LEARN. TEACH. LEAD.

Overview of Topics and Recommendations

SOPHE-ASCD Expert Panel on Reducing Youth Health Disparities

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 settings, worksites and national/state/local government. For more information on SOPHE, visit 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.

About the SOPHE-ASCD Panel on Eliminating 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.

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.

Recommendations from the Expert Panel include the following 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 classes

Background information on each of the overarching areas along with specific policy recommendations at the school, community, state, and national levels can be found in each of the corresponding factsheets at http://www.sophe.org/SchoolHealth/Disparities.cfm.

This factsheet provides a brief introduction to each overarching area and highlights policies that the Expert Panel recommends for implementation to reduce youth health disparities.

CROSS AGENCY COLLABORATION.

Many students, and particularly children and youth living in poverty, have health problems that can reduce learning.[1] New research by the education sector documents the need for cross agency collaboration to engage families and community health and social service agencies as partners to ameliorate the student health problems interfering with academic achievement.[2] When students receive both the education and health interventions that they need, academic performance and educational achievement levels improve.[3,4] Graduation from high school is associated with better health and an increase of six to nine years in average lifespan.[5] As income levels increase, positive health behaviors and health outcomes are enhanced.[6] Post-secondary education leads to even healthier lives by improving earning power, social status, and cognitive ability, which in turn influences positive lifestyle choices, an enhanced understanding of health issues, and better negotiations within the medical care system.[5] Better adult health status improves the health status of future children.[3]

USING DATA FOR CONTINUOUS IMPROVEMENT.

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). 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 a lack of early childhood education for students living in poverty,[7] inequitable distribution of master teachers,[8] inequitable K-12 funding,[9] lower parent involvement in the education of poor students[1] and chronic absenteeism among some students.[10] A major barrier to the achievement of poor students that is often overlooked is their physical and mental health status. Continuous improvement in the achievement of poor students requires data measuring the interventions known to improve student achievement, including access to health care.

HEALTH CARE ACCESS.

Healthy children are better learners.[4,11] Students distracted by a chronic disease, a toothache, or a mental health problem cannot achieve their learning potential. Although most people think that adolescents from 12 to 21 are generally a healthy population, in reality, they have illness and death rates that are twice the rates of younger children.[12] While instruction is the main business of schools, these health problems can significantly reduce learning. Moreover, engaging families and community health and social service agencies as partners to supplement the school resources reduces student health problems and improves academic achievement.[2] Yet too few communities have made essential health care accessible to youth by effectively linking the limited school health resources with the community's physical, mental, and dental health care services. Mechanisms for improving health care access include school based clinics, school-linked services to community agencies and individual practitioners, and community school approaches.

SAFE, SUPPORTIVE, & NURTURING LEARNING ENVIRONMENT

A safe, supportive and healthy learning environment is one in which students' physical, mental and dental health needs are addressed. There are short- and long-term consequences of an unsafe school environment. Short-term consequences include an increase in absenteeism, a lack of connectedness, and reduced learning. Long-term consequences of an unsafe school environment include psychological and physical health problems, and disrupted educational and professional attainment which can result in lower job status and lifetime earnings.[13] In addition to a safe environment, teachers must ensure an environment where learning expectations are met with ample academic support. Schools serving students located in high-crime and high poverty areas can create a safe, supportive learning environment.[13] A school building that is environmentally healthy also contributes to student achievement, reduces health problems, reduces absenteeism and improves the school's operating costs.[14] Quality teacher-student interactions along with instruction in K-12 social-emotional skills can improve the learning environment and help students thrive.

HEALTH EDUCATION.

Youth who engage in health-risk behaviors are at risk for both short– and long-term injury and illness. Approximately 50% of premature deaths are due to unhealthy lifestyles.[15] Many adolescents engage in multiple health risk behaviors. For example, alcohol use is a major factor in the three leading causes of death for teenagers—automobile crashes, homicide and suicide.[16] Chronic diseases in adults such as heart disease, cancer and diabetes are related to behaviors that are often established in youth: tobacco use, sedentary lifestyle and poor dietary choices. Evidenced-based health education programs have been shown to improve students' health behaviors and improve health literacy. Yet, quality health education K-12 is not routinely taught in all grades often because it is not a core subject in schools.

PHYSICAL EDUCATION.

Inadequate physical activity threatens both the current and future health status of youth. Lifestyle choices established in youth, including inadequate physical activity, poor dietary choices and tobacco use, lead to a range of chronic diseases such as heart disease, cancer and stroke. Physical inactivity in youth and poor dietary choices are also associated with more immediate chronic diseases, including childhood obesity and type 2 diabetes.[16] Overweight adolescents have a 70% chance of becoming overweight or obese adults.[17] Most youth do not meet the recommendation for 60 minutes daily of physical activity. Physical activity promotes physical and mental health, and there is substantial evidence that physical activity and physical fitness are related to academic achievement.[18] However, physical education is not a core subject in schools, and, therefore, it is often eliminated to make room for those core subjects that are tested.[19]

Expert Panel Policy Recommendations at the National Level

The Expert Panel identified a number of indicators that would lead to the reduction of youth health disparities that impact learning. The following is a list of actions that can be taken at the national level to reduce youth health disparities. For community and state level recommendations please reference the corresponding factsheets.

- Federal agencies develop funding and accountability mechanisms that cut across health and education sectors to ensure that the needs of the whole child are met from infancy though adolescence for all
  children and particularly low income, minority and ethnic students.
- Health education and physical education are identified as core subjects in the re-authorization of the Elementary and Secondary Education Act (ESEA).
- Federal tax incentives are provided to encourage results-based partnerships at the community level between the education, public health and health care sectors for improving the health and achievement of all students, and particularly low-income, minority and ethnic students.
- Federal tax incentives are provided at the community level for providers to locate primary care, dental/oral health services, vision and mental health services in underserved areas easily accessed by students and their families.
- Federal tax incentives are provided for pediatric and family medicine residency programs that promote residents' and medical students' access to educational experiences in school health, particularly in high poverty schools.
- Medicaid providers are accountable for a specific set of indicators for the whole child.
- 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).
- Culturally relevant programmatic interventions on childhood obesity are implemented with food equity programs such as WIC, food stamps, school breakfast, and school lunch programs.
- Reimbursement to schools for the school-based feeding programs is increased so that healthier options can be purchased and the dependency on competitive food options that generate income for schools are eliminated.

References

1. Barton P.E. & Coley, R. J. (2009). Parsing the Achievement Gap II, Princeton, NJ: Educational Testing Service. Available at http://www.ets.org/Media/Research/pdf/PICPARSINGII.pdf
2. Bryk, A., Sebrig, P.B., Allensworth, E.M., Luppesca, 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
3. Murray, Nancy et al. (2006) Education and Health: A Review and Assessment, Appendix E.in Code Red: The Critical Condition of Health in Texas. Available at: http://www.coderedtexas.org/files/Appendix_E.pdf
4. Basch, C. (2010) Healthier Students Are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap. A Research Initiative of the Campaign for Educational Equity. Teachers College, Columbia University, Research Review, No. 6. Available at http://www.equitycampaign.org/i/a/document/12557_EquityMattersVol6_Web03082010.pdf.
5. Alliance for Excellence in Education. (2010). High School Dropouts in America (Updated) Fact Sheets (PDF) Available at: http://www.all4ed.org/files/HighSchoolDropouts.pdf September 15.
6. Egerter S., Braveman P., Sadegh-Nobari T., Grossman-Kahn R., & Dekker M. (2009). Education Matters for Health. Princeton, New Jersey: Robert Wood Johnson, Commission to Build a Healthier America. Retrieved from http://www.rwjf.org/files/research/commission2009eduhealth.pdf
7. Anderson, Laurie M., et al. "The effectiveness of early childhood development programs: A systematic review." American journal of preventive medicine 24.3 (2003): 32-46.
8. 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
9. 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/
10. 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
11. Suhrcke, M. & de Paz Nieves, C. (2011) The Impact of Health and Health Behaviours on Educational Outcomes in High-Income Countries: A Review of the Evidence. Copenhagen, WHO Regional Office for Europe. Available at http://www.euro.who.int/__data/assets/pdf_file/0004/134671/e94805.pdf
12. Fox, H B. and McManus. M.A. (2009). Health Reform and Adolescents. The National Alliance to Advance Adolescent Health, Issue Brief. 2009, 3. Available at: http://www.thenationalalliance.org/pdfs/Brief3.%20Health%20Reform%20and%20Adolescents.pdf
13. 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
14. EPA. (2010). How Does Indoor Air Quality Impact Student Health and Academic Performance? Available at: http://www.epa.gov/iaq/schools/pdfs/student_performance_findings.pdf
15. Schroeder, S. A. (2007). We Can Do Better -- Improving the Health of the American People, N Engl J Med, 357: 1221-1228. Available at http://aysps.gsu.edu/ghpc/5894.
16. Newby, K. & Snyder, A. (2009). Teen Risk Behavior. The Ohio State University Extension Fact Sheet; Family and Consumer Sciences. Available at http://ohioline.osu.edu/hyg-fact/5000/pdf/5240.pdf
17. Castelli, D. M,, Hillman, C. H,, Buck, S. M., & Erwin, H. E. (2007). Physical Fitness and Academic Achievement in Third-and Fifth-Grade Students Journal of Sport & Exercise Psychology, 29, 238-252. Available October 18, 2011 at: http://www.kapoleims.k12.hi.us/campuslife/depts/electives/dance/Physical%20Fitness%20and%20Academic%20Achievement.2.pdf
18. Office of Minority Health. (2012) Obesity Data/Statistics. Washington DC: Office of Minority Health. Available at http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=537
19. Institute of Medicine. (2013). Educating the Student Body: Take Physical Activity and Physical Education to School. Washington, DC. Available at: http://books.nap.edu/openbook.php?record_id=18314