

Ohio Health Education Model Curriculum Advisory Committee

Meeting One Notes

June 21, 2018

Opening presentations

HPIO created a [page on our website](#) for the advisory committee. Presentation slides, as well as other relevant resources and materials, are posted there.

Amy Stevens (HPIO) discussed the health of Ohioans, the role of healthy behaviors and the current status of health education in Ohio. (See slides 5-20) Then, Kevin Lorson (OAHPERD) explained the need for a model curriculum, defined key terms and discussed the project plan. (See slides 21-34) Tina Dake, a health education teacher at Washington Local School District (Toledo, OH), described the National Health Education Standards and gave examples of how they are implemented in her school.

Opening discussion/project clarification Q &A:

- For whom in a district are we developing this model curriculum? (E.g., Are we expecting it to be used by health educators teaching health classes? Guidance counselors? Will it be used as a part of other classes?)

Kevin Lorson and Joseph Dake explained that the plan is to develop a model curriculum that anyone can implement. The goal is for a health educator to be the leader, but we understand that is not the reality in every school. It will include guidance and strategies that teachers and administrators can use more broadly than within a standard health class. For example, content for grades K-5 will likely require a different approach.

- Meeting participants recommended providing guidance in the model curriculum for how the content can be incorporated into/overlap with other subject areas. Intentional alignment across curricula will be important. For example, hand washing can be discussed as a part of an elementary science curriculum.
- The superintendents in the room recommended against incorporating accountability/measurement. They liked the focus on “skills and disposition” and believed that the pendulum not swinging toward greater accountability will be the best approach.
- The group acknowledged that it will be challenging to overcome the perception that health education takes time away from teaching other subjects.

Discussion question #1 – What problems are we aiming to solve by developing a model health education curriculum?

- Lack of guidance for teachers and school administrators regarding what to teach in health education
- Lack of consistency regarding what is taught in health education around Ohio
- Poor quality of health education in some instances

- Misconception of what health education is (skill-focused, rather than knowledge- or facts-based)
- Ohio's current approach to health education policy is reactionary (responds to existing or emerging crises, as opposed to being proactive)
- High healthcare costs
- Poor health outcomes
- Unhealthy and risky behaviors
- Children are often not prepared to be competitive in the workforce because of poor health

Discussion question #2 – What will be different if we are successful?

- More consistency in health education across schools and programs
- Health education will be viewed as an equally important school subject that is part of a well-rounded education that every Ohio student should receive.
- Ohio's health value rank will improve (currently Ohio ranks 46th among the 50 states and DC)
- Students will perform better academically (When students are physically, socially and emotionally healthier, they perform better academically)
- Teacher burnout rates will decrease; teachers will view their work as more rewarding
- Improved health literacy and health behaviors – not only among children in school but among the broader population (The influence will be spread to families and the wider community.)
- Future generations will be positively impacted. (The skills children learn will be passed on.)
- Students will develop a better understanding of all the factors that influence health (Researchers have estimated that about 30% of health is influenced by health behaviors, 20% by clinical care and 50% by the social, economic & physical environment, such as income, air and water quality, exposure to violence and educational attainment.)
- Students will become more involved in advocacy related to all the drivers of poor health

Discussion question #3 – How can we provide guidance and structure that supports local control? (*What should the writing teams keep in mind?*)

- It should provide a starting point for districts regarding what skills students should be taught and what would be valuable to cover in professional development. It should help districts make better decisions when developing local curricula.
- Clearly articulate to schools that they have choices and local control. For example, the curriculum should not say that districts must use a certain structure or certain people to teach health education.
- Provide suggestions to districts on how to make the curriculum relevant to their schools. (E.g., provide guidance to districts on how to do an assessment/survey of their student bodies to learn what the students do and do not know)
- Curriculum should honor that districts will be starting in different places and each district's journey will be different. For example, it should provide suggestions of how to start incrementally.
- Share beneficial outcomes for late adopters, as well as schools that are already doing more

- Encourage districts to add “local flavor” by identifying their biggest needs/problems and incorporating those topics into their curriculum (e.g., binge drinking)
- Point out to districts that community awareness is helpful

Discussion question #4 – How can this project best connect to and support related initiatives led by state agencies and others (e.g., Attorney General Joint Study Committee toolkit, HOPE curriculum, ODE strategic plan, State Health Improvement Plan, etc.)?

- The Attorney General Joint Study Committee toolkit and the process of developing it should be used as a resource/learning experience. For example:
 - Do not be prescriptive, but rather provide guidance and suggestions
 - Consider all different types of schools (e.g., suburban, rural, urban, etc.)
 - Celebrate/lift up examples of schools that are doing well (e.g. include profiles of a few different types of schools doing high-quality health education)
- The model curriculum should explain how it can overlap with other requirements (e.g., ODE requirements)
- It should link to these resources

Additional question from Kevin Lorson – How should the writing teams handle the legislatively-required topics?

- Standardize the student learning outcomes associated with these topics. Since districts are already required to teach them, the model curriculum should give them as much guidance as possible.
- Provide suggestions regarding into which standard the topics fit and provide resources for schools to address them. This way, schools would not be starting from scratch.

Other discussion:

- Laura Rooney mentioned The Ohio Department of Health’s [School Health Profiles Survey](#) for which data have been collected every two years since 2008. The most recent report is for 2015. (It was mentioned that these numbers are likely artificially inflated because they are based on self reports from schools. Schools may perceive that they have certain policies, curriculum components, etc. in place, although they may not be aligned with evidence or implemented in a consistent or widespread way.)
- A district’s rollout strategy will be important – utilize the state support teams, ESCs, etc. The best rollout strategy will differ from one district to the next.
- Guidance on incorporating mental health is important. People need to realize that health is about the whole person. Mental health should be included as a topic.

Next steps:

- Some advisory committee members may be asked to contribute to development of the model curriculum.
- The deadline to apply to serve on writing teams is July 14.
- Writing teams will begin work in July.
- Next Advisory Committee meeting – December 2018 (Draft outcomes will be available)