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*J Sch Nurs* 2006; 22; 310
DOI: 10.1177/10598405060220060201

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The Healthy Learner Model for Student Chronic Condition Management—Part I

Cecelia DuPlessis Erickson, RN, MPH; Patricia L. Splett, PhD; Sara Stoltzfus Mullett, RN, MPH; and Mary Bielski Heiman, RN, MS, CNS

ABSTRACT: A significant number of children have chronic health conditions that interfere with normal activities, including school attendance and active participation in the learning process. Management of students’ chronic conditions is complex and requires an integrated system. Models to improve chronic disease management have been developed for the medical system and public health. Programs that address specific chronic disease management or coordinate school health services have been implemented in schools. Lacking is a comprehensive, integrated model that links schools, students, parents, health care, and other community providers. The Healthy Learner Model for chronic condition management identifies seven elements for creating, implementing, and sustaining an efficient and effective, comprehensive community-based system for improving the management of chronic conditions for school children. It has provided the framework for successful chronic condition management in an urban school district and is proposed for replication in other districts and communities.

KEY WORDS: chronic care model, chronic health conditions, collaboration, evaluation, evidence-based practice, school nursing

INTRODUCTION

This article presents a model for the management of chronic health conditions of children in which schools and school nurses play an integral role. The aim of this comprehensive, community-based model is to enable students with chronic conditions to be healthy, in school, and ready to learn. The Healthy Learner Model for Student Chronic Condition Management (Healthy Learner Model) evolved from a school and community initiative to manage asthma that included an extensive evaluation. The model has been sustained over the past seven years and replicated in another district (Erickson, Splett, Mullett, Jensen, & Belseth, 2006; Splett, Erickson, Belseth, & Jensen, 2006).

LITERATURE REVIEW

Estimates of the number of U.S. children with chronic conditions vary widely depending on the definition (Newacheck et al., 1998). Based on the National Survey of Children with Special Health Care Needs, 13% of children have a chronic condition that results in special health care needs, and 20% of U.S. households with children are affected (U.S. Department of Health and Human Services [USDHHS], 2004). Approximately 8% of children ages 5 to 17 have conditions severe enough to limit their social role activities (Forum on Child and Family Statistics, 2006). The percentage of children with chronic conditions is increasing due to an increase in birth and trauma survival; advances in medical care and technology; improved public health measures for the prevention, treatment,
and control of infectious diseases; and improved diagnosis and case finding. In addition, the increasing prevalence of chronic conditions such as type 2 diabetes and extreme prematurity has introduced new categories of childhood chronic diseases (Allen, 2004).

**Challenges**

Children with chronic health conditions and their families are more likely to experience a decline in the quality of their life. Compared with other children, children with special health care needs are likely to use more health or related services; have increased risk for developmental delays; have greater concerns in the areas of self-esteem, autonomy, and self-reliance regardless of stage of growth and development; and are twice as likely to have emotional or behavioral problems (Vessey & Rumsey, 2004; James, Ashwill, & Droske, 2002; USDHHS, 2004). Children with chronic health conditions often experience school performance and attendance problems and have greater risk to their health and safety at school (Lowe & Miller, 1998; Msall, Avery, Tremont, Lima, Rogers, & Hogan, 2003).

Families are seriously challenged by the time and expense required to ensure their child receives needed care. The effect of a chronic disease on a child and his or her family may continue and even increase as the child grows older. Children with special health care needs are disproportionately poor and socially disadvantaged. Moreover, many of these children face significant barriers to health care (USDHHS, 2004).

Historically, school nurses have monitored and treated students with chronic conditions. As the number of students with chronic health conditions increases, it creates new challenges in the provision of school nursing services. The following activities require more time and expertise from school nurses (Herrmann, 2005; Lowe & Hoxie, 2005; Lowe & Miller, 1998; National Association of State School Nurse Consultants, 2000):

- Case-finding activities to identify students with chronic conditions who otherwise might fall through the cracks.
- Case management for students who also are impoverished, uninsured, recent immigrants, or from at-risk families.
- Development of individual student health and emergency plans.
- Delegation of care to unlicensed personnel and related planning, teaching, and monitoring of care.
- Participation in special education activities, including assessment, planning, and provision of nursing services.
- Increased requirements for documentation for health service and special education reimbursement.

School districts are challenged to meet federal and state laws and regulations. The Individuals with Disabilities Education Act (IDEA) of 2004 and the Rehabilitation Act of 1973, Section 504, require districts to provide services and accommodations for students with chronic conditions (Moses, Gilcrest, & Schwab, 2005). Recent trends in legislation bring new requirements for school districts without providing additional resources. For example, recent laws allow students to carry emergency asthma and allergy medications and require school districts to monitor specific chronic conditions such as asthma, diabetes, and allergies—all of which require plans for immediate intervention by school staff (Jones & Wheeler, 2004). School districts are expected to do more with diminishing resources and face increased risk of lawsuits if mandated services are not provided. Considering these challenges, a comprehensive model could guide districts and school nurses in collaborating others to plan and provide more effective health services for students with chronic conditions.

**Chronic Care Models**

Medical providers have recognized the need for a chronic care model that guides system change for chronic disease management and encourages high-quality care and improved outcomes for individuals with chronic disease (Wagner, Davis, Schaefer, Von Korff, & Austin, 1999; Bodenheimer, Wagner, & Grumbach, 2002a). The Chronic Care Model (CCM) was designed for the primary care setting. Elements include the community, the health system, self-management support, delivery system design, decision support, and clinical information system. The CCM is built on evidence-based change concepts that foster productive interactions between providers who have clinical expertise and resources and informed patients who actively participate in their own care. It has been implemented in a large number of organizations with positive results in the United States, the United Kingdom, and other countries. The functional and clinical outcomes expected to result from this model are quality care, healthier patients, more satisfied providers, and cost savings (Bodenheimer, Wagner, & Grumbach, 2002b; Bodenheimer, 2003).

Barr and colleagues identified a limitation of the CCM and expanded it for application at the population level by adding a stronger community perspective. The Expanded Chronic Care Model recognizes
the significant influence of the community in health promotion and the prevention and management of chronic diseases (Barr, Robinson, Marin-Link, Underhill, Dotts, Ravensdale, & Salivaras, 2003).

The World Health Organization (WHO) strengthened the community and policy aspects of the CCM to include a global perspective that addresses health conditions in developing countries. The WHO effort resulted in Innovative Care for Chronic Conditions (ICCC) that provides a framework for health systems design or redesign and recognizes the critical role that community leaders and care providers play. The ICCC stresses partnership with patients, their families, health care teams, and community partners. It also emphasizes program development based on local resources and demands (Epping-Jordan, Pruitt, Bengoa, & Wagner, 2004).

Many school districts, along with students and families, experience barriers to health care for chronic disease management that are similar to those affecting developing countries. The barriers identified by Epping-Jordan and colleagues (2004) include lack of medications, equipment, and supplies; lack of access to health care and specialty providers; multiple staffing patterns in the delivery of health services with increased use of paraprofessionals to provide services; and the challenge of providing for the health and safety of the population with scarce resources. None of the described chronic care models mention schools as a part of the community system.

**Chronic Care Initiatives in Schools**

There are examples of condition-specific, school-based initiatives and interventions for students with chronic health conditions, including asthma (Theis & McAllister 2001; Taras, Wright, Brennan, Campana, & Loefgren 2004; Clark, Brown, Joseph, Anderson, Liu, & Valerio, 2004), diabetes (Nimsgern & Camponeschi, 2005), and life-threatening allergies (Massachusetts Department of Education, 2002). Nies, Bickes, Schim, and Johnson (2002) describe schools as a partner in a community health nursing model that builds on the collegial collaboration of professional nurses in varied settings and that focus on a chronic condition such as asthma.

Additionally, the Centers for Disease Control and Prevention (CDC) has developed a Coordinated School Health (CSH) program that addresses physical, emotional, social, and educational development of students in kindergarten through 12th grade to help children become healthy and productive adults. The CSH model has eight components that link health and education: health education, physical education, health services, nutrition services, counseling and psychological services, healthy school environment, health promotion for staff, and family/community involvement. The CSH program has been applied to health promotion and prevention of chronic conditions (Kolbe, Kann, Patterson, Wechsler, Osoria, & Collins, 2004), including asthma (CDC, 2002). Despite these efforts, there is no comprehensive chronic care model to guide health services in schools for children with chronic conditions.

**THE HEALTHY LEARNER MODEL**

The Healthy Learner Model for Student Chronic Condition Management (Healthy Learner Model) is proposed as a bridge between the medical models that focus on adult clinical settings and the school initiatives that focus on the school environment. The Healthy Learner Model is an integrated, coordinated effort to optimize the health status and support the academic success of children with chronic conditions. For purposes of applying the model, a chronic condition is defined as one that has the following characteristics: (a) long-term impact on a child including potential limitations of age-appropriate activities, such as play or school; (b) requires medication for control of the condition; (c) need for ongoing medical care; (d) treatment, adaptation, or special assistance at home or school; and (e) may need technology assistance (i.e., insulin pump, gastrostomy tube). This definition is adapted from Stein and Silver (1999).

The Healthy Learner Model is an integrated, coordinated effort to optimize the health status and support the academic success of children with chronic conditions.
The Healthy Learner Model in Figure 1 identifies seven essential elements to ensure high-quality care and positive outcomes for students with chronic conditions. The synergistic elements are: (a) leadership, (b) evidence-based nursing practice, (c) capacity building, (d) chronic disease resource nurse, (e) the healthy learner, (f) partnership with families, and (g) partnership with health care providers. Brief descriptions of the elements and examples of related activities are given in Table 1, and Figure 1 illustrates the relationship of the elements.

Leadership is at the foundation of the Healthy Learner Model. Evidence-based practice is used to gather the best available scientific evidence and expert guidance to identify practice, policy, procedural, and system changes necessary to assure quality care for the specific chronic condition. Capacity building is used to prepare personnel, secure supplies and equipment, and to introduce system changes for program implementation. The chronic disease resource nurse helps school personnel implement the program and adopt best practices. The collaborative efforts of school nurses, families, and health care providers enable students with chronic conditions to be Healthy Learners.

The Healthy Learner Model is built on two requisites that are not identified as elements but are inherent to the model. The first requisite is professional school nursing. In this model the professional school nurse is a baccalaureate-prepared nurse who possesses knowledge, skills, and expertise in education, counseling, case management, and care coordination across school, health care, and community systems for children with chronic health conditions. The professional school nurse is integral to every element of the Healthy Learner Model. Adoption of the model enhances school nurse practice by enabling school nurses to function at a higher level and use their knowledge, expertise, skills, and time for planning and care coordination to improve student health, safety, and education outcomes.

The second requisite is evaluation. Evaluation is the systematic process of asking questions, choosing methods and gathering relevant data, analyzing and
interpreting the data, and applying findings in planning and decision-making. Evaluation promotes and reinforces systemic change during program development, implementation, and sustainability by providing ongoing data to assess process and outcomes and guide program decisions. Evaluation is also integral to every element of the model.

The outcome of the Healthy Learner model is an efficient and effective system of care for chronic condition management with improved communication and coordination among students, families, schools and health care providers. It results in students who are healthy and in school ready to learn.

**ELEMENTS OF THE HEALTHY LEARNER MODEL**

**Leadership**

Leadership is the critical foundation of the Healthy Learner Model. Leadership promotes a shared vision for healthy learners across the community and a shared commitment to optimum disease management for students with chronic conditions. Strong leaders in both the community and the school district bring to the table those who can advocate for and champion system changes in their organizations. Leadership ensures that sufficient resources are allocated to implement, evaluate, reinforce, and sustain other elements of the model. Ongoing leadership in the school district is essential to sustain success of the model over time.

**Evidence-Based Practice**

The Healthy Learner Model relies on evidence-based practice to promote quality care for positive outcomes. Evidence-based practice in school nursing is a process of identifying the best evidence and integrating it with nursing expertise and patient and family preferences to determine interventions for optimum outcomes (Adams & McCarthy, 2005; Polit & Beck 2004; Titler, Mentes, Rakel, Abbott, & Baumler, 1999). In the Healthy Learner Model, best evidence related to the identification and management of the specific chronic condition is reviewed with attention to potential impact on student health and academic success. This information is synthesized into evidence-based guidelines for nursing practice in the school setting. As a result, systems, strategies, and tools are developed that reduce barriers and facilitate adoption of the evidence-based guidelines by school nurses and others who provide care to students with the chronic condition. With attention to the unique needs of each student, school nurses apply the guidelines, monitor progress, and evaluate the outcomes of the care.

**Capacity Building**

Capacity building is essential to ensure that school health personnel and community health care providers can implement and sustain evidence-based disease management for a specific chronic condition. This requires investment in a comprehensive program that includes defining performance expectations; staff training to increase knowledge and skills and assure competency of personnel; tools that promote efficient and effective practice; dependable access to necessary equipment and supplies; documentation and evaluation procedures; and mechanisms for communication among parents, community health care providers, and schools. Evaluation supports capacity building by tracking progress in staff development and system changes as well as providing information to guide program adjustments. Capacity building enables and empowers school nurses and others to adopt evidence-based practice for the management of chronic conditions.

**Chronic Disease Resource Nurse**

The chronic disease resource nurse (Resource Nurse) is an experienced school nurse with clinical expertise in the chronic disease(s). The Resource Nurse is a champion for optimum chronic disease management and is available to support staff at building sites as they implement the chronic condition management program. Communication, organizational skills, and the ability to influence and guide others are critical to this role. The Resource Nurse coaches and mentors school staff who work with students to assure that the program is implemented with fidelity. Observation and skill validation are used to assess the knowledge and skill of health office staff and identify areas for additional training and reinforcement. In addition, the Resource Nurse provides invaluable feedback to guide program planning and evaluation. This position is most effective when the Resource Nurse is accessible full time during the school day, is not judgmental, and is not perceived as “management.” The Resource Nurse reinforces practice guidelines in schools, advocates for best clinical practice, and participates in community partnering activities.

**Healthy Learner**

A Healthy Learner is a student whose chronic condition is well managed, who is attending school, and is participating actively in the educational process. A Healthy Learner is able to function at his or her full potential physically, socially, emotionally, and academically. Healthy learners experience minimal epi-
sodes of illness, and experience fewer episodes of acute and emergency medical care and hospitalizations.

Students receive care to support their medical plan, foster understanding of the condition, and enable age and developmentally appropriate self-management skills (Betz, 2000). To accomplish this, school nurses perform several categories of services (National Association of State School Nurse Consultants, 1993). They identify students with the chronic condition (case finding), monitor and provide care at school (nursing care procedures), coordinate care with medical and other community providers, and provide emergency care. Nurses offer counseling and education that is age-appropriate, culturally specific, incremental, and ongoing.

Tailored education helps students take increasing responsibility for managing their chronic condition and promotes good general health, including personal care, nutrition, and physical activity (Selekman & Guilday, 2003). Teachers, nurses, and other staff coordinate efforts to assure appropriate accommodations are made for the student at school, including in classrooms, physical education, and the lunchroom. Systemic changes at the school and district level are also needed to support the Healthy Learner. This encompasses the areas of health curriculum, nursing practice, the school environment, and policies and procedures.

**Partnership With Families**

Partnership between parents of children with a chronic health condition and the school nurse is vital. This element recognizes that parents are the ultimate decision-makers and have the primary responsibility for managing their child’s chronic condition. The partnership supported by ongoing two-way communication empowers families to carry out this responsibility. It helps to ensure that the health and safety needs of the student are met at home and at school. Successful partnership can also improve the quality of life for students and their families and can help to decrease loss of work time for parents (Wheeler, Boss, & Williams, 2004).

Within the partnership, school nurses identify and respond to student needs and parent concerns, share relevant information, and intervene with families at risk, while being respectful of family preferences, values, and customs. Moreover, school nurses offer parents education specific to the chronic condition and overall good health practices; share objective assessment of the child’s ability to do self-care; provide information about resources available at school and in the community (e.g., Section 504 accommodations, special education services, access to health care, and support groups); and coordinate care by facilitating parent and health care provider communication. School nurses share documented health data and help parents frame questions to ask health care providers. By working with parents, school nurses are able to advocate for students by supporting appropriate medical care, regular school attendance, and active participation in school activities. The partnership empowers families to maximize the health and academic achievement of their child with chronic conditions.

**Partnership With Health Care Providers**

Partnership between community health care providers and school nurses is essential to establish a comprehensive initiative to address a chronic condition. Criteria for effective partnership include: (a) care guided by evidence-based guidelines; (b) professional education that includes chronic disease diagnosis, management, and performance standards; (c) awareness and knowledge of other community efforts to address the chronic condition; (d) care coordination and effective communication mechanisms that promote communication among health care providers, families, and school staff about current treatment plans, student health status, and home and school factors that may have an impact on management of the condition; (e) assured access to medication, equipment, and supplies; (f) commitment to a family-centered philosophy of care (as defined in the National Survey of Children with Special Health Care Needs [USDHHS, 2004]); and (g) advocacy and partnering with payers and health plans.

School nurses are critical partners for health care providers because they are able to provide regular observations of students’ health status, their ability to manage their conditions, and the effectiveness of prescribed medications and treatments. As partners, school nurses and health care providers advocate for health, education, and other services needed for the child’s chronic condition management and optimal participation in and attendance at school.

**IMPLEMENTATION OF THE HEALTHY LEARNER MODEL**

The testing ground for the elements of the Healthy Learner Model was the Healthy Learner Asthma Initiative (HLAI) that was initiated and rigorously evaluated in Minneapolis Public Schools (MPS) and selected clinics beginning in 1999. The successful implementation and continuation of the HLAI demonstrated that a comprehensive community-based model of care that includes schools can improve the management of pediatric asthma in a community (Erickson et al., 2006 [this issue, p. 319]; Splett et al., 2006). Positive evaluation data provided evidence to justify continuation of the HLAI in MPS.

The Healthy Learner Model has since been applied to the management of diabetes, life-threatening allergies, and mental health in MPS. It also has been implemented by St. Paul Public Schools as part of the
Controlling Asthma in American Cities Project, a seven-year collaborative grant funded by the CDC and administered by the American Lung Association of Minnesota. Components and tools emerging from the model are being disseminated to other school districts by the Minnesota Department of Health (Managing Asthma in Minnesota Schools, 2004; Keysser, Splett, Ross, & Fishman, 2006). The successful expansion of these initiatives verifies the usefulness of the Healthy Learner Model.

DISCUSSION

Chronic care improvement is a complex process that requires an entire system change (Bodenheimer, 2003). Existing chronic care models have not addressed schools and children. The Healthy Learner Model is proposed to fill that gap. To further test and assess the effectiveness of the Healthy Learner Model, it needs replication with other chronic conditions and in other settings, including rural and suburban districts with differing staffing patterns and with other community partners. Adopting the model requires planning to take into account specific community and school “culture,” staffing, and resources. In smaller school districts, the number of relationships, intensity of engagement, and simpler administrative structures of school and community partners may make adoption easier. In other settings, implementation of the Healthy Learner Model may require creative staffing and community partnerships. For example, the Resource Nurse or an evaluator could be employed by the district or contracted through a local health department, clinic, hospital, or nursing program at a college or university (Lindeke, Krajicek, & Patterson, 2001).

Leadership to launch the Healthy Learner Model can emerge from within the district or community. The leader(s) must be a catalyst for change by having passion for the initiative and have the ability to dialogue, collaborate, and influence others to “buy in.” Partners must be receptive to exploring innovative strategies and work together to build a system of chronic condition management that achieves positive outcomes for students. Partnering organizations will have different goals, but the shared vision of improved chronic disease management can be a driving force for collaboration. Health care organizations benefit from more appropriate health care utilization as well as fewer emergency department visits and hospitalizations. Schools benefit from improved student attendance and learning. Families and students benefit when schools and health care providers are “on the same page,” supporting and helping students manage their chronic condition. After the system changes have been implemented, administrative leadership is necessary for sustaining changes within the system.

The commitment to make a system change requires the investment of resources. This is a challenge in an environment of diminishing resources and therefore requires careful initial planning and ongoing evaluation to monitor progress, guide program decisions, and track outcomes. After the development and implementation phase, fewer resources are required to manage and sustain the changes.

Through partnering, organizations bring different resources and expertise to the table, thereby complementing and effectively extending resources (Fitzgerald & Freund, 1993). For example, schools have daily access to students with chronic conditions that require ongoing monitoring and care as well as a relationship with their families. School nurses assess and document students’ health status and ability to self-manage their chronic conditions and can provide objective information to families and health care providers. Parents have knowledge about their child’s condition, treatment plan, and response, and are involved in helping schools plan for the child’s health and educational services. They are a conduit between schools and health care providers. Health care providers and their organizations bring expertise in disease management, establish treatment plans, provide patient education, and enable access to medication, supplies, and equipment for home and school. In addition, health care providers and community organizations (e.g., American Lung Association and American Diabetes Association) can provide expertise to school districts about specific chronic diseases and assistance with capacity building and evaluation.

Formative, process, and outcome evaluations are critical in replication of the Healthy Learner Model in other settings (CDC, 1999). Sharing relevant evaluation data with collaborating partners helps strengthen the partnership and sustains the program by reinforcing successes, identifying areas for adjustment, and documenting positive outcomes associated with the collaboration.

IMPLICATIONS FOR SCHOOL NURSING PRACTICE

The Healthy Learner Model is the only comprehensive chronic care model to guide the health services of students with chronic conditions in the school setting. The Healthy Learner Model strengthens school nursing practice. As the number of students with chronic conditions and their respective needs place challenges on school districts, care models that support students with chronic conditions to be healthy learners must be developed and evaluated. The Healthy Learner Model by design emphasizes evidence-based practice and enables school nurses to use their expertise and skills for planning, care coordination, health, safety, and education activities—all of which benefit the student, family, school district, and health care providers.

Evidence-based practice that is informed by ongoing
Evaluation results in high-quality care for students. Polit and Beck (2004) describe that, in evidence-based practice, the utilization and implementation potential of a given model should be assessed for transferability, feasibility, and cost-benefit ratios. Evaluation of the Healthy Learner Model in asthma management demonstrated that the application of evaluation findings does lead to best practice (Splett et al., 2006). As the model suggests, the school nurse supported by leadership and resources can facilitate student chronic care needs, promote developmentally appropriate and individualized self-care skills, and foster learning. In addition, school nurse efforts improve attendance and participation in class, leading to academic success (Maughan, 2003). The model promotes the nurse-parent partnership and suggests that the expertise of the school nurse assists parents to foster student self-sufficiency and autonomy. Moreover, as student self-sufficiency and awareness of chronic care needs are learned and reinforced, the ultimate goal of transition to adult independence may be achieved.

Evaluation data showed that school nurses and other health team members experience increased job satisfaction, and improved working relationships when the elements of the Healthy Learner Model guide chronic condition management (Erickson et al., 2006; Splett et al., 2006). Participation in ongoing capacity-building activities with colleagues and professional peers decreases their sense of isolation, including role marginalization (Smith, 2004), and enhances their confidence in chronic disease care and management. The school health team is strengthened and made more efficient through explicit job expectations and standardized care defined in policies and procedures. School nurse skills are enhanced by developing their expertise with a chronic condition(s) and staying current with advancing technology. In addition, school nurses are able to practice safe and efficient delegation to unlicensed personnel, resulting in more opportunity for nursing case management, care coordination, and direct care and education for students with complex health care needs (National Association of School Nurse Consultants, 1995).

In addition to helping meet district attendance and academic goals, this enhanced level of practice can contribute to district funding through special education nursing activities and third-party reimbursement. Provision of appropriate care to students with chronic conditions promotes student health and safety at school and reduces the liability risk of the district.

**CONCLUSION**

The Healthy Learner Model emphasizes that partnerships linking health care providers, families, and schools are imperative to optimize the health and school performance of students with a chronic condition and make them healthy learners. Components of the Healthy Learner Model that facilitate this are leadership, evidence-based practice, capacity building, and the Resource Nurse. The success and sustainability of the Healthy Learner Asthma Initiative, discussed in Part II (p. 319), and its expansion to other schools indicate the potential usefulness of the Healthy Learner Model in other school districts and communities. Further testing is needed to validate the model and its application to other chronic conditions such as diabetes, seizure disorders, attention deficit, and mental illness. The Healthy Learner Model offers a way for schools and the community to ensure students with chronic health conditions are healthy and in school ready to learn.

**REFERENCES**


Massachusetts Department of Education. (2002).