

Reducing Youth Health Disparities Requires Data for Continuous Improvement

SOPHE-ASCD Expert Panel on Reducing Youth Health Disparities

In June 2010, the Society for Public Health Education (SOPHE) and ASCD convened 24 subject matter experts in health education, health care, public health and education to develop recommendations for eliminating health disparities among youth, based on best practices and policies. Recommendations from the Expert Panel includes these five overarching areas:

- Cross-agency collaboration
- Using data for continuous improvement**
- Health care access
- Supportive, nurturing & healthy learning environments
- Promotion of health-enhancing behaviors through K-12 health education and physical education

OVERVIEW

Using appropriate data to ensure continuous improvements in education outcomes is critical to our productivity as a nation. Measuring the inputs in education (i.e. the process variables such as experienced teachers, equitable resources and a nurturing and supportive learning environment) is also critical to understanding and improving the outcomes of education (e.g., achievement scores, high school graduation and attending college). This fact sheet examines the SOPHE-ASCD Expert Panel on Reducing Youth Health Disparities recommendation to better access and utilize data to promote continuous improvements in health and educational programming.



FOCUSING ONLY ON SCHOOL OUTCOMES DOES NOT ADDRESS ROOT CAUSES OF THE ACHIEVEMENT GAP.

Focusing only on the outcomes of schooling — grades, achievement scores, graduation, and college attendance — does not reveal many of the root causes of the achievement gap. These factors include inequitable distribution of experienced teachers,¹ inequities in funding,² lower parent involvement in the education of poor students³ and chronic absenteeism among some students.⁴ The inequity in educational resources that poor and minority students experience is often not emphasized, nor addressed. Another major barrier to the achievement of poor students that is often overlooked is their physical and mental health status.

POOR CHILDREN'S HEALTH STATUS AND BEHAVIORS HINDERS LEARNING.

Poor children have more chronic and infectious disease, injury and social/emotional and behavioral problems than their more affluent peers.⁵ Low-income children have nearly 12 times as many missed school days because of oral health problems.⁶ Poor students are more likely to be diagnosed with asthma (17% versus 12%) than youth living in more affluent families.⁷ Poor children living in families with an income of less than \$35,000, were twice as likely to have a learning disability (12%) than children (6%) living in families with an income of \$100,000 or more.⁸ Poor children experience more food insufficiency.⁷ These children are less likely to eat breakfast and are more likely to have poorer nutritional habits.⁹ Being undernourished can have lasting effects on overall health, cognitive growth, school performance, and behavioral and psychosocial problems.¹⁰ Finally, students living in poor families engage in more health risk behaviors, such as smoking, binge drinking, and a sedentary lifestyle,¹¹ which can also threaten learning.

DATA MUST BE MONITORED TO ADDRESS THE ACHIEVEMENT GAP.

To successfully address the achievement gap, schools must increase their focus on those modifiable risk factors such as chronic absenteeism and behavioral problems. These factors are more salient predictors of poor achievement than are the socioeconomic factors of race, poverty and family background.^{12,4}

Chronic absenteeism among students is associated with low academic achievement¹³ and dropping out of school,^{14,4} yet most schools do not track chronic absenteeism of individual students.¹⁵ Even poor 6th grade attendance predicts dropping out in high school.¹⁶ Chronic absenteeism can be reduced through the implementation of an early warning system that monitors and reports data,¹⁵ so that targeted interventions can be implemented.

Poor study behaviors reduces achievement. Allensworth and Easton⁴ found that those students in the 9th grade in Chicago Public Schools who reported higher rates of studying failed about 0.4 fewer courses than students with similar test scores and attendance rates but who studied less time.

ENGAGING IN HEALTH RISK-BEHAVIOR IS ASSOCIATED WITH REDUCED ACADEMIC ACHIEVEMENT.

Over half of all high school students have engaged in two or more health-risk behaviors, with 15% of students involved in at least five health-risk behaviors:¹⁷

- 21.9% of students had engaged in binge drinking during the 30 days before the survey¹⁸
- 20.7% of students had taken prescription drugs (e.g., Oxycontin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription¹⁸
- 33.7% of high school students are sexually active¹⁸

Students who engage in health-risk behaviors tend to receive lower grades than their classmates who do not engage in health-risk behaviors.¹⁹ While this association does not prove causation, academic failure is consistently associated with increased involvement across a variety of health risk-behaviors. Monitoring health-risk behaviors and implementing evidenced-based programming to reduce these behaviors can improve student outcomes.

“No Child Left Behind and its emphasis on standards, assessment, and accountability provided us with a way to know which students are succeeding and which are falling short. That’s why we must continue to measure — because what gets measured gets done.”²¹

Margaret Spellings, *Education Week*, January 12, 2012

CONTINUOUS IMPROVEMENT IN ACHIEVEMENT OCCURS WHEN DATA ARE USED TO INFORM STAKEHOLDERS ABOUT STUDENTS’ PROGRESS.

One of the benefits of the *No Child Left Behind* legislation was to begin to track students’ achievement by gender, ethnicity, income and English proficiency. Ten years after the legislation, systems of accountability have been established in every state. Further, the education sector in 2005 developed a nationwide system to assess 10 essential elements of achievement such as progress through K-12, test scores, graduation and drop out data, college readiness indicators and demographic data. By 2011, all but one state had incorporated at least eight elements into their state data tracking systems. Thirty-six states have all 10 Elements, up from zero in 2005.²⁰ States are also working to implement 10 necessary policies or actions to support effective data use. The first of the ten policies to make the data actionable is to: **Link state K–12 data systems with early learning, postsecondary education, workforce, social services, and other critical agencies.**²⁰ One of the critical agencies would be the state’s public health agency.



CONTINUOUSLY MEASURING REDUCTIONS IN BARRIERS TO ACADEMIC ACHIEVEMENT ENSURES ACADEMIC IMPROVEMENT OF POOR STUDENTS.

Measuring the outcomes of education alone, such as test scores and graduation rates, is not sufficient. Measuring continuous improvement in reducing the barriers to achievement (e.g., a poor learning environment, lack of family involvement, lack of health care access, engaging in health risk behaviors, inequitable resources, chronic absenteeism, and inexperienced teachers) are also critical to promoting student achievement and high school graduation. Margaret Spellings, former head of the U.S. Department of Education, has noted that what gets measured, gets addressed.²¹

One factor that is critical to students' success is a safe and supportive learning environment,²² yet only 21 states required schools to report school climate data to the public.²³ The research is also quite clear that family involvement improves achievement,²² as well as safety at school.²⁴ In low-income schools, teachers are less likely to initiate family involvement activities.²⁵ Requiring schools to monitor and improve student, staff and family perceptions of the learning environment, as well as increasing family involvement in their child's education, would improve

outcomes for poor students.

Additionally, the monitoring of health data (e.g., health-related absenteeism, health care access, chronic disease management and health-risk behaviors) would assist stakeholders to assess and correct additional barriers to academic progress.

THE LEGISLATIVE PRIORITY AGENDA OF ASCD¹⁷ HAS CALLED FOR THE ESTABLISHMENT OF A SYSTEM OF RECIPROCAL ACCOUNTABILITY AMONG POLICYMAKERS, FAMILIES, EDUCATORS AND STUDENTS TO ENSURE SUCCESSFUL STUDENT OUTCOMES.

"Just as educators have accepted accountability, so, too, must policymakers, parents, and communities accept their roles in student success. Public, user-friendly reporting of all education and student achievement data in disaggregated formats, including resource allocations and funding levels, will allow transparency, promote equity, and empower all interested parties to hold appropriate entities accountable for their responsibilities to children." - ASCD¹⁷



Every community needs the public health, health care, juvenile justice, social services agencies and education agencies engaged in cross-agency collaboration to improve students' health and learning, particularly for our most vulnerable children. These agencies can link efforts by sharing assessment data, measuring inputs as well as outputs in a process of continuous improvement of the health, learning and well-being of all students.

"We believe that investment in student performance data that is accessible, meaningful, and actionable to families is a core component of 21st century family engagement strategies."²⁶

Weiss & Lopez, Handbook on Family and Community Engagement, 2011

Expert Panel Policy Recommendations

Ensuring that all students progress equitably through the educational systems requires the collaboration of the education sector and the public health and health care sectors in each community to measure, report and reduce those learning barriers facing poor students. The Expert Panel recommended tracking of indicators that would indicate continuous improvement in measuring and reducing barriers, including:



Community and School Level:

- A district/municipal community coordinating committee measures the following indicators annually and disaggregates the data for each school in the district by SES status, race and ethnicity; disease-related absenteeism; chronic absenteeism; truancy; suspensions; student health behaviors; health literacy; fitness rates; teen birth rates; and perceptions of school climate of students, staff, and families; as well as the scores on national proficiency exams in the 4th, 8th and 12th grade and graduation rates.
- A district/municipal community coordinating committee reports annually to the community and to the state students' health, safety, and achievement indicators as a means to promote continuous improvement of academic achievement of low-income students.
- Public health, health care, social service and juvenile justice agencies utilize the education sector's student identification numbers so that their data can be shared and aggregated with educational data.
- Evidence of family communication and engagement activities within each component of the school health program occur and are annually reported to the municipal/district community coordinating committee.



State Level:

- State education agencies require students' fitness scores reported to the state as a mechanism to monitor continuous improvement in student fitness and physical activity.
- The State Health Department and the State Education Agency collaborate to share data and require the reporting of relevant local health and educational data of students.



National Level:

- Implementation of health care reforms includes attention to student indicators that influence achievement (e.g., chronic absenteeism, chronic disease management, health risk behaviors and preventative health care services).

About the SOPHE-ASCD Panel on Eliminating Youth Health Disparities

Convened in June 2010 in Washington, DC, the SOPHE-ASCD Panel on Eliminating Youth Health Disparities was a major first step in breaking down the silos between the education and public health leaders to address some of the most pressing problems facing poor children and youth. The summit promoted expert and innovative solutions for improved collaboration, programs and policies at the federal, state, district, community and school levels to reduce youth disparities and provide all children with a foundation for a healthy and productive future. For more information, see <http://www.sophe.org/SchoolHealth/Disparities.cfm>.

About the Expert Panel Sponsors

Founded in 1950, the **Society for Public Health Education** (SOPHE) provides global leadership to the profession of health education and health promotion and promotes the health of society. SOPHE's 4,000 National and chapter members work in schools, community-based organizations, health care setting, worksites and national/state/local government. For more information, see www.sophe.org. Founded in 1943, **ASCD** (formerly the Association for Supervision and Curriculum Development) is an educational leadership organization dedicated to advancing best practices and policies for the success of each learner. ASCD's membership includes 150,000 professional educators from all levels and subject areas - superintendents, supervisors, principals, teachers, professors of education, and school board members - in more than 145 countries. For more information, see www.ascd.org.

REDUCING YOUTH HEALTH DISPARITIES REQUIRES Data for Continuous Improvement

References

1. Institute of Educational Sciences. (2010). Closer Look 2010: High-Poverty Public Schools. In *The Condition of Education 2010*. Washington DC: National Center for Education Statistics. Available at: <http://nces.ed.gov/programs/coe/analysis/2010-section2b.asp>
2. Spatig-Amerikaner, A. (2012). Unequal Education: Federal Loophole Enables Lower Spending on Students of Color. Washington DC: Center for American Progress. Available at <http://www.americanprogress.org/issues/education/report/2012/08/22/29002/unequal-education/>
3. Barton P.E. & Coley, R. J. (2009). Parsing the Achievement Gap, Princeton, NJ: Educational Testing Service. Available at http://eric.ed.gov/ERICWebPortal/search/detailmini.jsp?_nfpb=true&_ERICExtSearch_SearchValue_0=ED505163&ERICExtSearch_SearchType_0=no&accno=ED505163
4. Allensworth E. & Easton, J.Q. (2007). What matters for staying on track and graduating in Chicago public high schools. Chicago: Consortium on Chicago School Research at the University of Chicago. Available at: <http://ccsr.uchicago.edu/content/publications.php>
5. Currie, J. & Lin, W. (2007). Chipping away at health: More on the relationship between income and child health. *Health Affairs*, 26, 331-344.
6. Holt K., & Barzel, R. (2010). Pain and Suffering Shouldn't Be an Option: School-Based and School-Linked Oral Health Services for Children and Adolescents. Washington, DC: National Maternal and Child Oral Health Resource Center. Available at <http://www.mchoralhealth.org/PDFs/schoolhealthfactsheet.pdf>.
7. Federal Interagency Forum on Child and Family Statistics. (2011). America's Children: Key National Indicators of Well-Being, Food Security, Washington, DC: U.S. Government Printing Office. Also available at <http://www.childstats.gov/americaschildren11/eco3.asp>
8. Bloom B., Cohen, R.A, & Freeman, G. (2011). Summary health statistics for U.S. children: National Health Interview Survey, 2010. National Center for Health Statistics. *Vital Health Stat.*, 10, 250.
9. Widome, R., Neuman-Sztainer, D., Hannen, P., Haines, J. & Story, M. (2009). Eating when there is not enough to eat: Eating behaviors and perceptions of food among food-insecure youths. *American Journal of Public Health*, 99(5):822-828.
10. Centers for Disease Control and Prevention (CDC). School Health Guidelines to Promote Healthy Eating and Physical Activity: Recommendations and Reports. September 16, 2011/ 60(RR05);1-71. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6005a1.htm>.
11. Lowry, R., Kann, L., Collins, J.L., & Kolbe, L. J. (1996). The Effect of Socioeconomic Status on Chronic Disease Risk Behaviors Among U.S. Adolescents. *JAMA*, 276(10):792-797.
12. Jerald C. (2007). Keeping kids in school: Lessons from research about preventing dropouts: Center for Public Education. Retrieved May 5, 2008 from http://www.centerforpubliceducation.org/site/c.kjXJ5MPIwE/b.1534275/k.ECEF/Research_review_Highperforming_highpoverty_schools.htm.
13. McCluskey C. P., Bynum T. S. & Patchin J.W. (2004). Reducing Chronic Absenteeism: an Assessment of an Early Truancy Initiative. *Crime and Delinquency*, 50 (2):214-234.
14. Balfanz, R., & Byrnes, V. (2012). Chronic Absenteeism: Summarizing What We Know From Nationally Available Data. Baltimore: Johns Hopkins University Center for Social Organization of Schools. Available at http://new.every1graduates.org/wp-content/uploads/2012/05/FINALChronicAbsenteeismReport_May16.pdf
15. Chang, H. & Balfanz, R. (2012). Let's Focus on Chronic Absenteeism. *Education Week*. January 18, 24-25.
16. Balfanz R. (2007). What your community can do to end its drop-out crisis. Center for Social Organization of Schools, Johns Hopkins University. Available at <http://www.every1graduates.org/whatyourcommunitycando.html>
17. Fox, H.B., McManus, M.A. & Arnold, K.N. (2010). Significant Multiple Risk Behaviors Among U.S. High School Students. Fact Sheet No. 8. Washington DC: The National Alliance to Advance Adolescent Health. Available at <http://www.thenationalalliance.org/pdfs/FS8.%20Significant%20Multiple%20Risk%20Behaviors.pdf>
18. Eaton, D.K., Kann, L., Kinchen, S., et al., (2012). Youth Risk Behavior Surveillance — United States, 2011. *MMWR*, 61 (4). Available at <http://www.cdc.gov/mmwr/pdf/ss/ss6104.pdf>
19. Centers for Disease Control and Prevention (2012). Health & Academics Data & Statistics. Atlanta, GA: Centers for Disease Control and Prevention. Available at http://www.cdc.gov/healthyyouth/health_and_academics/data.htm
20. Data Quality Campaign (2012). Data for Action 2011: Empower with Data. Washington D.C.: Data Quality Campaign. Available at: <http://dataqualitycampaign.org/files/DFA2011%20Annual%20Report.pdf>
21. Spellings, M. (2012). Maintaining the Federal Role in Accountability. *Education Week*. January 12, p 42.
22. Bryk, A., Sebrig, P.B., Allensworth, E.M., Luppescas, S., & Easton, J. Q. (2010). Organizing Schools for Improvement. Lessons from Chicago. Chicago: University of Chicago Press. Available at http://ccsr.uchicago.edu/downloads/8499safety_in_cps.pdf
23. Goertz, M. E., Duffy, M.C. & Le Floch, K.C. (2001). Assessment and Accountability Systems in the 50 States:1999-2000. University of Pennsylvania: Consortium for Policy Research in Education, CPRE Research Report SeriesRR-046, March.
24. Steinberg, M. P., Allensworth, E.M., Johnson, D. W. (2011). Student and Teacher Safety in Chicago Public Schools: The Roles of community context and School Social Organization. Chicago: Consortium on Chicago School Research. Available at http://ccsr.uchicago.edu/downloads/8499safety_in_cps.pdf
25. National Center for Education Statistics. (2006). School and parent interaction by household language and poverty status: 2003-03. Issue Brief. National Center for Education Statistics. September. Retrieved July 31, 2007 from <http://nces.ed.gov/pubsearch/pubsinfo.asp?pubid=2006086>
26. Weiss, Heather B and M. Elena Lopez. Making Data Matter in Family Engagement in the Handbook on Family and Community Engagement. Sam Redding, Marilyn Murphy, & Pamela Sheley, (Eds.). Lincoln, IL: Academic Development Institute / Center on Innovation & Improvement. 2011, 57-60. Available at <http://www.families-schools.org/downloads/FACEHandbook.pdf>