

# **North Dakota Coordinated School Health Blueprint**



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## North Dakota Coordinated School Health Blueprint

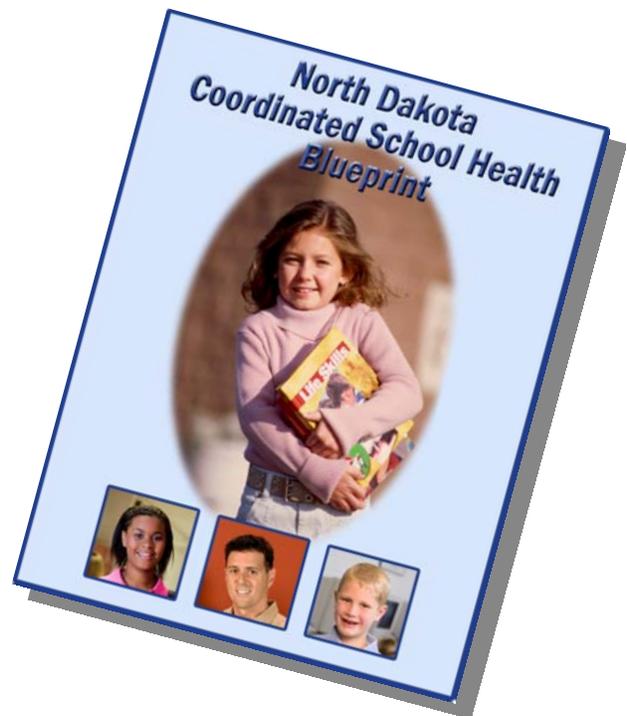
It all begins with two simple ideas: healthy students learn better and healthy youth become healthy adults. The Carnegie Council on Adolescent Development probably said it best: “Students who are hungry, sick, troubled or depressed cannot function well in the classroom, no matter how good the school.” [1]

An effective blueprint is one that describes what health problems will be addressed and how they will be addressed. The North Dakota Coordinated School Health (CSH) Blueprint reflects the unique assets and needs of youth in the state and identifies priority health issues and at-risk populations. The blueprint describes how proposed strategies will be funded and evaluated and defines the role of each participating organization. To foster the widest possible support, statewide stakeholders participated in the development and evaluation of the blueprint, which will be reviewed and updated regularly.

Additionally, this blueprint addresses disease burden, rationale for proposed goals, objectives and strategies, as well as resources and time lines. Key elements include methods of working with government leaders and establishing the organizational support and infrastructure necessary to promote policy-level interventions. The intended audience of this document is state agency personnel, school district personnel, public health units, non-government organizations, legislators, parents and students.

The purpose of North Dakota’s CSH Blueprint is to:

- Provide a design for coordinated and integrated statewide efforts to reduce the burden of tobacco use and youth obesity, improve eating patterns and increase physical activity.
- Set goals for improvement and create strategies to work toward given the range of evidence-based or theory-based strategies available.
- Draw together interested organizations and individuals to work toward shared goals.





## What Is Coordinated School Health?

Coordinated school health is a comprehensive, collaborative approach to developing the total well-being of school-age youth. The purpose of coordinated school health is to promote the best possible health outcomes for every student and to teach health concepts that help students make responsible decisions regarding their current and future health. In a comprehensive coordinated school health model, the school works in partnership with the family and community to ensure that each child begins and attends school in a positive condition of physical, mental and social well-being. At its core, coordinated school health is about keeping students healthy over time, reinforcing positive health behaviors throughout the school day and beyond, and making it clear that good health and learning go hand in hand. Research strongly indicates that collaborative efforts among family, community and schools are the most effective approaches for both health prevention and intervention.

### Coordinated School Health History

Concern about the health and educational achievement of young people and the recognition that education and health are intertwined have resulted in considerable interest in and attention to the quality of health programs in schools and communities. In the past, school health focused on human biology and hygiene. Today's health problems require more comprehensive programs that focus on knowledge, skill development, health interventions and health services for youth and referral/involvement of community experts and resources. While selected resources are available in schools and communities, the organization and infrastructure were not always in place to coordinate efficient delivery. The promotion and protection of the health of students has been a consistent purpose of public schools across the country and North Dakota.

In 1992, the Harvard School Health Education Project conducted a policy analysis of 25 national reports related to school-based health promotion. Five themes emerged from its analysis of these diverse reports and still stand as a current foundation for policy development:

1. *Education and health are interrelated.* Education affects health, health affects education, and many of the health problems affecting children, and thus their education, are preventable.
2. *The biggest threats to health are social morbidities.* The American Medical Association defines social morbidities as "those threats to health that are primarily the result of social environment and/or behavior." Many of these cause injury and death, including homicide, suicide and risk behaviors such as alcohol and drugs.
3. *A more comprehensive, integrated approach is needed.* Fragmentation of programs and services is a barrier to the effectiveness of services to children and their families. There is an urgent and compelling need for more comprehensive and coordinated policies, programs and services.
4. *Health promotion and education efforts should be centered in and around schools.* While there is still much debate about the school's role in children's lives, the school is where most children spend much of their time and is the one place in the community that is accessible and known by families.
5. *Prevention efforts are cost-effective.* The social and economic costs of failure to promote health and prevent disease are high and they continue to escalate. Prevention efforts do reduce the cost of intervention. [2]



## **Coordinated School Health Vision**

Prior to the North Dakota five-year grant award from the U.S. Centers for Disease Control and Prevention (CDC), state efforts to implement a comprehensive approach to school health were somewhat fragmented, with very limited resources, both human and fiscal. Through the implementation of the CDC grant, interagency coordination and a statewide coalition that supports the coordinated school health model is in unison. Dedicated staffs within both lead agencies are also in place and provide direction and guidance to the implementation process. From the beginning, a core belief among partners has been that “healthy students are better learners.”

The North Dakota Department of Public Instruction and the North Dakota Department of Health are pleased to present the North Dakota Coordinated School Health Blueprint. This document represents the collaborative vision of not only two agencies, but also statewide stakeholders who represent the vision unfolding daily as they work with, serve and protect the youth of North Dakota. Our strength will continue to be found in collaborative efforts to promote healthy lifestyles for children and youth.

We must ensure that every child is healthy and ready to learn. Imagine a day in North Dakota when every child has three nutritious meals a day, habitual physical activity, classroom education on health topics such as tobacco and other drug use, and a safe and healthy school environment. This document provides a beginning to make that day a reality. As stated by the Council of Chief State School Officers, “In the larger context, schools are society’s vehicle for providing young people with the tools for successful adulthood. Perhaps no tool is more essential than good health.”





## Coordinated School Health Components

Health is not just the absence of disease – it is comprehensive physical, mental and social well-being. Coordinated school health is comprised of eight components that effectively address students' health and thus improve their ability to learn. Each component makes a unique contribution while also complementing the others, ultimately creating a whole that is more than just the sum of its parts. No single component will achieve the level of health students need to support academic achievement. The following eight components work together to develop and reinforce health-related knowledge, skills, attitudes and behaviors and make health an important priority at school.





### ***Health Education***

Healthy schools require planned, sequential, K-12 curriculum that addresses the physical, mental, emotional and social dimensions of health. The curriculum is intended to motivate and assist students to maintain and improve their health, prevent disease and reduce health-related risk behaviors. It allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills and practices. Comprehensive health education curriculum includes a variety of topics, such as personal health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, and substance use and abuse.

- ✓ Students who participate in health education classes that use effective curricula increase their health knowledge and improve their health skills and behaviors.
- ✓ Comprehensive health education and social skills programs for high-risk students improve school and test performance, attendance and school connectedness.

### ***Physical Education***

A planned, sequential K-12 curriculum can provide cognitive content and learning experiences in a variety of activity areas such as basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics. Quality physical education should promote, through a variety of planned physical activities, each student's optimum physical, mental, emotional and social development and should promote activities and sports that all students enjoy and can pursue throughout their lives.

- ✓ Schools that offer intensive physical activity programs see positive effects on academic achievement even when time for physical education is taken from the academic day, including increased concentration, reduced disruptive behaviors, higher levels of self-esteem and lower levels of anxiety and stress.
- ✓ Physical activity is positively associated with academic performance.

### ***Health Services***

School health services should be provided for students to appraise, protect and promote health. These services are designed to ensure access and/or referral to primary health-care services, foster appropriate use of primary health-care services, prevent and control communicable diseases and other health problems, provide emergency care for illness or injury, promote and provide optimum sanitary conditions for a safe school facility and school environment, and provide educational and counseling opportunities for promoting and maintaining individual, family and community health.

- ✓ Preventive health services provided through schools, coupled with health education and counseling that promote healthy lifestyles and self-sufficiency, can help contain health-care costs.
- ✓ Schools with school-based health centers report increased school attendance, decreased drop-outs and suspensions, and higher graduation rates.



### ***Nutrition Services***

Quality nutrition services provide access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students. School nutrition programs reflect the U.S. Dietary Guidelines for Americans and other criteria to achieve nutrition integrity. School nutrition services offer students a learning laboratory for classroom nutrition and health education and serve as a resource for linkages with nutrition-related community services.

- ✓ Students who eat breakfast perform better on standardized tests.
- ✓ Students who regularly attend school breakfast programs perform better and have fewer psychosocial symptoms, less hyperactivity and better daily attendance.

### ***Counseling, Psychological and Social Services***

Students receive counseling and psychological services to improve their mental, emotional and social health. These services include individual and group assessments, interventions and referrals. Organizational assessment and consultation skills of counselors and psychologists contribute not only to the health of students but also to the health of the school environment.

- ✓ Youth receiving mental health services experience decreases in course failures, absences and disciplinary referrals and improved grade point averages.
- ✓ Children who participated in social service interventions aimed at promoting student success by improving parent-child and parent-teacher communication had improved academic performance.

### ***Healthy School Environment***

This component focuses on the physical and aesthetic surroundings and the psychosocial climate and culture of the school. Factors that influence the physical environment include the school building and the area surrounding it, any biological or chemical agents that are detrimental to health, and physical conditions such as temperature, noise and lighting. The psychological environment includes the physical, emotional and social conditions that affect the well-being of students and staff.

- ✓ The physical condition of a school is statistically related to student academic achievement.
- ✓ The physical condition of a school lends itself to lesser incidences of hallway disruption, bullying and violence. Students report an increased feeling of safety in a building that is well lit and clean.



### ***Health Promotion for Staff***

Healthy schools have opportunities for school staff to improve their health status through activities such as health assessments, health education and health-related fitness activities. These opportunities encourage school staff to pursue a healthy lifestyle that contributes to their improved health status, improved morale and a greater personal commitment to the school's overall coordinated health program. This personal commitment often transfers into greater commitment to the health of students and creates positive role modeling. Health promotion activities have improved productivity, decreased absenteeism and reduced health insurance costs.

- ✓ Teachers who participated in a health promotion program focusing on exercise, stress management and nutrition reported increased participation in exercise, lower weight, better ability to handle job stress and a higher level of general well-being.

### ***Family/Community Involvement***

An integrated school, parent and community approach is essential for enhancing the health and well-being of students. School health advisory councils, coalitions and broadly based constituencies for school health can build support for school health program efforts. Schools actively solicit parent involvement and engage community resources and services to respond more effectively to the health-related needs of students. [3]

- ✓ Schools that collaborate with students' families, local businesses, community organizations and health services see improved classroom behavior and increased PTA/PTO membership.
- ✓ Students whose parents are involved in their education show significant gains in reading and math, better attendance and more consistently completed homework than students with uninvolved parents.

Implementation of CSH or any of the above identified components is not initiated by one person – coordinated school health offers the opportunity for many to collaborate and actively participate in implementation of goals determined by the team through both formal and informal assessments. Coordinated school health is not something that just teachers and school personnel do – coordinated school health is a team that includes parents, students and community members. Coordinated school health is not just something that happens at school – coordinated school health involves knowledge, activities and information that can be supported day or night, week day or weekend; at home, church and any place people gather. Coordinated school health is not just for school-aged youth – coordinated school health concepts should become the staple of healthy lifestyles for all children, families and adults. Good health is critical at every age.



## Coordinated School Health Data and Justification

The North Dakota CSH Blueprint is a document grounded in data showing (1) the issue is important, (2) the identified audience is accessible, and (3) the interventions are based on promising practices. Moving this forward to a national perspective, on closer examination, six risk behaviors account for most of the serious illnesses and premature deaths in the United States. They include:

- Tobacco use.
- Abuse of alcohol and other drugs.
- Poor eating habits.
- Physical inactivity.
- Behaviors that result in intentional and unintentional injury.
- Sexual behaviors that result in HIV infection, other sexually transmitted diseases or unintended pregnancy. [4]

All identified risk behaviors are preventable, as are a vast array of associated social, emotional and physical conditions. For example, behaviors caused by tobacco use, poor eating habits and physical inactivity are entirely preventable. One-third of the annual cancer deaths in the U.S. are related to poor nutrition, sedentary lifestyle and excessive body weight. When schools, families and the broader community work together to support positive youth development, risk behaviors are reduced and students' health and academic achievement improve. Coordinated school health provides a framework for creating essential linkages among diverse individuals and activities, within and beyond school walls, to improve youth outcomes.

Schools, families and communities all have resources for reaching students. Each can reach students in different ways and influence young people's behaviors differently. Coordinated school health is an approach that brings together the resources of families, schools and communities to help students stay healthy and make the most of their educational opportunities. Multiple national reports and studies indicate that components of coordinated health, individually or in combination, have been noted to contribute to:

- Improved attendance and fewer dropouts, suspensions and disciplinary referrals.
- Decreased tobacco use among students and staff.
- Increased participation in physical activity.
- Greater interest in weight control and cholesterol levels.
- Healthier eating habits.
- Delay of the onset of risky behaviors, such as sexual intercourse and alcohol and other drug use.



Youth establish patterns of behaviors and make lifestyle choices that affect both their current and future health. By creating safe and nurturing environments for today's youth – environments that focus on young people's assets and minimize chances for engaging in health risk behaviors – we can help ensure that tomorrow's adults will be healthy and productive.

Societal factors contribute to adolescent health, safety and well-being. Health promotion and prevention strategies should be implemented in a collaborative effort. Coordination and cooperation across systems can strengthen efforts to address categorical health issues. Such joint efforts also can help to promote a more comprehensive approach for addressing adolescent health – an approach that views adolescents as whole persons who need a variety of opportunities for healthy development and a network of supports that will have a remarkable impact on their behavior and health outcomes.





## **Each CSH Blueprint goal will be accomplished using the following...**

**Develop partnership and coordination** – Build and maintain successful relationships with state agencies, local schools and local agencies that share goals, projects and resources.

Partnership and coordination form the foundation of any successful program. Strong partnerships “mesh” resources and messages and lend strength and momentum to an initiative that would be absent when one individual or group tries to “go it alone.” Coordination expands the potential for improving student health, reduces duplicative efforts and helps to more effectively achieve positive health and educational outcomes.

**Ensure effective data collection and use for program planning** – Collect data on youth risk behaviors and school health practices and policy to make decisions at the state level and to promote local decision-making efforts.

Data on student health and behavior is the basic building block for perceiving need and serves program planners by identifying subgroups of students most at risk. Data about health needs are critical in moving groups of people toward consensus about the need for action and in determining strategies as well as where to apply resources to impact health.

**Lessen health disparities and the achievement gap** – Design and implement specific school-based strategies directed toward youth at highest risk for poor health outcomes, risk behaviors and limited educational outcomes.

Health disparities in which a particular subgroup is at greater risk for a health problem require critical identification to tailor appropriate interventions that address at-risk students and their needs. This requires providing thoughtful and focused attention to the needs of students and the barriers to learning they face as individuals and as a group and providing adequate resources for those students.

**Promote school health practices and policies** – Evaluate and advocate existing state laws, policies and practice that support coordinated school health outcomes.

Establishing policies that support healthy school practices and student behavior can be a critical step in achieving sustainability. School health policies reflect the intent and commitment of school leaders and the community to create healthy environments. Crafting, promoting, implementing and revising effective school health policies are not a static process. Research and technology continue to move forward and community cultures change as more is learned about how to ensure the health of students.



**Promote professional development** – Create a greater variety of professional development opportunities available for school health stakeholders.

There is no more important step than professional development to ensure that students receive high quality, current best practices in both health curriculum and programs that are implemented with fidelity. All partners have a definitive role in ensuring professional development topics and prevention strategies are well resourced and accessible.

**Evaluate practices and policies** – Establish an ongoing systematic method of collecting process and outcome evaluation data on school health efforts in order to guide program decisions.

Through evaluation, school health programs improve and survive. By demonstrating results, school health advocates have evidence to convince administrators and policymakers of the continuing worth of programs and curriculum and to keep the momentum going in each community.





## **North Dakota's Blueprint for PANT: Physical Activity, Nutrition and Tobacco**

North Dakotans who engage in unhealthy behaviors are at increased risk for heart disease, cancer, diabetes and other chronic diseases. Scientific evidence suggests that one-third of cancer deaths are preventable because they are related to poor nutrition, physical inactivity, and overweight or obesity. All cancers caused by cigarette smoking, tobacco use and heavy use of alcohol can be prevented. There is much work to be done to reduce the burden of disease upon our youth. Addressing physical activity, nutrition and tobacco in productive goals and strategies will allow our youth to have access to resources and supports for healthy lifestyle choices.

The following work plan goals, objectives and activities were developed by several work groups. The objectives and activities highlighted in **red** were chosen as priorities for the CSH work plan cycle of 2008 to 2013. The lead agencies will be the North Dakota Department of Public Instruction and the North Dakota Department of Health.

### **Physical Activity**

**GOAL: Reduce the prevalence of obesity and chronic diseases through physical activity.**

**Objective 1: By February 28, 2013, collaborate with partners to increase access and opportunity for physical activity within the school setting in at least 75 percent of school districts within the funded Regional Education Association (REA).**

**Activities:**

- 1.1** Promote the integration of physical activity and physical education into school wellness policies and school improvement plans.
- 1.2** Promote the integration of physical activity into the classroom.
- 1.3** Promote daily recess periods for elementary school students, featuring time for unstructured, supervised active play.
- 1.4** Promote and advocate for the inclusion of physical activity in all before- and after-school programs.
- 1.5** Establish a system using available technologies that provides opportunities to share resources, programs and initiatives.

Refer to Appendix B for acronym descriptions.



**Objective 2: By February 28, 2013, promote and increase quality physical education\* within the funded Regional Education Association (REA) by 20 percent above baseline.**

**Activities:**

- 2.1 Increase the number of schools aligning local physical education requirements with state and/or national standards.
- 2.2 Promote and advocate for physical education as a core curriculum.
- 2.3 Enhance communication system using available technologies that provides opportunities to share resources, programs and initiatives.

Activity	Partners	Timeline	Data Sources	Professional Development	Evaluation	Indicators of Success
2.1	Funded REA, NDAPHERD, CSH Partners	2008-2010	REA Env. Scan, LEA survey, Profiles	Annual Roughrider Conference, NDAPHERD, DPI/DoH CSH	Annual Roughrider Conference, NDAPHERD, DPI/DoH CSH	20 percent above baseline
2.2		2008-2013				
2.3		2008-2013				

\* quality physical education – see definition in Appendix A



Refer to Appendix B for acronym descriptions.



**Objective 3: By February 28, 2013, partner with schools and/or community groups to create environments that support physical activity, as evidenced by the establishment and maintenance of at least three new partnerships.**

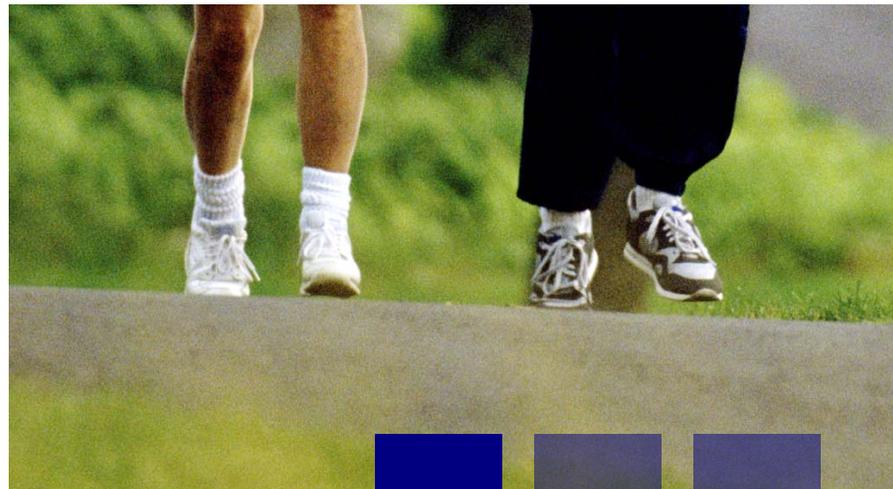
**Activities:**

- 3.1 Participate in efforts and activities to design, build and remodel schools and communities and their infrastructures to support healthy, active lifestyles.
- 3.2 Promote adequate, safe and accessible facilities for multiple-need levels.
- 3.3 Support and promote youth physical activity programs and initiatives, such as after-school programs, local parks' programs, "Safe Routes to School," and "Healthy North Dakota Communities."
- 3.4 Establish partnerships and maintain collaborative efforts with partners who have common concerns and share the vision of healthy North Dakota communities.
- 3.5 Promote and advocate for the inclusion of lifelong physical activity with groups and organizations that influence the span of the educational system.

**Objective 4: By February 28, 2013, integrate physical activity into worksite wellness initiatives, as evidenced by providing at least two trainings, presentations or resource-sharing opportunities per year.**

**Activities:**

- 4.1 Promote and support a staff wellness program that will provide education and opportunity for physical activity for all school staff to improve their own health and role model to students, parents and the community.
- 4.2 Promote and coordinate worksite wellness initiative with goals to prevent chronic diseases
- 4.3 through physical activity.



Refer to Appendix B for acronym descriptions.



## Nutrition

**GOAL: Reduce the prevalence of obesity and chronic disease through improved nutrition behavior.**

**Objective 1: By February 28, 2013, CSH will support and promote inclusion of the Dietary Guidelines and other science-based nutrition lessons in the health education curricula in at least 75 percent of districts within the funded Regional Education Association (REA).**

**Activities:**

- 1.1 Identify and support opportunities to promote health education as a graduation requirement.
- 1.2 Promote nutrition education which includes the federal dietary guidelines and MyPyramid for PK-12 school students and staff.
- 1.3 Collaborate with the Healthy School Nutrition Alliance to develop needed educational tools and resources for CSH.
- 1.4 Collaborate with partners to explore and make available the use of new technologies – e.g., made available through Prairie Public Television – to assist in marketing, distribution, education, etc., of nutrition programs.



Refer to Appendix B for acronym descriptions.



**Objective 2: By February 28, 2013, CSH will collaborate with partners to promote nutrition, healthy lifestyles and locally grown produce to at least 75 percent of school districts within the funded Regional Education Association (REA).**

**Activities:**

- 2.1** Develop and enhance partnerships to encourage greater school-family-community collaborations.
- 2.2** Support model standards to enable all North Dakota PK-12 schools to adopt and market consistent, uniform nutrition standards.
- 2.3** Encourage and support schools and communities to participate in the “Green and Growing Initiative” school garden projects.
- 2.4** Promote “Farm-to-School” programs and garden projects as part of North Dakota studies.
- 2.5** Enhance communication system using available technologies that provides opportunities to share resources, programs and initiatives regarding opportunities and benefits of family meals and breakfast.

<b>Activity</b>	<b>Partners</b>	<b>Timeline</b>	<b>Data Sources</b>	<b>Professional Development</b>	<b>Evaluation</b>	<b>Indicators of Success</b>
<b>2.1</b>	Local public health units, NDSU Extension, ND Depts. of Agriculture, DPI, Career & Tech Ed, ND School Nutrition Association, local school boards, staff, students, parents, food producers and vendors, school-related fundraising groups, local community action, Dairy Council	2008-2013	REA Env. Scan, LEA survey, Profiles	Annual Roughrider Conference, DPI/DoH CSH, statewide conferences (CEL, NDEA, SBA, CTE, REA), Teacher Center Network, NDUS pre-service program, DPI CNFD Cadre and staff	YRBS, School Health Index, School meal purchases, local wellness policies, REA Env. Scan	Increases in nutrition policies and infusion of locally grown produce in at least 75 percent of schools within funded REA.
<b>2.2</b>		2011	DPI CNFD monitoring reports			
<b>2.3</b>		2008-2013	REA Env. Scan			
<b>2.4</b>		2008-2013				
<b>2.5</b>		2008-2013				

Refer to Appendix B for acronym descriptions.



**Objective 3: By February 28, 2013, CSH will promote Coordinated School Health and PANT to school districts within the funded Regional Education Association (REA) to assist with the implementation of policy, procedures and practice.**

**Activities:**

- 3.1** Encourage participation in “comprehensive worksite wellness”
  - In partnership with Healthy North Dakota.
  - By encouraging participation in the Roughrider Conference.
- 3.2** Encourage health insurance providers to provide insurance for prevention and nutrition activities – e.g., membership at fitness facilities for PK-12 staff, students and families.
- 3.3** Support opportunities that provide funding for school nurses.
- 3.4** Continue to support the Healthy Weight Council’s *Weighing and Measuring Students Guidelines* by:
  - Identifying and obtaining needed resources.
  - Developing the Healthy Weight toolkit.
  - Ensuring the identification and utilization of appropriate health-care professionals.



Refer to Appendix B for acronym descriptions.



## Tobacco

**GOAL: Prevent initiation of tobacco products among young people.**

**Objective 1: By February 28, 2013, increase funding for tobacco prevention and control programs from 50 percent of the minimum recommended levels set by the Centers for Disease Control and Prevention (CDC).**

**Activities:**

- 1.1** Work with identified partner groups to:
  - Determine funding needs.
  - Determine methodologies to educate policymakers, partners and grassroots citizens.
  - Actively support related policies.
- 1.2** Explore the opportunities and challenges of integrating categorical funding.
- 1.3** Identify partnerships and funding opportunities with nonprofit organizations.
- 1.4** Justify the need for funding by developing a comprehensive youth counter-marketing campaign aimed at youth ages 12 to 17.



Refer to Appendix B for acronym descriptions.



**Objective 2: By February 28, 2013, increase the number of school districts within the funded Regional Educational Association (REA) with comprehensive tobacco-free school policies (Gold Star Policies) according to the baseline to be determined upon selection of REA.**

**Activities:**

- 2.1** Partner with the North Dakota School Boards Association (NDSBA), Regional Education Association (REA), North Dakota High School Activities Association (NDHSAA), PTA/PTO, North Dakota Council for Education Leaders (NDCEL), North Dakota Education Association (NDEA) and law enforcement to educate about the need for and benefits of tobacco-free policies.
- 2.2** Partner with youth associations (Boys and Girls State, Student Council; Family, Community and Career Leaders of America [FCCLA]; Students Against Destructive Decisions [SADD]) to educate and work toward policy development.
- 2.3** Ensure linkage of tobacco use prevention resources and materials to REA to include:
  - o Gold Star Policy.
  - o School Policy Tool Kit.
  - o A Tobacco-Free Workplace Tool Kit.
  - o CDC guidelines.
  - o Cessation and/or North Dakota Tobacco Quitline services for students, staff and parents.

<b>Activity</b>	<b>Partners</b>	<b>Timeline</b>	<b>Data Sources</b>	<b>Professional Development</b>	<b>Evaluation</b>	<b>Indicators of Success</b>
<b>2.1</b>	SBA, REA, NDHSAA, PTA/PTO, CEL, NDEA, law enforcement, DoH Tobacco Prevention Coordinators	2008-2010	REA Env. Scan, LEA survey, YRBS, Profiles, DoH Tobacco Prevention Coordinators	Annual Roughrider Conference, DPI/DoH CSH	Annual Roughrider Conference, DPI/DoH CSH	Increase in tobacco-free policies (Gold Star)
<b>2.2</b>	Boys and Girls State, FCCLA, SADD					
<b>2.3</b>	Funded REA					

Refer to Appendix B for acronym descriptions.



**Objective 3: By February 28, 2013, maintain the number of school buildings that implement evidence-based tobacco prevention curricula at 373.**

**Activities:**

- 3.1 Provide training about effective tobacco prevention to all staff.
- 3.2 Provide evidence-based curricula to schools that have trained personnel.
- 3.3 Develop, disseminate and collect evaluation on curricula implementation.
- 3.4 Develop bulletin/newsletter inserts.
  - o Create messages for daily announcements.
  - o Create e-mail messages.



Refer to Appendix B for acronym descriptions.

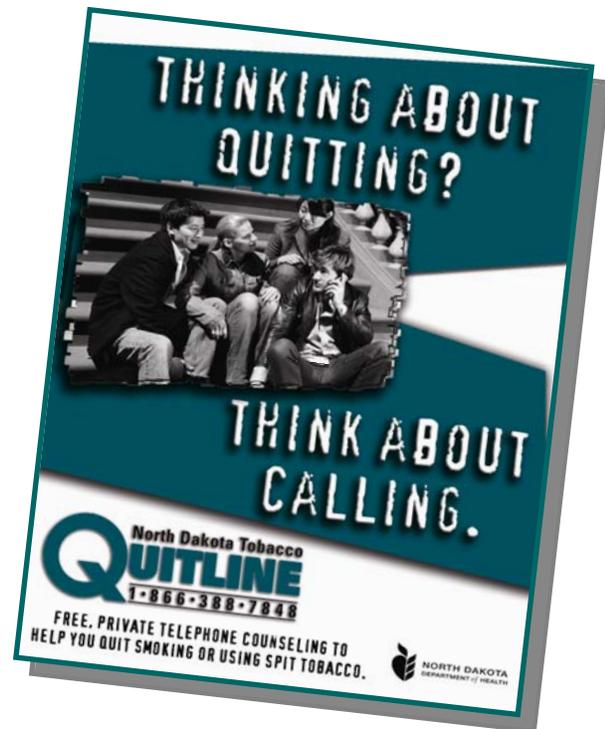


**GOAL: Promote quitting among young people and adults.**

**Objective 1: By February 28, 2013, increase the percent of youth who report they tried to quit smoking in the previous 12 months from 65 percent to 70 percent, according to the North Dakota Youth Risk Behavior Survey.**

**Activities:**

**1.1** Provide cessation and/or North Dakota Tobacco Quitline services for students and staff.



Refer to Appendix B for acronym descriptions.



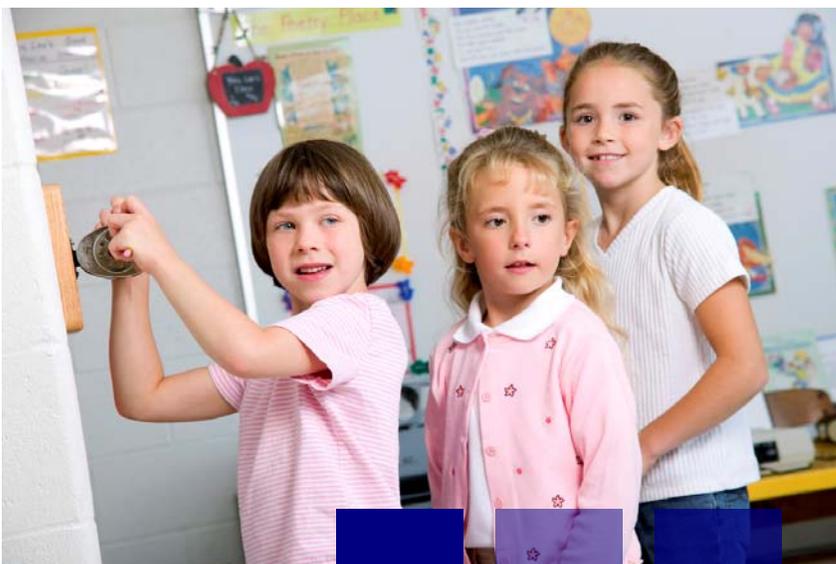
## Implementation and Evaluation

The purpose for developing and implementing this plan ultimately is to reduce the greatest risk behaviors for North Dakota youth as they become productive adults. The issues addressed by the goals of the plan are priority areas that should be addressed in North Dakota. The plan does not, however, rank the goals in terms of overall importance. Because the scope of the plan is broad and resources are limited, the goals and objectives in the plan must be further prioritized, and individual strategies must be embraced and addressed by specific groups and organizations.

Through a systematic process, the Coordinated School Health staff will further prioritize the objectives using specific criteria (e.g., the size of the burden, the strength of the evidence-based solutions known to exist, the likelihood that interventions will lead to significant improvements, the presence of major gaps in current efforts, the existence of important disparities and the feasibility of intervention). The result of the prioritization process will set the direction for initial implementation efforts of the coalition. In addition, partners and other key stakeholders can use the plan to select priorities consistent with their missions.

To achieve the goals and objectives of North Dakota's Coordinated School Health Blueprint, evidence-based strategies must be implemented. Only through ongoing, collaborative and coordinated effort by the coalition can we hope to achieve effective implementation of these diverse strategies. Coordinating existing resources and generating new resources to implement strategies will be a key function of the coalition.

In order to determine if the purpose is being achieved, the plan must be evaluated. Evaluation of the plan and the coalition's efforts will be important for determining the success of coordinated school health in North Dakota.





## References

- [1] Carnegie Corporation of New York, 1994. Abridged version of *Starting Points: Meeting the Needs of Our Youngest Children*, the report of the Carnegie Task Force on Meeting the Needs of Young Children.
- [2] Harvard School of Public Health, 1992.
- [3] CDC, Division of Adolescent School Health (DASH), 2002.
- [4] CDC, DASH, Promising Practices in Chronic Disease Prevention and Control, 2005.





## Appendix A

# Quality Physical Education

Quality physical education:

- Emphasizes knowledge and skills for a lifetime of physical activity.
- Is based on national standards that define what students should know and be able to do.
- Keeps students active for most of class time.
- Provides many different physical activity choices.
- Meets needs of **all** students, especially those who are not athletically gifted.
- Features cooperative, as well as competitive, games.
- Develops student self-confidence and eliminates practices that humiliate students (e.g., having team captains choose sides, dodge ball and other games of elimination).
- Assesses students on their progress in reaching goals, not on whether they achieve an absolute standard.
- Promotes physical activity outside of school.
- Teaches self-management skills, such as goal-setting and self-monitoring.
- Focuses, at the high school level, on helping adolescents make the transition to a physically active adult lifestyle.
- Actively teaches cooperation, fair play and responsible participation in physical activity.
- Is an enjoyable experience for students.

*Source:* U.S. Centers for Disease Control and Prevention (CDC).





## **Appendix B**

### **Acronyms**

#### **CEL**

CEL is the Council of Educational Leaders; the state professional association devoted to educational leaders.

#### **CNFD**

CNFD is Child Nutrition and Food Distribution; the unit within the North Dakota Department of Public Instruction that provides nutrition education and nutrition services for schools and other entities.

#### **CTE**

CTE is Career and Technical Education; the state agency responsible for vocational-technical programs.

#### **Env Scan**

An environmental scan is the acquisition and use of information about local school districts and building events, trends and relationships in a school's environment.

#### **FCCLA**

FCCLA is Family, Career and Community Leaders of America; a nonprofit national and state career and technical student organization for students in grades seven through 12 in family and consumer sciences education.

#### **LEA**

LEA is Local Education Agency; the North Dakota term given to any organized school district.

#### **NDAHPERD**

NDAHPERD is the North Dakota Association of Health, Physical Education, Recreation & Dance; the state-level organization for health and physical education teachers.

#### **NDEA**

NDEA is the North Dakota Education Association; the state teacher association.

#### **NDUS**

NDUS is the North Dakota University System; the state system of universities and colleges.

#### **Profiles**

The School Health Profiles is a biennial survey conducted by state and local education and health agencies among middle/junior high and senior high school principals and lead health education teachers.



### **PTA/PTO**

Parent-Teacher Associations/Parent-Teacher Organizations are available at most school. They include parent volunteers who support school programs, policies and partnerships.

### **REA**

REA is the Regional Education Association; a unit school districts grouped by geographical areas that work together to improve educational services to students and to enhance cooperation.

### **SADD**

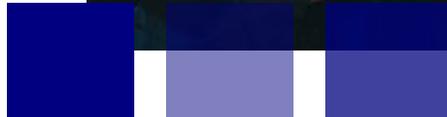
SADD is Students against Destructive Decisions; a local district/community organization that supports healthy decisions for youth in risk areas including suicide, teen pregnancy, violence, sexually transmitted diseases, alcohol, and drugs.

### **SBA**

SBA is the School Boards Association; the state organization that promotes school board advocacy and professional development.

### **YRBS**

YRBS is the Youth Risk Behavior Survey; a survey given every other year to students in grades seven through 12 to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability and social problems among youth and adults.







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