

4. EDUCATIONAL AND COMMUNITY- BASED PROGRAMS

Goal

Increase the quality, availability and effectiveness of educational and community-based programs designed to prevent disease, prevent disability and premature death, and promote the health and quality of life of all Kentuckians (*Healthy People 2010*, 1998)

Terminology

Community: A specific group of people, often living in a defined geographical area, who share a common culture, values and norms; and are arranged in a social structure according to relationships formed over a period of time.

Community-based: Located in various sites for various populations to address needs or problems of the community. (Stanhope, 1996)

Community-based program: A planned, coordinated, ongoing effort that characteristically includes multiple interventions to address identified problems in the community.

Community Health Planning or Community Health Improvement Plan: Helps a community mobilize; collect and use local data, set health priorities; and design, implement, and evaluate comprehensive programs that address community health and quality of life issues.

Health: A state of physical, mental, and social well being; not merely the absence of disease and infirmity.

Health Education: The use of materials and structured activities to promote healthy behaviors by informing and educating individuals or groups.

Healthy Lifestyle: Living in a manner to minimize risks of disease, disability and premature death and to increase the possibility of developing to maximum potential.

Health Promotion: Any planned combination of educational, political, regulatory, economic, environmental and organizational supports aimed at the stimulation of healthy behavior in individuals, families, groups and/or communities.

Healthy Community: A community that is consciously creating and improving their physical and social environments and expanding their community resources that enable

people to mutually support each other in performing all the functions of life and in developing to their maximum potential.

Healthy Public Policy: An explicit concern for health and equity in all areas of policy with accountability for health impact/outcome. The main aim of healthy policy is to create a supportive environment to enable people to lead healthy lifestyles by making healthy choices and to create social and physical environments to enhance well being.

Population-focused: Targeting a specific population or high-risk group. (APHA, 1996)

Preventive Health Services: (For the Medically Homeless) Family Planning, Prenatal Care, Well Child Care, WIC (Women, Infants and Children) Program, Adult Preventive Services and Chronic Disease Management and Support; Authorized in appropriation language or in grants and contracts with agencies of the United States Public Health Service. (Leach, 1999)

Public Health Functions: The three (3) primary responsibilities of Public Health are: Assessment, Health Policy and Assurance. (Institute of Medicine, 1988)

Public Health CORE Activities/Services: Seven (7) basic activities (mandated or authorized by statute or regulation) are the responsibility of Public Health including Environmental Regulations, Surveillance, Health Policy Development, Public Health Education, Communicable Disease Control, Risk Identification and Reduction, and Disaster Preparedness. (Kentucky Department for Public Health, 1998)

Quality of Life: Connotes an overall sense of well being for an individual or a pleasant and supportive environment for a community. For the individual, health-related quality of life has a strong relationship to a person's health perceptions and ability to function. For the community, health-related quality of life includes all aspects that have a direct and quantifiable influence on the physical and mental health of community members.

Settings—Workplace Sites, School Sites and Community Sites: Major social structures that provide locations and specific mechanisms for reaching defined populations, specifically targeted age groups, and for facilitating healthy choices to address quality of life issues. Health promotion may occur within one individual setting or across them all for a comprehensive community approach.

Targeted Age Groups: "Public Health" targets the "Entire Age Range for Total Population" of a Community or Specific Groups to include: Preconception, Birth through 3 years of age (Infant/Toddler Child Care), 4-5 years of age (Child Care, Preschool, Pre-kindergarten, Head Start ---Early Childhood Development), School Age (5-18 years of age), College Age (Post-secondary institutions), Workplace Sites, and Elder Care.

Overview

Attainment of the *Healthy People 2010* Objectives and improvement of health outcomes in Kentucky by the year 2010 will depend substantially on educational and community-based efforts (US DHHS, 1998). Community planning to fulfill Public Health's responsibilities/functions is the primary driving force in education and community-based services. Various community aspects, from both the State and local perspectives, are coming together to make achievement of the 2010 Objectives a reality. Representatives of the State Department for Public Health and the Department Of Education have jointly written this Chapter of Kentucky 2010 Objectives and will be promoting their coordination and collaboration at the local level in each community. The Governor's Office of Early Childhood Development has drawn from both the Department For Public Health and Department Of Education to develop their 2020 Plan for Statewide implementation (Kentucky Cabinet for Health Services, 1999). The two initiatives reinforce one another. The common theme is enabling communities to become the places for children to reach their potential, then progressively expanding that to the entire community. Reflecting this focus, the following underlying coordinated efforts are intended to stimulate and encourage collaborative action and efficient use of resources from multiple sectors and community systems to improve the entire range from individual health to healthier communities:

- Public Health addresses the entire age range of any given community's population.
- The entire community's population assessment is now required for Department for Public Health funding.
- The budgeting and planning process is increasingly progressive in mirroring the *Healthy People 2010* Objectives.
- Problem identification and implementation are community specific.
- Evaluation includes health outcomes for specific populations and entire community.
- The process of health planning is "community" driven.
- There is unprecedented coordination and collaboration:
 - within the Department For Public Health,
 - between the Department For Public Health and District/Local Health Departments,
 - within the Cabinet For Health Services,
 - between the Cabinet For Health Services and the Cabinet For Families and Children,
 - between the Department For Public Health and Department Of Education, and
 - with the Governor's Office.

We know that the health of our communities does not depend just on the health of the individuals, but also on whether the physical and social aspects of the communities make it possible for people to live healthy lives. People's health and quality of life depend on many community systems and factors and not simply on a well-functioning health care system. Making changes within the existing systems, such as the school system or the health care system, although perhaps more time-consuming, can effectively and efficiently improve the health of a large segment of the community. This approach tends to have a greater impact on the whole community than individual-oriented approaches. (US DHHS, 1998)

Similarly, most effective community promotion programs are those that implement a comprehensive intervention plan that utilize multiple intervention strategies, such as educational, policy and environmental strategies within various sites. Settings may be schools, workplace, and health care facilities within the community (US DHHS, 1998). These settings serve as channels for reaching the "targeted" population and, at the same time, generate the possibility of intervening at the policy level to facilitate healthy choices. (i.e.; Smoking cessation classes may lead to a decision for an agency to become "smoke-free".)

The school, ranging from preschool through college, provides an important setting for ultimately reaching the entire population, over time. Schools have more influence on the lives of youth than any other social institution, except the family. Because healthy children learn better than children with health problems, to achieve their educational mission, schools and colleges must help address the health and related social problems of youth. A focal point of their efforts, in this respect, must be to reduce health risks and improve the health status of youth. (US DHHS, 1998)

The growing cost of health care and the increasing problems of preventable acute and chronic illness have brought health education to the forefront of workplace concerns. Health promotion in the workplace is critical to the long-term maintenance of our Nation's health. Increasing awareness, promoting healthy individual lifestyles, fostering health-related behavior changes and creating supportive work environments are core to workplace health promotion. This all, in turn, is beneficial to managers, employees and the community at large (US DHHS, 1998).

While schools are natural settings for reaching children and youth, and the workplace reaches the majority of adults, efforts to reach the remainder of the community, particularly the older population, must involve the community at large. The elderly population, which was 10 times larger in 1990 than 1900, will double from 1990 to 2030 (US DHHS, 1998). The challenge for Public Health with this aging population is to minimize the impact of disease and disability through prevention, health promotion and assistive services in a range of settings.

Future efforts of Public Health must address health for all ages in the total population. Efforts are needed to document successes in health promotion and disease prevention.

Techniques for evaluating community processes and community health improvement activities must be refined. Partnering and linkages and the role of collaborative efforts must be examined. Communities must take ownership of their health and quality of life improvement process and must work to sustain initiatives that result in healthy people in healthy communities. What is learned must be shared in a timely and appropriate manner in order to achieve and assure long-term outcomes and improvements in health status for all Kentuckians (US DHHS, 1998).

Progress Toward Year 2000 Objectives

The Governor's Conference On The Future Of Public Health In Kentucky: Partners For Progress has set the stage for moving into the 21st century. As stated by Paul E. Patton, Governor, Commonwealth Of Kentucky, "Keeping each of us healthy in the first place is the critical job of the public health service." The Commissioner For Public Health, Rice C. Leach, M.D., noted the opportunity to plan and work together to establish how to deal with Kentucky's major health issues and determine a course for the future.

Several efforts have been instrumental in moving Kentucky Public Health toward 2000 Objectives. Deputy Commissioner, Department For Public Health, Sharon Stumbo, has spearheaded the development of the *Kentucky Public Health Improvement Plan*, written by 2,500 Kentuckians, to address:

- The Purpose of Public Health,
- The Current Status and Environment of Kentucky' Public Health System,
- A Vision for Public Health, and
- Kentucky Public Health Improvement Goals and Strategies.

A central theme of "The Plan" is supporting the primary functions of public health: *Assessment, Policy Development and Assurance*. Excerpts emphasize this focus:

- Public health priorities will be based on assessment of public health risks;
- More Kentuckians will take responsibility for healthier lifestyles, as recommended in *Healthy Kentuckians 2000*; and
- Public Health will follow the recommendations in *Healthy Kentuckians 2000*.
- Public Health will participate in formal and informal partnerships with both public and private sectors to achieve health improvement goals and maximize available resources.

As part of the implementation of this overall strategic plan, the Department for Public Health has formed the Public Health Practice Committee. Its various subcommittees formulate the operational activities to achieve the combined goals and objectives of the *Kentucky Public Health Improvement Plan* and *Healthy People 2000 Objectives*:

- Education Subcommittee
- Information Systems Subcommittee
- Forms Subcommittee
- Quality Assurance Subcommittee
- Community Assessment Subcommittee

- 8.1 To increase to at least 66 percent the number of local and district departments which participate in the Health Incentive Grant Program.

The Health Incentive Grant, per se, no longer exists. However, this objective is still relevant as it has “evolved” into an expanded effort. In 1992, Core Health Education was developed to promote expansion of health education in the Local Health Departments into the community. In 1998, the Department For Public Health began emphasizing “the community as the client” and programmatic management and funding has since been remolded to reflect this effort. The 1999-2000 Budgeting and Planning request from each Local Health Department now must be based on a community assessment. A menu of *Healthy People 2000* Objectives, MCH Block Grant Outcome Measures and Preventive Block Grant Outcome Measures represents Objectives and Related Activities of that Plan. The current year therefore makes funding available to 100 percent Local and District Health Departments for community-based health education.

- 8.2 To have conducted by at least five Kentucky communities, a full-scale community health review.

By 1996, three Health Departments had begun the Assessment Process for Excellence in Public Health (APEX-PH). These were Lake Cumberland, Northern Kentucky and Louisville-Jefferson County. Since then, several other Local and District Health Departments have completed various Community Assessments. One highly successful example is Barren River District Health Department, which has had tremendous acceptance and use of the “SAPO” (Surveillance, Assessment, Planning and Implementation, and Outcomes by Evaluation) Model. Prior to 1998, approximately 26 counties had initiated some form of Assessment of the Community.

In October 1998, the “Transition of Population-focused Community-based Core Public Health” Model (Acker & Burke, 1999) was made available to all Local and District Health Departments for elective implementation. Piloted by Woodford County Health Department, with technical assistance and consultation from the Public Health Nursing Branch, Division of Local Health Department Operations, the “Acker-Burke” Model has served as an “instrument” of transition in multiple Local and District Health Departments. All 120 counties received a copy of the Transition Model, 40 counties’ representatives attended "Training to Test", 37 counties have received on-site regional training to-date, and technical assistance, consultation and/or on-site training remains available to all upon request.

- 8.3 To implement planned and sequential comprehensive school health education of high quality for kindergarten through 12th grade in all of Kentucky’s school districts.

A project known as Health Promotion Schools of Excellence (HPSE) was initiated in Jefferson County in 1992. The project implemented planned sequential comprehensive school health and health education for kindergarten through 12th grade. In 1992, fifteen (15) schools participated. Currently, the 1999-2000 school year involves 57 schools, including 44 Jefferson County Public Schools and 13 Archdiocese of Louisville schools. HPSE is a public and privately funded collaborative effort that focuses not only on students but also their parents and the school staff. Data is being collected on student's physical fitness levels, health knowledge, attitudes and behaviors (Ciarroccki, 1999).

Other agencies working to establish Comprehensive School Health Education in Kentucky include Health Kentucky (formerly Health Care Access Foundation), the Good Samaritan Foundation, Inc. and the University of Kentucky College of Nursing. Health Kentucky created a framework entitled "The ABC's of Comprehensive School Health Education for Kentucky's Children." The Good Samaritan Foundation funded a two-year University of Kentucky College of Nursing project to develop the "ABC's" as a curriculum/resource guide set and to pilot test them in an elementary school and a middle school. Additional Good Samaritan Foundation funding allowed for expansion of the pilot testing and evaluation in several schools. These collaborative projects were conducted by nursing faculty and Community Health Nurse Interns supported by the Good Samaritan Foundation, Inc. A summit was held for Fayette County Public School principals and Site-Based Decision-Making Councils to promote Comprehensive School Health Education and to share successful models for conducting such education (Ricker, 1999).

Considerable effort has been given to Comprehensive School Health in the transition of Local Health Departments' responsibility for CORE Public Health in their function of Assessment, Health Policy Development, and Assurance. Various communities and groups have become organized to focus on the issue of "School Health" and what it should be in Kentucky. The Kentucky Comprehensive School Health Work Group has forwarded "*A Proposal For School Health*" to the Kentucky Commissioner of Public Health. House Bill 189 created a Legislative Task Force on Health Services in Schools in the 1999 Kentucky General Assembly Legislative Session and its recommendations should be forthcoming. The 2000 Legislative Session is expected to make clear how Kentucky is to proceed in this regard, in that a bill regarding school health is reported being drafted.

- 8.4 To ensure that senior citizens have access to health promotion information and activities in each of Kentucky's 120 counties.

As reported in the *Healthy Kentuckians 2000 Mid-Decade Report*, the Kentucky Department For Social Services received an award for technical assistance from the National Eldercare Institute on Health Promotions. A plan for the State's elderly health promotion was developed in cooperation with the Department For

Public Health and the Department For Mental Health/Mental Retardation. *Healthy Older Kentuckians* was written as both a health promotion plan and a guide for its implementation. It is intended to be used by those at administrative levels who develop programming for older adults as well as professional and private caregivers that have the responsibility of direct care.

The Cabinet for Health Services recognizes that it is time to plan for the future of our elderly citizens. By the year 2010 Kentucky is projected to have 86,692 people over the age of 85 years of age, almost double the number we had in 1990. The Office Of Aging Services, now in the Cabinet For Health Services, is a critical component in the effort to develop a long-term care plan for the elderly in the future. The Cabinet for Health Services spends over half a billion dollars a year on services for the elderly population.

The Sanders Brown Center on Aging, an affiliate of the University of Kentucky, conducts research, education and community services for the Alzheimer's program and the aging program. The Center provides a doctoral program, the graduate certificate program, and in-service training and continuing education in the field of geriatrics/gerontology. They also host an annual Summer Series on Aging seminar. Specifically for the older population, the Donovan Scholar Program allows anyone aged 65 or older to attend college free of charge.

2010 Objectives

Objectives for the School Setting

High School Completion

- 4.1. Increase to at least 90 percent the number of individuals, through age 24, who have completed high school.**

Baseline: Nationally, 86 percent of people aged 18 through 24 had completed high school in 1996.

<u>Select Populations (U.S.)</u>	<u>1996</u>
African American	83%
Hispanic	62%
White	92%
Male	Not available
Female	Not available

Note: High school completion numbers include those who received high school diplomas, as well as those who received alternative credentials such as General Education Development (GED) Certificate.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Data Source: Dropout Rates in the United States, 1996, U.S. Department of Education, National Center for Education Statistics.

4.2. Reduce the annual dropout rate for students enrolled in grades 9-12, to a rate of less than 5.0 percent .

Baseline: Kentucky had a rate of 5.3 percent of students, in grades 9-12, who dropped out in the period 1993-1997.

Note: Kentucky's dropout rate is based on four years' cumulative rates. (Although Kentucky's Department Of Education, Dropout Branch does not currently collect information on drop out rates by select populations, this information will be available in the future.)

Target Setting Method: To meet national objective, reduce dropout rate by 3.1 percent.

Data Source: Dropout Rates in Kentucky, 1997, Kentucky Department Of Education Dropout Branch.

Implementation Strategy:

There are many recommendations from the national, district and the school level for holding at-risk students in school longer and encouraging individuals who have not graduated from high school to complete their education, but there is no magical quick fix solution to the dropout problem. The problem is complex and requires a complex array of solutions. Dropouts have dissimilar characteristics, therefore, need different kinds of programs that respond to their individual circumstances and needs. Programs, to be effective, need to provide "one-on-one" intensive attention to at-risk students, who often must be convinced that they are competent and can be successful in school. The curriculum should include basic educational skills, social skills, and experiential education. In addition, the interrelated causes and multiple problems associated with dropping out call for comprehensive community-wide, multi-service approaches and multi-component programs. Children at risk need to be identified at a young age (as early as preschool) so early-sustained intervention can be applied. Success in the elementary grades diminishes the possibility of later dropping out in high school. In that the key to reducing the dropout rate is helping youth to overcome their sense of disconnectedness, it is imperative not to isolate or alienate any student from the school. Since not all factors related to dropout reduction are school controllable, solutions to the complex problem of dropouts cannot be achieved by the schools alone. It is a national problem that must be addressed by the whole society. It requires resources that go beyond the school. Solutions require a team approach-- the combined efforts of students, parents, teachers, administrators,

community- based organizations and business, as well as the federal, state and local governments (Woods, 1997).

School Health Education

4.3. Increase to 100 percent the number of Kentucky’s elementary, middle/junior and senior high schools that require the equivalent of 1 full year of health education.

Baseline: Kentucky currently mandates only 1/2 credit (½ school year) in health education in senior high school as a requirement for graduation).

Note the following operational objective: For this objective, health education refers to instruction on health education topics required in units of study, or in one or more health courses.

Target Setting Method: 100 percent improvement.

Data Sources: KRS 156.160 (Promulgation of administrative regulations by Kentucky Boards of Education),
KRS 156.070 (Powers and Duties of the Kentucky Board of Education),
704 KAR 3:303 (Program of Study Regulations),
704 KAR 3:305 (Minimum requirement for high school graduation).

Implementation Strategy: Urge consideration of statutory or regulatory change to reinstate meaningful school health education in all schools.

4.4. Implement effective health education curricula in Kentucky’s elementary, middle/junior and senior high schools addressing the 6 risk behavior areas that are the leading causes of morbidity and mortality among youth. (See following criteria)

Baselines: can be established for each of the 6 risk behavior areas using data from the Kentucky Youth Risk Behavior Survey.

Note: The Kentucky Youth Risk Behavior Survey (YRBS) measures the incidence and prevalence of behaviors that contribute to the leading causes of mortality and morbidity among youth in grades 9-12. By addressing and reducing these risk behaviors, schools and communities can promote the “resiliency” of young people and increase healthy behaviors. Measuring these risk behaviors will enable schools and communities to plan, evaluate and improve school and community based programs which prevent health problems and promote healthy behaviors.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Data Source: Kentucky 1997 Youth Risk Behavior Survey (YRBS)

Implementation Strategy: Urge increased funding for innovative programs (which have shown success) to use peer pressure to achieve this goal.

4.4.1. Implement effective health education curricula addressing Injuries and Safety (personal injury and safety including seat belt use, bicycle/motorcycle helmet use and drinking and driving).

With implementation of such curricula, Kentucky schools can impact youth behaviors to:

- Reduce deaths caused by alcohol-related motor vehicle crashes
- Increase regular motorcycle helmet use
- Increase regular bicycle helmet use
- Increase regular seat belt use

4.4.2. Implement effective health education curricula addressing Violence and Suicide (addresses suicide, physical fighting, weapons and fear).

With implementation of such curricula, Kentucky schools can impact youth behaviors to:

- Decrease individuals involved in physical fighting
- Decrease number of Kentucky students carrying weapons to school
- Increase the number of Kentucky students who feel safe on school property
- Decrease the number of individuals who consider, make a plan, or attempt suicide

4.4.3. Implement effective health education curricula addressing the use of Alcohol, Tobacco and Other Drugs (ATOD) (alcohol, tobacco products, marijuana, cocaine, steroids, and other illegal drugs, age at first use).

With implementation of such curricula, Kentucky Schools can impact youth behaviors to:

- Reduce smokeless tobacco use
- Reduce initiation of cigarette smoking by school age children and
- Reduce the number of school age youths who report having tried smoking cigarettes before age 13
- To raise by at least one (1) year the average age of initial use of alcohol and marijuana by Kentucky adolescents

- Reduce the proportion of young people who have used alcohol, tobacco, marijuana, and cocaine in the past 30 days
- Reduce the proportion of high school seniors engaging in recent occasions of binge drinking (5 or more drinks in a couple hours) of alcoholic beverages in the past 30 days
- Reduce the proportion of young people who have ever used inhalants, steroids, or other illegal drugs (such as LSD, PCP, ecstasy, mushrooms, speed, ice or heroin)
- Reduce the proportion of young people who have ever injected illegal drugs with a needle

4.4.4. Implement effective health education curricula addressing Sexual Behavior (where students have received information about Sexually Transmitted Disease (STD) such as HIV infection, sexual intercourse, and pregnancy prevention).

With the implementation of such curricula, Kentucky schools can impact youth behaviors to:

- Reduce the proportion of young people who are sexually active
- Ensure that one hundred percent (100 percent) of Kentucky's school-age youth know where to get good information about HIV infection
- Increase the number of sexually active, unmarried school-aged youth who used a condom at last sexual intercourse
- Decrease the number of school-age youth who have sexual intercourse with multiple partners
- Decrease the number of school-age youth who used alcohol or drugs at last sexual intercourse

4.4.5. Implement effective health education curricula addressing Body Weight and Nutrition (how students feel about their weight; what, if anything, students are doing to control their weight; how often students eat healthy foods and foods with limited nutritional value).

With the implementation of such curricula, Kentucky schools can impact youth behaviors to:

- Decrease the number of school-age youth using diet pills, laxatives or vomiting as a way to lose weight
- Increase the number of school-age youth who have consumed healthy foods in the past 24 hours
- Decrease the number of school-age youth who have consumed foods with limited nutritional value in the past 24 hours
- Increase the proportion of female students who take a multivitamin every day.

4.4.6. Implement effective health education curricula addressing Physical Activity (how often students engage in physical activities improving or maintaining aerobic capacity, flexibility and muscle strength; school-based physical activities including physical education classes and team sports).

With the implementation of such curricula Kentucky schools can impact youth behaviors to:

- Increase the number of children and adolescents ages 10-17 years who participate three or more times per week for at least 30 minutes per session in aerobic activity which is commonly or easily performed by adults.
- Increase the number of children and adolescents ages 10-17 years who participate three or more times per week for at least 30 minutes per session in an activity at least as vigorous as a sustained slow walk.

4.5. Increase the CATS (Commonwealth Accountability Testing System) Practical Living area of assessment to 14 percent to be equivalent to other academic areas at all grade levels.

Baseline: *The Practical Living and Vocational Studies* questions together comprise 7 percent of the CATS test.

Note: The Practical Living area of assessment on the CATS test includes the questions pertaining to health and physical education.

Target Setting Method: 100 percent increase in accountability for teaching health education.

Data Source: Kentucky Education Reform Act. KRS 158.6453. Kentucky Department of Education, Assessment and Accountability Office.

Implementation Strategy:

- Identify official organizations and professional groups to advocate for and facilitate the implementation of quality coordinated school health programs in Kentucky.
- Advocate via every avenue possible (from the Kentucky Legislature to individual Site-Based Decision-Making Councils) for every school to implement quality coordinated school health programs.
- Provide advice and resources to assist schools/districts in implementing quality coordinated school health programming using the following steps:
 - Use epidemiological data to plan and conduct a periodic assessment of student and family needs in order to determine strengths and weaknesses of existing health education and services
 - Involve community organizations and parents in the planning process and investigate how they can complement the health education and health

services; keep the community, especially parents, board of education, site-based councils, etc. consistently informed at all steps of development and implementation

- Involve health expert and school leaders as consultants
- Obtain broad-based, on-going community support and input by establishing an advisory committee of school representatives and representatives from community groups interested in the healthy development of youth.
- Identify scientifically proven comprehensive, Preschool through 12 health education programs to effectively meet school population needs and community standards
 - Maintain adequately trained/certified teachers
 - Develop policy to adequately address the identified health issues administratively (i.e. drug free school, safe school, tobacco free school policies) and to accommodate increased classroom time for health education and the types of physical and mental health services needed by the school population
 - Advocate for the desired programs and policies with appropriate approval-granting and funding bodies
 - Conduct periodic evaluation of the coordinated school health program to determine the degree to which it enhances the health of students and families

College Health Education

4.6 Increase to at least 12 percent the proportion of undergraduate students attending postsecondary institutions who receive information from their college or university on all six priority health risk behavior areas (behaviors that cause unintentional and intentional injuries, tobacco use, alcohol and other drug use, sexual behaviors, dietary patterns that cause disease, and inadequate physical activity).

Baseline: In 1995 the National College Health Risk Behavior Survey reported that 6 percent of undergraduate students received information from their college or university on all six topics.

Note the following operational definition: Post secondary institutions include 2- and 4-year community colleges, private colleges and universities.

Target Setting Method: 100 percent improvement.

Data Source: 1995 National College Health Risk Behavior Survey, (NCHRBS) CDC. This data source will be used for all objectives pertaining to college students.

Note: This age group is often overlooked, or at least, not targeted. They are caught between being adolescents at home, in high school, and being adults, possibly “out on their own” for the first time, in college. With the implementation of health promotion programs that address the six identified categories of behaviors that are responsible for more than 70 percent of mortality and morbidity in young adults, post-secondary institutions can impact student health status by:

- Reducing the proportion of students reporting drinking alcohol and driving
- Reducing the proportion of students who ride with drivers who have been drinking alcohol
- Reducing the proportion of students who go boating or swimming while drinking alcohol
- Decreasing the proportion of college students who rarely or never use safety belts when riding in a car driven by someone else and of students who rarely or never use safety belts when driving a car
- Reducing the proportion of college students who ride a motorcycle who rarely or never use a motorcycle helmet
- Reducing the proportion of college students who rarely or never use a bicycle helmet
- Reducing the proportion of college students who carry a weapon for non work-related purposes
- Reducing the proportion of female college students who have been forced to have sexual intercourse for the first time
- Reducing the proportion of college students who engage in physical fighting
- Reducing the proportion of college students who seriously consider attempting suicide and those who make a specific plan
- Reducing the proportion of college students who are smokers
- Reducing the proportion of college students participating in episodic heavy drinking
- Reducing the proportion of college students who use marijuana
- Reducing the proportion of college students who use cocaine
- Reducing the proportion of college students who use other illegal drugs (LSD, PCP, ecstasy, mushrooms, speed, ice or heroin)
- Increasing the proportion of college students having sexual intercourse who use condoms
- Reducing the proportion of college students who are overweight
- Increasing the proportion of college students who eat five or more servings of fruits and vegetables each day
- Reducing the proportion of college students who eat high-fat foods
- Increasing the proportion of female students who take a multivitamin every day
- Increasing the proportion of students who engage in vigorous physical activity for at least 30 minutes on at least three days out of seven, or who engage in moderate physical activity for at least 30 minutes on at least 5 days out of seven.

Implementation Strategy:

- Identify an organization, possibly the Kentucky College Health Association, to organize, encourage and facilitate health behavior assessment and intervention to reduce health risks of post-secondary students in Kentucky.
- Encourage each post-secondary institution to conduct a periodic assessment of their students' health behaviors, preferably using The Centers for Disease Control's College Health Risk Behavior Survey, with any additional questions the institution may desire.
- Encourage post-secondary institutions to plan effective, science-based educational, environmental, and policy interventions to reduce health risks in their student populations.

School Nurses

4.6. Increase to 100 percent the proportion of Kentucky's elementary, middle/junior, and senior high schools that have a nurse-to-student ratio of at least 1:750.

Baseline: In the 1997-98 school year, Kentucky's elementary, middle/junior and senior high schools had a nurse-to-student ratio of 1:1831.25. (342 nurses for 626,288 students) There were 29 school districts with no nurses during the same year (Kentucky Legislative Task Force on Health in Schools, 1999).

Note: Children's physical and mental health are linked to their abilities to succeed academically and socially in the school environment. The National Association of School Nurses recommends a ratio of 1 school nurse per 750 students.

Target Setting Method: To meet the national standard requires 245 percent improvement.

Data Source: Kentucky Department Of Education, Office of Student and Family Support

Implementation Strategy:

- Collaboration between the Department for Public Health, the Department of Education, and the Cabinet for Families and Children.
- Support "A Proposal for School Health to the Kentucky Commissioner of Public Health" prepared by the Comprehensive School Health Work Group.
- Work with Legislative Task Force on Health Services in Schools.
- Support Kentucky Public Health Association Resolution on School Health.
- Promote coordination and collaboration of Local Health Departments and Local Schools to complete their Community Assessments.

- Collaborate efforts with Family Resource and Youth Services Centers (FRYSC).
- Support increasing more school based clinics and more school based mental health workers.

Objectives for the Workplace Setting

Health promotion programs in the workplace can be instrumental in improving the health and well being of Kentuckians. The workplace provides an effective and convenient way to reach at least 60 percent of Kentucky adults with health education and screening initiatives to assist with enhancing the overall health of a community (Kentucky Health Interview and Examination Survey, 1993). Worksite wellness programs reinforce efforts by companies aimed at improving worker productivity, decreasing absenteeism due to injury/illness and increasing employee morale (Gebhart & Crump, 1990).

Comprehensive worksite wellness programs should contain elements related to health education; policies that promote healthy lifestyles and behaviors, such as smoking cessation; health nutrition alternatives in vending machines and cafeterias; and opportunities for physical exercise and employee assistance programs; in addition to screening programs for detection and prevention of health problems. Participation in worksite health promotion programs is essential in keeping Kentucky's workforce healthy, strong and productive (Hearney & Goetze, 1997).

Public Health has the responsibility to inform, educate and empower people about health issues (CDC, 1999). With the changing health care environment in Kentucky, comprehensive worksite wellness programs provide another marketing opportunity for local and district health departments. Worksite health promotion programs designed by the local and/or district health department can be specifically directed toward a community's health concerns based on information/data obtained from each area's population-based assessment. Public Health supports a culture, which values and meets needs for health improvement for all individuals. Public Health, linked with worksite health promotion, provides a win-win situation in effectively impacting Kentucky's health status.

- 4.8. (Developmental) Increase to at least 50 percent of worksites in Kentucky that offer a health promotion activity, preferably as part of a comprehensive worksite health promotion program.**

Baseline: No specific data for Kentucky.

Target Setting Method: Better than the best.

Potential Data Sources:

- U.S. Department of Health and Human Services. *1992 National Survey of Worksite Health Promotion Activities Summary Report*
- BRFSS: worksite wellness module to be included for data collection.
- Worksite Task Force: tap into current survey with additional questions.
- Data from Local Public Health Performance Assessment (in pilot stage).
- National Health Interview Survey data for companies that have at least 50 employees. (probability data for Kentucky)

Implementation Strategy:

- Develop a worksite wellness module to be included in Behavioral Risk Factors Surveillance System. (BRFSS).
- Local/District Health Department marketing to worksites: tailor existing services to meet the needs of employers and employees.
- Development of worksite questionnaire for all employers in Kentucky.

4.9. (Developmental) Increase to at least 37 percent the number of employees who participate in one or more “employer-sponsored” health promotion activities.

Baseline: No specific data for Kentucky available at this time.

Target Setting Method: Based on *Healthy People 2010* guidelines.

Potential Data Sources:

- Department of Health and Human Services: 1992 National Survey of Worksite Health Promotion Activities Summary Report.
- BRFSS: worksite wellness module to be included for data collection.
- Development of worksite questionnaire.
- Worksite Task Force: tap into current survey with additional questions.
- Data from Local Public Health Performance Assessment (currently in pilot stage).
- National Health Interview Survey data for companies that have at least 50 Employees

Implementation Strategy:

- Develop a worksite wellness module to be included in BRFSS.
- Local and District Health Department marketing to worksites: tailor existing services and programs to meet the needs of employers and employees.
- Development of worksite survey for all employers in Kentucky.

Objectives for the Community Setting

Community Health Education and Health Promotion

- 4.10. (Developmental) Increase by 25 percent the percentage of patients who report they are satisfied with the communication they receive from their health care providers about how decisions are made about their health care.**

Baseline: No baseline data available as of January 2000

Note: To be determined during 2000 through BRFSS data.

Target Setting Method: At least 25 percent over obtainable database.

Potential Data Sources:

- BRFSS
- Kentucky Nurses Association (KNA) questions on Nursing Boards
- Patient surveys/questionnaires

Implementation Strategy:

- Kentucky Department For Public Health will work with Kentucky Nurses Association (KNA) and Kentucky Medical Association (KMA) to conduct training for health care providers on improving communication with their patients. Work with State University medical schools to incorporate “the Patient as a Member of the Health Care Team” and patient communication skills into their respective curriculum
- Local Health Departments provide workshops for “Communication with Clients” open to all health care staff within the community
- Local Health Departments assure for provisions of the “Patient Safety Act” by providing patient teaching and communication that promotes understanding of the patient’s care/treatment.

- 4.11. Increase by 65 percent the percent of health care organizations that provide patient and family education.**

Baseline: 20 percent of health care organizations provide patient and family education.

Note: Additional baseline data will be available by July 2001. Health care organizations are defined as managed care organizations.

Target Setting Method: A 45 percent improvement over health care organizations.

Potential Data Sources:

- Activities will be monitored in accordance with both National Committee for Quality Assurance (NCQA) and Managed Care Organization standards, through routine/annual reporting.
- Review and update of guidelines at least once every two years, where appropriate.

Implementation Strategy:

- Have guidelines that include prevention or early detection interventions
- Distribute guidelines to members and practitioners
- Assure health promotion initiatives be in place to encourage members to use preventive health programs.

- 4.12. (Developmental) **Increase to 50 percent the proportion of managed care organizations and hospitals that provide community disease prevention and health promotion activities that address the priority health needs identified by their communities.**

Baseline: 20 percent of Managed Care plans were accredited by the NCQA as of April 1999.

Note: Health Employers Data Information Set (HEDIS) baseline data available by June 2001.

Target Setting Method: A 30 percent improvement over existing State baseline.

Potential Data Sources:

- On site reviews of Managed Care plans conducted by Department Of Insurance
- Review the number of accredited Managed Care plans by NCQA

Implementation Strategies:

- Develop Quality Assurance Standards
- Have guidelines for quality of care studies and monitoring, including attention to vulnerable populations.

- 4.12. **Increase to 100 percent the proportion of Local Health Departments that have established a community health promotion initiative that addresses multiple *Healthy People 2010* focus areas.**

Baseline: 100 percent of Local Health Departments submitted a Community Based Plan which included assessment, targeted objectives, strategies and evaluation as of July 1999.

Note: In the Planning Process, various assessment instruments have been utilized and specific methods are implemented to a varying extent by different agencies. Evaluation is still in the process of being developed in some areas. Full implementation and evaluation of each respective community is the overall objective for each public health agency.

Target Setting Method: Currently a community assessment plan is required by the Division of Resource Management for Local Health Department funding by Department For Public Health. Continue the assessment level at 100 percent; full implementation at 50 percent by 2005, with 100 percent full implementation by 2010.

Data Source: Annually, through submitted Community Based Activity Plans by Local Health Departments to Division of Resource Management.

Implementation Strategies:

- Department For Public Health Staff, in particular, the Public Health Nursing Branch and Programmatic Nurse Consultants, Administrators and Coordinators, provide technical assistance to enable full implementation of each Community Plan.
- Continue/maintain on-going current efforts through Department For Public Health. Continue to improve coordination and collaboration within the Department for Public Health.
- Focus on Public Health CORE Functions Activities/Services and Mandated Preventive Health Care.
- Develop new initiatives as needed.
- Concentrate efforts on communities/public health agencies that have yet to meet objective(s).

4.13. (Developmental) Increase by 50 percent the proportion of Local Health Departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs for racial and ethnic minority populations.

Baseline: No data available as of June 1999.

Note: Survey of Local Health Departments will be conducted before June 2000 to determine this need.

Target Setting Method: Improve by at least 50 percent over baseline data.

Potential Data Source: Survey of Local Health Departments will be conducted.

Implementation Strategies:

- Kentucky Department for Public Health (KDPH) will provide education and training on cultural diversity to Local Health Department Staff.
- KDPH will utilize the Migrant Network Coalition, Hispanic Coalition, Korean/Asian Coalition and the African/American Community in assessing, planning, implementation and evaluation programs for targeted populations.
- KDPH will utilize the Department of Adult Education and Literacy with program planning for this population.
- KDPH will utilize the Minority Management Trainer Coordinator, Eula Spears RN, from the Public Health Training Branch.
- Designate monthly as a different cultural diversity topics at the Local Health Department, including community organizations.

4.14. (Developmental) Increase by 25 percent the proportions of people age 65 and older that have participated during the preceding year in at least one organized health promotion program.

Baseline: No baseline data available as of January 2000.

Note: To be determined during 2000 through BRFSS data.

Target Setting Method: Improve at least by 25 percent over database.

Potential Data Sources:

- BRFSS data
- Survey the Senior Citizens' Centers quarterly/annually by Area Development District (ADD) through the office of Aging.
- Survey the "Triple A's" (Area Agencies on Aging) quarterly/annually.

Implementation Strategies:

- Increase the number of Local Health Department (LHD) community-based plans that target people aged 65 and older.
- Recruit elders that attend and utilize Senior Citizens' Center services.
- Increase/recruit elders in participation in activities such as
 - Pacesetters-walking program for 55 and older, increase participation from 2,000 at present
 - Bluegrass Games-increase number of counties participating, 90 percent at Present
 - "Conference for Seniors" the "Next Best Years of Your Life" held every September
 - Health Fair directed to independent living elderly
 - Booth and interaction at Adult Day
 - Encourage participation/attendance at seminars especially for the elderly,

such as Summer Series on Aging, the “Brown Bag” at LHD, which consists of nutritional screening, treatment, dentistry checks etc. Local Health Departments also do “Body Recall”, the aerobics workout. “Senior Games” are also held annually.

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