2021

Healthy Schools – Program Plan

Healthy Schools is a partnership between Deschutes County and Bend – La Pine Schools providing public health services directly within schools and school communities using collaborative, systemic, and integrative approaches *so that* school leaders, staff, students, and families in Deschutes County have access to high quality health promoting programs.

DESCHUTES COUNTY | Health Services, Public Health, Prevention and Health Promotion

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Purpose

The purpose of this program plan is to describe the Healthy Schools program and the steps for how it will be implemented and evaluated, as of the 2021-2022 school year. Program plans provide transparency, accountability, and alignment across partnerships. Because our partnerships are committed to quality improvement, this plan will evolve in order to adapt to the constantly changing needs, priorities, and resources available in our schools. Significant changes to our Healthy Schools program, implementation, and evaluation plans will be described in our annual reports.

Intended Audience

This program plan is intended for the following stakeholders (individuals who influence and are influenced by our program):

- School, district, and county administrators, leaders, and elected officials
- School staff and student leaders interacting with our Healthy Schools activities
- Leaders and practitioners for services delivered to schools
- Community members supporting health in schools
- Contractors, consultants, and professional peers supporting or replicating this work

Acknowledgements

This program was made possible through funding provided by **Bend-La Pine Schools** and **Deschutes County**. The commitment to joint funding and ownership of this program allows resources to be directed in a manner that addresses our local community's needs and priorities. This partnership is an innovative approach for school health coordination.

Special thanks also goes out to our colleagues in the following organizations for the extensive time and effort they have contributed to the development of this program:

- Bend-La Pine Schools district office staff
- Bend-La Pine Schools school building staff
- High Desert Education Service District
- Deschutes County Health Services - Public Health

Table of Contents

List of Tables and Figures

Important Terms and Definitions used in the Healthy Schools Program Plan

Multi-Tiered System of Supports (MTSS) - a model used in the education field that includes three tiers of supports layered upon each other to meet student needs (PBIS Rewards, 2021)

- Tier 1 - The foundational MTSS layer that provides universal supports to all students in a school environment; About 75-90% of students have their needs met through this universal level of support
- Tier 2 - A second layer of support, often in small groups, for students with additional needs not fully met by Tier 1 alone; About 10-25% of students need this additional layer of support and have their needs met between Tiers 1 and 2
- Tier 3 - A third layer of support that is usually individualized to provide students with needs not met by Tiers 1 and 2; Less than 10% of students need individualized supports

Public Health Prevention Framework - a model used in the public health field that includes three levels of prevention along the continuum of disease development

- Primary Prevention - Before a disease or condition ever begins to develop or before someone is exposed to a known disease-causing agent (like a virus, toxin, or addictive substance), primary prevention services aim to reduce preventable risk factors and protect against possible unpreventable risk factors that are commonly associated with a disease or condition
- Secondary Prevention - After someone has been exposed to a disease agent or certain risk factors, a disease or condition may be developing without noticeable symptoms, secondary prevention services aim to detect and treat a disease or condition early before symptoms appear to prevent symptoms or adverse effects of an underlying condition that could progress to a more severe level
- Tertiary Prevention - After a disease or condition has developed symptoms and adverse consequences, tertiary prevention aims to rehabilitate or accommodate the symptoms and consequences to prevent additional adverse effects

Institute of Medicine (IOM) Intervention Classification - a model used in the public health field that includes three classifications for the scope of audience or recipients for a service

- Universal - services delivered or interventions impacting an entire population, regardless of the level of risk or need for individuals
- Selective - services delivered or interventions targeting certain groups of people based on known risk factors or associations
- Indicated - services delivered or interventions tailored to an individual based on a specific indicator of disease or condition

Optimal Health - the dynamic balancing between fluctuations in the environment and an individual's physical, mental, emotional, social, spiritual, and intellectual health (National Academy of Science, Engineering, and Medicine [NASEM], 2020)

School Health - a field of public health centered on promoting health through schools and school communities to create conditions for all students to thrive

Coordinated School Health model - a model developed by the Centers for Disease Control and Prevention to improve coordination and alignment of school health improvements across all components of school health

Whole School, Whole Community, Whole Child (WSCC) model - an expanded version of the Coordinated School Health model, merging Coordinated School Health with the Whole Child model commonly used in the education field

School Health Index - a comprehensive tool aligning with the Coordinated School Health model and the Whole School, Whole Community, Whole Child (WSCC) model, providing standards for school health practices

Positive Youth Development (PYD) - an approach to youth development that can be applied to any context and has largely been applied and researched through 4H programs; Many PYD models exist, but one leading model is the Six Cs which focuses on youths' development of character, competence, confidence, connections (to adults and peers), caring/compassion, and contribution to community or society; Social and Emotional Learning is considered one model that aligns with parts of the PYD approach (Shek, Dou, Zhu, and Chai, 2019)

Social and Emotional Learning (SEL) - "the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions" (Collaborative for Academic, Social, and Emotional Learning [CASEL], n.d.)

School-wide Social and Emotional Learning (SEL) - an approach to extending SEL beyond the classroom and instructional time in order to embed SEL into all aspects of the school environment and engaging youth and families in the process

Social and Emotional School Climate - a positive school environment that fosters social, emotional, and mental wellbeing and inclusiveness for all students, staff, and families; a positive social and emotional climate in schools is associated with great school connectedness (Centers for Disease Control and Prevention [CDC], 2009)

School Connectedness - a students' belief that adults and peers in school care about their learning and them as individuals; School connectedness has been found to be the "strongest protective factor to decrease substance use, school absenteeism, early sexual initiations, violence, and risk of unintentional injury" and the second most important factor, next to family connectedness, to protect against emotional distress, disordered eating, and seriously considering or attempting suicide (Centers for Disease Control and Prevention [CDC], 2009)

Summary

The Healthy Schools program in Deschutes County will provide public health services directly within schools and school communities using collaborative, systemic, and integrative approaches. By 2023-2024, each high school in Bend-La Pine Schools will host a Public Health Specialist on their campus. The Public Health Specialist will serve as a school health coordinator for their high school and the middle school/s that feed into their high school. This program plan details the rationale and design of our Healthy Schools program; our Healthy Schools focus areas and mission, goals, strategies, and targeted metrics; and our implementation and evaluation plans.

Rationale for a Healthy Schools Program in Deschutes County

Schools are a logical and efficient setting for public health interventions for youth, with the potential for high impact. Schools are settings where learning is expected and new behaviors are learned and practiced daily. Children and adolescents spend nearly half of their waking hours at school for 13 years of their critical developmental life (National Association of Chronic Disease Directors [NACDD], 2013). More than 95% of youth ages 5-17 can be reached through schools (Centers for Disease Control and Prevention [CDC], 2019).

Health, educational attainment, and income potential are highly interrelated (Basch, 2011). Students who are physically, mentally, socially, and emotionally healthy have higher levels of attendance, engagement, and achievement (NACDD, 2017). Similarly, educational attainment is strongly and consistently associated with more health promoting behaviors, better health of oneself and their family, greater job opportunities, higher income, and better control over life and work stressors (NACDD, 2017; Egerter, Braveman, Sadegh-Nobari, Grossman-Kahn, & Dekker, 2011).

Healthy People 2030, a 10-year road map for national public health efforts, recognizes the critical influence of education on long-term health outcomes. Healthy People 2030 lists high school graduation as a key social determinant of health, specifically identifying on-time graduation rates as a leading public health objective (Healthy People, n.d.). Students who are chronically absent in Oregon (missing 10% or more of enrolled school days) are less likely to graduate on time (75% on-time graduation rate for chronically absent compared to 91% on-time graduation rate for regular attenders) (Oregon Department of Education [ODE], 2015). Students who are chronically absent in Oregon are also less likely to meet academic standards in reading and math compared to their regular attending peers (ODE, 2015). Students may be chronically absent due to physical health issues (asthma, dental pain, diabetes), mental health (fear, depression, and anxiety), safety issues (bullying and violence), and social factors (hunger, unstable housing and transportation, job loss, or lack of health insurance) (Robert Wood Johnson Foundation, 2016). Absenteeism and temporary or permanent drop out are 2 of the 5 causal pathways for how health affects a student's ability to learn (Basch, 2011). The other 3 ways health impedes learning are: sensory perceptions (vision and hearing), cognition (attention, memory, and executive function), and connectedness to and engagement with adults and peers (Basch, 2011).

Deschutes County has 3 public school districts. The table below describes the 4-year graduation rates and chronically absent rates for Deschutes County public school districts for the 2018-2019 school year. About 81% of Bend-La Pine students, 84% of Redmond students, and 91% of Sisters students graduated on time in 2019. Note that these Deschutes County graduation and chronically absent rates are averages. Disparities in these rates exist across multiple groups, including economically disadvantaged and underrepresented minority groups. The table below provides a comparison of these rates for the districts as a whole and for economically disadvantaged, for example.

Table 1: On-Time Graduation and Chronically Absent Rates for School Districts, Deschutes County

District	Group	On-time Graduation Rates (18-19)	Chronically Absent Rates (18-19)
Bend-La Pine	Total	81%	21%
Bend-La Pine	Economically Disadvantaged	70%	30%
Redmond	Total	84%	27%
Redmond	Economically Disadvantaged	80%	31%
Sisters	Total	91%	18%
Sisters	Economically Disadvantaged	77%	27%

Description of Selected Student Health Indicators in Deschutes County

Oregon uses multiple surveys and databases to monitor adolescent health. Most common surveys include the former Oregon Healthy Teens and former Oregon School Health surveys and the new Oregon Student Health survey which is combining and replacing the two former surveys as of 2020 (Oregon Health Authority [OHA], 2020a). These surveys gather self-report data from teens through questionnaires administered through schools who choose to participate (OHA, 2020a). Additionally, Oregon has state databases for immunizations and sexually transmitted infections. Below is a description of indicators of adolescent health in Deschutes County.

2019 Oregon Healthy Teens Survey Results for Deschutes County

The 2019 Oregon Healthy Teens survey provides us a pre-COVID-19 snapshot of adolescent health. The survey was only administered to 8th and 11th graders. Below is a table and summary of the health status for Deschutes County adolescents.

Table 2: Select 2019 Healthy Teens Results for Deschutes County		
Item	**8th Grade**	**11th Grade**
Difficulty concentrating, remembering, or making decisions	30%	32%
Difficulty doing errands alone	9%	10%
Unmet physical health care needs	16%	13%
Unmet emotional or mental health needs	20%	22%
Meeting the Positive Youth Development benchmark	57%	60%
Experienced bullying at school or on the way to school in the past 30 days	32%	17%
Feeling sad or hopeless for 2 weeks or more	30%	34%
Seriously considering suicide	19%	15%
Were pressured into having sex	n/a	14%
30-day alcohol use	11%	27%
30-day e-cigarette use (vaping)	13%	21%
30-day marijuana use	8%	18%

Positive Youth Development

In Deschutes County, about ⅗ of students (57% of 8th graders and 60% of 11th graders) meet the Positive Youth Development benchmark. Oregon's Positive Youth Development benchmark assesses a student's physical and mental/emotional health, confidence, competence, social connection to an adult or peer at school, and service to the community (OHA, 2011). Positive Youth Development is a strong predictor of other student health and achievement factors. In Oregon, students reaching the Positive Youth Development benchmark (OHA, 2011):

- Are more likely to have As and Bs on their report card
- More likely to have healthier behaviors, including more physical activity and healthier diet
- Less likely to have riskier behaviors, including substance use, fighting, having sex, and suicide attempts

Difficulty with Concentration, Remembering, or Making Decisions

About ⅓ of 8th and 11th grade respondents (30% of 8th graders and 32.4% of 11th graders) reported disabilities. Most commonly (24.4% of 8th graders and 25.3% of 11th graders) reported was difficulty concentrating, remembering, or making decisions due to a

physical, mental, or emotional condition. Difficulty with concentration, remembering, or making decisions are barriers to learning and achievement and risk factors for poor mental health and risky behaviors.

Suicide Risk, Depression, and Substance Use

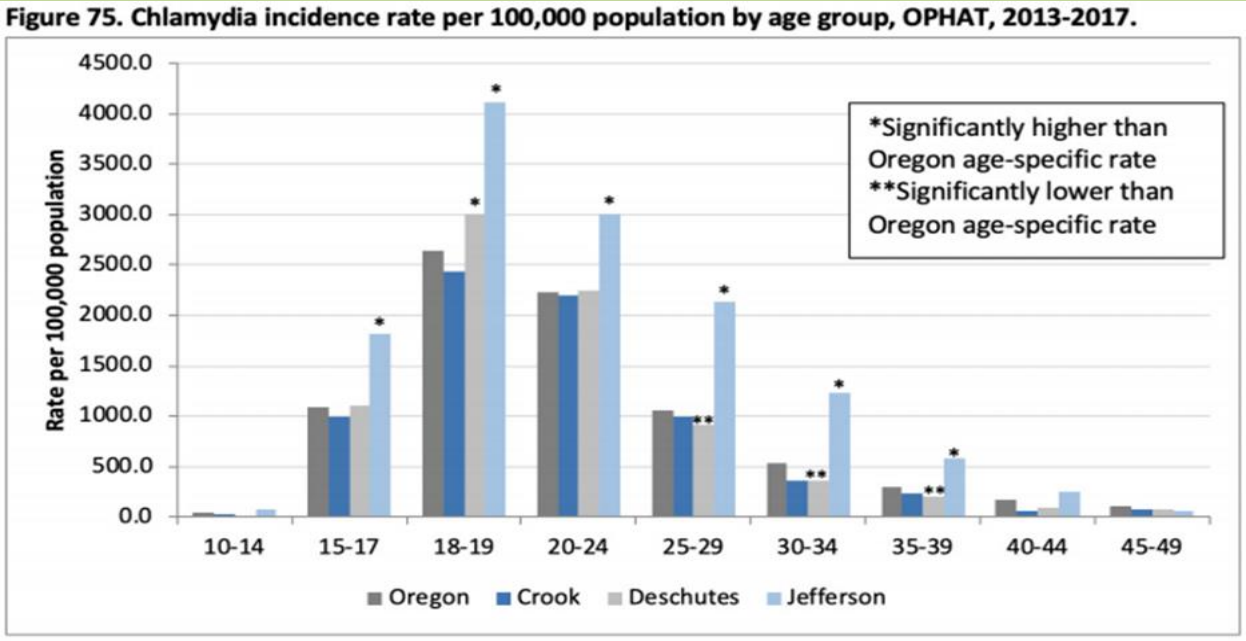
Suicide is a leading cause of death for Oregon youth. Suicide is a severe outcome of unmet mental health needs. In 2019, 19% of 8th graders and 15% of 11th graders reported seriously considering suicide. About ⅕ of students surveyed (20% of 8th graders and 22% of 11th graders) reported having unmet emotional or mental health care needs over the previous 12 months. About ⅓ of students surveyed (30% of 8th graders and 34% of 11th graders) reported feeling sad or hopeless for 2 weeks or more, Oregon's indicator for depression.

Substance use can be both a coping mechanism for mental, social, and emotional distress, as well as a cause of mental, social, and emotional distress. Oregon uses 30-day substance use as an indicator of frequent, potentially habitual, substance use. For 30-day substance use: alcohol is the most commonly used substance (11% for 8th graders and 27% of 11th graders), followed by e-cigarette (vaping) and marijuana (13% and 8% of 8th graders, respectively, and 21% and 18% of 11th graders, respectively).

Sexually Transmitted Infections (STIs) and HPV Immunization Rates

Similar to trends across the United States, most sexually transmitted infections (STI) in Deschutes County and Oregon occur between the ages of 15-24 (Central Oregon Health Council [COHC], 2019). Chlamydia is the most common reportable STI (COHC, 2019). Reportable diseases are those that require medical providers and laboratories to report newly diagnosed cases to the public health authority. Below is a table excerpted from the Central Oregon Regional Health Assessment illustrating the distribution of chlamydia diagnoses across age groups (COHC, 2019), illustrating the high number of diagnoses across the 15-24 age groups.

Figure 2: Screenshot from Central Oregon Regional Health Assessment representing new chlamydia diagnoses by age group



HPV (human papillomavirus) is the most common STI. The CDC estimates that about 85% of all sexually active people will have a HPV infection at some point in their lives, usually in their teens or early 20s (CDC, 2021). HPV is not a reportable STI so we do not have state or local HPV rates. HPV is one of few STIs that is preventable with a vaccine. Oregon tracks and reports HPV vaccine series initiation and completion for adolescents 13-17 along with other immunization records. For 13-17 year olds in Deschutes County, 72% have initiated at least 1 dose of the HPV vaccine series and 53% have completed the series (OHA, 2020c).

Table 3: 2020 HPV Immunizations for 13-17 year olds in Oregon

Item	Proportion
HPV Series Initiations	72%
HPV Series Completion	53%

Recommended Approaches and Frameworks for School Health

Coordinated School Health and Whole Community, Whole School, Whole Child (WSCC) Model

The best practice model for school health is the Coordinated School Health model, developed by the Centers for Disease Control and Prevention (CDC) in 1988. The premise of Coordinated School Health is the *alignment, integration, and collaboration between public health and education* to improve both health and learning outcomes. The Coordinated School Health approach emphasizes the importance of coordination across 10 components of school

health in order to share awareness of health issues and priorities, gain support for addressing health issues, leverage community resources, reinforce consistent health messages, and avoid duplication (NACDD, 2017). The following are recommended core processes for implementing Coordinated School Health (OHA, 2013; NACDD, 2017; RMC Health, 2014):

1. Designating a School Health Coordinator,
2. Establishing a representative school health team, with at least one school administrator, parent, and student,
3. Collaboratively conducting a school health practices assessment, and
4. Collaboratively developing and implementing a school health improvement plan.

The Coordinated School Health model was recently expanded into the Whole School, Whole Community, Whole Child (WSCC, pronounced "whisk") model, blending together the Coordinated School Health model with a Whole Child model used in the education sector. The blue bands in the expanded WSCC model below contain the original Coordinated School Health model. Many programs and practitioners using the original Coordinated School Health model still refer to their programs and this approach as Coordinated School Health, even though the model is now officially called WSCC by the CDC.

Figure 2: Whole School, Whole Community, Whole Child Model

Table 4: Component	NACDD's Component Definition (NACDD, 2017)
Health Education	Formal, structured health education consists of any combination of planned learning experiences that provide the opportunity to acquire the information and skills students need to make quality health decisions. Health education curricula and instruction should address the National Health Education Standards (NHES), incorporate the characteristics of an effective health education curriculum, and be taught by qualified, trained teachers
Physical Education and Physical Activity	A comprehensive school physical activity program (CSPAP) is the national framework for physical education and youth physical activity. It reflects strong coordination across five components: ● physical education, ● physical activity during school, ● physical activity before and after school, ● staff involvement, and ● family and community engagement. Physical education is the foundation of CSPAP, and is an academic subject for grades K-12. Curriculum should be based on the national standards for physical education, and classes should be taught by certified or licensed teachers endorsed by the state to teach physical education.
Nutrition Environment and Services	The school nutrition environment provides students with opportunities to learn about and practice healthy eating through nutrition education, messages about food in the cafeteria and throughout the school campus, and available food and beverages, including in vending machines, "grab and go" kiosks, school stores, concession stands, food carts, classroom rewards and parties, school celebrations, and fundraisers. School nutrition services provide meals and snacks that meet federal nutrition standards. All individuals in the school community can support a healthy school nutrition environment.
Health Services	School health services intervene with actual and potential health problems, including providing first aid, emergency care and assessment and planning for the management of chronic conditions (such as asthma, food allergies or diabetes). Health services also facilitates access to and/or referrals to providers, collaborates with community support services, and works with families to promote the health care of students and a healthy and safe school environment.
Counseling, Psychological, and Social Services	These prevention and intervention services support the mental, behavioral, and social-emotional health of students, and promote success in the learning process. Services include psychological, psychoeducational, and psychosocial assessments; direct and indirect interventions to address psychological, academic, and social barriers

	to learning, such as individual or group counseling and consultation; and referrals to school and community support services as needed.
Social and Emotional Climate	This refers to the psychosocial aspects of students' educational experience that influence their social and emotional development. The social and emotional climate of a school can impact student engagement in school activities; relationships with other students, staff, family and community; and academic performance.
Physical Environment	A healthy and safe physical school environment promotes learning by ensuring the health and safety of students and staff. A healthy school environment will address a school's physical condition during normal operation as well as during renovation, protecting occupants from physical threats, biological and chemical agents in the air, water, or soil, as well as those purposefully brought into the school.
Employee Wellness	Fostering school employees' physical and mental health protects school staff, and by doing so, helps support students' health and academic success. A comprehensive school employee wellness approach is a coordinated set of programs, policies, benefits, and environmental supports designed to address multiple risk factors (e.g., lack of physical activity, tobacco use) and health conditions (e.g., diabetes, depression) to meet the health and safety needs of all employees.
Family Engagement	Families and school staff work together to support and improve the learning, development, and health of students. School staff are committed to making families feel welcomed, engaging families in a variety of meaningful ways, and sustaining family engagement. Families are committed to actively supporting their child's learning and development.
Community Involvement	Community groups, organizations, local businesses, social service agencies, faith-based organizations, health clinics, and colleges and universities create partnerships with schools, share resources, and volunteer to support student learning, development, and health-related activities.

School Health Index

The Coordinated School Health/WSCC model has a companion tool, called the *School Health Index*, which serves as comprehensive standards for school health practices, an assessment tool to identify gaps in reaching the standards, and a tool for collaborative prioritization and planning for coordinated school health improvements. The School Health Index's standards are based on decades of CDC analyses comparing youth health data with school policies and practices. The School Health Index includes 11 modules: 1 for each of the 10 components of school health and 1 additional module for school policies and protocols. The School Health Index was recently updated in 2017.

Applications of WSCC/Coordinated School Health

Coordinated School Health has been implemented across the United States at state, county, district, and school levels. The model and the School Health Index is a *process* that can be used to address a range of health priorities. Most commonly, Coordinated School Health has been used to address obesity, physical activity, and nutrition, but more areas are beginning to use this model for mental, social, and emotional well-being.

At least two states have established legislation requiring Coordinated School Health. Tennessee led the nation in 2006 by adopting Coordinated School Health state-wide, legislating tax-payer funds to institute a Coordinated School Health Office at their state department of education and establishing full-time School Health Coordinators in every district and every school (Tennessee Department of Education [TDE], n.d.). Their primary focus areas are reducing obesity and improving physical activity and nutrition. Tennessee reports that physical activity for students increased from 25% in 2005 to 44% in 2017 (TDE, 2019). The State of Texas also passed legislation to require Coordinated School Health advisory committees in all districts, Coordinated School Health programs in all public schools, and annual school health reports on the Coordinated School Health activities. The Texas requirements include: physical health education designed to prevent chronic diseases, mental health education, substance abuse education, physical education and activity, and parent involvement (Texas Education Code 38.013.).

Oregon currently has CDC grant funding, along with 15 other states, to use this model for the Oregon Healthy Schools program. The CDC funding mechanism for Oregon only provides reach into just 6 school districts, none of which are in Central Oregon, and limits their focus to nutrition, physical education/activity, and managing chronic disease. Oregon Healthy Schools is using the School Health Index in the 6 school districts included in their program.

Oregon has used the Coordinated School Health model since at least 2010, most strongly whenever grant funding is available because Oregon has not legislated funding toward this model. In 2013, under a larger CDC grant, Oregon implemented Coordinated School Health widely and conducted an analysis of the relationship between schools who reached a "core capacity" for school health and student outcomes. Oregon defined the "core capacity" for school health as:

1. Having a designated school health coordinator,
2. Conducting an evidence-based school health assessments such as the CDC's School Health Index,
3. Having a school health team that includes school leaders and community partners, and
4. Including a health goal and objective in their School Improvement Plan, an educational plan.

Oregon's analysis found that 1 in 9 (or 11% of) Oregon's middle/high schools were able to demonstrate "core capacity" and found that those "core capacity" schools: implemented more

evidence-based school health practices, had more students reaching the Positive Youth Development benchmark, had healthier student behaviors, higher grades in high schools, 3 fewer attendance violations per 100 students, 4 fewer disciplinary actions per 100 students, and higher 4-year graduation rates. The barriers to reaching core capacity were identified as designated staff time and leadership for facilitating the process. *The analysis concluded that having a designated school health coordinator (at least .5 FTE) was the key enabling factor in reaching core capacity, and these associated outcomes.*

Design of Healthy Schools in Deschutes County

Our Healthy Schools program will implement the Coordinated School Health/WSCC model, using the School Health Index, with the following structures and focus areas, allowing Deschutes County Health Services and school districts to identify and address needs of students:

Formal Integration - Contracts or formal agreements made between partnering institutions to assure true integration of public health into the school settings and education system structures. School Districts and Deschutes County Health Services are 50/50 funding partners. Staff from partnering agencies are designated to Healthy Schools collaboration.

Healthy Schools Steering Committee - A committee including executive representation from each invested partner and other relevant agencies to direct overall program development and provide necessary approvals for integrations. The steering committee also includes an advisory subcommittee composed of veteran education and public health practitioners to advise program operations in between steering committee meetings.

District-level Alignment and Improvements - The Healthy Schools Supervisor works closely with designated district office staff to assess and address supports needed for Healthy Schools initiatives. District office staff include the directors of mental, social, and emotional wellbeing; discipline and restorative practices; secondary school curricula; and health services. District-level operations include supporting a district wellness committee; reviewing, recommending, and aiding in the development of district program and protocol developments; providing relevant professional development; providing health communications; and aiding in the implementation of district initiative in school settings with public health specialists.

Public Health Specialists in Schools - The core foundation of our Healthy Schools program is embedding a Public Health Specialist (PHS) into each high school to serve as the designated school health coordinator. As previously mentioned in the Recommend Approaches section, a designated school health coordinator, at least 0.5 FTE per school, was identified as the key enabling factor for sustainable school health improvements and improvements in student outcomes. The PHS will be hosted by their high school, but will also provide school health coordination services to the middle schools feeding into that high school as well.

As the school health coordinator, the PHS will be responsible for facilitating the collaborative, comprehensive data-driven school health improvement process. The roles and activities of the PHS may differ depending on the unique needs of the schools they serve and the school health needs identified by their school health team. Typical roles of the PHS include:

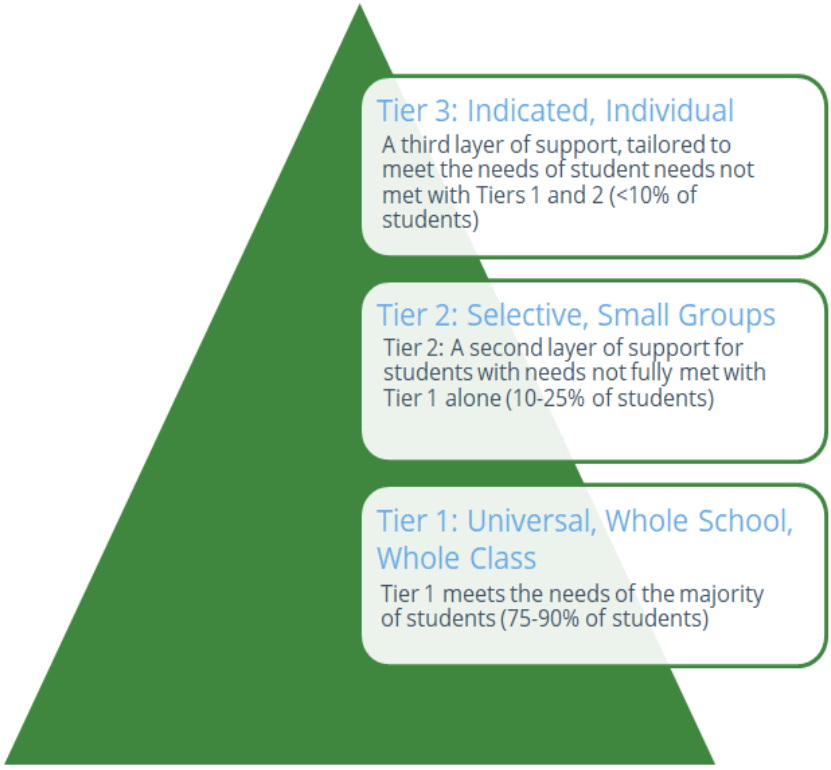
- Conducting school health assessments and reporting results
- Developing a school health improvement plan with a variety of school stakeholders, including admin, staff, parents, and students
- Coordinating and facilitating implementation of the school health improvement plan through engagements with admin, staff, parents, students, and community-based organizations
- Assisting schools with the development and implementation of health, development, or equity goals for school improvement plans
- Serving as a liaison between the school and external programs, such as Deschutes County Health Services, School-based Health Center, and community-based organizations
- Providing behavioral screenings for students, as needed
- Providing resource navigation to admin, staff, parents, and students
- Providing evidence-based health education to students and parents
- Providing health communications to entire school community and to targeted groups
- Providing parenting education to support adolescent health and development
- Providing training and coaching to improve evidence-based school health practices
- Supporting compliance with state and district health-related policies
- Coordinating implementation of school-wide Social and Emotional Learning
- Supporting student engagement initiatives and youth-led projects

Most of the Public Health Specialists' activities are in the Tier 1 and Tier 2 levels of the Multi-Tier System of Support (MTSS) model commonly used by schools (see Figure 3 below). Tier 1 activities are universal, reaching all students. We aim for the majority of the Public Health Specialist's activities to be Tier 1, which aligns with the Primary Prevention level in the Public Health Prevention Framework commonly used in the public health field. An example of Tier 1 activities are implementing school-wide social and emotional climate changes that affect the entire school environment. Tier 2 in MTSS activities are selective, often for groups of students based on certain risk factors indicating they need an additional layer of support on top of Tier 1 supports. Tier 2 aligns with the Secondary Prevention level of the Public Health Prevention Framework. The Public Health Specialist will provide Tier 2 activities, particularly in the interest of reducing inequities by certain student groups. An example of a Tier 2 activities is facilitating cultural connection activities for Latino/a/x students and families.

Tier 3 activities are indicated for an individual based on an individual's need. Students receiving Tier 3 interventions experience significant challenges that require more individualized supports than those provided in Tiers 1 and 2. Tier 3's individualized support can include assistance from specialized professionals such as counselors/therapists. There are few occasions in which Public Health Specialists provide Tier 3 activities. Brief screenings and referrals or program enrollment

related to our student health focus areas are examples of Tier 3 activities that would be acceptable, in the absence of other staff members available to perform the service. The Public Health Specialist will not supplant the role of any school staff, but may provide assistance and supports to school staff.

Figure 3: Multi-tier System of Support Model



Student Health Focus Areas - Our data-driven planning process has identified 6 focus areas for student health intervention:

- Suicide
- Substance Use
- Sexually-transmitted Infections
- Teen Pregnancy
- Immunizations
- Positive Youth Development (including Social and Emotional Learning)

School Health Improvement Focus Areas: Our stakeholder engagements and literature reviews have identified 3 school health improvement focus areas:

- Social and Emotional Climate
- Health Education
- Family Engagement

See the description of these three school health components in the Recommended Approaches section above.

Mission, Goals, and Strategies of Healthy Schools

Mission

Provide public health services directly within schools and school communities using collaborative, systemic, and integrative approaches *so that* students, families, and school staff in Deschutes County have access to high quality health promoting programs.

Goals

- Increase social, mental, emotional, and physical health supports in schools
- Increase students reaching Positive Youth Development benchmark
- Reduce unmet physical and mental/emotional health needs amongst students
- Reduce disparities by race/ethnicity, gender/sexual orientation, and income levels
- Increase on-time graduation rates

Strategies

Our Healthy Schools program will use the following strategies to improve student health:

1. Assessment of resources, readiness, and gaps in evidence-based school health practices
    a. Use interviewing to assess local school health resources available and how well used
    b. Use interviewing to identify key stakeholders and readiness for school health improvements
    c. Use School Health Index to collaboratively assess gaps and priorities in evidence-based school health practices
2. Resource mapping, navigation, coordination, and alignment
    a. Create a school health resource database to create a navigable school health system
    b. Use resource database/map to provide resource navigation, coordinate resources to fill gaps, and align resources to improve efficiency and reduce confusion/duplication
3. Collaborative, data-driven prioritization, planning and implementation of evidence-based school health practices
    a. Use the School Health Index and WSCC Implementation guides to set priorities, create school health improvement plans, and implement evidence-based school health practices
4. Strategic communications for multiple stakeholder groups
    a. Create a behavior change communications plan
    b. Use strategic segmentation and messaging to reinforce attitudes, norms, and behavior changes
    c. Use Success Stories to increase awareness and support for Healthy Schools and communicate progress/achievements

5. Continuous monitoring, evaluation, reporting, and quality improvement
    a. Develop a performance monitoring process
    b. Conduct Plan-Do-Study-Act cycles to improve quality
    c. Report progress to key stakeholders on annual bases
    d. Gather stakeholder feedback from reporting to integrate into program interactions

Key Performance Metrics

Below is a list of select metrics we will use as indicators of progress towards our program goals. See the full list of metrics in Appendix A.

Short-term Metrics:

- Healthy Schools will meet Oregon's "Core Capacity" for sustainable school health and implement 3 School Health Index Modules
- Healthy Schools' staff, students, and parents/guardians will increase their knowledge of resources and how to access them
- Bend-La Pine Schools' Health teachers will increase their knowledge and confidence in delivering evidence- and skills-based health education
- Bend-La Pine Schools' Health Education Scope and Sequence and approved curricula will be reviewed and revised as needed, based on readiness.

Intermediate Term Metrics:

- Healthy Schools' parents/guardians will have increased their knowledge and skills to support their ability to talk to their adolescents about alcohol, drugs, sex, suicide, and mental health concerns
- Healthy Schools' staff will implement best practices for health education, social and emotional learning, and restorative early interventions
- Healthy Schools will have an increase in the proportion of students reporting that there's someone they can go to at school for help with a health problem
- Healthy Schools have an increase in students reaching the Positive Youth Development benchmark

Long Term Metrics:

- Healthy Schools will have a decrease in students reporting 30-day alcohol, marijuana, and e-cigarette use.
- Healthy Schools students will have lower rates of STIs and teen pregnancies
- Healthy Schools students will have lower rates of seriously considering suicide
- Healthy Schools students will have a decrease in students' unmet physical health care needs
- Healthy Schools students will have a decrease in unmet mental/emotional health care needs
- Healthy Schools will have an increase in regular attendance rate (90% or more attendance for days enrolled)
- Zip codes with Healthy Schools will have an increase in HPV series completion
- Healthy Schools will have a decrease in disparities by race/ethnicity, sexual orientation, and income

Implementation Plan

Healthy Schools will be implemented in Bend-La Pine Schools with a 3-year phase-in approach. Each year beginning in the 2021 start of the academic year, two high schools (and the middle schools feeding into them) will be added to the program. A high school (and their feeder middle and elementary schools) enter the program by committing to provide their Public Health Specialist a workspace, fully integrate the PHS into their school staff, and administratively support school health assessments and improvements.

The PHS will launch Healthy Schools in their high school and middle school by: 1.Building relationships with school staff, students, and parents, 2. Identifying champions for school health improvements, and 3. Identifying existing structures or meetings that can be leveraged for school health improvement processes. The PHS will use the School Health Index to collaboratively assess, prioritize, and plan school health improvements. Similar to Oregon Healthy Schools' approach, our Healthy Schools program will focus on implementing 3 SHI modules each year, starting with our priority focus areas: Social and Emotional Climate, Health Education, and Family Engagement. Though it would be ideal to implement all 10 of the SHI modules in year 1, it is not practical considering the time limitations and competing priorities of the school staff. The PHS will aim to integrate the school health improvement process into as many existing structures and activities to reduce the burden onto school staff.

Healthy Schools will also partner at the district level to coordinate district-level interventions to support school health interventions, such as professional development, review and revision of Health Education Scope and Sequence and approved curricula, and increasing structural supports for evidence-based health education. The Healthy Schools supervisor will provide district-level supports and coordinate structural changes at the district level.

A behavior change communications plan will be developed over the first year. The Healthy Schools team will work with district and public health communications specialists to design the communications plan. The strategic communications plan will be launched in Year 2.

See Tables 4-7 below for timeline tables describing the major implementation activities for the 3-year phase in approach. Each activity includes a prefix identifying at which level the activity is occurring. The prefixes include:

- Program: Including activities that occur between the main partnering institutions to establish and build the program. These activities occur through the Steering and Operations Committees, certain stakeholders such as partnering school leaders, our institutional administration (such as contracts), or our program staff and internal program operations. Program level activities are mostly facilitated by the Healthy Schools supervisor or key partners in each partnering institution.

- District: Including activities that occur specifically for the district, such as reviewing and revising the district's Health Education Scope and Sequence or providing Health

Education professional development for all district staff. These are activities that create structure changes or reach beyond the internal program operations and the current cohort of Healthy Schools included in the program at a given time, such as communications content that goes out to all schools or all district families.

- Cohort 1: Including activities that occur at the middle and high school included in Healthy Schools (schools receiving a Public Health Specialist) over the 2021-22 school year. Activities occurring in the school cohorts are facilitated by the school Public Health Specialists.

- Cohort 2: Including activities that occur at the middle and high schools included in Healthy Schools over the 2022-23 school year. Activities occurring in the school cohorts are facilitated by the school Public Health Specialists.

- Cohort 3: Including activities that occur at the middle and high schools included in Healthy Schools over the 2023-24 school year. Activities occurring in the school cohorts are facilitated by the school Public Health Specialists.

Table 5: Year 1 Timeline Table for Implementation Plan

Year 1 (2021-22) Major Activities	Q1 (Jul-Sept)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
Program: Convene Healthy Schools steering committee	x			
Program: Identify Y1 school cohort	x			
Program: Institutionalize Healthy Schools: contracts and embed into new/existing institutional structures	x			
Program: Hire and train Healthy Schools Staff	x	x		
Program: Review student health data to determine programmatic focus	x	x		
Program: Develop program strategies, goals, objectives, metrics through data review and stakeholder engagements	x	x		
Program: Create program communications materials, including Roles/Responsibilities, presentation of student health data to stakeholder groups to increase readiness, and a baseline report with Bend-La Pine student health data	x	x		
Program, District, and Cohort 1: Assess school health resources and develop and continually update school resource map or guide		x	x	x
Program and District: Conduct Health Education Teacher survey to assess Health Education needs		x		
District: Provide Health Education report from teacher survey to district with recommendations		x		
District: Provide District-level Health Education professional development based on assessment		x	x	x
Cohort 1: Assess opportunities for staff, student, family, and community engagement in school health improvement assessment, planning, and implementation process		x		x
Cohort 1: Identify a variety of school-level stakeholders for and facilitate at least three priority SHI modules: Health Education, Family Engagement, and Social and Emotional Climate. Engaged stakeholders should include: school admin, schools staff affected by the module area, students, and parents/guardians. For students and parents/guardians, include at least 1 representative from each group with		x	x	x

higher risk of poor student health outcomes.				
Cohort 1: Identify school-level stakeholders for and facilitate at least three priority SHI modules: Health Education, Family Engagement, and Social and Emotional Climate		x	x	x
Cohort 1: Using SHI: Identify gaps in services/programs and collaboratively prioritize and create a school health improvement plan to address the student health outcomes and program areas of focus		x	x	x
Cohort 1: Provide coaching, training, resource navigation and public health services to and with school staff, parents, and students for issues related to our focus areas		x	x	x
Program: Continually assess and report successes and challenges for activities at the district level and Cohort 1 schools		x	x	x
Program: Develop a behavior change communications plan and evaluation plan			x	x
Cohort 1: Align the school health improvement plan with the School Design Plan and provide implementation support for the School Design Plan goals related to our focus areas			x	
Cohort 1: Publish at least 1 Success Story per high and middle school				x
Cohort 1: Present a school health improvement report for school stakeholders describing the achievements and challenges for Year 1's SHI process, findings from assessments, and school health improvement plan progress				x
Program and District: Identify 2022-23 school cohorts to start Healthy Schools; Gain school leadership commitments to host and integrate new Public Health Specialist into their staff				x
Program and District: Secure 2022-23 funding and recruit 2 additional Public Health Specialists with expertise in school health, health education, or prevention science				x

Table 6: Year 2 Timeline Table for Implementation Plan

Year 2 (2022-23) Major Activities	Q1 (Jul-Sept)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
Program: Publish a Year 1 Implementation Evaluation Report	x			
Program: Iterate Healthy Schools program based on implementation reporting from Cohort 1	x			
Program: Conduct intensive professional development for Public Health Specialist, including supporting Deschutes County Prevention and Health Promotion program implementation for related youth-focused suicide prevention, substance use prevention, positive youth development programs.	x			
Program: Develop behavior change communications content and communication channels needed (such as a website, blog, newsletter) based on assessments conducted in Year 1	x			
Program and Cohort 1: Test behavior change communications content with focus groups	x	x		
Cohort 1 and 2: Launch strategic behavior change communications to target audiences		x	x	x
Cohort 1: Re-engage school stakeholders and facilitate updates to the school health improvement plan for last year's modules and add these SHI modules: Physical Education and Physical Activity, School Policies and Practices, and Community Involvement		x	x	x
Cohort 2: Identify school-level stakeholders for and facilitate at least three priority SHI modules: Health Education, Family Engagement, and Social and Emotional Climate		x	x	x
Cohort 2: Using SHI: Identify gaps in services/programs and collaboratively prioritize and create a school health improvement plan to address the student health outcomes and program areas of focus		x	x	x
Cohort 1 and 2: Facilitate and track progress for implementing school health improvement plans		x	x	x
Cohort 1 and 2: Provide coaching, training, resource navigation and public health services to school staff,		x	x	x

parents, and students for issues related to our student health outcomes and program areas of focus				
Cohort 1: Publish at least 1 Success Story per high and middle school		x		x
District and Cohort 1 and 2: Facilitate 2022 Oregon Student Health Survey in all Bend-La Pine schools		x		
Cohort 1 and 2: Align the school health improvement plan with the School Design Plan and provide implementation support for the School Design Plan goals related to our focus areas			x	
Program: Request 2022 Oregon School Health Survey raw data and analyze results to assess indicators of progress towards program goals				x
Cohort 2: Publish at least 1 Success Story per high and middle school				x
Cohort 1 and 2: Present a school health improvement report for school stakeholders describing the achievements and challenges for Year 2's SHI process, findings from assessments, and school health improvement plan progress				x
Program and District: Identify Cohort 3 schools and secure commitments to host and integrate Public Health Specialists				x
Program and District: Secure 2023-24 funding and recruit 2 additional Public Health Specialists with expertise in school health, health education, or prevention science				x

Table 7: Year 3 Timeline Table for Implementation Plan

Year 3 (2023-24) Major Activities	Q1 (Jul-Sept)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
Program: Publish a Year 2 Implementation Evaluation Report and analysis of key performance indicators from Cohorts 1 and 2	x			
Program: Iterate Healthy Schools program based on implementation reporting from Cohort 1 and 2	x			
Program: Identify additional funding streams and begin funding applications	x			

Program: Conduct intensive professional development for Public Health Specialist, including supporting Prevention program implementation for related youth-focused suicide prevention, substance use prevention, positive youth development programs.	x			
Program: Develop behavior change communications content and communication channels needed (such as a website, blog, newsletter) based on assessments conducted in Year 2	x			
Cohort 1-3: Launch behavior change communications using segmented dissemination		x	x	x
Cohort 1: Re-engage school stakeholders and facilitate updates to the school health improvement plan for previous years' modules and add these SHI modules: Health Services, Counseling, Physical Environment, Nutrition Services		x	x	x
Cohort 2: Re-engage school stakeholders and facilitate updates to the school health improvement plan for last year's modules and add these SHI modules: Physical Education and Physical Activity, School Policies and Practices, and Community Involvement		x	x	x
Cohort 3: Identify school-level stakeholders for and facilitate at least three priority SHI modules: Health Education, Family Engagement, and Social and Emotional Climate		x	x	x
Cohort 3: Using SHI: Identify gaps in services/programs and collaboratively prioritize and create a school health improvement plan to address the student health outcomes and program areas of focus		x	x	x
Cohort 1-3: Facilitate and track progress for implementing school health improvement plans		x	x	x
Cohort 1-3: Provide coaching, training, resource navigation and public health services to school staff, parents, and students for issues related to our student health outcomes and program areas of focus		x	x	x
Cohort 1 and 2: Publish at least 1 Success Story per high and middle school		x		x
Cohort 1 and 2: Align the school health improvement plan with the School Design Plan and provide implementation support for the School Design Plan goals related to our focus areas			x	

Cohort 3: Publish at least 1 Success Story per high and middle school				x
Cohort 1-3: Present a school health improvement report for school stakeholders describing the achievements and challenges for Year 3's SHI process, findings from assessments, and school health improvement plan progress				x
Secure funding to continue Healthy Schools with the capacity built				x

Table 8: Year 4 Timeline Table for Implementation Plan

Year 4 (2024-25) Major Activities	Q1 (Jul-Sept)	Q2 (Oct-Dec)	Q3 (Jan-Mar)	Q4 (Apr-Jun)
Program: Publish a Year 3 Implementation Evaluation Report and analysis of key performance indicators	x			
Program: Iterate Healthy Schools program based on implementation reporting from Cohort 1-3	x			
Continue Healthy Schools with long-term funding	x	x	x	x
Support facilitation for the 2024 Oregon Student Health Survey		x		
Request and analyze raw 2024 Oregon Student Health Survey data as a 3-year assessment of Healthy Schools			x	x

Evaluation Plan

Summary

Healthy Schools is a coordinated school health improvement *process* driven by the school community to change and align multiple-components of the school's social and educational environment. Healthy Schools will be coordinating the process of implementing evidence-based programs and practices, which have already been evaluated for effectiveness using rigorous experimental or high-powered epidemiological studies. Our evaluation focus is not to retest the effectiveness of these existing evidence-based practices. Healthy Schools' evaluation focus will be on *quality implementation* of the coordinated school health improvement process and quality implementation of the evidence-based practices. We will also be monitoring short-, intermediate-, and long-term *indicators* of student health changes from Healthy Schools implementation. Annual reports will be produced to evaluate the program's implementation process, successes, and challenges; inform stakeholders of the program's

activities and progress; describe planned changes for quality improvement; and describe changes in the student health indicators being monitored.

Annual Report Details

Healthy Schools will produce annual reports on two levels:

1. School-level: By the end of each academic year, each Public Health Specialist will provide their assigned middle and high schools an annual report of their school health improvement process, including their baseline School Health Index scores and changes to their score over the year, the school's identified strengths and areas for improvements, the school health improvements planned and achieved, and recommendations for next year's actions. Public Health Specialists will collect stakeholder feedback to this report and incorporate feedback into the following year's work plan. The feedback from the schools will provide input to program-level changes.

2. Program-level: Before the start of the following academic year, the Healthy Schools program will publish a report including a synthesis of the baseline SHI scores and score changes, identified strengths and areas for improvement, school health improvements planned and achieved, and planned program iterations based on feedback. The annual reports will also include data for key metrics being monitored, as data are available. Some metrics will be available on a yearly basis due to our program tracking or surveillance systems, but most key metrics will only be reportable following even years as the Oregon Student Health Survey is only administered in the Fall of even years. The overarching questions we will aim to address with our Healthy Schools' annual reports are:
    a. To what extent were our planned major activities completed? (See the Implementation Plan timeline of major activities)
    b. What were the barriers to implementation?
    c. What were the facilitators of implementation?
    d. What is each school's baseline school health status according to the School Health Index scores? What improvements were made to the schools' health status according to the School Health Index scores?
    e. What gaps in evidence-based school health practices were identified and prioritized?
    f. What were the identified strengths and areas for improvement?
    g. To what extent were a variety of school stakeholders included in the school health assessment, prioritization, and improvement planning process?
    h. To what extent have our student health indicators changed, depending on data availability?
    i. What program changes are recommended to improve school health and student health?

Table 9: Sources of data and timelines for accessing and reporting data

Source	Type	Timeline for Reporting
School Health Index	• School health scores • Strengths and Areas for Improvement • Priorities	Yearly
School Health Improvement Plan and Tracking Sheet	• School health improvement process	Yearly
Oregon Student Health Survey	• Perception of supports, resources, and climate • Suicide consideration • Substance Use • Positive Youth Development • Unmet Health Needs	2023-2024
Orpheus Data	• Sexually transmitted infections (STI)	Yearly
ALERT Data	• HPV series completion	Yearly
Youth Truth Survey	• Student, family, and parent engagement • Student, family, and parent perceptions of culture • Student sense of belonging and peer collaboration • Parent perception of communication and feedback	Yearly

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Appendix A: Full List of Metrics

Implementation (Process) Metrics	Source of Data
Each school year in Healthy Schools, a school health team will be identified, including representative members who are admin, relevant staff, parents/guardians, and students.	Tracking Sheet
By the end of each school year in Healthy Schools, a school health team will assess school health scores, strengths, and areas for improvement using the School Health Index in the following order: ● Year 1: Social and Emotional Climate, Health Education, and Family Engagement ● Year 2: Physical Education and Physical Activity, School Policies and Practices, and Community Involvement ● Year 3: Health Services, Counseling, Physical Environment, Nutrition Services	School Health Index
By the end of each school year, the school health team will prioritize school health improvements and create a school health improvement plan using the School Health Index, in the following order: ● Year 1: Social and Emotional Climate, Health Education, and Family Engagement ● Year 2: Physical Education and Physical Activity, School Policies and Practices, and Community Involvement ● Year 3: Health Services, Counseling, Physical Environment, Nutrition Services	School Health Index and School Health Improvement Plan
By the end of each school year, at least two school health improvements from the school health improvement plan related to our focus areas will be implemented with stakeholder engagement.	Annual School Report
Throughout each school year, Public Health Specialists will track changes to the SHI scores through monitoring school health improvements.	School Health Index
By the end of each school year, Public Health Specialists will report to their high and middle schools their baseline SHI scores, changes in SHI scores, the school health improvement plan, successes, and challenges.	Annual School Report
By the end of year 1, Public Health Specialists will produce at least 1 Success Story for each high and middle school using the CDC's Success Story guidance.	Success Stories
After year 1, Public Health Specialists will publish at least 1 Success Story each semester for each high and middle school using the CDC's Success Story guidance.	Success Stories
School Health Improvement Outputs	Source of Data
By the end of year 1 in Healthy Schools, schools will increase the number	School Health

of practices they are implementing for a positive psychosocial school climate according to Module 7, CC1 in the School Health Index.	Index
By the end of year 1 in Healthy Schools, schools will increase the number of practices they are implementing to engage all students in extracurricular school activities to foster student sense of belonging according to Module 7, CC9 in the School Health Index.	School Health Index
By the end of year 2 in Healthy Schools, schools will increase their efforts to communicate with all families about school health activities and programs in culturally- and linguistically- appropriate ways, using a variety of communication methods, according to Module 10, CC1 in the School Health Index.	School Health Index
By the end of year 2 in Healthy Schools, schools will increase the number of parenting strategies shared and reinforced to parents/guardians, according to Module 10, CC2 in the School Health Index.	School Health Index
By the end of year 2 in Healthy Schools, schools will increase the opportunities family members have to reinforce learning at home that focuses on improving health knowledge and behaviors, according to Module 10, CC5 in the School Health Index.	School Health Index
By the end of year 2 in Healthy Schools, school staff will receive professional development on strategies for family engagement, according to Module 10, CC7 in the School Health Index.	School Health Index
By the end of year 2 in Healthy Schools, school staff will receive professional development on ways to assist parents seeking mental health services for students, according to Module 10, CC8 in the School Health Index.	School Health Index
By the end of year 2 in Healthy Schools, schools will provide regular updates to families on issues related to all aspects of student health, according to Module 10, CC9 in the School Health Index.	School Health Index
By the end of year 3 in Healthy Schools, all health education teachers will use age-appropriate sequential health education curricula consistent with Oregon and national health standards.	School Health Index
By the end of year 3 in Healthy Schools, schools will implement social and emotional learning for all students, according to Module 7, CC5 in the School Health Index.	School Health Index
By the end of year 3 in Healthy Schools, schools will be using all practices listed to foster a positive psychosocial school climate for all students, according to Module 7, CC1 in the School Health Index.	School Health Index
By the end of year 3 in Healthy Schools, schools will meet all 6 of	School Health

strategies to meet the needs of LGBT youth, according to Module 1, SH.6 of the School Health Index.	Index
Student Outcomes	Source of Data
By the end of year 2 in Healthy Schools, schools will increase the proportion of students reporting that there is at least one teacher or other adult in school that really cares about them by x%.*	Oregon Student Health Survey
By the end of year 2 in Healthy Schools, schools will increase the proportion of students reporting that there is someone at their school they can go to for help for a physical or mental health problem by x%.*	Oregon Student Health Survey
By the end of year 2 in Healthy Schools, schools will increase the proportion of students reaching the positive youth development benchmark by x%.*	Oregon Student Health Survey
By the end of year 2 in Healthy Schools, schools will increase the proportion of students reporting utilizing school-based health centers by x%.*	Oregon Student Health Survey
By the end of year 3 in Healthy Schools, schools will increase the proportion of students reporting that adults in their school respect people from different backgrounds.	Oregon Student Health Survey
By the end of year 3 in Healthy Schools, schools will reduce agreement with the presence of conflict or tension based on race, ethnicity, culture, religion, gender, sexual orientation, or disability.	Oregon Student Health Survey
By the end of year 3 in Healthy Schools, the proportion of students reporting that they've received health education on healthy and respectful relationships will increase by x%.*	Oregon Student Health Survey
By the end of Year 3 in Healthy Schools, schools will increase the proportion of 11th grade students reaching the positive youth development benchmark by x%.*	Oregon Student Health Survey
By the end of Year 3 in Healthy Schools, schools will reduce the disparities in reaching the positive youth development benchmark by income, race/ethnicity, and sexual orientation by x%.*	Oregon Student Health Survey
By the end of year 3 in Healthy Schools, schools will reduce the proportion of 8th grade and 11th grade students reporting alcohol use in the past 30 days by x%.*	Oregon Student Health Survey
By the end of year 3 in Healthy Schools, schools will reduce the proportion of 8th grade and 11th grade students reporting e-cigarette use in the past 30 days by x%.*	Oregon Student Health Survey
By the end of year 3 in Healthy Schools, schools will reduce the proportion	Oregon Student

of 8th grade and 11th grade students reporting marijuana use in the past 30 days by x%.*	Health Survey
By the end of year 3 in Healthy Schools, schools will reduce the proportion of students seriously considering suicide by x%.*	Oregon Student Health Survey
By xx, reduce disparities in substance use and suicide consideration by xx, sexual orientation, and xx by x%.*	Oregon Student Health Survey
By the end of year 3 in Healthy Schools, zip codes with Healthy Schools will have x% lower rates of STIs.	Orpheus Data
By the end of year 3 in Healthy Schools, schools will reduce the proportion of students reporting unmet physical health care needs by x%.	Oregon Student Health Survey
By the end of year 3 in Healthy Schools, schools will reduce the proportion of students reporting unmet mental or emotional care needs by x%.	Oregon Student Health Survey
By the end of year 3 in Healthy Schools, zip codes with Healthy Schools will have an increase in HPV series completion by x%.	ALERT Data
By the end of year 3 in Healthy Schools, student attendance rates will increase by x%.	At-a-Glance Report
By the end of year 3 in Healthy Schools, out-of-school suspension will reduce by x%.	At-a-Glance Report

*Healthy Schools is committed to data-driven decision making. For each of the metrics with "x%" as a placeholder, we are reviewing meaningful and reasonable measures of change set by leading public health entities or found in relevant school-based intervention research and evaluation.