



Health EDUCATION

& THE EVERY STUDENT SUCCEEDS ACT



Policy Brief

Advocating for Health Education in Schools

This policy brief examines the Every Student Succeeds Act of 2015 (ESSA), the nation's primary federal K-12 education statute, and explores avenues to advocate for health education curricula in the U.S. school systems. Included is a brief description of each ESSA title; the role of various ESSA stakeholders; frameworks that state and local education agencies can consider when implementing the law; examples of states with strong health education programs; and specific ways health and education stakeholders can support health education in ESSA's implementation at the state and local levels. With health education designated as a well-rounded subject in ESSA, advocates have a bold new opportunity to educate their state and local education agencies and to ensure future generations of children have the knowledge and skills to become healthy adults.



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Note: The Every Student Succeeds Act of 2015 designates health education and physical education as “well-rounded subjects” in the K-12 academic curriculum. Both health education and physical education are vital to improving health and academic outcomes and demand the same education rigor as other core subjects. Health education and physical education are distinct disciplines that are based on different standards and outcomes, and distinct instructional content, methods, and assessments. This brief focuses on health education as an academic subject, but readers are also encouraged to study and advocate for physical education and physical activity as part of ESSA implementation.

The Every Student Succeeds Act (ESSA) was signed into law in December, 2015 and reauthorizes the 50-year-old Elementary and Secondary Education Act (ESEA). For the first time, health education was specified as a “well-rounded subject,” on par with other core academic curricula.

Health education incorporates a variety of physical, social, emotional and other components focused on reducing health-risk behaviors and promoting healthy decision-making. Health education curricula emphasize a skills-based approach to help students practice and advocate for the health needs of themselves, their families and their communities. These skills help children and adolescents find and evaluate health information to make informed health decisions. Ultimately, health education aims to increase students’ awareness of healthy behaviors as well as how to advocate for their own well-being. Students who participate in health education curricula have reduced rates of obesity and improved health promoting behaviors such as increased physical activity and healthy nutrition (Melnik et al., 2013; Luepker et al., 1996; Hoelscher et al., 2010). Health education curricula focus on reducing risky behaviors before they become unhealthy habits that can follow into adulthood and ultimately impact health outcomes.

Health education is any combination of planned learning experiences using evidence-based practices and/or sound theories that provide the opportunity to acquire knowledge, attitudes and skills needed to adopt and maintain healthy behaviors.

Joint Committee on Health Education and Promotion Terminology, 2011

The link between health and academic performance is well documented. Healthy students are better learners than those who are ill (Basch, 2011a). Complications with vision, hearing, asthma, occurrences of teen pregnancy, aggression and violence, lack of physical activity and diminished cognitive and emotional ability can reduce academic success. For example, students who are physically fit have better academic outcomes than those who lack physical activity or are overweight (London & Castrechini, 2011). Comprehensive health education contributes to social and emotional learning and decision-making skills, and can decrease health illiteracy, which has been estimated to cost the nation 1.6-3.6 trillion dollars annually (U.S. Department of Health and Human Services, 2016).

EVERY STUDENT SUCCEEDS ACT (ESSA)

ORIGINS OF ESSA

In 1965, President Lyndon Baines Johnson signed the Elementary and Secondary Education Act (ESEA) into law (U.S. Department of Education, 2016a). This legislation allocated resource grants to low-income students and provided federally funded grant opportunities for struggling school systems across the U.S. Under President George W. Bush’s Administration, No Child Left Behind (NCLB) was enacted in 2002 and designated national education standards. NCLB was a federally based program that mandated states to follow standardized roles and procedures (Reardon et al., 2013; Rothert, 2016).

In 2012, President Barack Obama provided states the flexibility to obtain waivers for some NCLB requirements. In order to receive a waiver, states were required to submit plans that set high standards, alter existing accountability systems and develop evaluation standards for effective teaching (U.S. Department of Education, 2016a). In 2015, President Obama reauthorized ESEA under the title the Every Student Succeeds Act (ESSA).

ESSA allocates more responsibility and autonomy to state and local education agencies. The legislation aims to encourage more flexibility and innovation to improve education for all students. NCLB often rewarded high-achieving schools while placing punitive measures on lower-achieving schools; ESSA emphasizes support for the lowest-performing five percent of schools in the hopes of closing the achievement gap (Executive Office of the President, 2015).

In addition, ESSA promotes a more grassroots approach to education than NCLB by encouraging partnerships with community organizations and other public and private entities (Executive Office of the President, 2015). Under section 4107 of ESSA, funds are allocated to facilitate well-rounded education (formerly “core subjects”), which can be defined as anything that improves a student’s performance. **Health education was included for the first time in the list of well-rounded education subjects.**

OVERVIEW OF ESSA TITLES

TITLE I: IMPROVING BASIC PROGRAMS OPERATED BY STATE AND LOCAL EDUCATIONAL AGENCIES

Title I includes five sections, and is the largest portion of ESSA. Part A indicates funding should be allocated at \$15 billion in 2017 and \$16.2 billion in 2020 (National Conference of State Legislatures). States are required to implement “challenging” standards that are aligned with college-entrance requirements. Although ESSA continues NCLB’s testing requirements between 3rd and 8th grades, it allows states to use funds to audit their current assessment systems. ESSA indicates each state must create its own statewide accountability system. In order to comply, states must establish state-designed long-term goals for all students in the areas of academic achievement, high school graduation rates, and percent of individuals making progress in English language proficiency.

ESSA Part A also discusses the responsibility and relationship between the State Education Agency (SEA) and Local Education Agencies (LEAs). SEAs must consult with governors, state boards of education and members of the state legislature to submit a Title I plan to the U.S. Department of Education. SEAs must work with specific LEAs in need of support and improvement. In addition, an annual state report card is required and must be made available online. This provision requires states to publicly disclose their outcomes as well as their own standards and measures for improvement.

Parts B through E of ESSA’s Title I describe how SEAs will distribute funds based on specific criteria and the allocation of resources to special populations such as migratory children, neglected or at-risk youth, and low-income students.

TITLE II: PREPARING, TRAINING, AND RECRUITING HIGH QUALITY TEACHERS, PRINCIPALS OR OTHER SCHOOL LEADERS

ESSA legislation specifies that Title II will receive \$2.3 million until 2020 and will remain at this allocation level until re-evaluated. States must allocate 95 percent of their ESSA funding to LEAs, which must then allocate 80 percent of their funding to focus on students with families living below the poverty line and 20 percent to serve the total student population. Under this title, ESSA ends federal mandates for teacher evaluation and removes the “highly qualified teacher” requirement in prior legislation. SEAs may continue to use federally funded dollars to support teacher and principal evaluations.

TITLE III: LANGUAGE INSTRUCTION FOR ENGLISH LEARNERS AND IMMIGRANT STUDENTS

Title III of ESSA increases funding from \$756 million in fiscal year 2017 to \$885 million by fiscal year 2020. This title also indicates that no regulation will mandate the use of a specific pedagogical approach to educating English Language Learners (ELL).

TITLE IV: 21ST CENTURY SCHOOLS

Title IV is one of the most important parts of the ESSA legislation relative to health education. For this title, allocation of funding is based on the Title I funding formula and is comprised of five parts. Part A authorizes three activities: 1) providing students with a well-rounded education (STEM, arts, civics, International Baccalaureate (IB) /Advanced Placement (AP) courses, **health and physical education**); 2) supporting safe and healthy students through drug and violence prevention, school mental health, **health and physical education** and; 3) encouraging the effective use of technology for professional development and blended learning. Part B encourages communities to establish or expand activities within community learning centers that help to enrich the students’ academic and personal lives. Part C and D authorize the establishment of a charter school program as well as magnet school assistance. Part E authorizes awarding grants to establish family engagement facilities and to develop programs for training and assistance. Part F allocates funding for grants focusing on educational innovation and research, community support for schools, academic enrichment, and national activities for school safety.

TITLE V: STATE INNOVATION AND LOCAL FLEXIBILITY

This title authorizes SEAs’ and LEAs’ flexibility in selecting and funding programs that address the needs of the students within their respective jurisdictions. Restrictions apply to the allocation of funding from SEAs to LEAs when the money has been previously designated for another purpose. Additionally, this title excludes the NCLB requirement for SEAs, LEAs, and schools to spend equal funds on each student.

TITLE VI: INDIAN, NATIVE HAWAIIAN, AND ALASKA NATIVE EDUCATION

This portion of ESSA provides support and guidance for initiatives that are educational and culturally related to the needs of Indian, Native Hawaiian and Alaska Natives. Title VI also permits Native American community-based organizations to apply for LEA grants if no tribe or LEA school has submitted a request for funding.

TITLE VII: IMPACT AID

This title was revised to reduce subjectivity in ESSA and increase accountability of payment schedules. Furthermore, Title VII now permits eligible federally impacted school districts to access Impact Aid funding. When a school district has federal land within its geographic boundaries, such as a military facility, this land is exempt from taxation. This exemption prohibits a school district from receiving property taxes for such land, even if children who attend schools in the district are living there. Impact Aid provides financial assistance to school districts to help alleviate the loss of this revenue.

TITLE VIII: GENERAL PROVISIONS

Title VIII prohibits federal mandates that dictate standards and assessments to comply with ESSA. This provision was developed to limit federal influence in state and local school regulations and decisions. The federal government cannot require states to spend funds nor incur costs that are not covered by ESSA, endorse any curriculum, or develop and implement any nationalized test.

TITLE IX: EDUCATION FOR THE HOMELESS AND OTHER LAWS

Under Title IX, each state receiving ESSA funds must designate a Coordinator for Education of Homeless Children and Youth and have LEA liaisons for homeless children and youth. This title also includes Preschool Development grants that encourage partnerships with Head Start providers and maximize parental choice in decision-making. Suggestions are provided to LEAs and SEAs on addressing sexual assault, improper use of taxpayer funds, and other topics.

PRINCIPAL STAKEHOLDERS IN EDUCATION AND ESSA

Department of Education

ED cannot mandate that states and local school boards implement a set of educational standards but can still award and administer formal grant funds once the state develops its own standards and measures. Ultimately, the ED can provide guidelines and support states in their efforts, but is unable to implement and enforce regulations.

State Education Agency

State Education Agencies (SEAs) allocate funding and resources for state and federal programs and participate in policy development as well as engage in communication activities.

Local Education Agency

While transitioning to ESSA, Local Education Agencies (LEAs) are still required to continue to implement interventions mandated under NCLB for the 2016-2017 school-year. LEAs are no longer obligated to offer public school choice, attendant parental notification, or supplemental education services during the upcoming school year 3.

Title I Schools

Title I provides federal funding for disadvantaged students and aims to eliminate barriers to academic learning and achievement.

Parent-Teacher Associations (PTAs)

The ESSA removed the requirement that parents be notified if their child's teacher was considered unqualified. PTAs have a unique opportunity to work closely with LEAs and SEAs to advocate for the needs of the student body.

U.S. DEPARTMENT OF EDUCATION

Under No Child Left Behind (NCLB), the U.S. Department of Education (ED) managed and enforced national education standards. With the enactment of ESSA, much of ED's authority was transferred to the states. Although ED no longer manages and enforces national education standards, it can still award and administer formal grant funds for the 2016-2017 school year to states and districts receiving non-competitive grants. If a state develops new priority and focus schools, then it is required to report them to ED. However, states selecting to keep their current list of priority and focus schools until the end of FY 2016-2017 are not required to notify ED. NCLB required states to follow federal regulations; however, ESSA dictates that states develop their own standards and measures. In areas that are no longer required, the ED may still offer technical assistance, feedback, and support, but no formal process is required (U.S. Department of Education, 2016b). Also, the ED cannot require that states and local school boards follow certain requirements of ESSA. Although the ED can provide guidelines and support states in their efforts, it is unable to implement and enforce regulations.

STATE EDUCATION AGENCY

State Education Agencies (SEAs) are responsible for supervising public elementary and secondary schools and complying with federal laws and regulations. SEAs allocate funding and resources for state and federal programs and participate in policy development. They also monitor and report on the progress of their state's education programs. SEAs interact and collaborate with stakeholders to solicit funding; develop standards, goals, and regulations; and advise legislatures about education standards in the state. However, SEAs cannot dictate specific curriculum regulations, or establish local funding distribution formulas (The Aspen Institute, 2015).

Under ESSA, states have an increased level of control in education regulations. SEAs are required to develop state accountability plans. State accountability measures may include non-academic indicators such as chronic absenteeism, school climate and safety, and student engagement. Furthermore, ESSA created three new student subgroups—homeless students, foster care students and students with at least one parent in the military—for which states must collect data and are accountable in reporting. Additionally, states must implement evidence-based strategies, and administer statewide testing (i.e. single summative or multiple interim assessments) (ASCD, 2016c).

LOCAL EDUCATION AGENCY

Local Education Agencies (LEAs) are guided by state and federal regulations and procedures. Under ESSA, LEAs have more flexibility than under prior legislation in how they allocate resources; however, they must consult SEAs for technical assistance and support. While transitioning to ESSA, LEAs are still required to continue to implement interventions mandated under NCLB for the 2016-2017 school-year. However, LEAs are no longer obligated to offer public school choice, attendant parental notification, or supplemental education services during the 2017-2018 school year and beyond (U.S. Department of Education, 2016b). States must provide 95 percent of their federal funding to LEAs for improvement, corrective action or restructuring in Title I schools. LEAs are no longer mandated to provide improvement plans or restricted to hire paraprofessionals using their Title I, Part A funds. Furthermore, under ESSA, districts in partnership with superintendents have increased flexibility in improving their lowest-performing schools.

TITLE I SCHOOLS

Title I provides federal funding for disadvantaged students and aims to eliminate barriers to academic learning and achievement. The formula for Title I allocation will remain the same as previous legislation. To receive Title I funding, 40 percent of the families attending or residing in the attendance area of the school must be considered low-income (sec 1114(a)(1) of Title I of ESEA). Title I schools are under the jurisdiction of LEAs, but have flexibility in developing programming that meets the needs of their students.

PARENT-TEACHER ASSOCIATIONS (PTAs)

ESSA removed the NCLB requirement that parents be notified if their child's teacher was considered unqualified. A teacher's label of not highly qualified was based on a student's performance on standardized exams.

HEALTH EDUCATION AND ESSA

Under section 4107 of ESSA, funds should be allocated to facilitate well-rounded education, which can be defined as anything that improves the performance of a student. In addition to health education, a variety of other subjects such as physical education and art are designated as well-rounded subjects. SEAs and LEAs must decide how to define and implement a well-rounded education. ESSA includes a new requirement for schools to track at least one “nonacademic” indicator. These nonacademic indicators are essential to providing a well-rounded education and integral to the Whole School, Whole Community, Whole Child (WSCC) Model (See Figure 1)

The WSCC model was developed in 2014 by leaders from the fields of health education, public health, education, and school health to ensure that the health of the student, the teacher, and the school are taken seriously by educators and by those involved in the school improvement process. The WSCC framework combines and builds on elements of the traditional coordinated school health approach and the whole child framework by:

- Responding to the call for greater alignment, integration, and collaboration between education and health to improve each child's cognitive, physical, social, and emotional development;
- Incorporating the components of a coordinated school health program around the tenets of a whole child approach to education; and
- Providing a framework to address the symbiotic relationship between learning and health.

The framework is comprised of ten (10) components, such as health education, social and emotional climate, physical environment, community involvement and family engagement. The WSCC framework aims to connect school curriculum and health based on five tenets—healthy, safe, engaged, supported, and challenged—that help ensure effective education. The whole child approach implies that students’ health is influenced by multiple factors of their lives including their community and school. WSCC ideally should be implemented at the national, state, local and individual levels. The model is often referred to as “coordinated school health programs in individual schools” because the framework focuses on improving a child’s health on various levels.

ASCD and the U.S. Centers for Disease Control and Prevention (CDC) encourage use of the WSSC model as a framework for improving students' learning and health in our nation's schools. The School Superintendents Association updated its training materials and provided opportunities at conferences for its members to become trained in the model (ASCD, 2016b).

As of summer, 2016, some 19 states (e.g., Colorado, Maryland, Kentucky) and 57 school districts adopted policies to implement the WSCC model into their educational frameworks. For example, in Colorado, educators discussed the WSCC model during comprehensive health and physical education curriculum training in school districts (CDC, 2015). The West Virginia Department of Health and Human Services uses WSCC, along with the community schools model, to support schools and districts. Fort Worth Independent School District in Texas outlines several tasks each year for its



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

schools to implement based on the WSCC framework (ASCD, 2016b). Thus, more school districts and schools are working toward becoming a community school that focuses on the whole child.

HEALTH PROMOTING SCHOOL (HPS)

Schools provide an ideal environment to educate students about health behaviors such as nutrition. As students progress through grade levels, they become more autonomous in their decision-making and can practice healthy behaviors (Peralta et al., 2016). The health promoting school (HPS) model, while often focused on nutrition topics, provides a useful framework to increase knowledge and action-taking by students. A literature review done by Peralta et al. (2016), found that the HPS was implemented through cross-curricular, parental involvement, game-based or web-based methods, and contingent reinforcement.

HEALTH EDUCATION STANDARDS AND GUIDELINES

NATIONAL HEALTH EDUCATION STANDARDS

The Joint Committee on National Health Education Standards developed a framework with eight health education ideals for what students in kindergarten through twelfth grade should know and be able to do to promote personal, family and community health (See Table 1) (CDC, 2016b; CDC, 2012). The National Health Education Standards (NHES) provide a framework for teachers, administrators, and policy makers in designing or selecting curricula, allocating instructional resources, and assessing student achievement and progress. These standards, now in their second edition, have become an accepted reference and framework for the adoption of standards by most states. They include helping students comprehend and analyze health-related concepts such as disease prevention, psychosocial impacts on well-being, and health promotion. A key component of the standards and performance indicators is that students should be able to demonstrate a health-related skill. The indicators include students' abilities to set goals, engage in interpersonal communication, advocate for the health of themselves and their communities, and practice the promoted health behavior. The health education standards are distinct from other curriculum that is focused solely on nutrition and physical activity in that health education encourages students to be informed and empowered to make conscious health decisions.

AMERICAN ACADEMY OF PEDIATRICS (2016)

The American Academy of Pediatrics developed *Health, Mental Health and Safety Guidelines for Schools* to help teachers, principals, and others influencing the health of students. The goal of the guidelines is to focus on health, mental health and safety issues in schools to improve students' well-being and academic performance

National Health Education Standards	
<u>Standard 1</u>	Students will comprehend concepts related to health promotion and disease prevention to enhance health.
<u>Standard 2</u>	Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.
<u>Standard 3</u>	Students will demonstrate the ability to access valid information, products, and services to enhance health.
<u>Standard 4</u>	Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
<u>Standard 5</u>	Students will demonstrate the ability to use decision-making skills to enhance health.
<u>Standard 6</u>	Students will demonstrate the ability to use goal-setting skills to enhance health.
<u>Standard 7</u>	Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.
<u>Standard 8</u>	Students will demonstrate the ability to advocate for personal, family, and community health.

Table 1 - Joint Committee on National Health Education Standards, 2011.

(AAP, 2016). These guidelines provide evidence-based suggestions to health education specialists about ways to keep students healthy. The guidelines are meant to be used with other resources.

AMERICAN PUBLIC HEALTH ASSOCIATION (2016)

The American Public Health Association has several policy statements supporting health education as part of educational reform (APHA, 2010; APHA 2016), and calls for cross-sector collaboration to improve educational outcomes. In November 2016, APHA adopted a policy statement addressing the social determinants of education, which calls for encouraging school boards, parents and community members to evaluate implementation of ESSA to ensure equity. Schools, in partnership with health care providers and insurers must ensure that physical and mental health services are available e in schools, especially in communities where such services are most needed.



EXAMPLES OF EFFECTIVE HEALTH EDUCATION PROGRAMS

The National Association of State Boards of Education (NASBE) collects data for the NASBE State School Health Policy Database, which originally began in 1998 (National Association of State Boards of Education, 2016). Almost all states have guidance materials for wellness policies, but not all states maintain or enforce content and accountability requirements. Below are states identified by NASBE as having strong health education requirements and programs.

CALIFORNIA

The California State Board of Education believes that health literacy is an important component of health education (California Department of Education, 2009). Being health literate promotes critical thinkers, self-directed learners, effective communicators, and responsible and productive citizens. The state decided to focus on this topic based on results from the California Healthy Kids Survey, which indicated that youth possessed knowledge about health but not the skills to implement risk-reduction behaviors. Eight overarching health content standards for K-12th grades are specified to guide curriculum: essential health concepts, analyzing health influences, accessing valid health information, interpersonal communication, decision making, goal setting, and practicing health-enhancing behaviors and health promotion (California Department of Education, 2009). The California State Board of Education provides resources on how school systems should evaluate their health education curriculum. For example, the Los Angeles Unified School District follows the standards set forth by the state's department of education and requires a 90-hour full-semester health education course for middle and high school students (Los Angeles Unified School District, 2016).



DISTRICT OF COLUMBIA



The District of Columbia Office of State Superintendent of Education (OSSE) created health education curriculum based on the WSCC model as a framework to focus on health and academic outcomes. The curriculum addresses both evidence-based interventions and standards based on grade level capabilities, and includes the following components: mental and emotional health, safety skills, the human body and personal health, disease prevention, nutrition and alcohol, tobacco and other drugs (District of Columbia Office of State Superintendent of Education, 2016). DC must comply with the DC

Healthy Schools Act and associated assessment tools. DC has a formal system for monitoring and evaluating health education curriculum data.

NEBRASKA

Nebraska Department of Education (2016) employs a Coordinated School Health Program (CSHP) model that involves eight interactive components, including health education curricula. The state board of education encourages each school district to adopt its own plan for health education and provides guidelines. Since 2010, the CSHP engaged and evaluated a pilot program around the eight components. From the pilot, the school systems established partnerships with local organizations to achieve the goals of the policy. This linkage is vital to pooling resources and providing comprehensive health education curriculum.



NEW HAMPSHIRE



New Hampshire requires that the local school board provide health education programming that follows the national standards. In addition, a half credit of health education is a requirement for high school graduation. NH provides comprehensive and extensive resources for educators and other stakeholders on where to access materials about health education (New Hampshire Department of Education, 2016).

RHODE ISLAND

Rhode Island's Coordinated School Health Program (2016), Thrive, requires health education for all students (grades 1-12). Students are required to receive 100 minutes per week of health and physical education. Rhode Island's health education curriculum is aligned with its *Health Literacy for All* framework and uses coordinated school health programming to inform its standards.



OPPORTUNITIES FOR HEALTH EDUCATION IN THE ESSA

The designation of health education as a well-rounded subject in ESSA is a major achievement, but is only a first step in improving the quantity and quality of health education curricula in schools. Health education specialists and other health and education advocates must now work with SEAs and LEAs to promote and support student health. Consider these actions:



1) State and local stakeholders must be educated about ESSA's new provisions, the WSCC framework, and the vital role of health education in academic achievement. Advocacy is needed to increase the number of state education accountability plans that include comparable measures of health education as a "measure of school success" and/or in their State Report Card. For example, such measures may include chronic absenteeism, student engagement and peer-to-peer relationships. Health education must be included in a state's accountability system.

2) It is also vital to point out to SEAs and LEAs that under Title I, schools can develop evidence-based health and nutrition programs as well as comprehensive social-emotional support interventions (Fobbs et al., 2016). Increased flexibility for programming under Title I lends itself to implementing health education material into the curriculum.

Schools can apply for academic enrichment grants or look to the community for support and resources. Advocacy is needed to secure funding for health education now available to states under Title IV of ESSA.

3) With the inclusion of health education in ESSA, SEAs and LEAs are exploring health education guidelines for their curricula. State accountability systems can incorporate federal guidelines into state standards. Currently, the CDC recommends the following health education measures/indicators:

- Number of elementary school schools offering/students receiving 150 minutes of health education per week;
- Number of middle school schools offering/students receiving 225 minutes of health education per week; and
- Number of schools requiring health education for high school graduation.

Per Fobbs et al. (2016), states can mandate that in order for LEAs to receive professional development allocations, they must incorporate information about how they will promote student health and wellness. Health education should include indicators that improve the percentage of schools using the CDC's Health Education Curriculum Analysis Tool (HECAT) to analyze and improve the health education curriculum. Using HECAT, schools can conduct a clear, complete and consistent analysis of their health education curricula.

In addition, health education specialists and other education and health advocates must work to improve the percentage of schools using the CDC School Health Index (SHI) to assess the overall health of the school. Using the SHI, schools can conduct a self-assessment to identify areas for improvement in their overall health and safety policies and programs. ESSA provides a unique opportunity to promote, advocate and support health education curricula.

SUMMARY

The Every Student Succeeds Act of 2015 provides a new federal blueprint for enhancing K-12 education and fortifies our nation's longstanding commitment to equal opportunity for all students. The bipartisan legislation builds on key areas of progress in recent years, while modernizing and strengthening the role of state and local education agencies. For the first time, Health Education is designated as a well-rounded subject, along with other time-honored curricula such as reading or language arts, science and math. Health and education advocates have exciting opportunities to instruct school boards, superintendents, principals, communities, and parents about the new WSSC model, including the role of health education in improving students' health and academic outcomes. Let's roll up our sleeves in supporting ESSA implementation so that every student achieves a world-class education and has the building blocks of health knowledge and skills to become healthy and productive adults.

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