a meeting of school nurses, to further strengthen that superintendent's support for SHPs:

We're going to present on some of the things that we're doing with foster youth. He's a part of (a local mental health commission). So we'll probably talk about some of these partnerships that were put in place, how they brought back health assistants. We're going to celebrate those successes that we've had and bring him into a room with a bunch of school nurses who are pretty good at bending your ear.

This superintendent would receive accolades for his work to support SHPs to date, which could only increase his support in the future. This SHA said that he was taking care to prepare the superintendent so he would feel comfortable during the presentation, and said they would not "put him in a hot seat." SHAs need to nurture a trusting relationship with their superintendents.

This relates to political considerations for SHAs when advocating for SHPs with the superintendent. SHAs said they took care to protect their superintendent from political issues, especially vis-à-vis the also powerful school board; otherwise, SHAs could take the risk of alienating the superintendent. When asked what skills SHAs need to succeed in their role, one SHA outlined the importance of SHAs protecting the superintendent and other key decision-makers from politically uncomfortable dynamics:

Being aware of the political reality, knowing how to work with board members and how to navigate those waters, making sure that an individual knows whatever you communicate with the board member needs to be shared with the superintendent and your immediate supervisor, so that they don't put people in the cross hairs of a board member when they bring an agenda item that you're not aware of. I think a lot of times folks coming up through the administrative ranks don't get that kind of coaching around a political environment… a really key ingredient for a successful (SHA) or anybody that's working their way up in the organization is to really understand the political frame, how

to be effective at communicating without getting themselves in a situation where they've

leveraged the board member against the superintendent or another board member.

This harkens back to the earlier comment about building trust with the superintendent. One way

to build that trust, and not embarrass the superintendent (or a school board member), is to

prepare them for what might come up in a public forum, such as a school board meeting.

A different SHA described how she had recently gotten in trouble for not protecting her

superintendent in an email exchange:

The sup did wring me out two weeks ago because he said that I shouldn't have sent this

email to the board without talking to him first. He said, "You shouldn't do that because it

makes it like I don't know what I'm doing, like you know more than me. You should

never walk up to me or do that in front of the board." I went, "Oh, sir," I said, "I'm

mortified." I said, "I'm so sorry. I just was trying to get the job done, because I had these

parents in here complaining about Planned Parenthood and my affiliation with them or

that I was promoting abortion. I was teaching Positive Prevention, which is the research-

validated curriculum and they were complaining about it that it was an agenda – I was

trying to deal with them and they wanted a response and they had gone to the board. So I

emailed, "What are we doing about this, (superintendent's first name)?" He said, "You

should have never sent that email to the full board. You should have just sent it to me. It

makes it look like I'm not doing anything about it and you can't do that." I was like, "Oh,

I'm sorry." He goes, "I know you. That's fine." He's known me for five years. So he

goes, "No, I know you. You're a great employee. Just learn, don't ever do that again."

I'm like, "No problem, sir." I'm like that. You tell me don't do it and I won't do it again,

but sometimes, I do – I think I send things off and just – I'm really strong in some of my

emails, but I'm trying to be a little softer.

This example highlights some of the political issues that SHAs need to protect the superintendent

from. This SHA clearly embarrassed her superintendent via email. This was a political misstep

that might have resulted in more punitive actions. The superintendent asserted his authority over

her by reprimanding the SHA as an employee who should protect him. The whole issue of *why*

she sent the email became irrelevant, and she was not afforded any protection from angry,

seemingly misinformed parents. In the end, the SHA concluded that she needed to be "softer" in

her email communications. She was disempowered, and her original concern was not addressed.

Frequent superintendent turnover required SHAs to continually rebuild relationships and

cultivate support with a revolving door of superintendents, cabinet members, and supervisors. A

deputy emphasized this need: "Since (our SHA) has been in her role, there have been three

superintendents, I believe. It's an ongoing – it's building of relationships and communication, I

think and just doing that really well and doing it professionally." This implies a double-duty for

SHAs: get their work done, and at the same time, work to build relationships with the ever-

changing administrators who will, hopefully, support them in their work.

The school board.

As with superintendents, SHAs' work to educate and cultivate school board members'

support never ended because of board member turnover. As one interviewee said of his board:

"They don't know what's going on, so they come in with different agendas. So it's trying to

demonstrate that our role has always been for the students." Some SHAs said that they needed to

present to their boards about clinical staffing issues so the boards could make informed funding

decisions. For example, a deputy SHA wanted her school board to understand why only licensed

staff (e.g., school nurses, LVNs) should administer insulin to diabetic students: "We need to educate those higher up people and the school board as to why it's important to have a licensed person only in charge of that. That's such a hot topic and such a hot issue." Getting the board to understand the need for additional licensed staff is a challenge, because they are more expensive than unlicensed personnel such as health aides.

Several interviewees pointed out that funding for SHPs was subject to who was on the board, in addition to the superintendent. One interviewee felt that SHAs needed to understand that funding "fluctuates with the board also, so you have to understand the boards as well. That's another leadership skill, looking at that to see what the direction is and how you can parlay that a little bit." Several interviewees described doing just that: they attended school board meetings or read minutes from board meetings to learn about district hiring, funding, and policy decisions, even if these decisions did not impact them directly. As one SHA explained:

> On the school board agenda meetings, I always go to personnel assignments, resignations, placements and all that. I print those out on a monthly basis because I'm looking for who's shifting where, what is being politically aligned with what. You have to understand the politics of your district to be successful. As sad as that is, it's true, right? I have to look at all these teachers and where they are, who are the new hires, who do I have to go and figure out, who do I have to meet and greet and figure out if they're going to be – if we're talking about allies that way, who would or wouldn't be more aligned with helping me with having a seamless (health) screening day?

This is an example of how school board politics trickle down to site-based health work, such as doing health screenings. Another SHA described how political school board hiring decisions

could be. This SHA felt that in small, rural districts such as his, poverty made the board more invested in "looking out" for their family and friends to get jobs in the district.

SHAs said they presented at board meetings in order to prevent staff layoffs due to budget cuts. They sometimes asked parents and staff to come speak at the board meeting as well. For example, one school nurse remembered her SHA saying to her and other staff: "If you want to save your job then please come to the board meeting and speak about what you do because nothing speaks higher, louder than a nurse talking about the care she's giving and why it's important." This could be interpreted as the SHA recognizing that she alone could not persuade the school board to keep staff positions, and needed staff to state their case as well.

A deputy SHA in a different district said she started going to board meetings the year they laid off several school nurses, but not in any official capacity; she attended like a member of the public who could make a brief comment to the board. This was also true for SHAs who asked their staff to come to board meetings to proactively show the board the good that was coming of their funding support. One staff person said that just the night before, she and her fellow staff were at a school board meeting until 9:30pm. Her supervising SHA had worked hard to get the board to pass resolutions related to student health, including National Children's Mental Health Day and National School Nurse Day: "she e-mailed us five times reminding us to be there…It's a political move, to show the board and remind the board: 'This is why you fund us, look at all these people out here serving all these kids'." Another interviewee said that she and other nurses were organizing a presentation to the school board about how they needed additional health assistant staff. Regardless of specific request, all interviewees described a need to get school board support to maintain or expand their SHP.

One of the most interesting stories related to getting school board support was from an SHA who had been working to get a health course brought back as a graduation requirement. When she finally got the board's approval, she said it was a matter of getting the "right board at the right time." When she got her moment to present to the board, she outlined the negative outcomes that would come from not providing a health education course:

> My theme was The Price of Not Having Health. They said, "Why should we have health?" They were going to vote that night and I went, "Let's talk about the price of not having it." I went into mental health, physical health, sexual health, and just some statistics. The leading cause of the death, or health behaviors adopted in adolescence.

This SHA used data to make the case for preventing poor health outcomes. She also brought in people who gave public comment in support of the health course requirement. Part of how she got the health course requirement passed was because of the support of a board member who was championing her health class requirement:

> This board had one member - she is a leader of a charter school in this neighborhood for pregnant girls and kids who drop out and just get on the wrong path. She and I have always had a connection that is wanting to help these at-risk kids and have – health ed is a very strong aspect of their curricular experience. She's quite passionate and she's a strong board member. So with her anchoring this group - she also chaired the Safety Committee and I'm on the Safety Committee…

This SHA built a relationship with a board member who proved to be influential when the time came to present to the board. As the SHA told it, this supportive board member and other board members were actually yelling at each other during the meeting. At one point, the champion board member took someone who was opposing the health requirement out into the hall and said

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"Don't you sabotage this." After heated deliberations by the board, the superintendent spoke in favor of the SHA's proposal for the health course requirement:

> It went back and forth, but when it came down to it, the sup supported me and he said, "I'm with (SHA's first name)," which was great, he said that publicly at the board meeting because somebody said, "Well, how does the sup feel about this?" He was just sitting back at the – at the board meeting and he goes, "Well, I believe (the SHA) can do this." I was just like, "Oh, my gosh." Then they voted and it was a 6-1. The person who voted against it, she said, "I'm not against Health. I'm just against that year. I think we should put it off for two years. I think we are doing it too soon."

The superintendent used his influence to get school board members to vote for the health course requirement. In addition, the SHA built relationships with school board members, brought community members to testify in support of her proposal, and used data to make the case.

SHAs who had personal relationships with board members were cautious not to usurp the traditional hierarchy and process for getting the board's support for something. For example, one SHA involved a board member in a wellness committee she led. Another SHA attended state meetings with her school board members to help them describe to other districts' board members how new health laws could be implemented. She did this to build relationships and trust with her board members: "It's really, really valuable. It takes a lot of time, it takes a lot of my energy, but it really pays off." This investment of time in working side-by-side with board members helped her earn their support when she needed it. In addition, she helped them receive public recognition for their leadership in school health policy.

One supervisor said that when she needed to take a health policy or administrative regulation to the school board, her SHA would often come with her and make a presentation to

the board to explain the change. The supervisor describes the SHAs' role as a "champion" for student well-being as key to working with the board:

> She is very comfortable and they respect her. They ask her questions, they rely on her, and that's a good relationship that she has with the board. She's very passionate. I think it's her biggest positive component when she talks to the board…We have one board member that the two of them historically have had differing opinions and she will back it up by her facts which some board members may not always agree with and kind of look at it from a common sense or "well my kids..." kind of thing. I think to them, she's not just getting up there and saying, "Yes, yes, yes. Whatever you want, I'll do." She's proactive and she's championing the kids and she's championing her programs. I think that's what gives her that huge level of respect.

This supervisor felt that her SHA was successful in communicating with the board, by being factual and conveying her passion for students' welfare. In addition, she did not feel like it was problematic for the SHA to disagree with the board at times. How much the SHA's disagreement would impact the board's decisions was unclear.

Principals.

SHAs, deputies, and staff spoke at length about difficulties they'd had securing principals' support. Some SHAs thought that principals were preoccupied with concerns related to academic achievement, and did not have health issues on their radar. As one SHA put it:

> A kid could be having problems in the classroom, but they don't think to talk to the nurse to see if maybe he's not taking his meds if he's on ADHD or different things, it's just - they just don't think that way. As health people, we've got to think their way and get into their world.

Many interviewees complained about how principals did not recognize the value of SHPs. These interviewees also were intent on explaining why principals had such attitudes. The SHAs needed to make sense of their struggles with principals, maybe to deal with their frustration. As the above quote shows, some SHAs analyzed their interactions with principals to learn new strategies for getting through to them. This SHA determined that "health people" needed to frame what they could offer in terms that are aligned with principals' thinking.

One SHA told a story about how she learned about her district's political power structure from her challenging experience with one principal:

I was having difficulty speaking with and even getting access to the principal of our biggest high school who is a male. I wasn't having problems with other principals so I was very puzzled by, how come I can't get a hold of this gentleman? Well, there's a bit of a privilege there, being the male leader of the biggest high school in the district. That person reported directly to the superintendent, did not report to the assistant superintendent for secondary education. He had a lot of power. I did not understand that. I had to learn how to broker any issues that we needed to do at his school.

This SHA described how she came to recognize that the principal of this school had so much privilege that he felt under no obligation to even speak to the SHA. One aspect of the power dynamic in this situation is related to gender. Principals are predominantly male, and SHAs and school health staff are predominantly female. This reinforces the greater value placed on the principal's "masculine" authority, as opposed to the SHA's "feminine" lack of authority and status as a caregiver, not an administrator. Here again, the SHA coped with the situation by learning how to ask permission and carefully broker services with a district gatekeeper. This power dynamic between SHAs and principals is much like SHAs' relationships with their

supervisors and cabinet members, all of who operate within a structural hierarchy that devalues the "feminized" work of SHAs and their staff.

In order to reach students, interviewees presented an array of strategies to get principal buy-in. Most interviewees emphasized the importance of building personal relationships with principals, even more than they did with cabinet members, the superintendent, and board members. One SHA described her process of building relationships with principals:

Getting to know them and for them to get to know me, spending time with them, talking to them about different kids. In the beginning, it was a little difficult because a lot of people in (district city) have been here forever, which is good. They're like family. So the first couple of years I was the outsider….I spent a lot of time getting to know people and getting to know different schools … it's just building that trust where they know I'm here about the kids, I'm here about how can we help. Most of the principals are there. They want help for their kids and once that started to connect, that we were able to link them to services, then the doors opened for me. I was welcomed… and I had to prove myself.

For this SHA to get access to students, she first had to build trust with principals.

Other strategies shared by SHAs included "collaborating" with and "engaging" with principals. As one SHA said:

You want to engage the teachers, the principals in what you're doing so they can see the value. Because when you do everything quietly and you just go about your business, I don't think they always see it. You have to toot your own horn, if that makes sense.

This SHA was working to elevate the work of SHP staff so that principals would realize what they provide to students, and come to appreciate their services more.

Some SHAs wanted access to principals as a group to deliver training, or educate them on a current student health issue. One SHA outlined her difficulty getting access to principals:

> Getting messages to principals is really, really hard. We have a district update, we can put things in so the principals are supposed to read that, they don't, and we can't get in front of principals because they're so jam-packed with common core and all the things they need to do. That's very, very, very challenging.

The "district update" is a written update that goes out to all school sites. This SHA did not feel that was effective, and instead wanted to make a brief presentation to principals during one of their meetings. This was very difficult for her to arrange, though other SHAs described having more luck presenting to principals.

In trying to prevent students for being sent home for having head lice eggs (nits), one SHA provided a presentation to the districts' principals on the issue. One principal was particularly impressed with the SHA's presentation on how head lice are very hard to transmit. As a result, the principal asked the school nurse to present the same information to parents, and stopped requiring the school nurse to conduct regular head lice checks in classrooms. The SHA said she was very surprised to see changes taking place: "I thought, 'Wow, I felt a little power.'" This statement reveals that this SHA had not previously been able to make such changes to site-level health policies and procedures.

SHAs needed to negotiate principals' support for equipment for SHP staff too, so they could do their jobs at school sites. One deputy SHA described a problem where school sites were supposed to provide a computer for their school nurse. Since principals sometimes failed to do so, the SHA found money in their budget to purchase laptops for the school nurses:

Nobody wants to put that in their budget. In the principal's mind, "That's a health

services person so health services should supply that." So (our SHA) has a memo that she

sends out a couple of times a year saying, "This is what the school site is responsible to

provide for the health office." She's got buy-in from the assistant sup. She doesn't send

anything out like that without getting it approved. And that's the other thing, you need to

know that anything you send out needs to be approved and there's a process and, you

know. People who have only worked in hospitals don't understand a lot of that process.

It's like, "Well you just handle it." "Well, no, you don't."

This same deputy described how in order to get what they want, school nurses need to ask their

principal nicely, and not be demanding. This deputy identified a clear hierarchy through which

decisions are made, and deferential etiquette that both site staff and the SHA must employ when

working with principals. In this case, the SHA cannot even send a memo out to principals

without her supervisor's approval. This could indicate that SHAs have less independence and

authority than principals.

Interviewees talked about the need to finesse communications with principals when

dealing with SHP staff issues, so the principals would not get defensive. One SHA described

how she is careful not to criticize principals when problems arise between them and health staff:

It's sort of one those things where you never want to intimidate anybody. The idea is to

go in with the idea that you're a partner in this. "I got a call from so and so and there

seems to be a problem, I wanted to talk with you about this, maybe we can find a

solution." If you go in from that angle, it usually works a lot better than saying "Hey,

you've got a problem with this person and you better fix it now." You're going to get

resistance immediately and rather than having their hackles go up that you're criticizing

something that they're doing, it's better to go in and say, "Can we work together on this and figure out a way to resolve this." Over the years because of doing it that way, now when I call it's always kind of light even when it's something really serious or they'll call me really upset about something and I'll say, "All right, I need to come over, we need to talk about this." So I just stop my day and I'll take a couple of hours and I'll go over and sit down and listen to them. A lot of times… when they're really upset about something, let them vent it out, or let them tell me what it is that they're bothered about and just get to the very end. Once…they get past that emotional end of it - then they're more open to a conversation about how to resolve that.

This SHA employed "soft" skills like listening, empathy, and patience to give principals a chance to feel heard. These skills are part of how SHAs cope with situations where they cannot take the risk of alienating principals, because the delivery of SHPs relies on principal support. Another SHA described how she diffused problems between her staff and principals by chatting with the principals more socially:

I talk about sports, I'm a Dodger fan. I side track people and I go, "Do you ever go to Dodger games?" "Would you like to go?" I change the subject. I ask them if they work out, "What do you do to work out? How do you feel today?" I don't know, I just change the subject then all of a sudden, they're happy again.

This SHA would use shared interests, like sports, to connect with principals and resolve situations between them and her staff. This is a non-confrontational approach that allowed her to side step a potential power struggle with principals.

In some cases, principals are partners in the provision of services at their sites, because student health or behavioral issues impact operations at their schools. As one deputy described it:

When it comes to the site, there are certain things that you need to report to the principal, and yet you have a responsibility and you have a mandate to provide certain reports and information to your Director of Health Services. (Our SHA's) the one who does our evaluation but she does get input from the site principal. But if I have a kid who's not attending school or who comes to the health office five times a week, I'm not going to go to (our SHA) about that. I'm going to go to my vice principal or my principal and …when it comes to the children at their sites, they need to know what's going on.

SHA and deputy work involves socializing SHP staff to the power structures in the district, so they adopt deferential communication skills to maintain the support of their principal.

In some cases, SHAs faced difficulty rolling out their wellness policy at school sites. It required buy-in from principals to restrict classroom parties to offering only healthy foods. One supervisor was helping her SHA build the support of principals:

I've been pushing it pretty hard with my principals, and I think that it's going to come about but it's going to take some time, because they like the parties and they want to eat whatever they want, but we have to remember what we do it has to be good for kids on every level. Not just the instruction, it has to be on how we model that ourselves.

This supervisor was using her greater authority with school principals to help her SHA enact a component of their SHP. That she needed to do so illustrates the SHA's lack of power to get principals to make the changes she wanted. This example also demonstrates how SHAs who have secured their supervisor's support can "use" their supervisor's influence to persuade key gatekeepers, such as principals.

SHAs also had to negotiate with principals to try to influence how they handled student misbehavior. Rather than a "zero tolerance" policy whereby students would be automatically

suspended or expelled, SHAs tried to get principals to better understand their students' problems and find ways to help them. One SHA described her experience when she started her job:

> The social and emotional piece for most of the principals wasn't on their radar because it was very easy just to move the kids out. Zero tolerance. You act up, we move you out. It's like, "No, there are more reasons for this."

This SHA worked to help principals understand why students might behave badly at school. She told a story about a student who had been in five different foster homes plus a group home in the past year, and therefore had attended six different schools in the same period. The student had been exhibiting negative behaviors at his most recent school. In a meeting with the student and the SHA, the principal started off by saying to the student, "Well, your teachers don't want you back in the classroom." The SHA said she was very upset by this statement. In front of the principal, she apologized to the student for all the moving of schools, foster homes, and other changes he had been through. The student broke down crying. This is the conversation the SHA described having with the principal after the student meeting:

> I talked to the principal and I said, "You can't just tell the kid 'you're not wanted.' He's been told that six different times now, okay." It's just that once the principal heard that and saw him react, she changed her whole – her tone came down. It became softer, she became more open. Before it was like rawr rawr rawr! It was like barking at him and it's like, "get to know your kids. There's a reason." She said, "But, what do I do with the teachers?" and I said, "Well, let's put him on home hospital (instruction). Let's get him tested. Let's get the teacher out there one on one. I think he'll do fine. He loves his foster home. It looks like a good situation for him, and let's start there, and then we can see if he needs to be in a non-public school or what the results are from the IEP." It's just that

when she said that, I thought, "Oh my god. This kid is going to go off and he has every right doing that." [Laughter] It's just trying to get people to understand that and I think it's one kid at a time, one principal at a time.

This was a delicate situation in which the SHA did not approve of the principal's handling of the student's misbehavior, but had to remain calm and non-confrontational with the principal. The SHA modeled for the principal a different way to talk to students, and helped her to see how hurt the student was. The SHA also came up with an alternative solution: arranging for the student to receive instruction at home. This helped the principal "save face" with the teachers who did not want the student back in their classrooms. All told, this SHA successfully performed a dance that acknowledged the principal's authority, but also facilitated a positive outcome for the student.

Not all SHAs felt that they had actual allies in their district. When asked who in the district were her biggest supporters, one SHA said, "Everything you say can and will be used against you, so I do not consider anybody my ally. I have had things used against me. I trust no one. Isn't that sad? I am very selective. I am very careful." This SHA did not trust any of the administrators or school board members in her district to be actual allies who she could turn to for support. This speaks to the limits of what types of support SHAs might expect from the decision-makers in their districts.

Adjusting to working conditions.

When interviewees did not have success in securing needed resources, they practiced patience, persistence, and flexibility while they awaited another opportunity to make the request. They also figured out low-level "workarounds" when unable to get the explicit approval of decision-makers, such as implementing a new SHP at just one school.

Finding workarounds.

Some SHAs were more concerned about the appearance of following the chain of command than actually doing so. For example, one deputy sought allies outside of formal decision-making structures to help her solve a problem regarding getting a student with special health needs back on the regular bus:

> If this person isn't going to help me, who can I get help from that's not going to look like I'm going outside of the chain of command? - Which is very - especially in this district, you don't go outside of the chain of command. I'm much more vocal than (my SHA) is. When I'm frustrated about something, like when I couldn't get that kid back on the bus, I mean, I'm calling everybody I can think of. "What are we going to do to get this kid back on the bus?"… "Who do I have to talk to get this decided?" Then finally it was a matter of the site nurse and me making a plan to go around them. It's still not really resolved... But you have to be careful with your workarounds because then you might make somebody unhappy who's over you and, so. I'm not quite as diplomatic as [Laughter] (our SHA) is.

This deputy was candid about how she devised a "workaround" to meet the student's needs because she could not get formal approvals. She also expressed some caution about not making superiors unhappy with how she circumvented their authority. At the same time, she suggested that she was more willing to get things done outside the chain of command than her SHA supervisor was.

One SHA who had been in her role for over a decade was resigned to not getting administrative approvals from the most recent superintendent and cabinet members. Instead, she

said she just did what she needed to do to implement programs, bring in community agencies, or get grants:

> What I've learned is the work gets done at my level. If I always ask for permission to do things, we would get nothing done, so I've taken a lot of liberty in my job to seek out opportunities and just do it, bring money in, bring supports in and do it. Not everyone does it that way that I have. Well, I'm still here. I really haven't gotten my hand slapped too much because these are unique services. Health services is different, but I've gotten a lot of support. We got more nurses this year, we got everyone back plus some, so you do need to inform them. They need to know what's going on. They need to know what are the big topics, where the big impacts are on the kids.

"They" are district administrators at the cabinet level and the superintendent. This SHA differentiated between what she could do without seeking permission, and what "big topics" she needed to bring to her superiors. She spoke as though she felt more empowered than most other interviewees, maybe because she had survived as a SHA in her district for a long time. This same SHA said that when she couldn't get high-level approval for a district-wide program, she would just focus on establishing a few site-based programs: "Quite frankly, I go below. I keep just getting the programs in place and I get the early adopters to get to use them rather than trying to convince them (district leadership)." This SHA described a process by which she would not seek district leaders' approval, and instead would "fly below the radar" and just start smaller health projects at individual schools.

A few interviewees spoke of the importance of being courageous and taking risks to get SHPs in place, even though they might buck their district's status quo in the process. None of these interviewees were nurses. One SHA who was not a nurse said that it seemed like school

nurse administrators, because of how they were trained to defer to doctors in the medical establishment, were afraid to take risks:

> It's a medical model – it's very hierarchical. I mean this is your role, you acquiesce to the powers and you don't ruffle feathers and just do your job. Yes, it's different. Politics is huge, though - not being afraid of politics and understanding them, but some people don't mind dabbling in that and others don't even want to get close.

This SHA said that a prior deputy she worked with, who was a nurse, could not deal with the politics inherent in the job. The SHA, however, felt that being a risk-taker was an important skill as a leader, because "You can't stay too safe because you're not going to get out in front of what needs to be done." She described herself as a "scrappy fighter" who was not afraid to take risks.

A supervisor of a different SHA (who was also not a nurse) commended her SHA for taking risks in her job: "She's not afraid to say no. She's not afraid of just taking those risks and putting us out there, and she has had great success with it and she knows where to look. She knows what to ask." This suggests that the SHA took calculated risks, and sometimes refused to deliver something requested by superiors in the district hierarchy. This same SHA, whose background was as a teacher, said she was not afraid to ask directly for what she needed, and did not always work her way through the prescribed chain of command:

> I just go right up there, just email somebody. I need help with – sometimes when I'm involved with facilities, or finance or academics, I just email them and go, "Sorry to bother you but something urgent has come up. I need X, Y and Z." They're like, "Oh, sure, (SHA name). How are you?" They're great but nobody really bothers with the health department but when I go speak or do things or say this is happening, everybody is like, "Yay! I'm certainly not against it."

This SHA felt she was able to go directly to administrators in other departments to get what she needed, but only in "urgent" situations. She said she did not do so when it was a more routine matter, nor when it required high-level decision-making authority.

In another district, an SHA equated taking risks with leading efforts to improve educational and disciplinary equity:

> In addition to the counseling side or interpersonal relationship work or whatever it is, in this day and age there has to be a strong and authentic connection and ability to take the risk and be a leader in the work of equity. Student support services directors have to be willing to address disproportionality, address gaps, address the multiple forms of disparities that exist, and they cannot be afraid of the race conversation… student support services directors have to be risk takers in that area and courageous in that area and do their very best to lead the charge.

These quotes reflect a key theme in this study: the only sanctioned reason for SHAs to circumvent the chain of command, or challenge authority structures in their districts, is in their prescribed role as passionate "advocates" for students' welfare. This was echoed throughout the study. One supervisor explained why it was okay for her SHA to reach beyond her with SHP requests:

> (Our SHA) is very passionate and for someone in her position, she needs to not just wait by the wayside. These are children's lives and we need to be deliberate and intentional, and she is. You have to be willing to put it out there and ask for the stars and maybe you'll get all of it, maybe you'll get part of it but if you never ask, you don't know. Yes, so she's really good about just always putting things out there but she's also willing to go out and get it beyond me, which is great.

This interviewee was a new supervisor for the SHA, and newly appointed to her central office role. This may be why she felt comfortable with her SHA reaching beyond her to negotiate for SHP needs.

If school districts allocated core operational funds to SHPs, and empowered SHAs to make decisions, SHAs wouldn't have to always negotiate for children's physical and socio-emotional well-being. While these SHAs appear to be taking a courageous risk, they are acting out an assigned, disempowered "advocacy" role as part of a system that continues to marginalize SHPs, and by extension, SHAs.

Waiting.

Interviewees told stories of how they often could not get the support they needed for a new or expanded health program, so they waited for another opportunity to make their request. This required SHAs to remain prepared, gather more evidence, and monitor district opportunities by using a systems-perspective. When they determined it was a good time strategically, they could make a new request of decision-makers. This could be a practical strategy, as well as a coping mechanism for SHAs who had to deal with repeated denials to funding or programmatic requests.

Some study participants suggested that SHAs should have a broader view of the school district that allows them to anticipate district processes and potential opportunities to get a specific health program funded. One interviewee who had recently completed her administrative credential program said that it "has really shown me that you do need leadership skills and managerial skills and then an understanding of systems." Another SHA expressed the importance of understanding district structures: "Organizational structures are really important for people to understand and I think that they don't. It's like a business." Having a systems-perspective could

allow SHAs to be more strategic in deciding when and how they try to get support for different

aspects of their SHPs. Another SHA suggested this approach could help SHAs figure out what

programs or funding to pursue, or let go of:

> You have to know when to give up and when to come in a different door, being strategic.
>
> That's another key piece in being a leader, being strategic, stepping back and just really
>
> seeing the lay of the land and knowing where you can make your impact and where you
>
> can come in.

Another SHA recommended being both prepared and patient while awaiting a new opportunity

to get approval for a health program:

> When the moment comes, you have to have all your homework done to be ready to step
>
> in and make suggestions but you also have to be really patient. Hang in there when the
>
> times are tough and you're not getting your message across, and maintain those
>
> relationships with people who want to give you money, because if you let that go because
>
> you don't have the backing of your administration, you can't get it at the last minute.

This SHA was referring to community agencies or grant funders who might want to support a

specific health initiative that she could not get approved initially. She worked to sustain their

interest until she could get district administrators' permission. Her use of the term "make

suggestions" seems to reflect a deferential approach to trying to get the approval of decision-

makers.

> Another SHA felt that one of the most critical skills he employed in his position was

being able to wait, and try again:

> The skill set or leadership attribute I've had to use the most - how do I say it - is I guess I
>
> could call it the ability of being able to wait, or the law of timing, meaning that there have

been several things that I brought to the district and presented to colleagues and at the

end…there was no buy in. I knew it was a good program and something that our families

and students definitely need but if my colleagues don't get it, there's nothing I can really

do. I can't force it. So what I've learned how to do is put it on the shelf, let some time go

by, perhaps let a few occurrences happen, and then bring it back to the table…I come

back a little bit later, and it's almost as if it was somebody else's idea…. then people hear

it differently.

This SHA gave an example of district decision-makers not wanting to be involved in planning a

new community youth center that would house a full-service health center. He said he still went

to planning meetings, and then brought the idea back to district leadership a year or two later, at

which point they wanted to be involved in the youth center.

As illustrated above, SHAs expend a considerable amount of time and energy to

communicate effectively with principals, their supervisors, district leadership, and community

agencies. They have to adjust how they make the case for funding school health programs or

staff, or for the benefits of certain health policies or community partners' services. Emotional

labor underlies interviewees' descriptions of how SHAs modified and constrained their

communications with each individual decision maker and stakeholder.

There are three characteristics common to jobs that require emotional labor (Hochschild,

1983). First, they require face-to-face contact with the public, such as SHAs' work providing

health guidance to parents, school board members, or principals. Second, they require the

employee to produce an emotional state in another person. In all their efforts to secure political

support for health programs, SHAs must elicit a favorable, generous emotional reaction in their

supervisor, the superintendent, or a principal. The third characteristic is that the worker allows

their employer to exercise a degree of control over the worker's emotional activities. This is certainly true for SHAs, as they describe how they must be pleasant, nonthreatening, and deferential to all those in positions of greater power than they.

SHAs described this labor in a variety of ways. One SHA explained that she had to change how she presented herself for each school she visited:

What I find is I'm like a chameleon. They (her LVN staff) laugh at me because I'll stop at the door and I'll go - they don't do it anymore, but I do this and they're like, "Where are you going today?" I'm like, "(school name)." They're like, "Oh, so you're putting on your (school name) armor?" "Yes." You have to change your style, so not only do I have to have the frustration of trying to keep up with all the stuff that I have to do, I have to change the style of how I do it based on where I go. That is very exhausting… Everyone is different and each principal wants you to deal with things a little bit differently within the scope of the law. Do you know what I mean? So, there are twists on how you are able to pull kids (for health screenings or interventions) or when you can pull kids, if that makes any sense. It's exhausting.

Interviewees presented similar examples of having to shift their style or demeanor in order to be able to get funding, or even do their jobs. This can be tiring for many SHAs, as seen above.

Another SHA said that her work required her to know how direct she could be with certain administrators or staff:

You deal with a lot of different people and you have to be able to know how to approach to each one differently to be able to – it's not so much getting done what you want to get done, it's just a matter of knowing that some people you can be more direct with. Other people you have to do it a different way. You can't always approach it from the same

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angle. You have to approach it from different angles depending on who you're dealing

with.

This SHA reiterated the idea that SHAs have to approach their communications with each

individual differently. Another SHA who also had some school nursing duties described how

emotional labor was performed not just by her, but also by all the district nurses:

It's kind of like – it's always – it's kind of a challenge to do our jobs, in addition to doing

the job. So, I don't know if that makes sense, but there's often somebody unhappy with

us. It's not a good team feeling because there are barriers that a lot of people just don't

understand and when you have an administrator (supervisor) that doesn't remember us in

the big picture on top of it, it really muddies our role. So, we kind of fight each individual

battle to say why we need to be there, and I don't want to operate that way. I wish we

were welcomed and in some cases - we are not saying it's always like that - but it's just

kind of a culture here.

This SHA used "I" and "we" interchangeably, presumably to represent the challenges faced by

both her and her school nurse staff. She felt a lack of support from her supervisor as well as

multiple barriers impeded her work. Despite trying to elicit a positive emotional response from

decision-makers, she said she had a feeling that people were "unhappy" with her because she

was trying to "fight battles" related to funding, staffing, and SHPs.

Several SHAs and deputies spoke about having to constrain their emotional responses to

frustrating work experiences. Hiding their anger is one way that SHAs have allowed their bosses

to control their emotions. One SHA described how a previous deputy SHA decided to leave the

district because she became frustrated with how hard it was to make changes:

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I saw her get so frustrated. Knowing how to move things and how to articulate and find

ways to move around the system, she was so frustrated and she got so angry and that

came across at times and I think it was a turnoff to the powers that be, and when you're

trying to make a case for things, it's how you communicate those wants…It's this

matching (of other people's priorities), but you can't get pissed off. I mean you can, but

you better hold it in check or scream someplace else and then go back and find another

way, because if that's your ultimate goal, you got to keep that out in front.

This interviewee suggested that when the deputy got angry, it alienated the decision-makers she

was trying to convince. This speaks to the emotional labor involved when SHAs have strong

negative emotions, but have to hide those feelings from the public or administrators.

A deputy said she was learning a lot from watching her SHA work. One of the biggest

lessons she said she learned from him was to remain calm:

Watching him in action is very educational. He's very, very calm. He's very articulate

and he handles things that I can be watching him throw a spoon across the room, but you

would never know because he's on the phone talking to whoever he's talking to and by

the tone of this voice, you would never know that he was agitated. Those are the kinds of

things that I would have to say I learned from him.

This deputy admired that the SHA did not show his anger, even over the phone. Similarly, a staff

person in a different district admired that her SHA was always so composed and could "keep a

cool head to sit back and listen before jumping in and reacting." Another SHA said, "I don't get

caught up in the drama…. You can't. You just you have to stay even keel. You just, yes, you just

have to take it in." The problem with showing anger is that it often makes other people

defensive, angry, or uncomfortable. It is not acceptable for SHAs to cause emotional discomfort

in the power brokers whose political support they are trying to secure. Instead, they have to try to remain calm and "take it in" when faced with frustration, opposition, and disappointment.

Some SHAs spoke of how they and their caregiving staff often did not take care of themselves because they were focused on making sure others felt good. Some SHAs said they did not make requests for themselves in the same way they could for others. One deputy (who was a school nurse by training) described how she was requesting better pay for her health aides because they had increasingly complex responsibilities:

> It really demotes their worth. It really does. I mean they get the same amount of pay but they're doing more. It's just not reasonable. It's just like us - but we can ask for other people – nurses don't usually ask for ourselves.

In this example, the deputy SHA described how she and her SHA were advocating for health aides in a way that they would not for themselves. This, she said, was related to their primary identity as nurses. Ironically, if SHAs do not stand up for themselves, they may continue to be marginalized by district funding and power structures.

Some SHAs echoed a similar feeling of disappointment with how they had been treated. One SHA said sometimes the struggle of trying to communicate the need for SHPs to the school board and administrators was frustrating:

> I also have a kind of sadness all the time because we take care of ourselves, we don't complain, we don't have a very big profile, and so those who make decisions know about us - but a lot of times they don't. You kind of feel like raising your hand and say, "Hey, we're over here. We could be doing this for you." A lot of times I feel like people pat on you on the head and say, "Well, that's nice, but we're doing this." So, it's frustrating. There are times that I get down, but again my staff is wonderful and my boss always says

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to me, "You're getting cranky. Go out and take care of some kids." So I go out and I put

my white coat on and I work in health rooms for a little bit and get it all back again.

It is not surprising that SHAs like this one feel frustrated when they are patronized or

marginalized at every turn. This SHA reiterated how she and her staff do not complain or ask for

much. This acquiescence to the district's exclusionary focus on instructional programs may

further reinforce a structure that marginalizes SHPs, and by extension, SHAs. The above quote

may reflect an attitude in the supervisor that the SHA should get her needs met by shedding her

SHA role, and returning to direct care of children. The SHA actually found this helpful, further

validating the idea that her only power can come in the form of nursing, not serving as a district-

level administrator.

Other SHAs more directly described burnout with their constant struggle to get funding

support. For example, one SHA expressed frustration with frequent budget cuts and politicking:

Every time there are budget cuts, what's the first thing on the block? Health services. I'm

just over it. At some point, you have to – how many times do you get hit in the head

before you go, "Ouch"? .... There's going to be some of that. You can't avoid it because

you do have to learn your staff. You have to learn all the political dynamics. The biggest

burden is (politics) I think, if you're given the equipment, the space, and the staff to do

your job. Yes, the politics are huge, and then just being understaffed.

Other SHAs, deputies and their staff felt that SHAs' constant work to negotiate adequate staffing

levels, especially for school nursing, was one of the most exhausting parts of the job.

Many interviewees described some of the coping strategies they employed to deal with

the politics, frustration, and emotional labor inherent in their jobs. Some tried to cultivate a

"thick skin," possibly meaning that they would try not to personalize political attacks or

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disappointment. Trying to be "tough" is a protective mechanism employed by individuals, like SHAs, who have had to expend a lot of emotional energy, with very low rewards in return. One SHA said that she had be hurt before, but no longer cared what people thought of her:

> Having a thick skin in a school district is really important. I mean I could still get my feelings hurt, trust me. It has happened. It's like Sally Field when she won her award. "You really like me. You like me, don't you? You like me." It's like I don't give a shit if they like me anymore. It doesn't really matter because I'm going to go away and if we've got some programs in place to help our kids, then I've done my job, but I think that's – again, there's the thick skin.

This SHA said she was contemplating retiring from her position soon. However, she revealed that she had not always been immune to other's opinions, as she had her feelings hurt in the past. She sounded as though she was rejecting some of the emotional labor inherent in her role, by refusing to let her employer exercise control over her emotional state. Maybe, as she approached retirement, she was starting to distance herself from the emotion work required of her job.

Other interviewees said that in order to stay in their role, they needed a sense of humor above all else. SHAs and deputies throughout this study exhibited a good sense of humor. Their laughter was captured within many of the interview excerpts included in this analysis. Oftentimes, they seemed to laugh ironically, not because something was actually funny to them. This is a common coping mechanism. As one supervisor said of SHAs, "I think humor, you must have that for survival." Similarly, a deputy said of her SHA "She has a good sense of humor too, which I think is very important in an administrator position - it defuses many tense situations." This suggests that SHAs can also use humor as an interpersonal tool to get what they want from power brokers.

With all of the effort SHAs put into their daily responsibilities and ongoing communications to secure support for SHPs, it is a wonder that they found joy in their work. Participating supervisors described their SHAs as passionate "advocates" who "championed" student health needs. Similarly, SHAs seemed to embrace their assigned role as the voice for student well-being. This advocacy and caring role was integral to the meaning many interviewees derived from their work. In the next chapter, the meaning SHAs' ascribed to their work is examined.

Chapter 7: The Meaning of School Health Administrators' Work

In order to sustain what can be frustrating, emotionally labor-intensive work processes, SHAs have created an ideological narrative of their work as valuable, needed, and rewarding. Most interviewees spoke of serving a larger purpose, or mission, to help improve students' health and well-being. Some participants described finding meaning in some of the relational aspects of their jobs, such as mentoring staff. Still other SHAs said they found satisfaction in making systems-level changes that brought additional resources to improve students' health.

Working with Purpose - Improving Children's Health

Many study participants used a narrative to describe the meaning of their work that was based on their caring and greater purpose in helping children. They explained that they work as SHAs for the same reasons that they became school nurses, counselors, or teachers: they love children, and care deeply about their welfare. As one SHA simply stated: "I love kids. I always knew I want to work with kids." A different SHA said that from the time she was a kid she wanted to work with children, and devoted herself to that as a babysitter, swimming teacher, and hospital volunteer. She went on to say that working with children is her purpose in life:

It's always been my job and I just feel like if I'm not the one advocating on their behalf I can't trust that somebody else will. So, there have been other opportunities that I've had to do other types of jobs and I think I will do those jobs really well but because I believe so strongly that kids need someone like me to speak up on their behalf and for me to teach other people how to do this, that's why I do it… Honestly, I think that's why I'm here really. I feel like that's really my purpose in life is to make sure that I'm an advocate for children. I've learned all these things from my parents and my teachers and my aunts and uncles and my grandparents about "education is the only thing that will give

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somebody a leg up in life and if they don't have it, it's going to be very difficult for them

to get outside of whatever it is that they're in" and poverty being one of the biggest things

that we deal with in this district. I believe everybody can learn. It's just a matter of how

we're teaching them.

This SHA, like others in this study, was very clear that her work as an SHA held meaning for her

because of her devotion to helping children. A well-established theme in literature on the

meaning of work is that individuals' work purpose is fulfilled when they feel like what they do

has significance (Rosso, Dekas, & Wrzesniewski, 2010).

One deputy suggested that public health nursing involves a lot case managing, which

relates to what she does now, even though she does not work directly with children:

I feel like I'm just case managing on a bigger level, like the school is the kid [Laughter]

and you're pulling in resources that support the higher mission I guess…Well, I like

school health. I really do so I do think I'll stay. Maybe I can work to make the system

better. Yes, I think that I will. I think school health has other benefits, too. I do like what I

do.…I just like the overall mission. I wouldn't be doing this if it weren't for the overall

mission because it's big challenges.

This deputy SHA felt like the meaning of her work – fulfilling the "higher mission" of school

health – outweighed the "big" challenges she was facing in her role. Like this deputy, multiple

SHAs felt strongly that their work does have significance, insofar as it supports the larger

purpose of helping students be healthier.

Several SHAs described work they did to support individual students, even though they

were responsible for student services district-wide. This seemed to help them stay connected to

their original purpose for working in school health or support programs. After a very upsetting

death of a child in her district, one SHA described a change in how she thought about her work with students:

> It's just a different view on life in general, that these kids are precious commodities. You know home visits will just impact me to see how they're really living, and on weekends I would think about them, and think, "Oh, my gosh. That's what their situation is, but it's more profound than that." It's hard to explain. I love them more. I do. So, the kids that I do get my hands on, I really enjoy when I get involved on that level now. I value it.

This SHA had a combined role of providing direct services and program administration. Her caring for the students was what sustained her through the frustrating, political parts of her job. Another SHA described seeing students in health internships he helped establish and at a district health fair:

> It's the tingly feeling I get when I see those kids in their white coats at (a nearby health sciences) University. It's the tingly feeling I get when we have a health fair and you see a mom and five kids, and she's really trying to do everything she can for her family. They're trying to get vaccines. You can tell that they're really impoverished. Those are the things - that's pretty cool - or the health fair where a brother brings in his sister. She needs to get a physical, and you find out … He dropped out of the alternative school. So you said, "You can't do that. You're 18-years-old. You need to finish high school." So I'm like "I going to put you in contact with…the principal of this alternative independent." So I said, "Come here." So we put them back together, and now that student is at school. I mean, hopefully he'll finish. That's exciting. That's what makes it fun.

Examples like this demonstrate how SHAs see the positive impact of their administrative labor, which is distanced from their history in direct service such as school nursing, counseling, or teaching. In a review of literature on the meaning of work, Rosso et al (2010) found that when individuals perceive that they are having a positive impact beyond the self, they feel greater self-efficacy and higher levels of meaningfulness in their work.

One SHA who is the only school nurse in her district, had worked there for a time, and then left the job for several years. She was approached about returning to her job by a former coworker, but wasn't interested until she had a chance encounter with a former student at a gas station in their town:

> I turned around and there's this older girl holding a kid and I'm like, "Can I help you?"
> She's like, "You don't remember me." I'm like, "Should I? Should I remember you?"
> She goes, "I went to (school name). You were the school nurse. Do you remember? You
> helped me," and she told me her name….I left there and got in my car. It almost made me
> cry. I was like, "Oh, my gosh." So, that was my – if there are signals or whatever. The
> next day I called, I said, "Okay, I'll come interview" because that was just like it gave me
> goose bumps. You don't think you were helping, but I obviously touched her.

This SHA came back to her position because she felt that she could actually make a difference in some students' lives. Chapter 5 established that SHAs' work is likely colored by a frustrating lack of power to effect SHP improvements. Given that, it is understandable that when asked about the joys in their work, SHAs reach for individual interactions with students or events where they can reconnect with the feeling that their work has both impact and significance.

Some of the female SHAs and deputies who came from the traditionally female-dominated professions of school nursing, social work, or teaching used a "caretaking" narrative

to describe not only the value of their work, but also what brought them to their current jobs.

Some SHAs, deputies and staff described initially starting to work in school nursing because it

worked well for their schedules when they had children. Similarly, some interviewees took their

jobs as SHAs or deputies because of life circumstances such as wanting a job closer to home. In

some cases, family obligations had transitioned from being a parent to providing care to aging

parents. As one SHA explained her reason for taking the job in the first place:

> I live about five minutes from here. I'm from here. I was born and raised in the same
>
> area. I went to public school here…. At night, I'm a caregiver. I have my 90 year old
>
> mother. She has congestive heart failure and aortic stenosis and Type 2 Diabetes. I have
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> to care for her, do her dinners and her medicine.

Feeling needed and effective as a care provider in both their jobs and at home has sustained some

SHAs in their roles. For others, it is the relationships they have at work that hold the most

meaning.

Finding Rewards in Work Relationships

Some interviewees found the greatest meaning in their work from their relationships with

their staff or the support of their supervisor. For example, one SHA shared how much she

enjoyed getting to interact with students' families and staff in her efforts to promote healthy

eating and physical activity:

> Seeing them, they're like "Thank you. Because of this, my kid wants me to make
>
> smoothies instead of taking them to McDonald's. Because of you I have CalFresh," -
>
> because I have an outreach worker in the office - "You got to get CalFresh, you got to get
>
> Medi-Cal, we got to get you locked in. I've got a case manager for you. Let's go, get it
>
> done." People are like, "Oh, my god. How do you do all?" It's like, because you get

people who have similar passion and I have a passion around helping the people that need it the most… When my staff are excited, when I come out and they're smiling and seeing their families that they are helping, and they are excited and they're smiling, and we exercise or we make a salad together. That's just so fun. It's just work is really fun. I love that about my job…. That's a really fun part, is to see people being motivated about helping people and to share that excitement because I do have some people who, a lot of people who are in this for the same reasons I am. They just really want to help.

The interesting thing this SHA brings up is how she gets pleasure from being around "people who have similar passion" and share in her commitment to help others. This speaks to a concept threaded through social constructionist and interpersonal sense-making theories that the meaning individuals find in their work is influenced by cues in their work environment (Rosso et al, 2010). When SHAs feel like they and their staff share a similar work purpose, their own work has greater meaning. This may contribute to SHAs' affinity for the staff they supervise, and their original professional work as direct caregivers or teachers. As outlined in Chapter 3, SHAs' professional identities seemed to be tied to their original profession. As SHAs, they have no peers in the way that school nurses or principals do. Given that SHAs' efforts to increase funding for SHPs are often thwarted, and they relate most closely with the staff they supervise, it is no surprise that SHAs' interpersonal sense-making is most positive when they are with their staff.

Supervisors used very similar language to describe the work their SHAs do, repeating words like "advocate," "mission," and "heart." One example of this was when a supervisor described how effective her SHA was:

She just cares about what she does and she wants to provide the best service that she can. It's not a job for her, it's a passion for her. It's a moral imperative for her and that's what makes her excellent.

Quotes like this suggest that SHAs present themselves to others, such as their supervisors, in a manner that reflects the greater purpose driving their work. When supervisors reflect this back to SHAs in a positive way, it could contribute to the interpersonal sense-making that SHAs experience at work. On the other hand, when SHAs present themselves as passionately pursuing a "moral imperative" with their supervisors and other decision-makers, it could be a strategy to convince others of the value of SHPs. Regardless, the way SHAs and their staff, deputies, and supervisors all describe SHAs as passionate "advocates" for children's health can only serve to reinforce positive social cues that help SHAs feel like their work has both impact and significance.

One SHA described the purpose for his work as promoting educational equity for all students, and particularly for African-American students who were being disproportionately suspended and expelled. He explained that he believed that institutionalized racism was the cause of disproportionate disciplinary actions being taken against students. This SHA described coming to his district specifically because of his approach to equity for all students:

When I came into this district, it was under the notion of equity. So the previous superintendent saw me do an equity presentation and asked me if I would apply for a position here…. It's hard work, but strategically… I do want us to do more work on how we can address this explicitly from a racial perspective, and we talk about it all the time. I mean in our district-wide administration group, we went through … the five Why's process…. it was about what is our biggest inhibitor as a district and, it wasn't me

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standing up there doing a presentation, it was everybody going through this collective

process. At the end of the day, racism was at the top, so that was profound.

This SHA enjoyed this instance of interpersonal sense-making with his administrator peers

because it validated his purpose – eliminating racial inequity from his district's disciplinary

practices.

Male SHAs also used a "caring" narrative to explain what brought them and sustained

them in their roles. For example, one SHA said he was born and raised to care for others:

I think maybe having been born that way maybe it's what led me to become a school

psychologist and going into the counseling field and just a concern for others. My dad

was like that and my mom. I remember my grandmother - hearing stories about her - that

she would help – she would take in people that didn't have food, tried to help them. She

was poor, but she would try to do as much as she could. When they were traveling

through that small town, she would let them stay the night, feed them.

This SHA has internalized the way in which his family members would care for others in the

community. This ideology got him started as a school psychologist, and then sustained him in his

role as a SHA. This SHA felt frustrated that sometimes other administrators did not demonstrate

the same mission to care for children and families. He told a story of being at county meetings

with other administrators complaining about things parents said or did, to which his response

was "You came into this profession to serve." The caring ideology was so central to the meaning

of his work that he expected other administrators to share a similar ideal. When they did not, it

provided a social cue that maybe his work did not have the same significance or purpose that he

hoped.

When asked why she decided to assume the deputy SHA role, one interviewee described how much she enjoyed mentoring staff in her role: "I think because I'd already done supervisory work, so that part of it was familiar to me, and I like the mentoring part of supervising." Another deputy also decided to accept her role as staff trainer and supervisor because she loved teaching and also because her SHA asked her to take the position:

> Well, (my SHA) asked me. I did think about it for a long time. I enjoy teaching a lot. I enjoy the student interaction and things. If I can help improve our department, kind of bring up our standards a little bit with setting up some teaching programs, and if I can mentor some of our new staff and things like that, to me it's very, very rewarding… Like I told you, I don't really pay attention to money. So the personal game is what's important to me. So that's really, really, really valuable.

For this deputy, it was allegiance to her SHA supervisor, as well as the opportunity mentor new staff that gave her work meaning. Belonging and contributing to groups and communities at work can also give employees' work greater meaning. Multiple studies suggest that when employees contribute something of value to their coworkers, the contributing employees feel like their work is more meaningful (Rosso et al, 2010). SHAs' and deputies' sense of the significance and impact of their work may be enhanced by training, supporting, and mentoring their staff.

Another deputy described the support she received from her SHA boss as making her job more meaningful. She said that in her previous job, she had to complete all of her job responsibilities alone:

> I was often relied upon to be the sole person whereas I don't feel like that here. (My SHA) does stuff with me so that makes a huge difference. I don't feel alone. I do manage stuff but she's right there with me managing it, too… Here, I feel very blessed in that

sense. That's better. It's a lot but it's all with her, too. We meet every day. We tackle

stuff together.

This deputy clearly felt daily support and encouragement from her SHA. Her SHA may have

been helping make this deputy's job more meaningful by encouraging her to "transcend personal

needs or goals in favor of those tied to a broader mission or purpose" (Rosso et al, 2010, p.101).

Her SHA, too, was likely enjoying the interpersonal sense-making she could engage in with this

deputy. This reciprocity could increase the meaningfulness of both of their work experiences as a

result.

Other interviewees commented on how important supervisory or mentoring support was

to them. One SHA plainly stated: "If anybody you talked to has any nice things to say about me,

I would give her (my mentor) credit for that. She was a great mentor. Anything that I do well, I

would give her credit for." She explained that her mentor taught her a lot about both what her job

entailed and how to do it effectively. A school nurse who said that she was applying to an

administrative services credential program asked her SHA (boss) to help her review her

application essay. What's most interesting is how she described the role she's hoping her boss

will play for her: "I asked her to kind of be a mentor/parent role for me." This school nurse

craved the mentoring support that her SHA could provide her. Obviously, this was so she could

learn about being an administrator from her SHA, but it could also be because the school nurse

wanted to spend time with someone who could build her sense of purpose and impact as she

moved into a SHA role.

Several SHAs with a background in nursing described their pleasure at working with

school nurse peers. One SHA said she really enjoyed meeting with other SHAs in her county: "I

meet with (the county group) once a month and go up and see how we're dovetailing with what

they do and we share resources. So, it's a lot of collaboration and planning, and that's the part I enjoy." Another SHA shared her pleasure at working with and supervising school nurses because they were so direct with their feedback:

> Just working with the people, I love working with nurses. It's interesting because I think I've got this theory that there's certain personalities that go into certain jobs. I think nurses are extremely forthright, they're problem solvers which is not – some say it's not usually women but women are not normally - they want to talk about it but they don't want make a decision. I don't think that's true to nurses, I think nurses go to nursing because they want to make decisions and they're very direct. Not all educators are that way but I think most nurses are. So it's a lot of fun working with them because you get immediate feedback which is great. Whether it's good or bad I don't care, I just love getting the immediate feedback. Then being able to work with them, I mean the creativity of it is just phenomenal…. I will tell you I am kind of unofficial I will say I'm a bit of an odd duck. I don't have to work and so because I know I don't have to work, it's a wonderful reliever. If I felt I had to work it would be a lot harder. Because I don't have to, it makes it something I do that's just really enjoyable.

This SHA made it clear that she does not need to work because she is financially comfortable without a salary. What keeps her in the job is getting to work with other nurses, whom she respects and clearly enjoys. She seems to be experiencing a type of *belongingness*, which several theorists have identified as one way that employees find meaningfulness in their work due to a shared identity (Rosso et al, 2010). For her, the joy is working as a nurse administrator, with other nurses. This is also a clear example of SHAs' identification with their original professional affiliation (in this case nurses), and not with other administrators.

Another interviewee viewed the joys of her work as largely due to her belongingness with a close colleague. This deputy described how meaningful her partnership has been with her colleague, who is also a deputy, but works in counseling and mental health issues:

I truly feel very fortunate to be in the role I'm in for as long as I've been in with the staff. I think that's part of why it works because I have worked with my colleague for the 12 years. We were hired on the same day so we kind of speak the same language and people often confuse us even though we look nothing alike [laughter], but because we have similar philosophies or there are things that complement one another in terms our skill set. It's a partnership that has definitely worked and gotten a lot of things done when you just didn't think you could.

This deputy's mutual support with her coworker was so meaningful that she felt that it even increased her self-efficacy. Theorists call this *interconnection*, a construction of the meaning of work that transcends the self for a collective contribution to work that is believed to positively impact society (Rosso et al, 2010).

Another SHA described her commitment to the community and coworkers as sustaining her, even when the stipend she received for serving as the SHA was so low:

I don't live in this community but I really like it. I love the people. After all of these years, I find myself having some feelings of dedication. When the last person retired, no one wanted to take the position. I took the position, partly – not under duress but partly because who else was going to take it? I didn't want someone to take it that didn't have the vested interest of the community at heart. I do like the superintendent, it's just a great, great, group of people to work for. That's probably the motivating factor. It's the people, the community, definitely not the money since it's a $2,000.00 stipend, which is not a

great deal of money. I'll take the money but it's not a big incentive. It was more for just

because I liked it… I like the community. I love the families and having, seeing kids be

healthy and learning things, doing better in life. I do like it, it's the best.

This SHA's narrative related to the meaningfulness of her work seems to be informed by having

a greater purpose and belongingness with the school community, as well as a strong

interconnection with her colleagues. This made her work meaningful and worthwhile, despite her

obvious frustration with the very low financial compensation she received.

Making Systems Change

Many SHAs said that the most enjoyable part of their jobs was putting programs and

systems in place to help students be healthy and succeed in the school environment. Even when

it took a long to see the fruits of their labor, SHAs and deputies alike felt pleased when they

succeeded in getting students the services they needed. This is a type of purpose-driven work

where SHAs' perceived impact is felt at the systems-level, such as policy, funding, or staffing

improvements. For example, this deputy described her satisfaction with securing funding for

additional staffing:

I love those wins when we've actually made the progress of getting additional staffing,

we've made the progress of getting that nurse on the bus with the kid that's trach

dependent, of getting the LVN support for insulin. Whether it's me alone or whether it's

me as the lead of the whole group of nurses, that we are making an impact, that's the

most satisfying for me. I believe that we are making an impact. I believe that key people

in the district hierarchy understand more about what we do and why we do it and coming

to believe that we do make that impact.

This deputy tied her enjoyment of her role to getting additional staffing and securing better services for students. At the same time, she reiterated her belief that district decision-makers saw the success of their SHPs. This suggests that this deputy also craves some external acknowledgement from those with the authority to continue to fund (or not) their SHP staff.

One SHA shared an example related to her great joy in knowing that school health staff were there helping students:

Diabetic students who come in who have unlicensed staff supporting them, and they might be an eighth grade student and they have a very limited ability to be independent with their care, and as soon as we get our school nurses and LVNs involved, you just see the immediate change in that student's ability to learn and to become more independent with their own bodies and with their own care. I think that's always a nice thing for me to see, that we're still able to – even though we have our challenges with staffing and even with the cuts that have occurred - that we're still able to provide and we're still able to be successful with our students from the healthcare side of things.

This SHA, too, spoke directly to budget and staffing cuts as she outlined her program's success with students. While SHAs and deputies are all too aware of their challenges securing political and funding support, they still find meaningful purpose in their ability to oversee programs that improve children's health.

Some interviewees talked about missing direct service with students, but still found pleasure in making systems-level changes in their districts. For example, one deputy explained why she chose to work as a deputy who mostly does SHP grant writing and development:

I like operations and efficiency and school-based health. I always have. I don't get to work on the site with kids anymore so that's a bummer. I always really enjoy that so I'm

a little sad about that but at least I guess the stuff that I'm doing impacts the department.

For example, if we do get the grant for electronic health records, that impacts every site

nurse and makes every kid safer. That's a nice feeling being able to do that.

This deputy seemed to be trying to convince herself of the value of her efforts in grant writing, at

the same time that she could see how getting certain grants could trickle down to improving

student safety.

One staff member was considering applying for her SHA's position upon her retirement.

She described systems-level policy changes as motivating her to apply for the position:

Leading people and looking at the systems, those are all things I get excited about. It's

why I want to go into admin, and I love direct service, but that's really I think where my

passion is. Like I was a policy geek, do you know, like it's cool [Laughter], and

everybody hated that class. Like this turns me on. I love how this works and how like it

all flows out. So, I think I embraced that about myself.

This staff person's enthusiasm for policy change and "leading people" was similar to the goals of

existing SHAs.

For some SHAs, the greatest satisfaction came from getting policies passed that would

better serve students' well-being. For example, one SHA said "One of the reasons I decided to

come into the position was because of the idea of being able to reach more kids and changing

program policies to make it better for kids." For others, it was about translating policies into new

staff procedures and systems of care: "I've had time to delve into policy, and I enjoy that. I like

protocol and I like everybody being on the same page." A few SHAs talked about how they liked

their program coordinator role, even when it was challenging:

The coordinating of services, I love doing that, and getting more services for kids….I

love the challenge. I love figuring out things. I love getting things in place. I like to study,

so I love studying all that stuff, but I just love putting programs in place for kids and, yes,

or connecting someone to something or showing them a way to do it.

This SHA's comment about "connecting someone to something" harkens back to the brokering

role outlined in the previous chapter.

Several other SHAs found meaningful purpose in their ability to bring in community

health resources to meet student health needs. For example, one SHA had been working on

starting a school-based health center (SBHC) for several years. He had hoped that a SBHC could

serve as a training ground for high school students interested in health careers. Since becoming a

SHA, he made this happen:

That's the most satisfying part, building those linkages and relationships and bringing

those resources…. So (a specific school site) now has students that are interested in

health which is the focus, would be able to be a part of that side by side with the (local)

University students and faculty… that was one of my goals was to not only create these

school-based health centers to service students and families but also as great training sites

for high school age students.

This is another example of the brokering role that many SHAs often play. It also illustrates the

amazing array of community and university services that SHAs often bring in to schools, much

to students' and families' benefit.

One SHA thought that interviewees should be asked whether they would do the SHA job

over again. When asked whether she would, she said yes:

I think I would do some things a lot differently and other things I would do just the same. So yes, but I would. It's been a good experience in general. I mean it's been – some of it has been really hard but a lot of it has been very rewarding and it allows me to be very creative and collaborative and visionary. Those are all good things.

This SHA provided a good summary of how SHAs find meaningful purpose and interconnection in their work, despite the inherent challenges. Overall, interviewees felt the same overall satisfaction with their work. One SHA described her role in almost aspirational terms: "The nurse administrator job for school nursing has so many possibilities. To be respected in your school district is a hard work, but it's wonderful work because you can really leverage health care." This SHA offers an interesting overview of the work of SHAs: the difficulties they face navigating a system that marginalizes them, the important contributions they currently make to ensuring children's health at school, and the potential the role holds for establishing even more comprehensive school health programs.

The irony is that the SHAs in this study are working as hard as they can to try to fulfill their mission to promote children's health, and yet their labor doesn't change, but rather perpetuates, disempowering district structures. Instead of continuing to think of the potential of SHAs and their programs in aspirational terms, this study suggests that policymakers and practitioners should examine how to address the financial and structural barriers to SHAs' ability to more effectively serve children's health needs.

Chapter 8: Conclusion

Discussion

The qualitative findings from this study yielded new theoretical understandings of the work experiences of a small sample of school health administrators. As marginalized mid-level managers, SHAs have developed an array of brokering strategies to secure political support for school health staff, programs, and policies. While SHAs certainly employ cross-sector and collaborative leadership skills to build beneficial relationships with community health agencies and other district departments, their stories detail a lack of authority to act autonomously as visionary leaders. This is due to the structural disempowerment of SHAs and their programs within school districts. Superintendents, school board members, and instructional administrators control power dynamics in school districts, which are largely informed by funding mechanisms and politics. While district decision-makers share SHAs' interest in student well-being, they often do not have the understanding or political will to fully fund or support school health programs (SHPs). As a result, SHAs do not have access to needed funding, information, or support.

Though SHAs' specific responsibilities and backgrounds varied widely, they shared key areas of expertise, including practical knowledge related to their original professional training in school nursing, behavioral health, teaching, and/or special education; knowledge of public education laws and student health and safety policies; competencies in training and managing a geographically dispersed staff; and proficiency in billing (e.g., LEA Medi-Cal, MAA), grant writing, and reporting.

All SHAs said they had to juggle multiple demands each day, including ensuring student safety and adequate staffing; providing health guidance to staff, administrators, and parents;

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attending district or community health agency meetings; and collecting data for billing, grant writing, and program development purposes. Some SHAs in larger districts were able to allocate funding from their budgets to establish deputy SHA positions for support with staff training and supervision, grant writing, or billing.

School district funding and administrative power structures marginalized both SHPs and SHAs. Most interviewees were excluded from their district's executive cabinet, where many funding decisions were made. School boards and superintendents exercised enormous control over whether and how much SHPs are funded, and many interviewees' described their decisions as highly political. Principals had a powerful gatekeeper role that determined whether, what, and how SHPs would be implemented at their school sites. SHA titles typically reflected a lower placement in the organizational chart than other administrators with similar responsibilities, which led to lower salaries. Many SHAs operated without a job description specific to their role, which could contribute to others not knowing what they do and a lack of succession planning.

SHAs exercised some "operative control" in terms of managing staff, conducting billing, and providing health guidance. However, they described inadequate "allocative control" in terms of determining how much funding would be available or allocated within their school health programs (Reed, 1991). Every allocative decision, and even some operational decisions, required approvals at several levels within the district hierarchy. In addition, SHAs had to negotiate site-level SHP staffing, procedures, and resources with principals. Like some other middle managers, SHAs did not have access to the "lines of power" they needed to do their jobs (Kanter, 1979). This means they did not have adequate access to needed program resources, information, or support. As a result, SHAs may be less effective, as they are forced to respond to demands

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placed on them by both decision-makers and their staff, rather than engaging in proactive

program planning or leadership activities (Kanter, 1979).

As a result of this structural disempowerment, SHAs expended considerable energy

trying to secure decision-makers' political support so they could actually complete their job

responsibilities. SHAs employed three main brokering strategies: 1) raising awareness of student

health needs and the benefits of SHPs; 2) cultivating powerful allies by building relationships

with decision-makers, and 3) adjusting to working conditions by waiting and devising lower-

level workarounds.

SHAs had to respond to multiple decision-makers' specific interests, or "logics of action"

(Boulton & Houlihan, 2010). They did this by adjusting how they presented themselves and their

requests to their supervisors, the executive cabinet, the superintendent, the board, and each

school principal. The way in which SHAs tried to present themselves as decision-makers would

like to see them, rather than as they really felt, constitutes a type of emotional labor (Hochschild,

1983). One example of this is how SHAs had to hide their anger and frustration at repeated

denials of funding support, and instead presented a calm, deferential demeanor.

SHAs' identity is tied to their original profession, not to their current role as a SHA.

SHAs do not yet have a "professional identity" in the same way that other administrators from an

instructional background do (e.g., principals who started out as teachers, and then became central

office administrators). SHAs are usually the only health manager in their district, and have

limited opportunity to interact with other SHAs. All SHA interviewees expressed curiosity about

other SHAs participating in this study. They wanted to know about other SHAs' scope of work,

titles, and SHP components. For example, one SHA said, "I wish there was way for everybody to

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come together…. I'd love to meet other people who are in this position. So if you can form like an association, that we could have a conference, I would love it."

When SHAs wanted peer support, they found opportunities to interact with others from their original profession, where they found a meaningful shared purpose, belongingness, and interconnection. For example, SHAs with a background in school nursing might attend a conference put on by the California School Nurses Organization. Their administrative peers do not treat SHAs as though they have a unique professional identity. Instead, they are typically treated based on their original profession – e.g., nurse, social worker. Even when SHAs get an administrative services credential, they are not afforded the same level of authority as their administrator peers with an "instructional leader" identity. SHAs may also reinforce this by representing themselves, first and foremost, as care providers. This is the professional identity from which they derive strength, authority, and the meaning of their work.

SHAs are not prepared for their role through a specific SHA professional development program. Instead, they must complete a standard administrative services credential program, where they do not receive any training specific to their role. While in these programs, they are often treated as "different" from their mainstream instructional leader classmates. In some cases, they have received devaluing messages from classmates that they will never be viewed as knowledgeable, authoritative district administrators. Administrative services credential programs primarily serve to socialize SHAs to their marginalized "place" in the district hierarchy.

There are problems associated with SHAs being treated as though they are still working in their original professional realm. While they are given respect for their clinical expertise, they are not given the decision-making authority afforded to other administrators. SHAs often come from female dominated "caring" professions associated with femininity, such as nursing and

social work. School administrative positions, from principals to superintendents, are typically male-dominated, despite the fact that teaching is still female-dominated. With most school administrators acting in a masculinized role (regardless of gender identity), SHAs are feminized and devalued as care providers. This marginalization of SHAs permeates much of their treatment within district structures. I believe that this inequity, along with lower salaries as compared to other administrators, has led to the exploitation of many of the SHAs in this study. As a result, SHAs are often not viewed as the high-level administrators they actually are, with leadership skills far exceeding their clinical expertise.

Larger institutional priorities and funding streams in public education also lead to marginalization of SHPs and SHAs' work. There is very little funding for SHPs in California (Baker et al, 2015). Only a few districts in this study allocated any additional funding they received through the Local Control Funding Formula to SHPs, despite SHAs' requests to do so. There still remains an opportunity to tie SHPs to reduced absenteeism and suspensions, which are LCFF-mandated outcomes monitored through Local Control Accountability Plans.

Making a link between SHPs and improved attendance or suspensions would require additional data collection that most SHAs do not have the workforce or data systems to collect. Some SHAs in this study were trying to improve data collection or implement health services-specific electronic recordkeeping systems that would allow them to better track service delivery and outcomes. Other researchers of California's SHPs have called for data collection systems that could "monitor the health and educational outcomes of children with special health care needs" in order to demonstrate the impact of SHPs (Baker et al, 2015, p. 318).

Despite the many challenges faced by SHAs and their deputies, these qualitative interviews have revealed that they are remarkably hardworking, resilient, and dedicated to

ensuring children's health and safety. SHAs overcame structural and funding barriers to successfully hire, train, and supervise a diverse, and dispersed, workforce. They formed innovative partnerships with community health agencies to bring needed health services onto their school campuses. These SHAs researched and interpreted complex, ever-changing health and education laws to maximize student health and to minimize district liability. Through an array of negotiations with district decision-makers, billing processes, and grant development work, SHAs leveraged all potential funding resources to bring additional health programs to their students. SHAs' important contributions to children's well-being are not just meaningful to them, but also to a society that values giving all children an opportunity to succeed in school and life.

Limitations.

This study was limited to a select sample of 30 school health administrators and their deputies, staff, and supervisors. Study findings are not reflective of the potential structures or administrative roles in districts that do not employ any type of SHA, as interviewees were not recruited from such districts.

Interviewees may have been influenced in what they said, and how they responded to my questions, by how they perceived me as a researcher and faculty member. My professional status and former experience as a school nurse and school health program development consultant could have led interviewees to tell me what they thought I wanted to hear. Conversely, I likely appeared to be of a similar social status as most of my interviewees, which may have made them feel more at ease with sharing their experiences with me.

As a sole researcher conducting this study, I had time and resource limitations given the scope of my dissertation project. Given these limitations, I focused on verifying major concepts rather than every emerging theme. Also, if there had been multiple researchers involved in this

project, each researcher could have independently coded and analyzed the interview transcripts to establish intercoder reliability.

Implications.

Inadequate SHP funding in California puts schools at risk for failing to provide essential health supports to children with special health care needs (CSHCN) (Knauer et al, 2015). In addition, CSHCN are at increased risk for school failure if their health needs are not met (Murray et al, 2007; Rosas et al, 2009; Vinciullo & Bradley, 2009). The multiple manifestations of school failure, including chronic absenteeism, suspension, and dropout, could cost children their education. School failure also costs school districts money, as it impacts their ADA and their continued funding through LCFF. Statewide underfunding of SHPs is a school system inefficiency, leading to time lost and energy wasted as SHAs constantly work to secure funding. On the other hand, with adequate funding for SHP staff, SHAs could do more of what they already do well: develop comprehensive health programs, cultivate staff effectiveness, establish appropriate policies and procedures to promote health and prevent district liability, and form beneficial community health partnerships.

Professionalizing SHAs' administrative leadership role could help legitimize their work and give them greater skills and authority. A first step in such professionalization is to collect statewide data on SHAs. California does not currently require school districts to report on whether anyone manages their school health programs (SHPs), and if so, who fulfills this role. The California Department of Education should add a reporting requirement to school districts' annual staff reports through the California Basic Educational Data System (CBEDS) to identify whether they have someone who manages their SHPs. If the district does not employ any school health staff, the district could identify who manages the contracts they have with a nursing

service to perform federally-mandated special education assessments and state-mandated screenings. Once the state has this data, position information (e.g., title, job description, salary) can more easily collected from the existing SHAs in California.

Identifying existing SHAs and their current titles and responsibilities would also help the state pave the way for another potential policy recommendation: standardizing SHA position descriptions and titling conventions. SHAs should be appropriately compensated and given more authority for the high-level management, budgeting, and risk mitigation work they do. The California Department of Education (CDE) could help districts treat their SHAs more equitably by providing districts with sample position descriptions and titling conventions for their SHAs. The CDE could help define more appropriate SHA titles, position descriptions, and salaries. The CDE could also recommend that SHAs be included in higher-level communications and decision-making, such as having a seat within their district's executive cabinet. In addition, they could require districts to demonstrate how SHAs are included in districtwide planning, financing, and decision-making processes as a part of their existing reporting requirements, such as through the LCAP development and monitoring process.

SHAs do not currently have access to role-specific training or professional development opportunities. The CDE could help address this by partnering with state universities' administrative services credential programs to establish a few pilot SHA credentialing programs. The CDE could facilitate a planning committee of SHAs, other administrators, educators from administrative services, school nursing, and pupil personnel services credential programs, and school health researchers to establish core competencies for SHA preparation programs. Such a committee could also help guide the development of more immediate professional development and networking opportunities for existing SHAs.

Next steps.

Upon completion of this dissertation, I plan to engage in dissemination of research findings, initiation of additional research projects, and participation in efforts to fulfill the aforementioned policy recommendations.

Research findings will be disseminated at academic conferences and through journals. The Journal of School Nursing, the Journal of School Health, and the School Social Work Journal would all be appropriate to reach the primary audience: academics and practitioners in school health. Abstracts will also be submitted to state and national school health conferences, including the American School Health Association, the National Association of School Nurses, the School-Based Health Alliance, and the California School Nurses Organization.

Two audiences who have the authority to change school district power structures to include SHAs are school board members and high-level administrators, including superintendents and their deputies. I will submit abstracts to the California School Boards Association's and the Association of California School Administrators' annual conferences. Through these presentations I will share study findings outlining structural barriers to serving students' health needs, and suggesting how improved decision-making and communication with SHAs could benefit their students.

Future research projects include deeper qualitative inquiry into the work of school health administrators in California. Subthemes that emerged from this study will be explored more thoroughly. One of these themes is how SHAs who do not have a background in nursing establish supervisory and clinical supports for their school nursing staff. Another theme for deeper exploration is how SHAs' original professional training influences their role, interests,

and strengths as a SHA. A third theme meriting further analysis is how SHAs form and sustain district partnerships with a variety of community health agencies.

I also teach in the school nurse credential program as well as the traditional undergraduate and master's programs in nursing at California State University Sacramento (CSUS). CSUS also offers a pupil personnel services credential through the School of Social Work, and an administrative services credential program through the School of Education. I plan to talk to interested CSUS faculty and departmental leadership from these programs to explore piloting a school health administrative services credential program.

Lastly, I will pursue opportunities to discuss research findings from this and subsequent studies with state school health policy groups and representatives from the CDE. I would be honored to advise state education officials in developing model SHA job descriptions and training programs.

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Appendix A – Recruiting Email

I am writing to ask if you are interested in participating in an interview on the work of school health administrators in California. I am conducting this study as part of my dissertation research at UC Davis. The Institutional Review Board at UC Davis has reviewed and approved this study (IRB ID #676675-1).

School health administrators (SHAs) are the individuals who manage health programs at the central office level in school districts. SHAs have a variety of titles, so SHA is just a descriptive term, not a job title. The types of programs they oversee include school nursing, mental health, health education, and other health services. Some SHAs oversee additional, non-health related programs as well. Some school districts have no SHA. There is very little research specifically focused on the management of school health programs.

The goal of this qualitative study is to better understand how SHAs think about their day-to-day responsibilities and role/s related to school health programs. I also hope to identify what strategies they employ to secure resources for and manage health programs within their school districts. To this end, I am conducting interviews with a select group of SHAs, their supervisors, their staff, and school principals to understand the roles and responsibilities of SHAs from multiple perspectives. I am also reviewing documents like SHA job descriptions and where they're placed in district organizational charts. Once I have completed my research, I plan to prepare 2-3 articles for publication based on what I learn.

If you agree to participate, I will come to a location convenient to you to conduct a one hour-long interview. Before we begin the interview, I will review the attached consent form with you and ask you to sign it. The interview will be confidential. In any resulting published articles, I will only refer to you by your job category (e.g., SHA, school health services provider, SHA's supervisor, school principal) or a unique number that I will assign you. Your name and workplace will not be included in subsequent publications. Efforts will be made to limit use or disclosure of your personal information, including research study records, to people who have a need to review this information. Organizations that may inspect and copy your information include the IRB and other University of California representatives responsible for the management or oversight of this study.

Participating in this study is voluntary, and offers no direct benefits to participants. However, I hope you will consider participating in the study, as your perspective will greatly enrich our understanding of the unique nature of the SHA role.

Please let me know if you have any questions.

Thank you,

Samantha Blackburn, RN, MSN, PhD Candidate
UC Davis Betty Irene Moore School of Nursing

███████████████████████████

School Health Administrators

Job responsibilities
- What programs do you oversee? (Health, MH, other)
- How many (and what kinds of) staff do you supervise?
- Who is your supervisor (title)?
- What is a typical day like for you?
- What are your job responsibilities?

Challenges/joys
- What are the most challenging aspects of your job? The most satisfying?

Leadership skills
- What kinds of leadership skills have you most needed in your job, and why?

Job description, org chart
- How does your formal job description compare with what you do?
- What are your thoughts about where your position is placed in the organizational chart?

Goals/outcomes/vision
- What kinds of outcomes you would like to see come from your district's health services program?
  - What are superintendent/school board expectations of program?
  - Staff expectations?

Funding
- How are your SHS funded?

Supporters, allies, decision-making
- Who are your closest partners or supporters in the district?
  - How have you secured their support?
- Who are other key decision-makers/influencers in your district (policy, funding)?
- How have you secured buy-in from principals (allocate site funds)?

LCFF/LCAP
- How were health/support programs included in your districts' LCFF/LCAP?
- How has the implementation of LCFF changed your programs?

Community partnerships
- Tell me a bit about your experiences forming/sustaining partnerships w/ community providers

Motivators for SHA role
- Why are you doing this job?

Job pathways
- How did you come to be in this position?
- How long have you been in this role?
- Which previous professional experiences/education best prepared you for this position?
- What kind of preparation do you think SHAs like yourself would most benefit from?

Open

- What else should I have asked you about your work?

SHA Supervisors

Job responsibilities
- Could you first tell me your title and what you do in the district?
- How many (and what kinds of) staff do you supervise, in addition to the SHA?
- Who is your supervisor?

Compare to SHA
- What do you think are the key roles and responsibilities of SHAs?

Job pathways
- What preparation (education, credentialing) might best help SHAs for their role?

Supporters, decision-making
- What supports (district, professional, or other) do you think can help your SHA best serve in this role?
- Who are the key decision-makers in your district, who influence over SH funding or expansion?
- How has your SHA secured their support? What other approaches might work?

Goals/outcomes/vision
- Tell me about the role of health programs in your district.
- Expectations/anticipated outcomes you have for program?
  - Whether/how different for superintendent or school board?

LCFF/LCAP
- How has the implementation of LCFF changed your school health programs?
- How have student health supports been included in your districts' LCAP?

Open
- What I should have asked you about your school health programs or the work of your SHA?

SHA Staff and Deputies

Responsibilities
- Could you first tell me your title and what you do in the district?
- Do you supervise staff, and if so, who?

Perspective on SHA role
- Please tell me what your SHA does – everyday and occasional tasks and responsibilities
- What challenges do you think your SHA faces in her role?

Supervision
- How does s/he support you as a direct service provider?

Decision-making
- Who do you think are key decision-makers, who can support SHS programs/funding?
- How has your SHA secured their support? (and what hasn't worked as well?)

SHP expectations, vision
- Are there specific outcomes you would like to see come from your district's health services program?
- Do you think your SHA has different expectations for your health programs? If so, what are they?
- Do you think the superintendent or the school board has different expectations or anticipated outcomes for your district's health programs? If so, what are they?

Interest in SHA role
- Would you work as a SHA given the chance? Why/not?

Open
- Is there anything that I should have asked about your district's SHS as relates to the work of your SHA?

Title of research study: Exploring the Work of School Health Administrators in California

Investigator: <u>**Samantha Blackburn**</u>

Why am I being invited to take part in a research study?

As a school health administrator (SHA), SHA's supervisor, or school health services staff you are uniquely qualified to share your perspective on the work of SHAs in California.

What should I know about a research study? (Experimental Subject's Bill of Rights)

- Someone will explain this research study to you, including:
  - The nature and purpose of the research study.
  - The procedures to be followed.
  - Any common or important discomforts and risks.
  - Any benefits you might expect.
- Whether or not you take part is up to you.
- You can choose without force, fraud, deceit, duress, coercion, or undue influence.
- You can choose not to take part.
- You can agree to take part now and later change your mind.
- Whatever you decide it will not be held against you.
- You can ask all the questions you want before you decide.
- If you agree to take part, you will be given a signed and dated copy of this document**.**

Who can I talk to?

If you have questions, concerns, or complaints, or think the research has hurt you, talk to the researcher Samantha Blackburn at (or email her at   .

This research has been reviewed and approved by an Institutional Review Board ("IRB"). Information to help you understand research is on-line at http://www.research.ucdavis.edu/IRBAdmin.You may talk to an IRB staff member at   , or 2921 Stockton Blvd, Suite 1400, Room 1429, Sacramento, CA 95817 for any of the following:

    Your questions, concerns, or complaints are not being answered by the research team.
    You cannot reach the research team.
    You want to talk to someone besides the research team.
    You have questions about your rights as a research subject.
    You want to get information or provide input about this research.

Why is this research being done?

This research is being done to better understand how school health programs are managed by school district administrators. These managers are called school health administrators (SHAs) for the purposes of this study. SHAs play an important role in developing, implementing, and evaluating school health programs. Health programs such as school nursing and mental health services help promote the health and safety of all public school students. There is very little

research on SHAs' roles and responsibilities. This study aims to explore a group of SHAs' and school stakeholders' perspectives on SHAs' work in California. We will interview a select group of SHAs, their supervisors and staff, and a small group of school principals who use site funds to expand their schools' health programs.

How long will the research last?
We expect that you will be in this research study until its completion in May 2016.

How many people will be studied?
We expect about 30 people will be in this research study, which will be conducted entirely in California.

What happens if I say yes, I want to be in this research?
You will participate in one or two 1 hour-long interviews. These interviews will take place at a time and location convenient to you.

What happens if I do not want to be in this research?
You may decide not to take part in the research and it will not be held against you.

What happens if I say yes, but I change my mind later?
You can leave the research at any time and it will not be held against you.

What happens to the information collected for the research?
Efforts will be made to limit use or disclosure of your personal information, including research study records, to people who have a need to review this information. We cannot promise complete confidentiality. Organizations that may inspect and copy your information include the IRB and other University of California representatives responsible for the management or oversight of this study.

Are there other research opportunities?
If you are interested in being contacted for future research, please provide your phone number and/or email. This is completely optional.

_____(initials) Yes, I am willing to be contacted for future research opportunities. My phone number and/or email is: _____

Signature Block for Capable Adult

_____
Signature of subject   Date

_____
Printed name of subject

_____
Signature of person obtaining consent   Date
(Samantha Blackburn, researcher)

Appendix D - IRB Approval Letter

UNIVERSITY OF CALIFORNIA, DAVIS

BERKELEY · DAVIS · IRVINE · LOS ANGELES · MERCED · RIVERSIDE · SAN DIEGO · SAN FRANCISCO — SANTA BARBARA · SANTA CRUZ

SACRAMENTO, CALIFORNIA 95817

OFFICE OF RESEARCH
IRB Administration
TELEPHONE: 916 703-9151
FAX: 916 703-9160

October 30, 2014

Samantha Blackburn
The Betty Irene Moore School of Nursing
Phone:
Email:

Dear Ms. Blackburn,

On October 30, 2014 the IRB reviewed the following protocol:

Type of Review:	New Project
Title:	Exploring the Work of School Health Administrators in California
Investigator:	Blackburn, Samantha,
IRB ID:	676675-1
Funding:	Departmental
Documents Reviewed:	Application for Review Description of Study / PI Protocol Recruitment Materials Consent Documents Questionnaires/Surveys/Assessment Tools
Determination:	Exempt Category 2
Comments/Conditions:	This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are being considered and there are questions about whether IRB review is needed, please submit a modification request to the IRB for another determination. In conducting this protocol you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

This Assurance, on file with the Department of Health and Human Services, covers this determination:
FWA No: 00004557
Expiration Date: June 13, 2018
IORG: 0000251

Sincerely,

Cynthia M. Gates, J.D., R.N, C.I.P.

- 1 -   Generated on IRBNet

Associate Director, Institutional Review Board Administration
University of California, Davis
2921 Stockton Blvd., Suite 1400
Sacramento, CA 95817