Coordinated School Health

2018-19 Annual Report

Tennessee Department of Education | October 2019

Cover image provided by Maury County Schools

Table of Contents

Introduction 3
- Coordinated School Health 3
- Tennessee Data 4
- CSH Infrastructure 7

CSH Components 8
- Health Services 8
- Physical Education & Physical Activity 10
- Nutrition Services 10
- School Counseling, Psychological, and Social Services 11
- Healthy School Environment 12
- Health Education 12
- School Staff Wellness 13
- Students, Family, and Community Involvement 13

Conclusion 14

References 15

Introduction

There are many factors that play a role in the success of our children. According to the Centers for Disease Control and Prevention (CDC), "the academic success of America's youth is strongly linked with their health. Health-related factors such as hunger, physical and emotional abuse, and chronic illness can lead to poor school performance." Additionally, health-risk behaviors such as early sexual initiation, violence, and physical inactivity are consistently linked to poor grades and test scores and lower educational attainment (Dunkle, Carlson, Spriggs, 2008).

In turn, academic success is an excellent indicator of the overall well-being of youth and a primary predictor and determinant of adult health outcomes. Leading national education organizations recognize the close relationship between health and education, as well as the need to foster health and well-being within the educational environment for all students.

Scientific reviews have documented that school health programs can have positive effects on educational outcomes, as well as health-risk behaviors and health outcomes (Harper, 2007). Similarly, programs that are primarily designed to improve academic performance are increasingly recognized as important public health interventions.

Coordinated school health (CSH) is an evidence-based model developed by the CDC designed to promote healthy school environments so children arrive at school ready to learn. In 2006, Tennessee became the only state in the nation with a legislative mandate and $15 million in state funding per year to implement CSH in all school districts. CSH funding can be used to hire a coordinator or support staff and purchase basic materials and resources necessary to implement CSH, thereby advancing student health and improving academic outcomes. Coordinated school health is comprised of eight components: 1) health education, 2) physical education/physical activity, 3) health services, 4) school counseling, psychological, and social services, 5) nutrition, 6) healthy school environment, 7) staff wellness, and 8) student, family, and community involvement.

This report provides information on CSH programmatic outcomes and selected student health indicators data in Tennessee for the 2018-19 school year.

Coordinated School Health

Historically, school health programs and policies in the United States have resulted, in large part, from a wide variety of federal, state, and local mandates, regulations, initiatives, and funding streams. Prior to statewide implementation of CSH in Tennessee, many schools had a "patchwork" of policies and programs regarding school health with differing standards, requirements, and populations served. Professionals who oversaw the different pieces of the patchwork came from multiple disciplines: education, nursing, social work, psychology, nutrition, and school administration, each bringing specialized expertise, training, and approaches. The statewide coordinated school health initiative helped to streamline school health programs across the state and provide consistency for students.

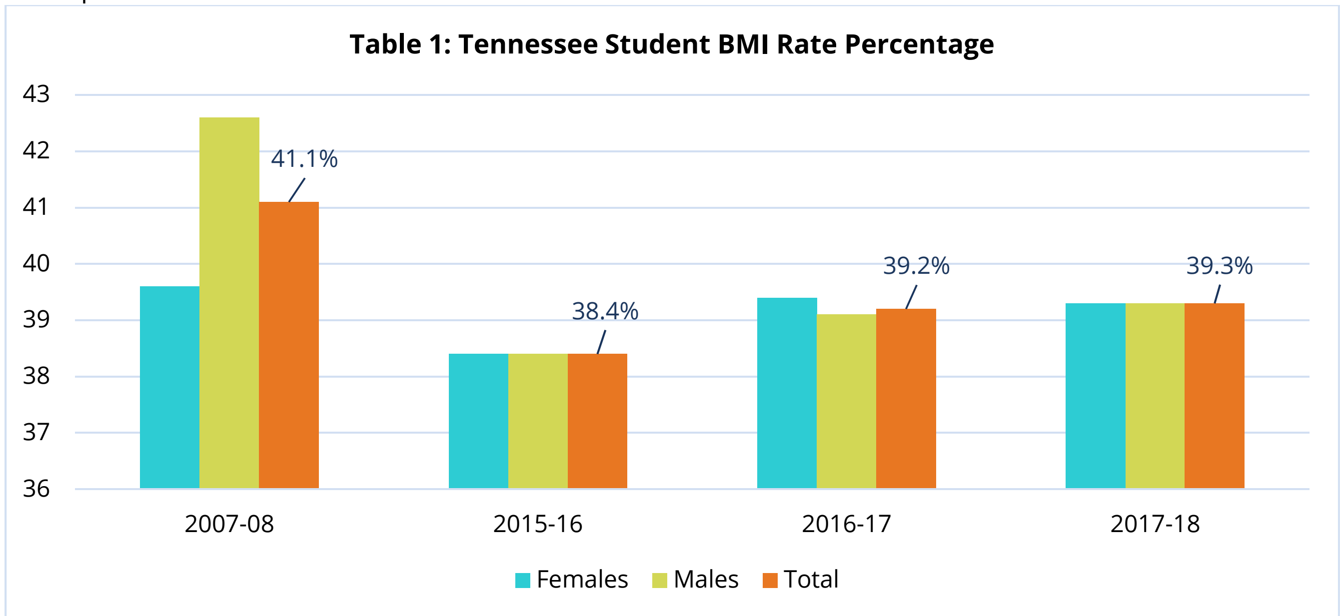
Coordinating the many parts of school health into a systematic approach enables schools to:

- eliminate gaps and reduce redundancies across initiatives and funding streams;
- build partnerships and teamwork among school health and education professionals;
- build collaboration and enhance communication among public health, school health, and other education and health professionals in the community; and

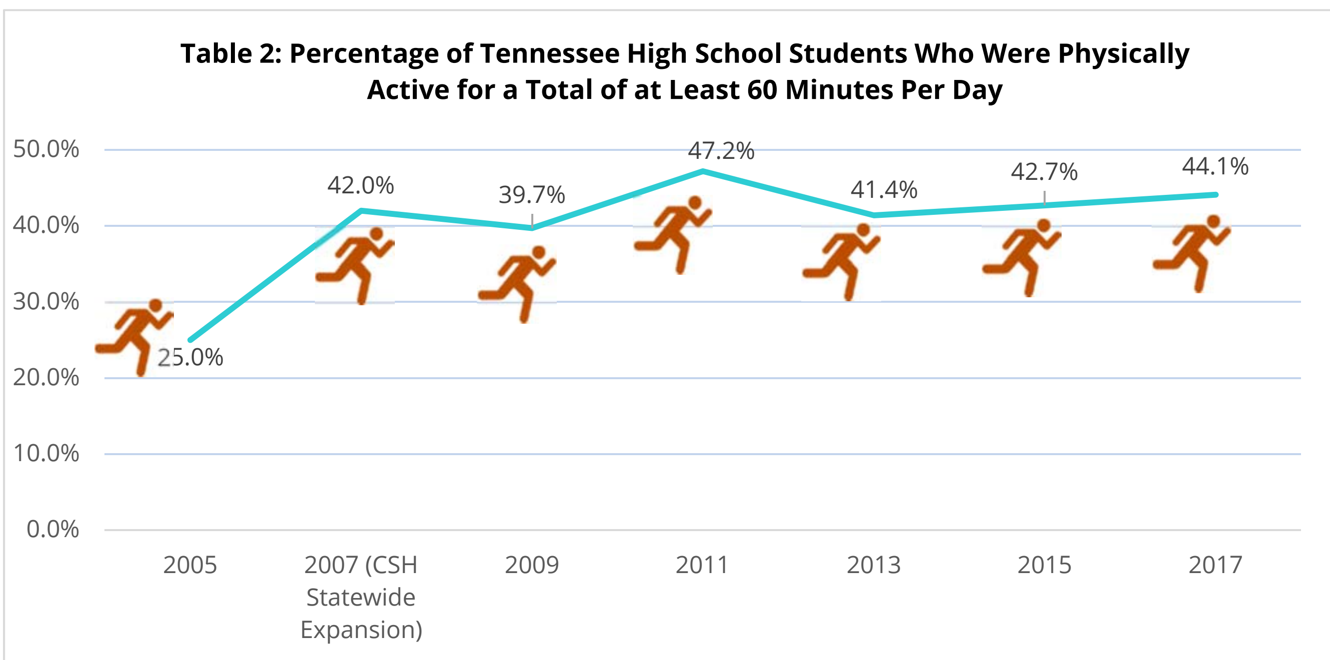
- focus efforts on helping students engage in protective, health-enhancing behaviors and avoid risky behaviors.

Tennessee Data

As indicated in Table 1, Tennessee student body mass index (BMI) rates declined from **41.14** percent in 2007-08 to **38.4** percent in 2015-16, but for the past three years BMI rates have plateaued to an average of **39.97** percent.

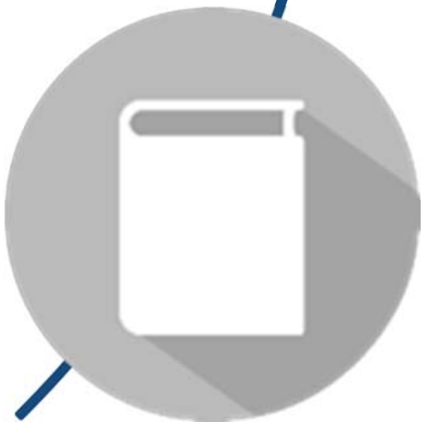


As indicated in Table 2, according to the CDC's Youth Risk Behavior Survey (YRBS), the percentage of Tennessee students who were physically active for a total of at least 60 minutes per day on five of the past seven days substantially **increased** from **25 percent** in 2005 to **44.1 percent** in 2017 (CDC, 2017a).



CSH district coordinators secured an **additional $36 million** in health grants and in-kind resources for Tennessee schools in the 2018-19 school year, which were used to expand local capacity to address school health priorities. CSH district coordinators have also used CSH state or federal grant funds along with resources from community partners to provide **71** schools with walking tracks/trails, **74** schools with in-school fitness rooms for students, and **73** schools with new and/or updated playgrounds.

During the 2018-19 school year, **72 percent** of districts contracted or worked with a community-based mental health provider to provide school-based therapy for students.

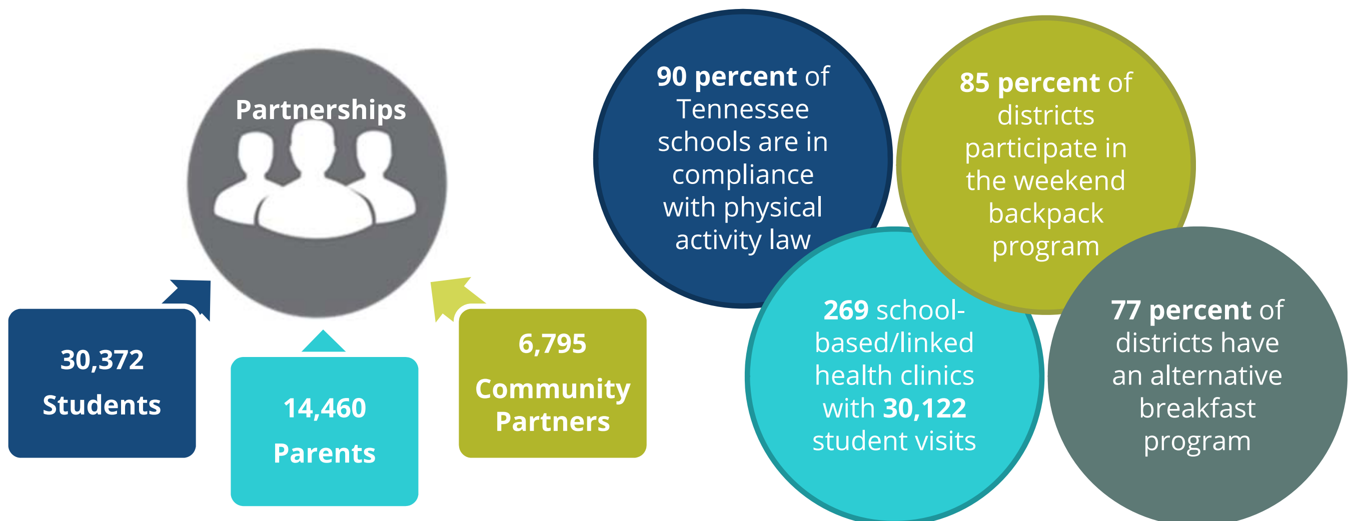


During the 2018-19 school year, there were **5,091,191** student visits to a school nurse. **4,439,882** of those visits resulted in a student's ability to return to class instead of being sent home which results in an **87 percent** return-to-class rate.

Approximately **1.4 million** student health screenings occurred in Tennessee public schools. Those screenings resulted in **89,432** referrals being made to a health care provider for additional medical attention through parental notification. Only **23,215** or **26 percent** of those referrals were confirmed with a school staff member.

Finally, **269** schools have a school based/linked health clinic and **80 percent** of those use telemedicine to provide services.

Parent and student partnerships are emphasized in all aspects of CSH. In the 2018-19 school year, CSH district coordinators worked with **6,795** different community partners and coalitions. Also, CSH statewide partnered with **30,372 students** and **14,460 parents** to address school health priorities (Tennessee Department of Education, 2019b).



Ongoing Challenges

The total number of students with chronic illnesses or disability diagnoses increased by **100 percent** between 2004-05 and 2018-19.

Only **60 percent** or **1,734** schools employed a nurse full time in their school.

Only **43 percent** of districts provide mental health support to staff.

Only **20 percent** of districts report meeting the goal of one certified social worker for every 1,500 students.

Only 35 percent of districts meet the goal of one certified psychologist for every 1,000 students.

The rate of Tennessee high school students reporting they attended daily physical education classes in an average week declined from **30 percent** in 2005 to **26 percent** in 2017.

CSH Infrastructure

According to Tennessee State Board of Education's *Standards and Guidelines for Tennessee's Coordinated School Health Policy 4.204,* the following infrastructure elements must be in place in every school district in order to implement the CDC's evidence-based CSH model with fidelity:

Each district will establish a full-time position for a coordinator/supervisor of school health programs at the system level for school systems with 3,000 or more students. School systems with fewer than 3,000 students will establish a position for coordinator/supervisor of school health programs at 50 percent time or more and are encouraged to enter into a consortium with other school systems to apply for funding. The coordinator/supervisor position in both cases will be in addition to other school health component staff and school system coordinator/supervisor positions.

The policy additionally requires that each district establish the following:

- *A School Health Advisory Council (SHAC) that includes a representative of the school system(s), staff, students, parents, civic organizations, community agencies, the faith community, minority groups, and others concerned with the health and wellness of students with at least two-thirds of the members being non-school personnel. The Advisory Council will recommend policies and programs to the school system and also develop and maintain an active working relationship with the county health council.*
- *A Staff Coordinating Council on School Health for the school system that is representative of all eight components of the coordinated school health program. The Staff Coordinating Council will seek to maximize coordination, resources, services, and funding for all school health components.*
- *A Healthy School Team at each school in the system that is representative of all eight components of the coordinated school health program. The team will include the principal, teachers, staff, students, parents, and community members with at least one-half of the team members being non-school personnel. The Healthy School Team will assess needs and oversee the planning and implementation of school health efforts at the school site.*

Additionally, districts are required to:

- *develop and maintain local school system policies that address and support coordinated school health and each of the integrated components*;
- *develop and maintain a staff development system for orienting and training administrators, principals, and other school leadership team members that allows for informed decision making in adopting and implementing the coordinated school health model at the school system and school level*;
- *develop and maintain a system of assessing and identifying the health and wellness needs of students, families, and staff that will be used in developing system policies and strategic plans; school health programs, curriculum and initiatives; and school improvement plans*;
- *incorporate into all School Improvement Plans (SIP), easy-to-implement and appropriate assessments and surveys, improvement strategies and services, and integrated learning activities that address the health and wellness needs of students and staff*;
- *identify and obtain additional financial support and program collaboration with community agencies/organizations along with other external financial support to supplement the Basic Education Program (BEP) funding formula and the additional CSH funding provided for the school health program*; *and*
- *develop and maintain a system and process for annual evaluation of progress and outcomes for the coordinated school health program effort, including the impact on the student performance indicators required by the State Board of Education in TCA § 49-1- 211(a) (3) and any state-designated health outcomes for students and staff.*

CSH Components

Health Services

In 2017, the National Association of School Nurses (NASN) and the American Academy of Pediatrics (AAP) recommend that school districts provide a full-time school nurse in every school building. When schools employ a full-time nurse, there is a reduction in the achievement gap that students with chronic health conditions face; students are less likely to miss school due to illness, and smaller nurse-to-student ratios are associated with lower absenteeism rates and higher graduation rates. A student's health is directly related to his or her ability to learn. Children with unmet health needs have a difficult time engaging in the educational process. The school nurse supports student success by providing health care through assessment, intervention, and follow-up for all children within the school setting. The school nurse addresses the physical, mental, emotional, and social health needs of students and supports their achievement in the learning process.

Components of the Whole School, Whole Community, Whole Child model (2017) emphasizes that health services in schools should be provided and/or supervised by school health nurses or other qualified health professionals in order to properly appraise, protect, and promote the health of students. School health services include providing first aid, providing emergency care and assessment, and planning for the management of chronic conditions (e.g., asthma or diabetes).

The figure below represents health services data from the 2018-19 school year (Tennessee Department of Education, 2019c).

Eighty-seven percent of visits to the school nurse resulted in a return to class.

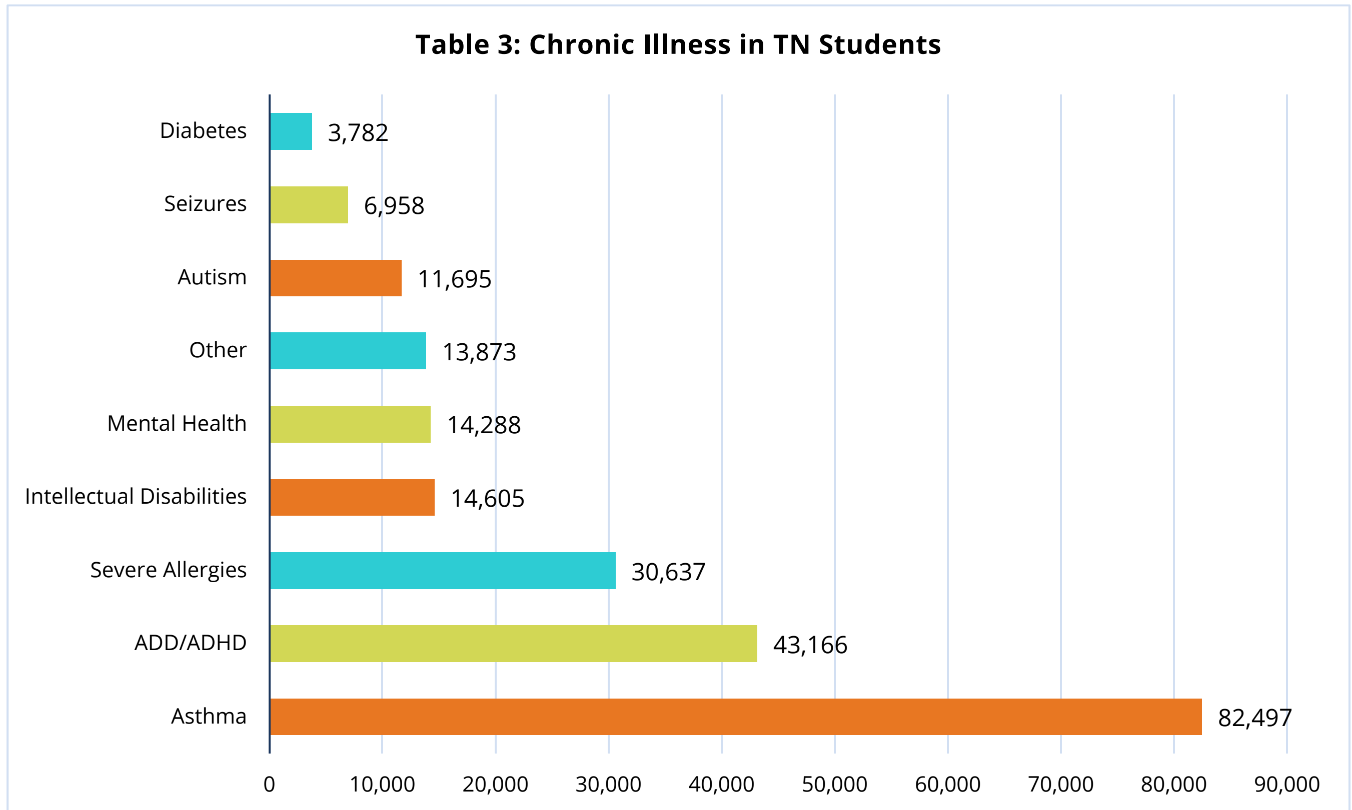
1,401,025 health screenings were conducted in schools.

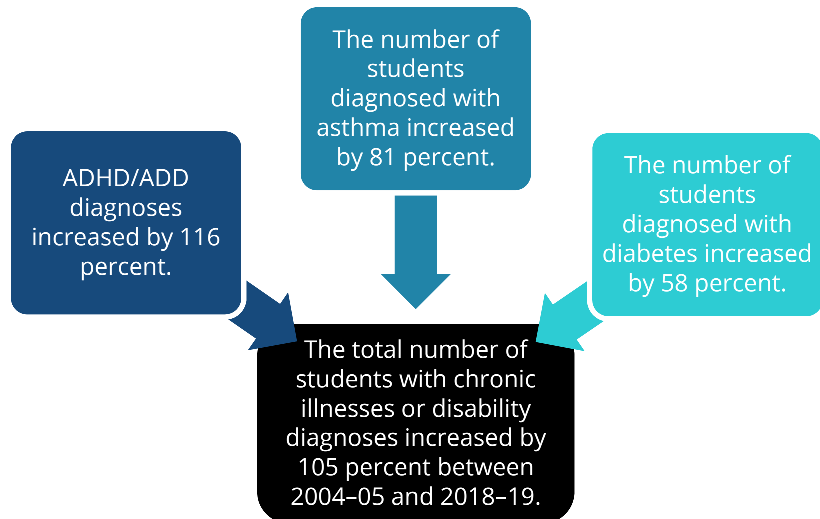
Of the **1,401,025** screenings conducted, **89,432** resulted in a referral.

221,501 students have a chronic illness or disability diagnosis.

Table 3 below provides evidence for the increased need for qualified health professionals in Tennessee schools, such as school nurses. During the 2018-19 school year, **221,501** students in Tennessee public schools had a chronic illness or disability diagnosis. Of those students with a diagnosis, the most common were asthma (**37 percent**), ADHD/ADD (**19 percent**), and severe allergies (**14 percent**) (Tennessee Department of Education, 2019c).

The figure below represents data on chronic illnesses or disabilities in the 2018-19 school year.





Physical Education & Physical Activity

All children in Tennessee should be exposed to both quality physical education and physical activity programs. A Comprehensive School Physical Activity Program (CSPAP) is a multi-component approach by which school districts and schools use all opportunities for students to be physically active, meet the nationally recommended 60 minutes of physical activity each day, and develop the knowledge, skills, and confidence to be physically active for a lifetime. A CSPAP reflects strong coordination and synergy across all of the components: physical education as the foundation; physical activity before, during, and after school; staff involvement; and family and community engagement (Shape America, 2017).

Physical education is an academic subject and serves as the foundation of a CSPAP. Physical education is characterized by planned, sequential pre-K through grade 12 curriculum that is based on the national and state standards for physical education. Physical education provides cognitive content and instruction designed to develop motor skills, knowledge, and behaviors for healthy active living, physical fitness, sportsmanship, self-efficacy, and emotional intelligence (Shape America, 2017)

Physical activity in schools can be offered in a variety of settings throughout the day including before and after school. Physical activity should be in addition to the essential physical education class, not a replacement. The most common ways students engage in physical activity include recess, integration into classroom lessons, physical activity breaks, exercise clubs, and intramural programs (Shape America, 2017).

Highlights of physical education and physical activity in districts during the 2018-19 school year include (Tennessee Department of Education, 2019b):

- Since the implementation of CSH statewide, coordinators have secured funds for walking tracks or trails at **555** schools, **374** in-school fitness rooms for students, and **444** new and/or updated playgrounds.
- **27** new physical activity/physical education policies and guidelines were approved.
- Out of 136 districts, **64 percent** reported that they do not deny physical education as a form of punishment.

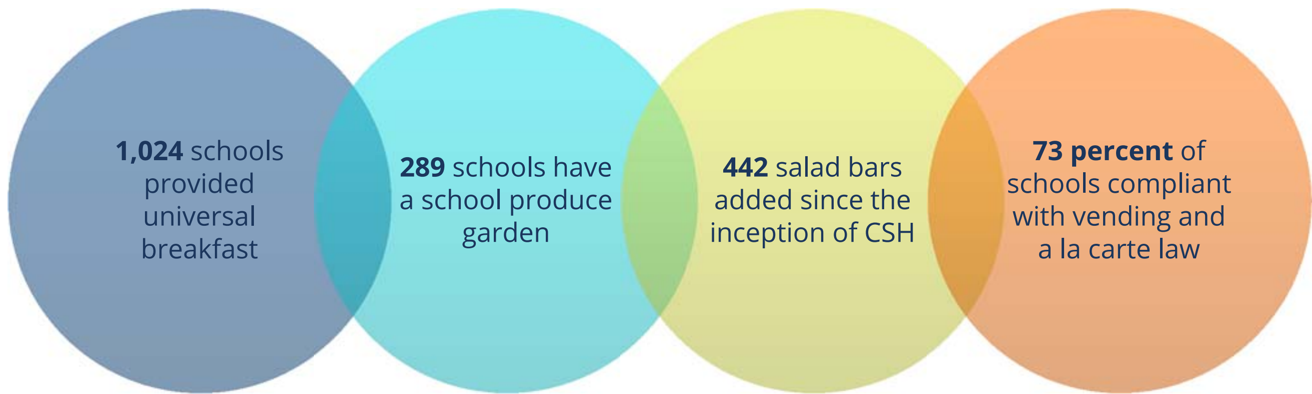
Nutrition Services

According to the Food Research & Action Center (2016), behavioral, emotional, mental health, and academic problems are more prevalent among children and adolescents struggling with hunger, and these students statistically have lower academic scores and grades compared to their peers.

School nutrition offers students opportunities to learn about and practice healthy eating through the foods and beverages served on school grounds, nutrition education, and communications about food in the cafeteria and throughout the school campus. Whole School, Whole Community, Whole Child (2015) states students typically have access to foods and beverages in numerous locations within the school, including the cafeteria, vending machines, grab ‘n’ go kiosks, schools stores, concession stands, classroom rewards, classroom parties, school celebrations, and fundraisers.

The School Nutrition program is responsible for providing nutritious meals and snacks for students in schools. School Nutrition administers the USDA's National School Lunch Program, School Breakfast Program, and Afterschool Snack Program across the state. According to School Nutrition (2017), all public schools in Tennessee are on the National School Lunch Program, which provides nutritionally balanced, low-cost, or free lunches to children each school day.

Highlights of nutrition services in school districts during the 2018-19 school year include (Tennessee Department of Education, 2019b):



School Counseling, Psychological, and Social Services

One in five youth live with a mental health condition, but less than half of these individuals receive needed services. Undiagnosed, untreated, or inadequately treated mental health conditions can affect a student's ability to learn, grow, and develop (National Alliance on Mental Illness, n.d.).

Counseling, mental health, and social services are provided to assess and improve the mental, emotional, and social health of students. Schools offer services such as developmental classroom guidance activities and preventative educational programs in an effort to enhance and promote academic, personal, and social growth. Students who may have special needs are served through individual and group counseling sessions, crisis intervention for emergency mental health needs, family/home consultation, and/or referrals to outside community-based agencies when appropriate. The professional skills of counselors, psychologists, and social workers are utilized to provide coordinated "wrap-around" services that contribute to the mental, emotional, and social health of students, their families, and the school environment.

Highlights of school counseling, psychological, and social services in school districts during the 2018-19 school year include (Tennessee Department of Education, 2019b):

- 1,553 counselors were provided professional development organized or funded by CSH.
- 99 percent of districts met the goal of one certified counselors per 500 students.
- 27 new or updated policies and guidelines were developed or approved.

Healthy School Environment

A healthy and safe school is defined by the physical and aesthetic surroundings and the psychosocial climate and culture of the school. A healthy and safe school environment supports positive learning by ensuring the health and safety of students and staff. A healthy physical environment includes the school building and its contents, the property on which the school is located, and the area surrounding it. [23] The quality of the psychological environment includes the physical, emotional, and social conditions that affect the safety and well-being of students and staff.

Highlights from the 2018-19 school year include (Tennessee Department of Education, 2019b):

- The number of schools providing bullying prevention programs to students increased from **744** schools during the 2011-12 school year to **1,347** schools in the 2018-19 school year.
- **99 percent** of districts reported that all schools have an active safety team; **100 percent** adopted a comprehensive district-wide safety plan.
- **546** schools implemented an air quality management program such as Tools for Schools.
- **87** percent of districts applied for the department's Safe Schools grant funding.
- **1,268** full-time school resource officers are allocated to school districts to serve general education students.

Health Education

Health education is as important as other academic subjects and is critical to students' education and development. Appropriate Practices in School-Based Health Education (2015) states the time, instruction, and support devoted to health education should be comparable to that of other subjects.

73 percent of coordinators partner with county health departments to address teen pregnancy prevntion

99 districts have district-wide comprehensive health education policies/guidelines

100 percent of districts use health education curricula to address tobacco/nicotine/vaping prevention

Health education helps students acquire the knowledge, attitudes, and skills they need for making health-promoting decisions, achieving health literacy, adopting health-enhancing behaviors, and promoting the health of others. Comprehensive school health education includes curricula and instruction for students in pre-K through grade 12 that address a variety of topics such as alcohol and drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity, safety and injury prevention, sexual health, tobacco use, and violence prevention (Whole School, Whole Community, Whole Child, 2015).

School Staff Wellness

Wellness opportunities such as health assessments, health education, and physical fitness activities are provided to all school staff, including the administrators, teachers, and support personnel, to improve their health status. These opportunities encourage staff to pursue a healthy lifestyle that contributes to their improved health status, improved morale, and greater personal commitment to the overall coordinated school health program. This personal commitment often transfers into greater commitment to the health of students and serving as positive role models. Health promotion activities conducted on-site improve productivity, decrease absenteeism, and reduce health insurance costs.

Highlights of health promotion for staff in school districts during the 2018-19 school year include (Tennessee Department of Education, 2019b):

93 percent of districts offer school staff the influenza vaccine as part of their staff wellness program

206 school-based health clinics provide **3,531** school staff with health-related services.

330 schools have fitness rooms for staff. **Eighty percent** are the result of CSH funding or involvement.

Students, Family, and Community Involvement

The involvement of parents, community representatives, health specialists, and volunteers in schools provides an integrated approach for enhancing the health and well-being of students both at school and in the community. School health advisory councils, coalitions, and broadly-based constituencies for school health can build support for school health programs. School administrators, teachers, and school health staff in all components actively solicit family involvement and engage community resources, expertise, and services to respond effectively to the health-related needs of students and families.

Highlights of students, parents, and community partners in school districts during the 2018-19 school year include (Tennessee Department of Education, 2019b):

89 percent of districts have developed a policy/guideline/protocol to allow communities to use school buildings/grounds when schools are not in session (joint-use agreements).

99 percent of school districts have partnered with their county/regional health department during the 2018-19 school year to provide health education and health services.

100 percent of districts reported that they partnered with students to achieve CSH goals.

Conclusion

Coordinated school health encourages healthy lifestyles, provides needed supports to at-risk students, and helps to reduce the prevalence of health problems that impair academic success. It is an effective approach designed to connect physical, mental, and social health with learning. CSH improves children's health and their capacity to learn through the support of families, communities, and the schools working together. CSH is an invaluable framework that creates and sustains healthy schools and healthy children.

References

America Association of School Administrators. (2007). AASA position statements. Position statement 3: Getting children ready for success in school, July 2006; Position statement 18: Providing a safe and nurturing environment for students; July 2007.

Appropriate Practices in School-Based Health Education. (2015). Retrieved September 6, 2017, from http://www.shapeamerica.org/publications/products/upload/Appropriate-Practices-in-School-Based-Health-Education.pdf

Association for Supervision and Curriculum Development. (2011). Making the Case for Educating the Whole Child. Alexandria, VA.

Basch, C.E. (2010). Healthier Students Are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap. *Equity Matters*: Research Review No. 6. New York: Columbia University.

Carlson S.A., Fulton J.E., Lee S.M., Maynard M, Drown DR, Kohl III H.W., Dietz W.H. (2008). Physical education and academic achievement in elementary school: data from the Early Childhood Longitudinal Study. *American Journal of Public Health* 2008; 98(4):721–727.

Centers for Disease Control and Prevention (CDC). (2018). Tennessee high school youth risk behavior survey data, 2005-2017. Retrieved September 1, 2019, from http://www.cdc.gov/healthyyouth/yrbs/index.htm

Centers for Disease Control and Prevention (CDC). (2010). The association between school-based physical activity, including physical education, and academic performance. Atlanta, GA: U.S. Department of Health and Human Services.

Components of the Whole School, Whole Community, Whole Child (WSCC). (2015). Retrieved September 6, 2017, from https://www.cdc.gov/healthyschools/wscc/components.htm.

Council of Chief State School Officers. (2004). Policy Statement on School Health.

Division of Population Health, Centers for Disease Control and Prevention. (2014). Health and Academic Achievement. Retrieved September 6, 2017, from https://www.cdc.gov/healthyyouth/health_and_academics/pdf/health-academic-achievement.pdf

Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion. (2017). Managing Chronic Health Conditions in Schools: The Role of the School Nurse. Retrieved from https://www.cdc.gov/healthyschools/chronic_conditions/pdfs/2017_02_15-FactSheet-RoleOfSchoolNurses_FINAL_508.pdf.

Dunkle M.C., Nash M.A. (1991). *Beyond the Health Room*. Washington, DC: Council of Chief State School Officers, Resource Center on Educational Equity.

Food Research & Action Center. (2016). Research Brief: Breakfast for Learning. Retrieved September 6, 2017, from http://frac.org/wp-content/uploads/breakfastforlearning-1.pdf

Freudenberg N, Ruglis J. (2007). Reframing school dropout as a public health issue. *Preventing Chronic Disease* 2007; 4(4):A107.

Harper S, Lynch J. (2007). Trends in socioeconomic inequalities in adult health behaviors among U.S. states, 1990–2004. *Public Health Reports* 2007; 122(2):177–189.

Muenning P, Woolf SH. (2007). Health and economic benefits of reducing the number of students per classroom in US primary schools. *American Journal of Public Health* 2007; 97:2020–2027.National Alliance on Mental Illness. (n.d.). Mental Health in Schools. Retrieved from https://www.nami.org/Learn-More/Public-Policy/Mental-Health-in-Schools

National Center for Health Statistics. (2011). *Health, United States, 2010: With Special Feature on Death and Dying*. Hyattsville, MD: U.S. Department of Health and Human Services.

National School Boards Association. (2009). Beliefs and Policies of the National School Boards Association. Alexandria, VA: National School Boards Association.

School Nutrition. (n.d.). Retrieved September 1, 2017, from http://www.tennessee.gov/education/topic/school-nutrition.

SHAPE America. (n.d.). Retrieved September 1, 2017, from www.shapeamerica.org.

Spriggs AL, Halpern CT. (2008). Timing of sexual debut and initiation of postsecondary education by early adulthood. *Perspectives on Sexual and Reproductive Health* 2008; 40(3):152–161.

Srabstein J, Piazza T. (2008). Public health, safety and educational risks associated with bullying behaviors in American adolescents. *International Journal of Adolescent Medicine and Health* 2008; 20(2):223–233.

Tennessee Department of Education (2010). Office of Coordinated School Health (OCSH). OCSH Executive Summary 2008-09.

Tennessee Department of Education. (2019). Annual coordinated school health district applications, 2007-08 through 2018-19. Unpublished raw data.

Tennessee Department of Education. (2019). Annual health services surveys, 2004-05 through 2017-18. Unpublished raw data.

Tennessee Department of Education. (2019). Tennessee public schools: A summary of weight status data, 2017-18. Nashville, TN: Tennessee Department of Education, Coordinated School Health.

Vernez G, Krop R.A., Rydell C.P. (1999). The public benefits of education. In: Closing the Education Gap: Benefits and Cost. Santa Monica, CA: RAND Corporation; 13-32.