National Survey of School Employees: COVID-19, School Reopening, and Student Wellness

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ABSTRACT

BACKGROUND: During spring 2020, COVID-19 forced widespread United States school building closures in an unprecedented disruption for K-12 students and staff. Partnering with the American School Health Association (ASHA), we sought to identify areas of concern among school staff planning for school reopening with the goal of addressing gaps in resources and education.

METHODS: This 16-item web-based survey was distributed via email to 7467 ASHA members from May to June 2020. Topics focused on 3 Whole School, Whole Community, Whole Child components: physical environment, health services, and mental health. Chi-square tests were used to identify differences in responses by school characteristics and school role on each survey item.

RESULTS: A total of 375 respondents representing 45 states completed the survey. The majority were female (91.7%), white (83.4%) and non-Hispanic (92.2%), and school nurses (58.7%). Priority concerns were feasibility of social distancing (93.6%), resurgence of COVID-19 (92.8%), and the availability of health supplies (88.8%).

CONCLUSION: Understanding staff concerns in the context of the Whole School, Whole Community, Whole Child model better positions the school community to address ongoing gaps and changing needs as schools continue to address COVID-19 complications.

Keywords: child and adolescent health; COVID-19; school reopening; school health; whole child model; whole community; whole school.

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During spring 2020, the COVID-19 pandemic forced widespread closures of physical school buildings and cessation of traditional, in-person instruction in the United States in an unprecedented disruption of kindergarten through 12th grade (K-12) schooling. School closures due to COVID-19 have impacted at least 124,000 US public and private schools with nearly every state either ordering or recommending that schools remain closed through the end of the 2019-2020 school year. At the end of the traditional school year in June 2020, more than 55 million US children had missed months of in-class instruction.

The importance of in-person instruction is well-documented. Schools are fundamental to child and adolescent development and provide students with everything from academic instruction to reliable nutrition and mental health services. In turn, the closing of schools can exacerbate social, economic,
and health inequities among children and families.\(^3\) As the COVID-19 pandemic evolves, there is growing awareness of the disproportionate impact of school closures on children nationwide, specifically vulnerable children.\(^4\)

The physical and behavioral health of children was anticipated to be affected as access to school-based services (free and reduced-price meal programs and behavioral health resources) became limited with school closures.\(^3\) Although schools nationwide made efforts to continue to meet the needs of students by quickly converting to online platforms, academic inequities among students remained as a result of inequities in family access to technology.\(^6\) Due to these inequities, the American Academy of Pediatrics (AAP) strongly advocated that all policy considerations for the 2020-2021 school year be underscored with the goal of having students physically present in the classroom.\(^7\)

Our team collaborated with the American School Health Association (ASHA) to survey school staff membership regarding nonacademic concerns as schools reopened for the 2020-2021 school year. Whereas many schools reopened in August–September 2020, this information remains relevant as school districts continue to move between virtual, hybrid and in-person instruction based on rates of COVID-19 in their communities. Our web-based survey focused on the Whole School, Whole Community, Whole Child (WSCC) components of physical environment, health services, social and emotional climate, and counseling, psychological, and social services. Our goals were to identify primary areas of concern related to school reopening, and share this information with ASHA membership and school personnel to facilitate information sharing and dialogue. In addition, we intended to provide resources specific to concerns raised in the survey.

**METHODS**

**Participants**

The survey was distributed to the 7467 ASHA members via email. Inclusion criteria included individuals who were 18 years or older, English literate, and were employed part-or full-time by a K-12 school as of March 2020 as self-reported by participants during screening.

**Instrumentation**

The study team worked collaboratively with ASHA leadership to design the survey. The National Institute of Health’s Repository of COVID-19 Research Tools was also reviewed though no school-specific survey items were identified for inclusion.\(^8\) Brief, semi-structured interviews were conducted with 3 school employees known to the research team to guide instrumentation development. Questions included: What are your biggest concerns about reopening the school building? What do you perceive to be students’/staff members’/parents’ greatest needs in the recovery phase? and What resources are limited to you that would facilitate the smooth transition back to school? Feedback from the interviews was used to develop survey focus areas and survey questions based on the WSCC components of physical environment, social/emotional climate, counseling, psychological and social services, and health services. For the purposes of this study, we combined the social and emotional climate and counseling, psychological, and social services into an area we labeled “mental health.”\(^9,10\) Respondents were asked to rate their level of concern with items within the WSCC focused school reopening items on a 4-point Likert scale. Additional survey categories included participant demographics (state, school role), school closure status, and school characteristics (locale, public/private status). The final survey question prompted respondents to select resources they wished their school would provide as they prepare for school reopening.

**Procedure**

Potential participants from ASHA’s membership list were contacted via electronic mail. Electronic mail communications were sent directly from ASHA, blinding the Penn State team’s access to member profiles. Because not all ASHA members indicate their professional role in their member profile, the survey was sent to all members with language specific to recruit eligible school staff. The recruitment email contained a link to connect interested school employees to REDCap (Research Electronic Data Capture), a secure, web-based software platform designed to support data capture for research studies.\(^11,12\) Eligibility was confirmed by self-reported screening questions and participants that screened eligible were immediately provided access to complete the 20-minute survey. The survey was open for 2 weeks from May 19, 2020 to June 3, 2020 and during this time a maximum of 3 reminders were sent via electronic mail to encourage participation. The final reminder specifically called on school staff from 7 states (Hawaii, Kansas, Montana, North Dakota, South Dakota, Wyoming, and Mississippi) to complete the survey, in support of reaching all 50 states and the District of Columbia.

**Data Analysis**

School region, defined by US State Census regions,\(^13\) was applied to participant records before analysis. Demographic data were summarized for all participants. For ease of interpretability, survey responses were dichotomized as “not concerned” (not at all concerned/not really concerned) and
“concerned” (somewhat concerned/very concerned). Concerns related to WSCC focused school reopening items were examined by the following school characteristics: school region, school level, school locale and the participants’ role at school. Chi-square tests were used to identify differences between school characteristics (region [northeast, north central, south, west], level [elementary, middle, high school or multiple levels], location [rural, urban]) and role in school (nurse, educator, other [administrator, school counselors, etc.]) on each survey item.

RESULTS

Survey responses represented 5.0% (N = 375) of ASHA’s membership list. Among the 375 respondents the majority were female (91.7%), white (83.4%), non-Hispanic (92.2%), and school nurses (58.7%). Respondents represented 45 states, with no respondents from Hawaii, Kansas, Montana, North Dakota, and South Dakota. Table 1 displays demographics and school characteristics of the survey respondents. Most respondents represented public schools (89.6%) the majority of whose buildings closed in March 2020 (98.1%). Most respondents (81.0%) were uncertain regarding their district’s reopening plan for the 2020-2021 academic year.

WSCC Focused School Reopening Items

Table 2 provides summary data of WSCC focused reopening items. Respondents consistently reported the highest level of concern with survey items related to the physical environment. Respondents were particularly concerned about the feasibility of social distancing among students and staff (93.6%) and the safety of transportation for students who rely on public transportation and/or school buses (87.4%). Respondents were less concerned about the number of students who now qualify for free/reduced meal programs as a result of parent(s) losing employment (72.3%) and the availability of community supports that provide indoor or outdoor education or recreation activities (69.2%). Primary concerns regarding school health were the resurgence of COVID-19 (92.8%), chronic illnesses not being properly managed (88.8%), and the availability of health supplies (88.8%). Respondents were least concerned about the potential increase of overweight/obesity rates (64.3%). Mental health items also received consistently high levels of concern with the exception of reestablishing trusting relationships/rapport with students and their families (54.8%). Primary mental health concerns included the increased number of students referred (87.7%) and the availability of internal staff capacity to meet this increased number of students (87.4%). Notably, each WSCC focused reopening item in the survey garnered “concern” ratings for more than 50% of respondents.

Table 1. Characteristics of Survey Respondents

| Response N (%) |
|----------------|
| Sex           |
| Male          | 19 (5.1%) |
| Female        | 344 (91.7%) |
| Other         | 3 (0.8%) |
| Prefer not to say | 9 (2.4%) |
| Race          |
| Missing       | 1 |
| White         | 312 (83.4%) |
| Black or African American | 30 (8.0%) |
| Asian         | 3 (0.8%) |
| Native Hawaiian or Pacific Islander | 1 (0.3%) |
| American Indian or Alaska Native | 5 (1.3%) |
| More than one race | 7 (1.9%) |
| Prefer not to say | 16 (4.3%) |
| Hispanic      |
| Missing       | 2 |
| Yes           | 344 (92.2%) |
| No            | 18 (4.8%) |
| Prefer not to say | 16 (4.3%) |
| Highest level of education |
| Missing       | 1 |
| High school diploma or equivalent | 9 (2.4%) |
| Associates degree | 38 (10.2%) |
| Bachelor's degree | 144 (38.5%) |
| Master's degree | 167 (44.7%) |
| Doctoral degree | 16 (4.3%) |
| Region        |
| Missing       | 59 |
| Northeast     | 89 (28.2%) |
| North Central | 61 (19.3%) |
| South         | 94 (29.7%) |
| West          | 72 (22.8%) |
| Level         |
| Missing       | 28 |
| Elementary/primary | 106 (29.4%) |
| Middle school/junior high | 44 (12.2%) |
| High school   | 53 (14.7%) |
| Multiple levels | 159 (42.4%) |
| Type          |
| Missing       | 1 |
| Public        | 336 (89.6%) |
| Private       | 22 (5.9%) |
| Charter       | 15 (4%) |
| Other         | 2 (0.5%) |
| Locale        |
| Missing       | 1 |
| Rural         | 123 (32.9%) |
| Suburban      | 144 (38.5%) |
| Urban         | 107 (28.6%) |
| Role          |
| Educator      | 86 (22.9%) |
| Nurse         | 220 (58.7%) |
| Other         | 34 (9.1%) |

Reopening Concerns

Overall, no statistically significant differences were found relating to concern of in-person instruction by school region, school level, or school locale. There were notable differences between survey items related to the physical environment and school health by
Table 2. Concerns Related to Returning to In-Person Instruction (N = 375)

| Item                                                                 | Concerned | Not Concerned | Missing |
|----------------------------------------------------------------------|-----------|---------------|---------|
| Physical environment                                                 |           |               |         |
| Feasibility of social distancing among students and staff in the hallways, classroom, cafeterias, etc. | 351 (93.6) | 24 (64)       | 0       |
| Safety (cleanliness, social distancing) of transportation for students who rely on public transportation and/or school buses. | 327 (87.4) | 47 (12.6)     | 1       |
| Number of students who opt not to return to the school building (homeschool, cyber school). | 294 (78.8) | 79 (21.2)     | 2       |
| Students who now qualify for free/reduced meal programs as a result of parent(s) losing employment. | 271 (72.3) | 104 (27.7)    | 0       |
| The school building being appropriately cleaned (were low-emitting products used in and around the school and school grounds during initial sanitation?). | 266 (71.3) | 107 (28.7)    | 2       |
| Availability of community supports that provide indoor or outdoor education or recreational facilities/activities during the school year (YMCA). | 258 (69.2) | 115 (30.8)    | 2       |
| School health                                                        |           |               |         |
| Resurgence of COVID-19 in the fall/winter 2020.                      | 332 (92.8) | 27 (7.2)      | 2       |
| Students whose chronic illnesses were not properly managed during the pandemic. | 332 (88.8) | 42 (11.2)     | 1       |
| Availability of health supplies for applying standard or universal precautions in your school (disposable gloves, masks, disinfectants). | 333 (88.8) | 42 (11.2)     | 0       |
| Ability to meet state screening and documentation requirements (immunizations, vision/hearing). | 274 (74.1) | 96 (25.9)     | 5       |
| Availability of school health services provided by external agencies (local health department, hospitals). | 255 (68.5) | 118 (31.6)    | 2       |
| Overweight/obesity rates as a result of quarantine.                  | 240 (64.3) | 133 (35.7)    | 2       |
| Mental health                                                        |           |               |         |
| Increased number of students referred for behavioral (internal and/or external) or emotional concerns. | 329 (87.7) | 46 (12.3)     | 0       |
| Availability of internal staff capacity to manage a potential increase of mental health concerns. | 326 (87.4) | 46 (12.3)     | 0       |
| Availability of counseling, psychological, or social services provided by outside agencies/organizations (counseling centers, hospitals). | 294 (79) | 78 (21)       | 3       |
| Ability to reestablish trusting relationships/rapport with students and their families. | 205 (54.8) | 169 (45.2)    | 1       |

respondents’ role at school (Table 3). Specifically, respondents who serve as nurses reported greater levels of concern for safety of transportation (91.3%, p = .013), ability to meet state screening (81.0%, p = .001), and the availability of health supplies (93.6%, p = .002) compared to those categorized as other types of school professionals.

Reopening Resources

School staff primarily requested resources related to updated school safety policies/procedures (N = 324, 86.4%) and training/professional development for school staff (N = 318, 84.8%). Respondents were less likely to request health-related materials/handouts (N = 266, 70.9%) or activities with families/caregivers (N = 154, 41.1%).

DISCUSSION

Overall, the survey results indicate the primary concerns for school reopening were within the WSCC component physical environment, such as social distancing feasibility and transportation safety. Concerns in all surveyed WSCC areas were not influenced by US regional location, level, or locale, and echo national concerns of student and staff safety. Level of concern did vary, however, by role within the school on safety of transportation, ability to meet state screening and documentation requirements, and availability of health supplies.

Not surprisingly, the 2 greatest concerns were the feasibility of social distancing (93.6%) and the resurgence of COVID-19 in the fall/winter 2020 (92.8%). Recognizing and prioritizing these concerns will be an important part of the school planning landscape for the foreseeable future. School personnel who responded to this survey were specifically looking for school safety policies and procedures as well as professional development opportunities related to COVID-19. These data align with safety concerns rated highly in the WSCC focused reopening items. Once immediate physical environment and safety concerns are addressed, secondary WSCC concerns (health services, social and emotional climate, and counseling, psychological, and social services) are likely to rise to the forefront, as these topics were areas of concern with our respondents. Schools that have directed resources to address physical and safety measures may be ill-prepared to meet other vital WSCC components. Furthermore, wellness factors (mental health, physical education, and activity) have a long history of being secondary to academic priorities despite evidence showing connection. It is even more likely that
Table 3. Concerns Related to School reopening Among Reported School Role (N = 375)

| Item                                                                 | Physical environment | School health | Mental health |
|---------------------------------------------------------------------|----------------------|---------------|--------------|
| **Level of Concern N (%)**                                          | Educator (N = 86)    | Nurse (N = 220) | Other (N = 69) | p-Value     |
| Feasibility of social distancing among students and staff in the    | 79 (91.9)            | 211 (95.9)    | 61 (88.4)    | .064        |
| hallways, classroom, cafeterias, etc.                                |                      |               |              |             |
| Safety (cleanliness, social distancing) of transportation for       | 68 (79.1)            | 200 (91.3)    | 59 (85.5)    | .013        |
| students who rely on public transportation and/or school buses.     |                      |               |              |             |
| Number of students who opt not to return to the school building     | 61 (71.8)            | 174 (79.5)    | 59 (85.5)    | .109        |
| (homeschool, cyber school).                                         |                      |               |              |             |
| Students who now qualify for free/reduced meal programs as a result  | 60 (69.8)            | 163 (74.1)    | 48 (69.6)    | .643        |
| of parent(s) losing employment.                                      |                      |               |              |             |
| The school building being appropriately cleaned (were low-emitting   | 56 (65.1)            | 159 (72.6)    | 51 (75)      | .326        |
| products used in and around the school and school grounds during    |                      |               |              |             |
| initial sanitation?).                                               |                      |               |              |             |
| Availability of community supports that provide indoor or outdoor   | 56 (65.1)            | 153 (70.2)    | 49 (71)      | .645        |
| education or recreational facilities/activities during the school    |                      |               |              |             |
| year (YMCA).                                                        |                      |               |              |             |
| **Primary concerns regarding school health included the number of    |                      |               |              |             |
| students whose chronic illnesses were not properly managed during   | 77 (89.5)            | 207 (95)      | 62 (89.9)    | .152        |
| the pandemic (88.8%), and the availability of health supplies for   |                      |               |              |             |
| applying standard or universal precautions in your school (disposable| 74 (86)              | 199 (90.5)    | 59 (86.8)    | .463        |
| gloves, masks, disinfectants).                                      |                      |               |              |             |
| Ability to meet state screening and documentation requirements      | 70 (81.4)            | 206 (93.6)    | 57 (82.6)    | .002        |
| (immunizations, vision/hearing).                                     |                      |               |              |             |
| Availability of school health services provided by external agencies | 59 (69.4)            | 144 (65.8)    | 52 (75.4)    | .317        |
| (local health department, hospitals).                               |                      |               |              |             |
| Overweight/obesity rates as a result of quarantine.                 | 52 (60.5)            | 138 (63.3)    | 50 (72.5)    | .266        |
| **Primary mental health concerns**                                  |                      |               |              |             |
| Availability of counseling, psychological, or social services       | 65 (76.5)            | 177 (80.8)    | 52 (76.5)    | .598        |
| provided by outside agencies/organizations (counseling centers,     |                      |               |              |             |
| hospitals).                                                         |                      |               |              |             |
| Increased number of students referred for behavioral (internal and/or | 72 (83.7)            | 198 (90.0)    | 59 (85.5)    | .265        |
| external) or emotional concerns.                                    |                      |               |              |             |
| Availability of internal staff capacity to manage a potential       | 75 (87.2)            | 190 (87.2)    | 61 (88.4)    | .962        |
| increase of mental health concerns.                                 |                      |               |              |             |
| Ability to reestablish trusting relationships/rapport with students | 43 (50.6)            | 121 (55.0)    | 41 (59.4)    | .547        |
| and their families.                                                 |                      |               |              |             |

these secondary concerns will take the proverbial “back seat” as safety concerns potentially outrank even academic priorities while schools continue to adapt to new learning structures.

Schools provide our children and adolescents with social and emotional skills, reliable nutrition, physical/mental health services, and opportunities for physical activity. Primary concerns regarding school health included the number of students whose chronic illnesses were not properly managed during the pandemic (88.8%), and the availability of health supplies for applying standard or universal precautions in the school (disposable gloves, masks, disinfectants) (88.8%). Whereas the total number of students remains unreported, it is likely many students who engage with school-facilitated health care, such as vaccinations and other screenings, may have missed out or have yet to receive these vital health provisions while schools nationwide fluctuate among virtual, hybrid, and in-person learning. Additionally, although respondents were least concerned about the potential increase of overweight/obesity rates (64.3%) it is also believed children confined at home struggled, and will continue to struggle, to achieve the recommended 60 minutes a day of moderate-to-vigorous physical activity. The WSCC model highlights the importance of family and community involvement in schools as vital to the learning, development, and health of students. By understanding the school health concerns of school staff (resurgence of COVID-19, improper management of chronic illnesses, availability of health supplies for applying standard/universal precautions, and ability to meet state screenings), schools will be prepared to garner support from community agencies and outside groups who can provide valuable resources for student health and learning. When schools engage the community and families in meaningful ways through the WSCC model they improve student health and learning, subsequently supporting and reinforcing healthy behaviors in multiple settings, both at home and the school building. This becomes particularly vital as schools continue to transition between learning environments.

Mental health items also received consistently high levels of concern with the exception of reestablishing trusting relationships/rapport with students and their families (54.8%). Primary mental health concerns
included the increased number of students referred for mental health services (87.7%) and the subsequent availability of internal staff capacity to meet this increased number of students (87.4%). This concern is supported by research demonstrating that the COVID-19 pandemic may worsen existing mental health problems and lead to more cases among children and adolescents as internal and external factors such as social isolation and economic recession worsen.13 Schools are potentially overlooked in the role they play in the delivery of health care, namely mental health services. However, schools have long served as a mental health system for many children and adolescents.16 In the wake of the pandemic, government organizations such as the Centers for Medicare and Medicaid Services and Substance Abuse and Mental Health Services Administration have issued guidance to increase and improve the delivery of mental health services to schools.17 One of these models involves districts coordinating with community health agencies to deliver services within schools. This model echoes the framework of WSCC, which supports the process of building a trusting and collaborative relationship among administrators, teachers, students, parents, and community resources.18

In identifying other WSCC areas of concern, we have positioned ourselves to collect and provide targeted professional development and policies/procedures that meet the ongoing needs of schools as they transition between remote, in-person, and hybrid learning. Evidence has shown that if planned, implemented, and evaluated appropriately, the WSCC model has the potential of increasing the connectedness of students to schools, promoting a healthier school environment, and improving professional practices of teachers and school staff. Together, these outcomes not only increase the likelihood of academic success, but also overall improved student and staff health.18 As we look to meet the concerns of ASHA members and school staff nationwide, we continue to collect and share guidelines and professional development opportunities that include areas of the WSCC model outside and including the immediate physical environment.

A Call to Action

Our group, along with others have created a call to action to include WSCC items beyond the physical environment in school reopening plans. To assist school staff requesting policies and procedures, the Centers for Disease Control and Prevention (CDC) and the AAP have created reopening readiness and planning tools.19 Guidance provided by the AAP and the CDC support school reopening plans that promote healthy behaviors, environments, and operations to reduce the spread of COVID-19. Considerations for the physical environment and student safety are at the forefront of these guidelines; however, other WSCC components are also addressed. The AAP’s guidelines recommend that schools adopt a plan that considers the mental health needs of both students and staff.7 Additionally, the Society of Health and Physical Educators (SHAPE) America created guidance to continue to meet the physical activity and education needs of our students within the current climate. Their 2020-2021 School Reopening Considerations: K-12 Physical Education, Health Education, and Physical Activity guide is intended to assist administrators, staff, and teachers as they prepare for the school year whether instruction is in-person, distance learning, or a hybrid approach.20

In addition to these written guidelines and considerations, ASHA held a virtual, day-long event: Preparing for a New Learning Environment: Considerations in the Era of COVID-19 to aid schools in keeping students and staff safe and supported.21 This event gathered experts from the CDC, American School Counselor Association, the Global Recess Alliance, and several other public health professionals. Recognizing the value of the WSCC framework, ASHA provided guidance and resources that expanded beyond the physical environment during their all-day, virtual event. Topics ranged from the WSCC components of school health to physical education and activity (recess strategies) to mental health resources. The recorded sessions, including the latest guidelines for schools, are available to the general public to assist in information and resources sharing for reopening planning.

As detailed above the COVID-19 pandemic has had an unprecedented impact on schools nationwide, and ongoing risk mitigation and student response plans will be an important part of the school planning landscape for the foreseeable future. Our immediate response has included an executive summary of survey results with resources on reopening plans and risk mitigation plans to foster information sharing as well as links to webinars designed to assist schools in keeping students and staff safe and supported.

Limitations

There are several limitations within the study design that should be addressed. Although we have representation from 45 states, the sample size only accounts for 5% of ASHA members. Further, over half of our respondents were school nurses, whose perspectives may not be representative of other school staff (administrators, school counselors, food service, etc.). Our respondents were largely non-Hispanic, white, females, which is likely influenced by the large proportion of school nurses.22 This leads to less generalizable results. Additionally, we must consider the timing of our survey. A survey completed a month later may have yielded different results due to the
We propose several implications below: as they work to improve student and staff health.

ongoing gaps and changing needs.

in response to the pandemic. Understanding staff health impacts of COVID-19, many of which are still unknown. Schools reopened in the fall and continue to shift between virtual, hybrid and in-person instruction, an unknown. This is similar to several other surveys utilized during this time. The authors also acknowledge that schools have reopened since the survey was conducted, but the ongoing shifts in instruction (in-person, remote, and hybrid) due to the fluctuations in the pandemic still make the findings and concerns relevant.

Conclusions

Regardless of location and school level, our survey of ASHA school staff clearly indicates similar challenges and risk prioritization. School staff focus on the physical challenges of school reopening may leave staff ill-prepared to address the mental and physical health impacts of COVID-19, many of which are still unknown. Schools reopened in the fall and continue to shift between virtual, hybrid and in-person instruction in response to the pandemic. Understanding staff concerns within the context of the WSCC model better positions the school community to effectively address ongoing gaps and changing needs.

IMPLICATIONS FOR SCHOOL HEALTH AND EQUITY

Our findings may further assist school administrators as they work to improve student and staff health. We propose several implications below:

• Create an opportunity to advocate for a focus on school health including the creation of school health teams that involve all WSCC components. These teams facilitate space for communication and coordination around the health and well-being of students. This structure provides flexibility as circumstances change regarding the current pandemic or with the emergence of new school health challenges.

• Administer staff support for ongoing professional development opportunities to enhance self-efficacy for communicating with students and families during learning transitions (in-person, virtual, and hybrid). This can be accomplished in partnership with local public health agencies and/or utilization of the previously mentioned resources.

• Encourage the creative use of technology by school nurses and guidance counselors to interface with families regarding students’ chronic medical conditions and mental health concerns, respectively. When possible, schools should work with the district’s information technology (IT) department to better understand their technological options. Surveys can be utilized to determine the most accessible technology platforms available to students and families as schools navigate learning transitions.

• Redesign mass school health screenings to be conducted in small, socially distant groups. Encourage collaboration with local hospitals and health care providers to assist school nurses in the administration of required screenings.

Human Subjects Approval Statement

This study was approved by the Penn State College of Medicine Institutional Review Board (IRB #15176) with an exempt determination. All participants gave their implied consent to participate through completion of the survey.

Conflict of Interest

All authors declare no conflicts of interest.

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