2019
Child Health Advisory Committee Recommendations for Coordinated School Health

Background

The Child Health Advisory Committee (CHAC) was created in 2003 by the Arkansas General Assembly through Act 1220 of 2003. The purpose of Act 1220 and CHAC was to establish a formal group of professionals who would focus on obesity prevention strategies with a specific emphasis on public school students through the implementation of the Coordinated School Health Program.

The committee meets monthly to review the most relevant trends; promising, practices and policies, resources; and state and local activities. Following this review, CHAC develops recommended best practices for education professionals, public health professionals, business leaders, policy makers, and community leaders across the state.

The four areas of focus for the 2019 CHAC Recommendations reflect the committee's goals, which are based on current resources available to Arkansas schools and community partners. The committee determined these focus areas have the most potential to enhance awareness and education regarding factors contributing to the state's obesity epidemic.

The committee chose to focus its recommendations on the following areas:

I. **Enhance Awareness of Mental Health within Schools**
II. **Improve Student Access to Nutrition**
III. **Improve Community and Parent Engagement**
IV. **Improve Access to Resources for Physical Education**

The CHAC was very deliberate when determining the priorities set forth in the 2019 recommendations to focus on those that pose the least fiscal impact while serving as a resource for strategies that schools and community leaders may implement by utilizing current resources and enhancing current activities. The CHAC encourages the ADE and ADH to make these recommendations available to their constituents as a resource to promote health strategies in schools and communities.

Summary of Recommendations

I. Enhance Awareness of Mental Health within Schools

1. The Child Health Advisory Committee recommends schools provide resources and education that connect chronic disease, including obesity, to adverse childhood experiences (ACEs) for students and staff.

2. The Child Health Advisory Committee recommends the Division of Elementary and Secondary Education of the Arkansas Department of Education (ADE) provide professional development on ACEs for school staff to include, but not limited to, hot to teach students and how to identify individuals with signs and symptoms of ACEs.

II. Improve Student Access to Nutrition

3. The Child Health Advisory Committee recommends school districts employ, contract, or partner with provider organizations to enable access to services of a Registered Dietitian/Licensed Dietitian (RD/LD) to provide Intensive behavioral therapy (IBT) for students and staff experiencing obesity. Arkansas public schools should be deemed as a Medicaid provider of nutrition counseling services necessary to prevent and treat obesity and be eligible to seek reimbursement.
4. The Child Health Advisory Committee recommends Out of School Time (OST) programs on school campuses align with the nutrition and physical activity standards set forth for public school students during the school day and school personnel engage their community OST organizations to promote the adoption of similar standards as a part of their daily program.

III. Improve Parent and Community Engagement

5. The Child Health Advisory Committee recommends that the Division of Elementary and Secondary Education of the Arkansas Department of Education facilitates the development and fielding of a parent engagement survey to gather information from schools and parents as to how to best communicate and engage with parents regarding child health and wellness, inclusive of nutrition, physical activity, and mental health.

6. The Child Health Advisory Committee recommends that the Division of Elementary and Secondary Education of the Arkansas Department of Education provides standard guidance and resources for schools, parent teacher organizations, and community groups to facilitate parent engagement through social media and targeted in-person events. The guidance should be developed in collaboration with the Arkansas Department of Health to also include ways in which schools have/could partner with state and local medical and mental health professionals to engage with student/parents/teachers in an event/presentation about child and family wellness. Logistical considerations include staffing, funding, and timing in context of school year calendar and other communications and events.

IV. Improve Parent and Community Engagement

7. The Child Health Advisory Committee recommends collecting information regarding the following of physical education (PE) best practices at each school with the results included in My School Info. School administrators will would be given a list of PE best practices and would check off their school's participation, or lack of participation, for each specified best practice at the individual building level; this information would be collected for reporting purposes only. The list should include the following questions at a minimum:
    a. Is there a content certified teacher for PE?
    b. Is there a written sequential curriculum?
    c. Are there continuing education hours in content area yearly for PE (6 hours)?
    d. Are there opportunities for inclusion during PE and physical activities for children with disabilities?

8. The Child Health Advisory Committee recommends that the Division of Elementary and Secondary Education expands the feedback tools used for the pilot recess program to include all elementary schools to gather impact statements on the state's expansion of extending recess. Information will be shared with teachers and administrators for the purpose of tracking classroom, school, district, and statewide effects.

Full Recommendations Report with Rationale

I. Enhance Awareness of Mental Health within Schools

1. The Child Health Advisory Committee recommends schools provide resources and education which connect chronic disease, including obesity, to adverse childhood experiences for students and staff.

   Rational: "Adverse Childhood Experiences (ACEs) of abuse, neglect and family dysfunction between birth and age 18 can disrupt brain development and limit social, emotional and cognitive functioning.1 ACEs are the root cause of many serious academic, social and behavioral problems that have the potential to prevent a child from receiving the full benefits of education.2 Experiences of poverty, extreme discrimination and community violence as well as other traumatic experiences can also impair the development of the growing brain and body." http://www.hmprg.org/wp-content/themes/HMPRG/backup/ACEs/Education%20Policy%20Brief.pdf

   Fiscal impact: None identified.

   Resources:
   - Felitti, V.J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., Marks, J. S. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

2. The Child Health Advisory Committee recommends the Arkansas Department of Education, Division of Elementary and Secondary Education provide professional development for ACEs, that may include trauma informed for school staff to include, but not limit to, how to teach students and how to identify individuals with signs and symptoms of ACEs.

   Rational: "Adverse childhood experiences (ACEs) of abuse, neglect and family dysfunction between birth and age 18 can disrupt brain development and limit social, emotional and cognitive functioning. ACEs are the root cause of many serious academic, social and behavioral problems that have the potential to prevent a child from receiving the full benefits of education. Experiences of poverty, extreme discrimination and community violence as well as other traumatic experiences can also impair the development of the growing brain and body." http://www.hmprg.org/wp-content/themes/HMPRG/backup/ACEs/Education%20Policy%20Brief.pdf

   Fiscal impact:
   Training cost estimates:
   Youth Mental Health First Aid Certification Training (6 hour training for staff members). An estimate of $25-$35 cost per person for training materials. Please note that all MHFA trainings are capped at 30 participants per 6 hour session. Substitute teacher pay should be estimated at $75-$100 per person per day. Please also note that with the high rates of required professional development for educators, a stipend for ACE training (while unlikely) would be highly encouraged for attendance and educator buy-in.

   Resources:
   - House Bill 1608 http://www.arkleg.state.ar.us/assembly/2019/2019R/Amendments/HB1608-H1.pdf
   - Mental health first aid: https://www.mentalhealthfirstaid.org/

- "Mental Health First Aid teaches how to identify, understand and respond to signs of mental illnesses and substance use disorders."
- "Youth Mental Health First Aid is designed to teach neighbors, teachers, parents, peers, and caring citizens how to help a youth or teen who is experiencing a mental health or substance use challenge or is in crisis."
- Substance Abuse and Mental Health Services Administration: Applying the Strategic Prevention Framework: https://www.samhsa.gov/capt/applying-strategic-prevention-framework
- Education Brief: ACEs for Educators and Stakeholders:http://www.hmprg.org/wp-content/themes/HMPRG/backup/ACEs/Education%20Policy%20Brief.pdf

II. Improve Student Access to Nutrition

3. The Child Health Advisory Committee recommends school districts employ, contract, or partner with provider organizations to enable access to services of a Registered Dietitian/Licensed Dietitian (RD/LD) to provide Intensive behavioral therapy (IBT) for students and staff experiencing obesity. Arkansas public schools should be deemed as a Medicaid provider of nutrition counseling services necessary to prevent and treat obesity and be eligible to seek reimbursement.

Rationale: In school year 2017-2018, 39.5 percent of Arkansas public school students were overweight or obese. These youth are more likely to be at risk for a variety of health problems such as cardiovascular disease, type 2 diabetes, and bone and joint problems. Overweight or obese children who have associated chronic conditions have annual outpatient visit and prescription drug expenditures up to 32.2 percent and 35.0 percent higher, respectively, than children who are at a healthy weight. The U.S. Preventive Services Task Force (USPSTF) recommends screening and follow-up comprehensive, intensive behavioral interventions to promote improvements in weight status. USPSTF concluded that intensive behavioral therapy (IBT) is an effective component in obesity management. IBT consists of measurement of Body Mass Index, dietary/nutritional assessments and intensive behavioral counseling that promotes sustained weight loss through high intensity (i.e., regular and frequent) diet and exercise interventions. Studies show less than six months of RD-provided nutrition therapy for adults with overweight or obesity yields significant weight loss of approximately one to two pounds per week. IBT provided for six to twelve months yields significant mean weight loss of up to 10% of body weight, which is typically maintained beyond one year. The USPSTF reviewed existing evidence and found that IBT can lead to an average weight loss of 4 to 7 kg (8.8 to 15.4 lbs.) and improve glucose tolerance, blood pressure and other physiologic risk factors for cardiovascular disease. A USPSTF report indicates that for patients with obesity and elevated plasma glucose levels, IBT interventions decreased the development of diabetes by about 50% over two to three years. These patients' also demonstrated improved blood pressure, waist circumference and glucose tolerance. The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention. Registered Dietitians are readily available across the state, according to a 2014 survey of RDs in Arkansas, to provide services to children within all of the state's counties.

Fiscal Impact: Survey data from the Arkansas Employee Benefits Division indicates cost to the state health plan are 34.5% more for obese individuals than non-obese people, higher if the risk factors of smoking and physical inactivity are included. School-based Medicaid billing does not impact the state's budget, as Arkansas public schools are responsible for fulfilling the Medicaid match requirement independently.

Resources:

- Arkansas Center for Health Improvement - http://bmi.achi.net/
- https://onlinelibrary.wiley.com/doi/full/10.1038/oby.2009.67

- U.S. Preventive Services Task Force https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-children-and-adolescents-screening1

4. The Child Health Advisory Committee recommends Out of School Time (OST) programs on school campuses align with the nutrition and physical activity standards set forth for public school students during the school day and school personnel engage their community OST organizations to promote the adoption of similar standards as a part of their daily program.

Rationale: Healthy lifestyle education and action doesn't stop when the school bell rings. According to the Arkansas Out of School Network (AOSN), 65,107 students K-12 participate in Arkansas OST programs. In Arkansas, 82% of the programming occurs within a school building and often is a collaborative partnership between the school and community based organization. The Centers for Disease Control and Prevention (CDC) defines Out of School Time (OST) as, "a supervised program that young people regularly attend when school is not in session. This can include before- and after- school programs on a school campus or facilities such as academic programs (e.g., reading or math focused programs), specialty programs (e.g., sports teams, STEM, arts enrichment), and multipurpose programs that provide an array of activities (e.g., 21st Century Community Learning Centers, Boys & Girls Clubs, YMCAs)." Schools have access to USDA opportunities to provide snacks and meals after school that meet federal standards. Schools should also develop relationships with their OST providers to enhance local adoption and promotion of healthy eating and physical activity standards and support student health and learning.

Fiscal Impact: None identified.

Resources:

- Center for Disease Control Out of School Time contains guidance, resources and references for Arkansas through the Coordinated School Health Program.
- Arkansas Out of School Network (AOSN), www.aosn.org
- The Alliance for a Healthier Generation – HEPA Standards http://afterschoolalliance.org/Issue-Healthy-Eating-Physical-Activity.cfm

III. Improve Community and Parent Engagement

5. The Child Health Advisory Committee recommends that the Division of Elementary and Secondary Education of the Arkansas Department of Education facilitates the development and fielding of a parent engagement survey to gather information from schools and parents as to how to best communicate and engage with parents regarding child health and wellness, inclusive of nutrition, physical activity, and mental health.

Rationale: Evidence for current levels of parent engagement in the state at the school and district level has not been well documented. A baseline assessment of current activities, strategies, and perspectives regarding parent engagement and child health will help inform future parent engagement efforts.

Fiscal Impact: None identified.

Resources:
CDC References:
https://www.cdc.gov/healthyschools/parentengagement/parentsforhealthyschools.htm
Guide https://www.cdc.gov/healthyschools/parentengagement/pdf/guide.pdf

6. The Child Health Advisory Committee recommends that the Division of Elementary and Secondary Education of the Arkansas Department of Education provides standard guidance and resources for schools, parent teacher organizations, and community groups to facilitate parent engagement through social media and targeted in-person events. The guidance should be developed in collaboration with the Arkansas Department of Health to also include ways in which schools have/could partner with state and local medical and mental health professionals to engage with student/parents/teachers in an event/presentation about child and family wellness. Logistical considerations include staffing, funding, and timing in context of school year calendar and other communications and events.
Rationale: Since the passage of Act 1220 in 2003, new options for parent engagement have become available, including social media platforms. The use of social media by schools and districts varies throughout the state but represents a cost-effective and timely method of engaging with parents.

    - Separately, opportunities for in-person parent engagement regarding child health are limited, although in many communities' schools represent the most singular meeting place for parents. Because of this, School-based events geared toward child health education represent a viable option for parent engagement. School staff may have dedicated time to plan and organize parent-friendly activities and events (i.e. provide parents with seminars, workshops, health screening opportunities and information on health topics such as monitoring children activities, modeling healthy behaviors, talking to children about health-related risks and behaviors, etc.) and provide parents the opportunity to participate in those activities.

   Fiscal Impact: None identified.

   Resources: None identified.

7. The Child Health Advisory Committee recommends that the Division of Elementary and Secondary Education of the Arkansas Department of Education review current BMI parent letter language and consider updates to the language so that it is less of a warning and more of a proactive set of recommendations to improve acceptance and efficacy. The Division of Elementary and Secondary Education of the Arkansas Department of Education should explore options for including the contents of the letter in an annual child wellness report alongside other health indicators, and options for secure online access by parents.

   Rationale: Anecdotal reports from school personnel indicate inconsistent practices in proactively distributing the BMI letters to parents. Anecdotal reports also indicate that some parents have reacted negatively to the letter and the original intent is not always well understood. Negative feedback from the letter has contributed to some extent to schools not proactively distributing the letters.

   Fiscal Impact: None identified.

   Resources:
    - Current 2018/2019 school year Letter Examples: http://bmi.achi.net/BMIContent/Documents/120708_CHR_English-final_for_web.pdf

IV. Improve Access to Resources to Physical Education

8. The Child Health Advisory Committee recommends collecting information regarding the following of physical education (PE) best practices at each school with the results included in My School Info. School administrators will would be given a list of PE best practices and would check off their school's participation, or lack of participation, for each specified best practice at the individual building level; this information would be collected for reporting purposes only. The list should include the following questions at a minimum:
    - Is there a content certified teacher for PE?
    - Is there a written sequential curriculum?
    - Are there continuing education hours in content area yearly for PE (6 hours)?
    - Are there opportunities for inclusion during PE and physical activities for children with disabilities?

    Rationale: This will provide information for families when comparing schools; teachers looking for the right environment in which to teach and would give the impression of how supportive the administration is of Physical Education and Physical Activity. This will also encourage development and use of standards that would compare with the current format and use of academic standards.

    Resources:
    - A.C.A. § 20-7-135 (e)(1)(B)(i)
    - A.C.A. § 20-7-135 (e)(1)(B)(iii)
    - A.C.A. § 20-7-135 (e)(1)(B)(v)
    - A.C.A. § 20-7-135 (e)(1)(B)(vi)

    Fiscal Impact: A modification of existing school reports would be required, as well as updating the format of My School Info to communicate the information.

9. The Child Health Advisory Committee recommends that the Division of Elementary and Secondary Education expands the feedback tools used for the pilot recess program to include all elementary schools to gather impact statements on the state's expansion of extending recess. Information will be shared with teachers and administrators for the purpose of tracking classroom, school, district, and statewide effects.

    Rationale: While research has shown that increased physical activity correlates to positive changes in the classroom, collecting the data from our own experiences will support continued commitment to this mandate. This will also allow identification of outlier data points that can be studied for best practices so that recommendations may be formulated from schools with extraordinary impact and given to schools that are not seeing as much improvement. This would also allow for state-to-state comparisons

    Fiscal Impact: A modification of existing school reports would be required.

    Resources: Act 641 of 2019