This packet is an introduction and brief summary of information related to the strategy listed below. It is not exhaustive and is intended to be a starting point for the conversations that will take place at the Next Steps event. Your expertise and experience with this topic will help to fill in gaps and round out the conversation.

Strategy: Build capacity around the coordinated school health model

Group Charge: Create a plan for implementation of the Whole School, Whole Community, Whole Child model in the St. Louis City/County region via building infrastructure and capacity to support schools and school leaders.

WHAT WE KNOW

Background

In general

- Health and education are interrelated
  - Higher levels of education are associated with good health, and children and families in good health tend to have better education-related outcomes.[1]
- Health affects education
  - Factors related to health affect the ability to learn[2,3,4,5] which in turn, impacts whether a student completes high school.[6]
  - Childhood illness, mental health problems, and poor school performance and risky behaviors can lead to high school dropout.[7]
    - The effects of childhood illness on education are influenced by access and utilization of medical care.[8]
    - Mental health issues are often not identified or treated and can lead to poor school performance or dropout.[8]
    - Students who earn low grades are more likely to engage in risky behaviors,[9] which can then lead to school dropout.
- Education affects health
  - Americans with less education are more likely to have health problems, to smoke, and to be obese.[10,11]
  - American adults without a high school diploma are likely to die 9 years sooner than college graduates.[11]

About this strategy

- As a place where children spend a significant amount of time, school plays an important role in their health and development and can be a central point for coordinating the delivery of health programs.[6]
- The Centers for Disease Control and Prevention (CDC) recommend integrating health-promoting practices into the school setting12 and established a coordinated school health (CSH) model in 1987.[13]
  - Creating a CSH plan can help identify and eliminate gaps in services, prevent duplication, develop partnerships, and improve communication among school health professionals, educators, and families.[6]

- ASCD (formerly known as the Association for Supervision and Curriculum Development) established the Whole Child Initiative to help move educational goals beyond academic achievement and towards the development and success of the whole child.[13]
- In March 2014, the ASCD and CDC developed the Whole School, Whole Community, Whole Child (WSCC) model to integrate their approaches.[13] See **Appendix A: Whole School, Whole Community, Whole Child** for more information on the new model. The WSCC model consists of ten components:[13]
    - Health education
    - Physical education and physical activity
    - Nutrition environment and services
    - Health services
    - Counseling, psychological, and social services
    - Social and emotional climate
    - Physical environment
    - Employee wellness
    - Family engagement
    - Community involvement

Figure 1: Whole School, Whole Community, Whole Child model

Source: Centers for Disease Control and Prevention. (2015). Adolescent and School Health. Whole School, Whole Community, Whole Child. Retrieved from http://www.cdc.gov/healthyyouth/wscc/index.htm. Accessed 1/7/2016.

Effectiveness

- CSH programs can help improve academic success by reducing student absenteeism and dropout rates.[6]
- Interventions within the CSH framework that focus on specific areas, such as childhood obesity, physical activity, and nutrition, have been found to be effective, but very little research or evaluation addresses the health effects of the full CSH model.[14]
- Research also has found that CSH programs have a positive effect on academic outcomes, such as gains in reading, improvements in achievement test scores, grade improvement, attendance rates, and high school completion.[15]

Need In St. Louis

Health outcomes

- Compared with white students, African American students experience five times the rate of injuries from violence and 11 times the rate of asthma-related visits to the emergency room. [6]
- African American youth report higher rates of diagnosis for mental health problems (28% vs 12%),[16] are more likely to visit the emergency room for mental health conditions (rate of 3.7 vs 7.0 per 1,000 individuals under age 15),[17] and have a higher rate of hospitalizations for mental health conditions (rate of 38.9 vs 58.4 per 10,000 individuals under age 15).[18]
- African American teens in St. Louis City and St. Louis County are three to four times more likely to become pregnant compared with white teens.[19]
- African American teens, age 15-19, in St. Louis are significantly more likely to contract chlamydia (10 times more likely in City; 17 times more likely in County) and gonorrhea (21 times more likely in City; 34 times more likely in County).[20]

Education outcomes

- Compared with white students, the proportion of African American students who are frequently absent from school is twice as high, the high school dropout rate is five times higher, and the proportion of third graders with below-basic English Language Arts proficiency is six times higher. [6]
- A high percentage of African American students are performing at the below basic level on the MAP eighth grade math test, and several districts also have high rates of African American students classified as below the basic level in Algebra I.[1]

Current state of CSH in Missouri

- The number of schools that restrict unhealthy foods is increasing in Missouri.[6] However, there have been declines in the percent of secondary schools with a school health council, community involvement on school health councils, and proportion of schools with a school health coordinator.[6]

PLANNING & IMPLEMENTING A WHOLE SCHOOL, WHOLE COMMUNITY, WHOLE CHILD PROGRAM

Best Practices

Key components based on lessons learned from CSH and whole child approaches:

- **Infrastructure** within the school and district to support health-related activities, such as: [14]
  - School health coordinator;
  - District-level school health advisory/coordinating council; and/or
  - School-level health teams/committees
    - Councils or teams include school or district representatives from all 10 components, as well as community members, parents, and students.
- Systematic **assessment** to identify and prioritize health-related needs and plan for how to address the needs[14]
  - Possible tools are School Health Index and Healthy School Report Card.
  - Key elements of this component:
    - Use data
    - Define priorities
    - Assess resources
    - Develop goals and objectives
    - Develop action plan with timeline
- Strong **leaders**/champions and administrative **support** and **buy-in** to help overcome challenges and sustain commitment.[14,21]
- Community involvement to shift school culture and provide resources[14]

For more information, see **Appendix B: Lessons Learned from the Whole Child and Coordinated School Health Approaches**.

Putting the Model into Action[22]

- Form a committee of individuals who represent all 10 components of the WCCC model, as well as other school staff, the school administrator, and individuals who represent students, families, and the community.
- Conduct a needs assessment to determine health-risk behaviors, health-promoting behaviors, and the relationship between these behaviors and academic achievement.
  - Data can be collected from nationally available data (e.g., YRBSS), locally available data (e.g., county health department), or school-specific data (e.g., breakfast or lunch meal counts).
- Identify priority health-related areas and set realistic expectations with clear outcome indicators.
- Determine the relationship between the identified health-related outcomes and academic achievement. Working on areas that have a clear relationship with academic achievement will increase participation and engagement.
- Identify and select interventions that have been found to be promising or effective, while keeping staff capacity in mind.
- Engage the individuals who will be implementing the program to determine how the interventions will be coordinated.
- Invite other organizations outside of the school/district to be a part of the committee.
- Create a concrete action plan with timelines and assignments for each activity.
- Develop a process and outcome evaluation plan.
- Implement and monitor the implementation of the action plan.

For this to become a regional priority, a coordinating group is necessary to convene key stakeholders, advocate for the WCCC model, and offer technical assistance and evaluation support to districts and schools.

For more information, see **Appendix C: A Whole School Approach: Collaborative Development of School Health Policies, Processes, and Practices**.

Cost Estimate[23]

CDC outlined eight priority actions for states to take to support school health programs and provided cost estimates for each area. The priority areas and cost estimates are intended for states and are not guidelines for schools or school districts. The priority areas and cost estimates are described below: Having this information may assist regional actors in advocacy for increased school health support at the state level.

- Monitor critical health-related behaviors and the effectiveness of school policies and programs in promoting health-enhancing behaviors and better health.
    - $50,000 for states to complete YRBS every 2 years
- Establish and maintain dedicated program-management and administrative-support systems at the state level.
    - $200,000 to support key positions in health and education agencies each year
- Build effective partnerships among state-level governmental and nongovernmental agencies and organizations.
    - $5,000 to support interagency program committee activities each year
    - $10,000-$25,000 to support a state school health coordinating council each year
- Establish policies to help local schools effectively implement coordinated school health programs and CDC's school health guidelines.
    - No specific cost estimate, but states should allocate sufficient funds for a school health council, school health coordinator, and school health program in all districts.
- Establish a technical assistance and resource plan that will provide local school districts with the health they need to effectively implement school health guidelines.
    - $120,000 to support personnel, technical assistance delivery, and resource development each year
- Implement health communications strategies to inform decision makers and the public about the role of school health programs in promoting health and academic success among young people.
    - $25,000 to support communications personnel and the implementation of a school health communications plan each year
- Develop a professional development plan for school officials and others responsible for establishing coordinated school health programs and implementing of CDC's school health guidelines.
    - $120,000 for professional development each year
- Establish a system for evaluating and continuously improving state and local school health programs
    - $24,000 to support evaluation efforts.

TOTAL: $529,000 to $544,000 annually

For more information, see **Appendix D: Building a Healthier Future Through School Health Programs**.

Examples

Locally

- Operated by St. Louis Children's Hospital, Healthy Kids Express is a mobile outreach program that partners with school districts, day care centers, and Head Start programs to provide screenings, immunizations, and dental care treatment to 20,000 children in our region.[6]

Nationally

- The Indiana and Michigan Departments of Education and Health and Great Lakes American Cancer Society worked together to develop the MICHIANA School Health Leadership Institute.[6] The Institute offers training to district teams to help them successfully implement coordinated school health programs, along with ongoing support and technical assistance.
- In 2006, advocates convinced Tennessee state policy-makers to fund $15 million to expand coordinated school health throughout the state.[6] Every school in Tennessee was required to conduct the CDC's School Health Index, an assessment and planning tool for coordinated school health. Collaboration and partnership were key elements of this success story.
- The state health and education departments in Arkansas work together to operate the Coordinated School Health Program (CSHP) in school districts across the state. [21] The program is supported by state laws addressing body mass index screening, physical activity requirements, a state-level Child Health Advisory Committee, and the establishment of a wellness committee in each school district. The state also established 22 school-based health centers across the state.
- State health and education departments in Kentucky have worked to increase awareness, adoption and implementation of CSH.[21] Buy-in from leadership has facilitated the adoption of policies to support healthier schools and student, such as the Program Review process. The Program Review assesses and sets standards for the integration of health into school-level policies.

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