



Date: November 6, 2016

To: Arizona Department of Education

From: AZHPE, Edunuity, Healthy Future Arizona, Empower Youth Health

Subject: ESSA & School Report Card submission

We would like to submit the following preliminary input to the ESSA and School Report Card policy-making processes:

Introductions

AZHPE is the Arizona Association of Health & Physical Education, the Arizona affiliate of SHAPE America (the national Society of Health And Physical Educators). AZHPE was established in 1931, and has close to **1000 members, and represents the approximately 2600 certified physical and health educators of Arizona**. Edunuity is the non-profit social entrepreneurial organization, which is advocating for improved health and education policies in Arizona, including serving in the state leadership of the Empower Youth Health (EYH) program, and co-founding the Health Future Arizona (HFA) initiative. Healthy Future Arizona is the statewide initiative & coalition to dramatically improve Arizonans' health, in the broadest sense of the word, with the vision of Arizona becoming the healthiest state. Empower Youth Health is a low cost, evidence-based, K-12, systemic program, which assists schools in dramatically improving and expanding physical, nutrition and wellness education, in line with state physical and health education standards. As a result of improved health outcomes from EYH and other HFA programs, Healthy Future Arizona expects the health sector to invest a growing amount of sustainable new money into schools, building to \$300-500 million/year over the next 5-10 years.

Accountability: Meeting The Physical & Health Education Standards and Mandates

Elementary and Middle Schools

The state of Arizona mandates physical education for elementary and middle school, and provides excellent standards for physical and health education. **Per state requirements, students must be competent in physical education before being promoted to 9th grade. Local school boards (are supposed to) determine competency.**

However, many K-8 schools offer little or no physical education, and **few schools appear to be assessing competency in a valid, regular manner**, because they are not required to conduct such assessments. On the other hand, if the state of Arizona required physical education assessments, schools would focus much more on expanding and improving their physical education programs.

Competency is clearly defined by the state physical and health education standards. The following are key **stated goals of Arizona for physical and health education**. These goals clearly focus on improving the lifelong health behaviors of students:

Most recent (2015) physical education standards: “The goal of physical education is to develop literate individuals who have the **knowledge, skills and confidence to enjoy a lifetime of healthful physical activity.**”

Most recent (2009/2010) health education standards: “The educator’s role includes teaching skills and functional information (essential concepts), helping students **determine personal values that support healthy behaviors, helping students develop group norms that value a healthy lifestyle, and helping students develop the essential skills necessary to adopt, practice, and maintain health-enhancing behaviors.**”

High Schools

Physical education is not required for graduation from high school. Moreover, there is no state policy on allowing substitutes or granting exemptions/waivers for school districts regarding physical education time and requirements. As a consequence, many high school students may now never get the experiences and knowledge needed for active and healthy living. Districts can readily allow students to substitute JROTC, marching band, and/or interscholastic athletics, and earn credit for physical education. None of these substitute activities address any of the national or Arizona physical education content standards. These non-physical-education programs have fundamentally different purposes. Even for the one physical content standard that directly addresses engaging in physical activity, there is evidence that JROTC does not come close to meeting the recommended levels of physical activity (e.g., Lounsbery, Holt, Monnat, Funk, & McKenzie, 2014).

Background and Rationale

To our knowledge, currently, no information on physical and health education is being assembled by the state, except for a very small percentage of schools participating in self-reported health behavior surveys, such as Arizona Youth Tobacco Survey, Arizona Youth Survey (AYS) or Youth Risk Behavioral Survey (YRBS(S)). YRBS includes only a few, very limited, and only student-self-reported questions relating to physical activity and physical education among high school students (YRBS, 2015), and the other surveys do not cover physical education or activity. The following are the only relevant questions from the YRBS 2015 survey:

- During the past 7 days, on how many days were you physically active for a total of at least 60 minutes per day?
- In an average week when you are in school, on how many days do you go to physical education (PE) classes?

What is more, YRBS results are aggregated for the entire state, and are not provided to the public by the state, with data on particular school districts or individual schools.

Furthermore, currently, no physical or health education metrics are included in the A-F accountability formula. We are seeking a voluntary option for schools to have the choice to provide timely, valid, reliable physical and health education data, in order to qualify for A-F bonus points. *If schools do not participate, not providing data would not harm their scores.* Conversely, if a school does opt to include data on health education and physical education, it could earn bonus points toward a better overall school grade.

Partly as a result of the lack of assessments, lack of published outcome metrics, and non-inclusion in the school accountability grading formula, ***schools have in many cases diminished physical and health education to such an extent, that many DO NOT and CANNOT meet state physical and health education standards.*** The state currently has no adequate way of determining, to what extent physical education is being taught, and to what extent standards are being met.

This lack of information conflicts with the intent of ESSA and its inclusion of physical and health education as well-rounded subjects. ESSA implies that this ignorance of well-rounded subjects' quantity and quality is problematic and should be reformed.

This lack of data would be considered totally unacceptable and intolerable for reading, writing, math and science. But it has been tolerated by Arizona leaders and school districts for decades, even as the state has updated physical education standards “on paper” as recently as 2015.

Arizona stands to gain considerable funding support for health and physical education through ESSA, if it can show that it is making a genuine attempt to provide all its students, with what in ESSA is referred to as a “well-rounded education.” Title II and IV money is to be earmarked by states specifically to support this “well-rounded education.” Schools that opt to track the status of their health and physical education programs, would be in a much stronger position to obtain the ESSA funding made available through the state.

Importantly, if schools are requested to include data on the status of their health and physical education programs, in the information provided to the state as part of the School Report Card, **this policy would place ADE (and the state as a whole) at the forefront nationally.** Arizona could become the first state to track these data for these two essential school subjects; currently, to our knowledge, there are no other states using the school report card, as a state-level tracking mechanism to periodically assess the status of these subjects.

Other Considerations

Unfortunately, objective assessments of student cardiovascular fitness and BMI in many lower-income Arizona schools indicate that a very large percentage of Arizona students engage in unhealthy behaviors, which are likely to lead to a life of chronic health conditions (Reeves, 2016; DeHeer, 2014).

Objectively, physically measured aerobic and BMI data from a range of schools in both northern and southern Arizona imply that actual child obesity may be much worse than sampled, self-reported data such as YRBS indicate. It appears that **adolescent child obesity may be in the 20-30% range in many lower-income schools.** This is 50% or more higher than indicated by YRBS student-self-reported data, which is

the only statewide, regularly sampled data on school-age child obesity/BMI—and only covers high school students (YRBS, 2015).

In addition, recent fitness assessment data seem to indicate that the **percentage of students with cardiovascular fitness may be as low as 15-20% of K-12 students**, in many lower-income Arizona schools. The lack of aerobic fitness may be much worse among high school students, since obesity tends to increase and fitness to decline, as students age with inadequate physical activity. **The majority of students then leave school, headed for a life of chronic diseases (CDC, 2016).**

In the past, this might simply have been considered neglect. However, as more and more objective data emerge, and as these data are brought to policy-makers' attention, **what was neglect becomes negligence.** We need to consider, what our own organizational and individual responsibility may be, as over **one-third of students in Arizona head for an adult life of diabetes**, and over half live adulthood with one or more **preventable** chronic conditions (*Pediatrics*, 2012; Diabetes.org; Boyle et al, 2010; CDC, 2014-16; Schneiderman et al, 2014; Edunuity estimates).

Furthermore, as health costs from chronic health conditions continue to increase, they are putting growing pressure on education investments and other state and family spending. For example, **health spending increased from 15% of the state budget in 2003 to 20% in 2016, while education spending's share of the budget has declined.**

While many complain about state prison spending, the amount of money which could be re-purposed for education from health spending in Arizona, if Arizonans were healthier, dwarfs any potential savings from corrections budgets. **But without effective physical and health education, we are locking in ever higher health budgets, and putting more and more education dollars at risk, for many decades to come.**

A key focus of our recommended ESSA and School Report Card metrics is on healthy behavior, as indicated by the state standards, including data on and policies and practices leading to healthy behavior.

Healthy behaviors are also the key controllable drivers of health outcomes. The biggest, preventable root causes of poor health are inadequate physical activity, unhealthy nutrition, and smoking. Alcohol and other substance abuse are also key preventable contributors to poor health. Over half of health conditions and costs are considered preventable (CDC, 2016; Mensah, 2006).

As a nation, we have done an excellent job at reducing smoking, through multi-pronged efforts such as legislation, social marketing, and targeted taxation, with significant assistance from health education in schools. In comparison, while school meal nutrition appears to be improving to some extent, **schools have generally done very little to increase physical activity opportunities**, even though students spend upwards of 6-7 hours at school each day for 12-13 years (well over 14,000 hours)(AZHPE, 2016; YRBS, 2015). As noted as well in ASCD's "Whole School, Whole Community, Whole Child" (WSCC) initiative, educating/serving the "whole" student is essential.

Health behaviors and outcomes can also have a major impact on academic achievement, focus and attention, self-efficacy and self-discipline, and student engagement at school (e.g., USDHHS, 2010, Trost & van der Mars, 2010; Ahamed et al, 2007: Action School! BC; Donnelly et al, 2009: PAAC; Hillman, Castelli et al,

2007- ; Hollar et al, 2010; Kamijo et al, 2011, 2012; Shephard, 1996; Desy et al, 2013; Rumberger, 2011).

Health behavior and outcomes also heavily impact college and career success, include job performance and retention, as well as family financial health, and other aspect of life-readiness and success in life (DeVol et al/Milken, 2007). More broadly, good health contributes to economic development, while poor health harms productivity, including contributing to absenteeism and “presenteeism” (job underperformance) (e.g., Baicker, Cutler, & Song, 2010; Gettman, 1997). Thus, poor health also harms business profits, reduces state GDP and tax revenue, and harms the state’s ability to fund schools--while increasing demand for state and taxpayer health spending. This combination is a very harmful “double-edged sword”.

There are at least **two recent, breakthrough examples**, of what effective physical and health education can achieve in Arizona:

- **Empower Youth Health (EYH), at a scale-cost of \$10/student/year**, is the Healthy Future Arizona initiative’s first-step focus for statewide scaling. **EYH increased cardiovascular fitness levels from 17% fit at baseline to 78% fit after 3 years, in a low-income population of 16,000 K-12 students in Pima County (Reeves, 2016).** What is more, recent multi-decade studies in Sweden show a **strong association of teen aerobic fitness with 1/3 reduced risk of heart attacks (Hogstrom et al, 2014) and 1/2-2/3 less diabetes in middle-age (Crump et al, 2016).** BMI (body mass index) among Empower Youth Health participants also improved by ~20% compared to what would have normally occurred without the program.
- Another example is the **Fit Kids program in greater Flagstaff.** Northern Arizona Healthcare has been investing almost \$1 million per year for 4+ years from its own surplus, to increase moderate-to-vigorous physical activity (MVPA) in local K-8 schools--with a resulting **50% reduction in obesity trajectory (DeHeer, 2014).**

If all health care providers in Arizona invested in a similar manner to Northern Arizona Healthcare, this would total \$100 million per year new money into schools. If health plans matched this amount, the total would be \$200 million. In addition, research evidence indicates that this investment has a very rapid payback with very high return on investment (ROI). With federal and state monies on top of that, we can reach over \$300 million annually in sustainable new dollars from the health sector going into schools. This is part of the physical and health education community’s potential contribution to “Project 456”.

But we need some support from the ADE and the State Board of Education to help achieve this, in the form of ESSA-related policies and practices, including the proposed School Report Card, and the revised A-F Accountability formula.

ESSA Recommendations

AZHPE and its partners recommend that Arizona’s implementation of ESSA include at least the following points:

- 1) Physical and health education are important parts of whole-child life-readiness and a well-rounded education. They **help prepare children for overall success in life**, including success with college and career.
- 2) Schools should **implement physical and health education (PE & HE) to the standards agreed by the State Board of Education (SBE)**.
- 3) **Physical and health education are essential subjects**, as indicated by Arizona state standards and mandates, and reinforced by ESSA's well-rounded subjects designation, requiring adequate staffing, funding, training, equipment, facilities and other resources.
- 4) **Academic achievement is not improved by shifting instructional time away from PE**, and schools which have maintained PE instructional time have not experienced reduced achievement (e.g., Trost & van der Mars, 2010; Trudeau & Shephard, 2008; Wilkins et al, 2003; USDHHS, 2010; Lees & Hopkins, 2013; Rasmussen & Laumann, 2013; RWJF, 2009; Shephard, 1996; Trudeau, 2010).
- 5) **Moderate-to-vigorous physical activity (MVPA)**, in particular, has been shown by extensive research to improve academic achievement:
 - a. Regular physical activity throughout the day can contribute to improving academic performance (Ahamed et al, 2007: Action School! BC; Donnelly et al, 2009: PAAC)
 - b. **Moderate-to-vigorous physical activity (MVPA) improves academics** (Hillman, Castelli et al, 2007- ; Hollar et al, 2010; Kamijo et al, 2011, 2012; Shephard, 1996)
- 6) Physical education, physical activity, and sports **increase engagement & reduce drop-outs** (Desy et al, 2013; Rumberger, 2011).
- 7) **Effective school physical and health education can dramatically improve students' health during their years in school** (e.g., Domino et al, 2009; Fullerton et al, 2012; Hampl et al, 2007; Katz et al, 2010; Kuhle et al, 2011; MACPAC, 2015; Pelham et al, 2007; Schuch et al, 2016; Skinner et al, 2016; Thapar et al, 2012; Wang et al, 2005). **Health outcomes also play a major role in lifelong success, including career and job productivity** (DeVol et al/Milken, 2007) and **salary and net disposable income** (Council of Economic Advisers, 2009; BLS, 1988-2016).
- 8) **Recess** provides an important opportunity for student physical activity, and it must be provided in adequate amounts K-8, and in a **safe and comfortable environment for all children** (American Academy of Pediatrics, 2012).
 - a. It is not acceptable to eliminate recess in elementary and middle schools. This deprives students of essential physical activity time needed for a well-rounded education, adequate cognitive development, focus & attention, and a healthy life.
 - b. **At least 20 minutes of recess per day is recommended K-8** by SHAPE America.
 - c. Quality recess requires **adequate training and supervision**, as described more below.
 - d. As students move into high school, and require more flexibility in their schedules, alternative options for non-physical-education-based physical activity should be provided to all students, through access to any unused physical activity venues and opportunities throughout the school day, and before- and after-school as well.
- 9) In order to determine if physical and health education standards are being met, and to continuously improve them, valid assessments must be utilized by schools.

- a. AZHPE recommends that **FitnessGram** be one of those assessments. It is a nationally validated, long-standing, multiple-factors assessment, which has evolved from the Presidential Youth Fitness Test. However, it should not become the only metric that schools provide as evidence, and it should be implemented in the manner recommended by AZHPE.
 - b. Multiple other valid measures should be used by schools. **AZHPE should be consulted** on the practicality, timeliness, validity and reliability of any proposed alternative assessments.
 - c. A practical, timely, valid, reliable individual **portfolio assessment**, which could provide a broad assessment of students' capabilities, and which could include FitnessGram and other assessments, would be an ideal long-term assessment goal. This would need to be defined more in the future.
 - d. AZHPE should be asked to review and amend any proposed assessments, which would be recommended by the State. ADE can then review AZHPE recommendations, and SBE could approve them.
- 10) # **Minutes of physical education:** The state's long-term goal for enabling adequate physical education, as described in Arizona state standards, should be the nationally, SHAPE-America-recommended and CDC-recommended:
- a. **150 minutes/week in elementary school;**
 - b. **225 minutes/week in middle and high schools.**
- 11) Schools should target achieving **60 minutes/day of moderate-to-vigorous physical activity** (MVPA) for each student (USDHHS, 2008).
- a. This can be accomplished through **a combination of physical education, recess, classroom activity breaks, before- and after-school programs, lunchtime programs**, and in other ways.
 - b. **Adequate quality training and support** must be provided to physical education teachers, other teachers, other school staff, and student volunteers, in order to provide adequate MVPA quality and quantity.
 - c. [Empower Youth Health is an example of a program, which can help schools affordably reach the recommended number of MVPA minutes, including providing training & support.]
- 12) Students learn about healthy nutrition behavior, directly through **nutrition education**, and indirectly through the school's **nutrition policies and practices**, including the quality of school meals. Schools should utilize valid assessments and systems for ensuring quality and quantity of nutrition education, policies and practices, and quality of meals, snacks, beverages and other at-school nutrition--including student satisfaction with school meals, since this impacts consumption.
- a. School nutrition education is essential for students to develop healthy nutrition habits, and should also meet state health education standards.
 - i. AZHPE should be asked to review and amend any proposed nutrition education assessments, which would be recommended or required by the State. ADE can then review AZHPE recommendations, and SBE could approve them.
 - b. **Adequate quality and quantity nutrition is essential for students to develop adequate brain capacity and neural connections to optimize their academic achievement** (Best, 2010; Chaddock et al, 2010, 2011; Davis et al, 2011; Edwards et al, 2011; Frisvold, 2015; Geier et al, 2007; Hillman, 2010; Hollar et al, 2010; Howie & Pate, 2012; Kamijo et al, 2011-

2012; Mackey, A., Finn, A., et al, 2015; Pontifex et al, 2010, 2013; Singh et al, 2012).

Quality nutrition in schools is essential for physical and overall health and for optimizing cognitive development and related academic achievement.

- c. Nutrition-related and health education and nutrition policies and practices assessments could include:
 - i. **School Health Index (SHI)**, which provides an evidence-based template for a school wellness policy plan, and a partial assessment of the quality of that plan.
 - ii. **USDA's Healthier US School Challenge (HUSSC)**, with the long-term goal of schools reaching the Gold level, as a partial demonstration of physical education and nutrition-related quantity and quality.
 - iii. **Youth Risk Behavioral Survey (YRBS)** nutrition-related questions, as an evidence-based CDC-endorsed method for privacy-protected, confidential, student self-reporting of nutrition behavior.
 - iv. Other YRBS questions anonymously assessing other aspects of students' health behavior, with individual privacy fully protected, and results only provided on an aggregated anonymous basis.
 - v. Schools, which survey students annually using YRBS, would be able to **confidentially survey students' health behavior in a range of ways, including physical, social-emotional, and mental/behavioral, while fully protecting students' privacy.**
 - d. Schools should endeavor to implement **Breakfast in the Classroom**, as an evidence-based practice to improve student nutrition, cognition, and academic achievement (Frisvold, 2014-15).
 - e. Schools should only provide supplemental snacks and beverages, which are supported by evidence-based school physical and health education policies and practices, which promote student wellness.
- 13) **Recess:** Creating a safe, inclusive environment for students engaged in physical activity is essential. Recess should be **supervised by personnel with quality training**, who are able to both maximize moderate-to-vigorous activity, and to help students reduce and resolve conflict, and develop their social-emotional skills during a time of potential conflict (Playworks, 2016).
- a. Conflict at recess can create problems in transitioning to productive classroom instruction. On the other hand, harmonious, active recess can help students burn off excess energy, and focus and self-regulate better when back in the classroom, while improving the classroom and school culture.
 - b. Peer recess coaching by trained older students should also be encouraged, in order to reduce the cost of quality recess supervision.
- 14) **Student-led education and activities:** Given limited staff and instructional time during school hours, schools should develop student volunteers capable of supplementing school personnel work, including:
- a. Leading or assisting with before-, during-, and/or after-school physical activity, nutrition, and other health education.

- b. Schools should provide adequate training and leadership, in order to optimize the success of student-led efforts.
- 15) **Community partnerships:** Schools are encouraged to increase and optimize their partnerships with community organizations and individuals, including parents and non-profit organizations, in order to improve overall physical and health education and student health outcomes.
- 16) **Schools must be accountable** to provide key aggregated, privacy-protected physical education, recess, physical activity, and nutrition-related information each year to ADE:
 - a. *including for use by parents and the public*
 - b. including, as relevant: for the School Report Card (see below), the A-F Accountability formula, etc.

“School Report Card” Recommendations

We recommend that ADE include the following metrics in the School Report Card. All public schools should be required to report this information annually. Currently, no information on physical and health education is being assembled for each school and on a regular basis, for the state, parents and the public. *Partly as a result of this, schools have in many cases reduced physical and health education to such an extent, that they cannot meet state physical and health education standards and related requirements.*

These Report Card data will help ADE, education leaders, public health authorities, policy-makers, as well as parents and the public, to understand better what is happening with physical and health education in Arizona schools, and to take appropriate action.

Given Arizona’s state content standards, the principal focus in the recommended School Report Card metrics, is on students’ health behaviors. Health behaviors and outcomes can have a major impact on academic achievement, focus and attention, self-efficacy and self-discipline, student engagement at school, as well as on college and career success, family financial health, and other aspects of life-readiness and success in life. (References noted earlier.) In addition, health behaviors are also the key controllable drivers of health outcomes. The biggest, preventable root causes of poor health are inadequate physical activity, unhealthy nutrition, and smoking.

(Bold indicates highest priority for immediate implementation; other recommended metrics listed could be added in subsequent years, if not feasible in the first year):

1a) Average # minutes physical education/week:

Option A: Does your school provide the nationally recommended number of minutes of PE per student?:

150 minutes per week, elementary (K-5/6) students	Yes	No
225 minutes per week, middle school (Grades 6/7-8) students	Yes	No
225 minutes per week, high school students	Yes	No

Option B: How many minutes per week of physical education does your school provide for each grade:

Kindergarten **0 1-29 30-59 60-89 90-119 120-149 150-189 190-225 226+**

Grade 1 **0 1-29 30-59 60-89 90-119 120-149 150-189 190-225 226+**

Etc. through Grade 12

1b) If physical education is not offered in each grade, list grades where it is offered: _____

1c) Is physical education offered throughout the full school year? Yes No

2) Average # minutes of recess/day:

Option A: Does your school provide the nationally recommended 20 minutes recess per day for each student?:

20 minutes daily, elementary (K-5/6) students **Yes No**

20 minutes daily, middle school (Grades 6/7-8) students **Yes No**

Option B: How many minutes per day of recess does your school provide for each grade:

Kindergarten **0 1-10 11-19 20-29 30-44 45-59 60-89 90+**

Grade 1 **0 1-10 11-19 20-29 30-44 45-59 60-89 90+**

Etc. through Grade 8

3a) # of days per week that physical activity programming open to all students is offered, beyond physical education: 0 1 2 3 4 5

3b) Average # minutes physical activity/day offered, beyond physical education:

Elementary 0 1-30 31-60 60+ Don't know

Middle school 0 1-30 31-60 60+ Don't know

High school 0 1-30 31-60 60+ Don't know

4) Recess managed by individual trained with evidence-based quality in how to increase moderate-to-vigorous physical activity, minimize conflict, & to develop social-emotionally?

Yes, all recess time Yes, some recess time No

5) Which other options for physical activity are provided (check all that are offered):

Before-school programs? Lunchtime programs? After-school programs? Fitness centers? Intramural sports? Interscholastic sports? Summer programs?

Other _____

6a) High school requires physical education for graduation? Yes No

6b) What % of students use substitutes for physical education requirements? <10% 10-24% 25-49% 50+% (examples of substitutes include JROTC, marching band, sports)

7a) Does your school grant waivers to exempt students from physical education? Yes No

7b) If Yes, what % of students receive waivers? <10% 10-24% 25-49% 50+%

8) Are your physical education teachers certified in physical education? Yes, all Yes, some No

9) Average # minutes per week of health education per student (offered not as part of physical education):

Not offered 0 1-10 11-19 20-29 30-44 45-59 60-89 90+ Don't know

10a) School wellness policy plan: Yes, completed Pending/being developed No Not applicable

10b) School wellness committee: Yes Pending/being developed No Not applicable

10c) Who is on school wellness committee? (check all that apply):

PE teacher Nutrition services Classroom teacher School nurse Principal/vice-principal
Other administrator Student Parent District staff Other _____

11) Did your school participate in School Health Index (SHI)? Yes, completed Pending No

If completed, what is the most recent SHI average self-assessment Module Score for:

Module 1: Health/Safety/Environment 0-24% 25-49% 50-69% 70-79% 80-89% >90%

Module 2: Health Education 0-24% 25-49% 50-69% 70-79% 80-89% >90%

Module 3: Physical Education & Activity 0-24% 25-49% 50-69% 70-79% 80-89% >90%

Module 4: Nutrition Services 0-24% 25-49% 50-69% 70-79% 80-89% >90%

12a) Using FitnessGram/other valid physical fitness assessment? Yes No Don't know

if Yes: % students in Healthy Fitness Zone, or the equivalent (most recent data):

0-19% 20-39% 40-59% 60-79% 80-89% 90+% Don't Know

12b) Using a portfolio or resume physical education assessment? Yes No Not sure

12c) Please describe your physical education assessment process: _____

13a) Healthier US School Challenge (HUSCC) level

Gold Silver Bronze Pending/in progress Not applicable

13b) Do you use other similar valid nutrition & PA assessments (which one?: ____; which level achieved?: ____)

14) Breakfast in classroom? Yes, offered Planning/implementing No

15a) Nutrition quality of school meals: High Medium Low

How does school measure meal quality? (check any that apply):

HUSSC SHI Wellness policy WellSAT 2.0 School's opinion Other: _____

15b) Does school measure student satisfaction with school meals? Yes No

16a) For middle and high schools: Which of the following surveys does your school administer at least every 1-3 years?

YRBS Yes No

AZ Youth Survey Yes No

AZ Youth Tobacco Survey Yes No

School Health Profile Yes No

17) For middle and high schools: Do you understand the prevalence of other student health risk behaviors at your school, including the following, which have been collected in a confidential manner, have been aggregated, and have been privacy protected?:

17a) % students smoking currently: 0% 1-4% 5-9% 10-14% 15-19% 20-29% 30+% Not collected

("currently" = "current use", defined as "the use of any form of tobacco during the past 30 days, including just a puff of a cigarette or dip of chew"; utilizing Arizona Youth Tobacco Survey, Arizona Youth Survey or YRBSS question format)

17b) % students suffering from depression or other mental/behavioral health issues Yes No

17c) % students with alcohol or other non-tobacco substance abuse issues Yes No

Notes

PE: physical education.

HE: health education.

MS: middle school.

HS: high school.

PA: physical activity;

MVPA: moderate-to-vigorous physical activity.

SHI: School Health Index.

ADE: AZ Dept. of Education.

SBE: AZ State Board of Education.

HFZ: Healthy Fitness Zone (i.e., % students at the level of fitness for good health, per criterion-referenced standards):

<http://www.cooperinstitute.org/healthyfitnesszone>

Detailed references are available upon request.

We much appreciate ADE's work on this. We are looking forward to working with you and others on this.

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