

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)

Overview

The health of our communities depends in large part on whether the physical and social aspects of the communities make it possible for people to live healthy lives. There is a dynamic and unavoidable interaction between individuals and their environment. While lifestyle choices are ultimately individual choices, these personal decisions are made in the midst of a complex mix of social and community relationships and environments that can actively support or obstruct personal change. Research has shown that behavior change is more likely to happen and be maintained when a person's environment is altered in a manner that supports the change.

This complex of interrelationships between people and their social and community networks is termed "the Socioecological Model". The different levels of the model include: Individual (personal behavior change), Interpersonal and Group (family or peer groups), Institutions and Organizations (such as schools, faith organizations or worksites), Community (local policy makers, planners and civic organizations), and Societal or Public Policy (state or national level policy or law). The most effective community promotion programs are those that take into account the different levels of the Socioecological Model, implementing multiple intervention strategies across multiple settings. For example, community promotion programs that involve educational, policy and environmental strategies within schools, workplaces, and health care facilities within the community have a greater chance of succeeding. 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 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 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.

The growing cost of health care coupled with 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, in turn, is beneficial to managers, employees, and the community at large.

Summary of Progress

Progress has been made in several areas of educational and community based programs. The high school dropout rate has actually been reduced, which means that more Kentucky citizens are in a position to hold better jobs, earn a better income, and are more likely to have health insurance. Progress has been made in school health programs. The decrease in the ratio of students to school nurses and the implementation of a coordinated school health program statewide will impact policies and programs in all Kentucky schools. In community health programming, local health departments are offering more and more programs to Kentucky citizens which address multiple Healthy Kentuckians 2010 objectives. They are also offering culturally appropriate programming to meet the needs of different social and ethnic groups. as well as serving more older citizens than ever before.

Progress toward Achieving Each HK 2010 Objective

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.

Data Source: 2000 U.S. Census

Baseline: 74.7 percent: Analysis of 2000 census by the Kentucky State Data Center (KSDC) at the University of Louisville. KSDC Demographic, Education and Workforce Data Tables (Series 1)

HK 2010 Target: 90 percent

Mid-Decade Status: See baseline

Strategies for Achieving Objective:

- Objective 1.1 and sub-objectives 1.1.1 and 1.1.1.a of the Kentucky Department of Education's (KDE) Strategic Plan states that... "Every student is in school and making strong progress... with a decrease in the

dropout rate overall and an increase in the graduation rate overall. The KDE is addressing all objectives through focused and coordinated initiatives. Special emphasis has been placed on dropout reduction and reducing performance gaps among subgroups of students to meet requirements adopted by the General Assembly in 2002 (Senate Bill 168)” Source: Kentucky Board of Education, Strategic Plan Progress Report, 2005.

4.2. Reduce the annual dropout rate for students enrolled in grades 9-12, to a rate of less than 5 percent.

Data Source: 1993-2004 Nonacademic Briefing Packet (State Summary) Kentucky Department of Education Office of Assessment and Accountability

Baseline: 5.2 percent in 1997

HK 2010 Target: 5 percent or less

Mid-Decade Status: 3.4 percent in 2004

Strategies for Achieving Objective:

Same strategies as for Objective 4.1

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. (DELETED)

Reason for Deletion: The KDE is not working toward a statewide initiative to require one full year of health education at this time.

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 Revision for 4.4.1 to 4.4.6)

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). (See Revisions – note that objectives 4.4.1 to 4.4.6 are condensed into one objective listed as 4.4R in revisions.)

- 4.4.2. Implement effective health education curricula addressing Violence and Suicide (addresses suicide, physical fighting, weapons and fear).** (See Revision – note that objectives 4.4.1 to 4.4.6 are condensed to one objective listed as 4.4R.)
- 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).** (See Revision – note that objectives 4.4.1 to 4.4.6 are condensed into one objective listed as 4.4R.)
- 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).** (See Revision – note that objectives 4.4.1 to 4.4.6 are condensed into one objective listed as 4.4R.)
- 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).** (See Revision – note that objectives 4.4.1 to 4.4.6 are condensed into one objective listed as 4.4R.)
- 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).** (See Revision – note that objectives 4.4.1 to 4.4.6 are condensed into one objective listed as 4.4R.)
- 4.4R. (REVISION 4.4.1 – 4.4.6) Increase to or maintain at 95 percent the proportion of public middle and high schools that require instruction in the areas that contribute to the leading causes of morbidity and mortality among youth.**

Reason for Revision: This revision reflects how the data on health education are collected through the School Health Education Profiles (SHEP).

Data Source: SHEP (Only 2002 data are available)

Baseline: in 2002	Percent of Middle Schools	Percent of High Schools
Requiring Instruction In: HIV Prevention	97.3%	98.2%

Sexually Transmitted Disease	94.7%	98.2%
Human Sexuality	77.6%	92.0%
Accident or Injury Prevention	93.4%	96.4%
Alcohol or Other Drug Use Prevention	97.4%	98.2%
Suicide Prevention	66.7%	83.6%
Tobacco Use Prevention	98.7%	98.2%
Violence Prevention	85.5%	90.1%
Benefits of Healthy Eating	100%	98.2%
Risks of Unhealthy Weight Control	96.0%	97.3%
Accepting Body Size Differences	89.3%	95.5%
Decreasing Sedentary Activity	89.2%	93.6%

*Public Schools Only

HK 2010 Target: Increase or maintain all areas to at least 95 percent

Mid-Decade Status: See baseline

Strategies to Achieve Objective:

- Promote at both the state and local levels the value of instruction regarding behaviors which contribute to morbidity and mortality in youth
- Continue to collect SHEP data
- Continue to promote local health departments providing health education to students in schools and community settings. (Evidence based curricula and best practices such as Reducing the Risk (RTR), Postponing Sexual Involvement (PSI), Take 10!, TEG/TAP, etc. are used.)

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. (DELETED)

Reason for Deletion: The CATS System is currently being revised to meet the requirements of the “No Child Left Behind” Act.

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). (DELETED)

Reason for Deletion: There are no statewide data on college health risk behaviors, and these types of data are not expected to be collected in the near future.

School Nurses

4.7. 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. (See Revision)

4.7R. (REVISION) Increase the nurse to student ratio to 1:750 among Kentucky's elementary, middle/junior, and senior high schools.

Reason for Revision: Revision reflects how data on the nurse to student ratio are collected.

Note: This objective was listed as 4.6 in HK 2010. It will now be referenced as 4.7R.

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

Baseline: In the 1997-98 school year there was a nurse-to-student ratio of 1:1831.25 (342 nurses for 626,288 students), In that same school year, there were 29 school districts with no nurses (Kentucky Legislative Task Force on Health in Schools, 1999).

HK 2010 Target: 1:750

Mid-Decade Status: In the 2004-2005 school year there was a nurse-to-student ratio of 1:1426 (458 nurses for 653,248 students). In that same year, there were 22 school districts with no nurses (KDE Max People Manager Directory Verification 2005).

Strategies to Achieve Objective:

- Identify resources to improve student health through consultation, technical assistance, and development of quality measures
- Facilitate statewide and local data collection and reporting of school health services
- Encourage school nurse certification as defined by the Kentucky Educational Professional Standards Board

Objectives for the Workplace Setting

- 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.**

Data Source: 2001 Kentucky Cardiovascular Health Worksite Survey

Baseline: Of Kentucky Worksites with 100 or more employees, 39 percent offered a health promotion activity in conjunction with a comprehensive worksite health promotion program in 2001.

HK 2010 Target: 50 percent

Mid Decade Status: See baseline

Data Needs: Repeat Worksite Survey to assess 2010 status

Strategies to Achieve Objective:

- Cabinet for Health and Family Services (CHFS) will lead by example in maintaining an employee worksite wellness program which includes physical activity and nutrition activities.
- Kentucky Department for Public Health (KDPH) will continue to work with local health departments to provide assistance to any worksite interested in developing and/or expanding a comprehensive worksite health promotion program.
- KDPH will continue to work with local health departments to provide health promotion activities to community worksites as well as local health department staff.
- Provide statewide training on “Winners Circle”. “Winner’s Circle” will provide guidelines and implementation strategies to promote healthful eating in worksite vending and cafeterias
- Provide information to employers on incentive-based programs to encourage physical activity, such as pedometer walking challenges
- Encourage employers to enact policies to support new mothers in breastfeeding
- Encourage employers to develop policies or guidelines for providing healthy food and beverage options at work related gatherings (work meetings or social events)

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

Data Source: 2001 Kentucky Cardiovascular Health Worksite Survey

Baseline: 23 percent in 2001

HK 2010 Target: 37 percent

Mid Decade Status: See baseline

Data Needs: Repeat worksite survey to assess 2010 status

Strategies to Achieve Objective:

- See strategies for Objective 4.8.

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. (DELETED)

Reason for Deletion: There are no data to track this objective, and no data are anticipated in the near future.

4.11. Increase by 65 percent the percent of health care organizations that provide patient and family education. (DELETED)

Reason for Deletion: There are no data to track this objective, and no data are anticipated in the near future.

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. (DELETED)

Reason for Deletion: There are no data to track this objective, and no data are anticipated in the near future.

4.13. Maintain the annual operating standard of 100 percent of Local Health Departments that submit a community health promotion plan that addresses multiple *Healthy People 2010* focus areas.

Note: In HK 2010 this objective was listed as 4.12. The objective will now be referenced as 4.13.

Data Source: Annual Community Based Activity Plans of Local Health Departments submitted to the Division of Administration and Financial Management.

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

HK 2010 Target: 100 percent

Mid-Decade Status: 100 percent of Local Health Departments submitted a Community Based Plan which included assessment, targeted objectives, strategies and evaluation as of July 2005.

Strategies to Achieve Objective:

- This objective has been met. However, KDPH will strive to maintain this high level of achievement by continuing to require local health departments to submit a community based plan of activities which addresses *Healthy Kentuckians 2010 Prevention Initiatives* on a yearly basis.
- KDPH staff will provide technical assistance to local health departments to enable full implementation of each community plan.
- Continue to improve coordination and collaboration across programs and branches within the KDPH
- 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)

4.14. (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.

Data Source: Annual Community Based Activity Plans of Local Health Departments submitted to the Division of Administration and Financial Management.

Baseline: 5 local health departments reported providing 27 activities to 615 participants addressing objective 4.14 during Fiscal Year 2002.

HK 2010 Target: 8 local health departments

Mid-Decade Status: During Fiscal Year 2003, 6 local health departments reported providing 19 activities to 2,176 participants addressing Objective 4.14.

Strategies to Achieve Objective:

- Provide education and training on cultural diversity to local health department staff
- Utilize the Migrant Network Coalition, Hispanic Coalition, Korean/Asian Coalition and the African/American community in assessing, planning, implementing and evaluating programs for targeted populations
- Utilize the Department for Adult Education and Literacy in planning programs for this population
- Utilize the Minority Management Training Coordinator from the Public Health Training Branch
- Designate monthly, a different cultural diversity topic for local health departments

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

Data Source: Community Based Planning Data Warehouse

Baseline: 30,544 people age 65 and older participated in at least one community-based health education/promotion program conducted by local health departments during Fiscal Year 2003.

HK 2010 Target: 25 percent increase over baseline would equal 38,180 seniors participating in a program conducted by local health departments.

Mid-Decade Status: During Fiscal Year 2004, 49,872 people age 65 and older participated in at least one community-based health education/promotion program conducted by local health departments. This is a 61 percent increase from the previous fiscal year.

Strategies to Achieve Objective:

- Increase the number of local health department community-based plans that target people age 65 and older.
- Increase participation in Pacesetters Walking Program.
- Encourage participation/attendance at seminars especially for the elderly, such as the Summer Series on Aging and the “Brown Bag” at local health departments--which consists of nutritional screening, treatment, dentistry checks, etc.

- Increase the number of local health departments who offer “Body Recall” aerobic workout classes.

References

- 1993-2004 Nonacademic Briefing Packet (State Summary), Kentucky
- Department of Education Office of Assessment and Accountability
- Kentucky Board of Education, Strategic Plan Progress Report, 2005
- Kentucky Legislative Task Force on Health in Schools, 1999
- Kentucky Department of Education Max People Manager DirectoryVerification, 2005

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4. Educational and Community Based Programs – Summary Tables

Summary of Objectives for Educational and Community Based Programs	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
4.1. Increase to at least 90 percent the number of individuals, through age 24, who have completed high school.	74.7% (2000)	≥90%	74.7% (2000)	N/A	Census
4.2. Reduce the annual dropout rate for students enrolled in grades 9-12, to a rate of less than 5 percent.	5.2% (1997)	≤5%	3.4% (2004)	Target Achieved	KY Dept. of Education
4.3 (DELETED)					
4.4R. Increase to or maintain at 95 percent the proportion of public middle and high schools that require instruction in the areas that contribute to the leading causes of morbidity and mortality among youth.	See Below	Increase to or Maintain at 95%	See Below		
2002 Baseline	Middle % High %	Middle % High %	Middle % High %	N/A	SHEP
HIV Prevention	97.3 98.2	95 95	97.3 98.2		
Sexually Transmitted Diseases	94.7 98.2	95 95	94.7 98.2		
Human Sexuality	77.6 92.0	95 95	77.6 92.0		
Accident or Injury Prevention	93.4 96.4	95 95	93.4 96.4		
Alcohol or Other Drug Prevention	97.4 98.2	95 95	97.4 98.2		
Suicide Prevention	66.7 83.6	95 95	66.7 83.6		
Tobacco Use Prevention	98.7 98.2	95 95	98.7 98.2		
Violence Prevention	85.5 90.1	95 95	85.5 90.1		
Benefits of Healthy Eating	100 98.2	95 95	100 98.2		
Risks of Unhealthy Weight Control	96.0 97.3	95 95	96.0 97.3		
Accepting Body Size Differences	89.3 95.5	95 95	89.3 95.5		
Decreasing Sedentary Activity	89.2 93.6	95 95	89.2 93.6		
4.5.- 4.6. (DELETED)					
4.7R. Increase the nurse to student ratio to 1:750 among Kentucky's elementary, middle and junior high schools.	1:1831.25 (1997-98)	1:750	1:1426 (2004-05)	Yes	KY Dept. of Education

Summary of Objectives for Educational and Community Based Programs	Baseline	HK 2010 Target	Mid-Decade Status	Progress	Data Source
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.	39% (2001)	≥50%	39% (2001)	N/A	CHWS
4.9. (Developmental) Increase to at least 37 percent the number of employees who participate in one or more “employer-sponsored” health promotion activities.	23% (2001)	≥37%	23% (2001)	N/A	CHWS
4.10 – 4.12. (DELETED)					
4.13. Maintain the annual operating standard of 100 percent of Local Health Departments that submit a community health promotion plan that addresses multiple <i>Healthy People 2010</i> focus areas.	100% (1999)	100%	100% (2005)	Target Achieved	Activity Plans of LHDs
4.14. (Developmental) Increase by 50 percent the proportion of Local Health Departments (LHDs) that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs for racial and ethnic minority populations.	5 LHDs reported providing 27 activities to 615 participants (FY 2002)	8 LHDs	During fiscal year 2003, 6 LHDs reported providing 19 activities to 2,176 participants (FY 2003)	Yes	Activity Plans of LHDs
4.15. (Developmental) Increase by 25 percent the proportion of people age 65 and older that have participated during the preceding year in at least one organized health promotion program.	30,544 65 and older participants via LHD programs (FY 2003)	≥38,180	49,872 65 and older participants via LHD programs (FY 2004)	Target Achieved	Community Based Planning Data Warehouse

N/A = Only baseline data are available. Not able to determine progress at this time.