

Curriculum Framework for Health Education K-12



June 2022

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Section 1: Introduction

The Rhode Island Department of Education (RIDE) is committed to ensuring all students have access to high-quality curriculum and instruction as essential components of a rigorous education that prepares every student for success in college and/or their career. Rhode Island's latest strategic plan outlines a set of priorities designed to achieve its mission and vision. Among these priorities is Excellence in Learning. In 2019 Rhode Island General Law (RIGL) § 16-22-31 was passed by the state legislature, as part of [Title 16 Chapter 97 - The Rhode Island Board of Education Act](#), signaling the importance of Excellence in Learning via high-quality curriculum and instruction. RIGL § 16-22- 31 requires the Commissioner of Elementary and Secondary Education and RIDE to develop statewide curriculum frameworks that support high-quality teaching and learning.

Health Education Guiding Principles

The goal of health education in Rhode Island is students who are health literate and have the essential skills to live healthier lives. The Rhode Island Health Education Framework Advisory Group developed a set of guiding principles for health education. These guiding principles envision a future in which health education is recognized as an essential content area in the curriculum and provides the same rigor and relevance as other content areas.

Our guiding principles are that health education should:

- be predicated on comprehensive, skills based, age and developmentally appropriate curriculum, aligned with best practice instruction;
- be recognized as a core content area in the overall K-12 curriculum and carry the same rigor and relevance as other subjects, such as math and science; be delivered by certified health educators trained in using a student-centered approach;
- be aligned to and implemented with best practice methods related to learning environment, curriculum, instruction, and assessment;
- include medically accurate information and a range of health-related topics at developmentally appropriate ages;
- include inclusive and diverse language and materials to meet the needs of every learner;
- integrate [social and emotional learning \(SEL\)](#) content for students to acquire and apply the skills needed to establish and maintain positive relationships with others; and
- be delivered with trauma informed practices.

Additionally, we believe it is crucial that:

- Schools and communities advocate for the crucial role of health education;
- Schools provide a positive social and emotional climate that is conducive to effective teaching and learning;
- Adults in schools are models and advocates for health-promoting behaviors;
- Families and school staff work together to support and improve students' learning, development, and health; and

- Community groups and local businesses create partnerships with schools to offer resources and volunteer support for student learning and health promoting activities.

RI Department of Education's Guiding Principles for Frameworks:

The following five guiding principles are the foundation for all RIDE's Curriculum Frameworks. They are intended to frame the guidance within this document around the use and implementation of standards to drive curriculum, instruction, and assessment within a Multi-Tiered System of Support (MTSS).

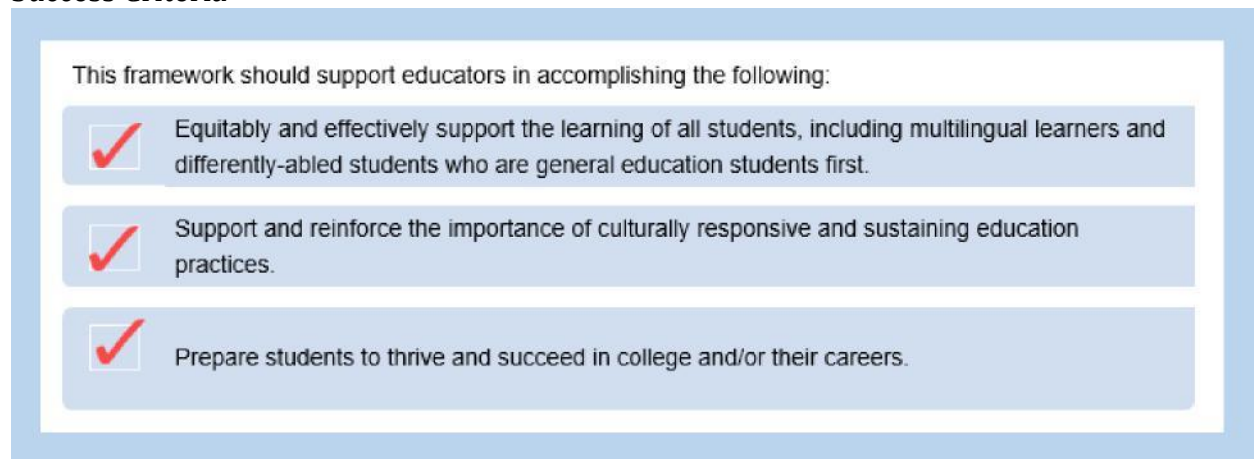
1. Standards are the bedrock of an interrelated system involving high-quality curriculum, instruction, and assessment.
2. High-quality curriculum materials (HQCMs) align to the standards and, in doing so, must be accessible, culturally responsive and sustaining education, supportive of multilingual learners, developmentally appropriate, and equitable, as well as leverage students' strengths as assets.
3. High-quality instruction provides equitable opportunities for all students to learn and reach proficiency with the knowledge and skills in grade-level standards by using engaging, data driven, and evidence-based approaches and drawing on family and communities as resources.
4. To be valid and reliable, assessments must align to the standards and equitably provide students with opportunities to monitor learning and demonstrate proficiency.
5. All aspects of a standards-based educational system, including policies, practices, and resources, must work together to support all students, including multilingual learners and differently-abled students.

Rhode Island's Approach to Health Education

Health education in Rhode Island shall be based on a comprehensive K-12 curriculum — aligned with the [National Health Education Standards](#) - which is skills-based and emphasizes health literacy development. Well-designed, effective health education allows students to acquire the knowledge, attitudes, and skills they need to make health-promoting decisions, resulting in positive health outcomes. The Rhode Island Department of Education, governed by the Council on Elementary and Secondary Education, approves and supports policy around instruction and is a resource for instructional materials and population data around health risk behaviors.

Health education is an important part of building students' health literacy, however it is best combined with broader efforts to support student health and well-being. To achieve this, the [Rhode Island Department of Education](#) (RIDE) supports the implementation of the [Whole School, Whole Community, Whole Child \(WSCC\)](#) Framework in Rhode Island schools. Further, RIDE supports health education as a vehicle for supporting social and emotional skills development for K-12 students. RIDE creates conditions for every Rhode Island student to think critically and collaboratively, and act as a creative, self-motivated, culturally and globally competent learner. Rhode Island students are prepared to lead fulfilling and productive lives, succeed in academic and employment settings, and contribute meaningfully to society ([RIDE Strategic Plan, 2021](#)).

Success Criteria



This framework should support educators in accomplishing the following:

- Equitably and effectively support the learning of all students, including multilingual learners and differently-abled students who are general education students first.
- Support and reinforce the importance of culturally responsive and sustaining education practices.
- Prepare students to thrive and succeed in college and/or their careers.

The Whole School, Whole Community, Whole Child (WSCC) Framework

The WSCC Framework is a comprehensive school or district-based, systemic approach that emphasizes the need for collaboration and coordination of people, policy, and practice to support the whole child with the shared goal of improving both education and health outcomes.

The Whole School, Whole Community, Whole Child (WSCC) Framework was released through a partnership between the [Association for Supervision and Curriculum](#)

[Development](#) (ASCD) and the [Centers for Disease Control and Prevention](#) (CDC) in 2014 to provide an integrated model of health and learning.¹ The WSCC Framework:

- Places youth at the center, surrounded by the tenets of the Whole Child that strives for all students to be healthy, engaged, safe, challenged and supported.
- Elevates the need for coordinated policies, processes and practices.
- Highlights ten key components or “roles” within a school setting related to health and learning with health education as one of the ten components.
- Places the school within the context of community, acknowledging that schools are often the hub of communities and are reflective of its needs and strengths, while highlighting the role of community partners in supporting student health and learning.

The coordination and collaboration across policies, practices and programs gives the framework its power to impact health and academic success. When considering health education within the framework, family support, the link between student health knowledge and engagement in other areas of school, and the use of evidence-based curricula come into play. Families play a critical role as they work with schools to support and improve students' learning, development, and health.



¹Centers for Disease Control and Prevention. (2021, March 23). *Whole School, Whole Community, Whole Child*. Whole School, Whole Community, Whole Child. Retrieved August 20, 2021, from <https://www.cdc.gov/healthyschools/wsccl/index.htm>

Health Education as a Vehicle for Social and Emotional Learning

Health education is a primary vehicle for social and emotional learning (SEL). Social and emotional learning is an integral part of the health education curriculum through which students are able to acquire and practice skills that enable them to establish and maintain positive relationships with others. Health literate individuals make health-promoting decisions, adopt health-enhancing behaviors, promote the health of others, and become assets to the entire community.

Social and emotional learning provides students with the skills, tools, strategies and supports necessary to achieve the developmental tasks of childhood and adolescence, including recognizing and managing emotions, developing care and concern for others, establishing positive relationships, making responsible decisions, and handling challenging situations constructively and ethically. Research has demonstrated that these skills and competencies are necessary for establishing healthful behaviors and achieving academic success.²

The development of social and emotional learning skills are protective factors that support students' ability to practice health-promoting behaviors. A person can develop and improve their social and emotional skills throughout their lifetimes. Social and emotional skills are necessary for life success and are the priority skill identified by employers.³ School wide approaches that support SEL are an emerging trend being used to support academic and behavioral outcomes, especially among high-risk youth. The Rhode Island Council on Elementary and Secondary Education endorsed the [RI SEL Standards: Competencies for School and Life Success](#) in 2017.⁴

² Collaborative for Social and Emotional Learning. "What is SEL?" CASEL, 2021, <https://casel.org/what-is-sel/>. Accessed 16 August 2021.

³ RI Department of Education (RIDE). Social and Emotional Learning Skills in the Workplace. RIDE , 2019, [Social & Emotional Learning \(ri.gov\)](#). Accessed 19, August 2021.

⁴ RI Department of Education. (2017). *SEL Standards: Competencies of School and Life Success*. Social and Emotional Learning. Retrieved August 20, 2021, from <https://www.ride.ri.gov/Portals/0/Uploads/Documents/Students-and-Families-Great-Schools/Health-Safety/Social-Emotional-Learning/RI-SEL-Standards-Linked.pdf>

Support for Student Health and Well-Being

Role of Families and Communities

As suggested in the WSCC Framework, it is essential that students are surrounded with the environmental supports and access they need to establish and practice healthy living skills. For this to be possible, community systems, such as public health and education, and people, such as parents and caretakers, need to work in concert with one another to ensure that children and youth are growing up in a health-promoting environment. Multiple resources are available within the community and school to address the needs of students of all ages.

A part of this system is ensuring strong support and advocacy for quality health education. Communities play a key role in supporting healthy school environments, including financial support for programs, as well as strong policies and mandates around health education. Community leaders are also essential members of local wellness committees, as are parents and caretakers. When we meet the needs of the whole child, the entire community benefits. Further, members of the community, parents and caretakers can support student health by simply and effectively modeling healthy behaviors for youth to emulate.

Role of Districts in Supporting Health Education

School districts play a key role in the development of healthy students. District school committees create policies that support health education programs aligned to the National Health Education Standards, evidence-based curriculum, and skills-based instruction. District wellness subcommittees provide guidance on all aspects of student health and make recommendations regarding health education curriculum and instruction, as well as review and complete annual compliance reports in order to ensure accountability of quality health education implementation. District leadership must ensure comprehensive and inclusive instruction, aligned with this RI Health Education Framework, and ensure all students receive at least the minimum number of instructional minutes required by RI state law/regulation. School districts must hire certified and properly endorsed educators and provide time and support for quality professional development in order to continually improve teaching practices. Professional development incorporates strategies around skills-based effective practices, age and developmentally appropriate instruction, and trauma-informed care. Lastly, districts ensure that school climates promote positive social and emotional wellness for conducive teaching and learning.

Section 2: Implementing High Quality Curriculum Using this Framework

All of Rhode Island’s curriculum frameworks are designed to provide consistent guidance around how to use standards to support the selection and use of HQCMs, evidence-based instructional practices, as well as valid and reliable assessments, all in an integrated effort to equitably maximize learning for all students.

The curriculum frameworks include information about research-based, culturally responsive and sustaining education, and equitable pedagogical approaches and strategies for use during implementation of HQCMs and assessments in order to scaffold, develop, and assess the skills, competencies, and knowledge called for by the state standards.

Rhode Island has a proud tradition of promoting the health of its students through comprehensive school health education programs as prescribed by actions taken by the Rhode Island General Assembly over the years. The Rules and Regulations for School Health Programs ([R-16-21-SCHO](#)), Parts I and II lists requirements school health education programs must meet, while also supporting the establishment of safe, nurturing school environments that are aligned with appropriate health practices.

This Rhode Island Health Education Framework can guide district curriculum committees with:

- Curricular and instructional support materials, such as a K-12 scope and sequence with grade level performance descriptors;
- Supports for cross-disciplinary articulation of health information and services essential for high quality learning;
- Comprehensive K–12 health education curricula and programs, consistent with best practice and inclusive methods and materials;
- Advocacy for professional and highly qualified standards in health education licensure, in collaboration with accreditation agencies and institutions;
- Promotion of differentiated instruction in ways that meet the emotional, intellectual, physical, and social needs of students;
- National and state health education information and resources, supporting educators with curricular decisions based on data and priority risk factors; and
- Support of the requisite for health education instructional time.

This framework does not take the place of, or in any way diminish, the statutory health education requirements each school district must meet. Rather, it offers a lens through which we can better focus on the teaching and learning of health that will carry children into the next decade. The Health Education Standards define the skills that all Rhode Island students should have as a result of their K-12 health education programs.

Overview and Connection to Other Frameworks

RIDE has developed curriculum frameworks in the following content areas: [English Language Arts /Literacy Curriculum Frameworks](#); [Mathematics Curriculum Framework](#); and [Science Curriculum Frameworks](#). Frameworks in technology, arts, history and social studies are forthcoming. Coherence across the curriculum frameworks includes a common grounding in principles focused on connections to content standards and providing equitable and culturally responsive and sustaining learning opportunities through curriculum resources, instruction and assessment.

Additionally RIDE recently produced the [Blueprint for Multi Lingual Learner \(MLL\) Success](#). The term, MLL, reflects the agency's asset-based approach in serving students who come to Rhode Island schools with broad linguistic repertoires. A similar Blueprint for Differently Abled Students is in progress. The Blueprints and complementary resources provide tools and context to help build on the strengths of students while ensuring access to high quality educational experiences.

There are bidirectional opportunities to connect Health Education with other content areas. Health Education can support research skills to identify evidence-based principles, critical analysis and higher order thinking skills that are necessary to meet performance expectations in other content standards. Similarly, pertinent health education content can be reinforced and emphasized in other content areas. These opportunities may be more obvious in elementary curriculum where the elementary certified educator may also teach health education. However, health educator representation on educator teams and connections through school improvement processes can facilitate opportunities to make cross curricular connections.

Culturally Responsive and Sustaining Health Education

To meet the needs of every student, it is imperative that health education curriculum and instruction is aligned to equity, diversity, & inclusion principles and best practices. Health education provides opportunities to address health related social justice issues. Content that addresses current health issues can address standards including advocacy, critical thinking, problem solving, empathy and communication skills.⁵ A focus on population health concerns can support civic engagement and community service.

Skills-based health education, taught with inquiry and collaborative methods, can be transformative. Health education instruction that promotes literacy around inclusion, democracy, social justice, and equity empowers students to analyze the influences of persistent disparities and the power relationships that re/produce inequities, resulting in skills that can lead to advocacy and community action. The implementation of culturally responsive and sustaining interdisciplinary connections within health education in a safe learning environment allows for students to develop an awareness of their own perspectives and allows them to see the world in different ways. When students are able to identify persistent health disparities and learn skills to advocate for change on many issues, such as gender identity, gender expression, sexual orientation, race, ethnicity and/or socio-economic status, they develop the confidence to reflect on their own values, social norms, and assumptions.

“Social justice pedagogies involve identifying inequalities and empowering individuals or groups to take social action to achieve change (Gerdin et.al, 2020).”⁶

RIDE has developed [culturally responsive & sustaining education \(CRSE\) tools](#) that are structured across five elements: diverse identities, cultural awareness, high expectations, instructional engagement, and critical consciousness. Curriculum materials that demonstrate alignment to these elements, by design, set a foundation for educators to develop and enact culturally responsive and affirming instructional practices. CRSE supports adoption of the framework by educators and administrators and supports alignment of the framework with MLL and DAS Blueprints as well as Universal Design for Learning to ensure all students can engage meaningfully with grade level instruction.

⁵ Birch, David A. “Addressing social justice through school health education: Thoughts on an expanded focus.” *Journal Of School Health*, vol. 91, no. 6, 2021, pp. 439-432, <https://onlinelibrary.wiley.com/doi/10.1111/josh.13017>. Accessed 16 8 2021.

⁶Gerdin, G., Larsson, L., Schenker, K., Linnér, S., Mordal Moen, K., Westlie, K., Smith, W., & Philpot, R. (2020). Social Justice Pedagogies in School Health and Physical Education-Building Relationships, Teaching for Social Cohesion and Addressing Social Inequities. *International Journal of Environmental Research and Public Health*, 17(18), 6904. <https://doi.org/10.3390/ijerph17186904>

The Rhode Island Health Education Standards

In Rhode Island, the health education standards align to the National Health Education Standards.⁷ The National Health Education Standards are written expectations of the skills and knowledge students should have at the end of high school.

Standard 1 : Students will **comprehend concepts** related to health promotion and disease prevention to enhance health.

Standard 2: Students will **analyze the influence** of family, peers, culture, media, technology, and other factors on health behaviors.

Standard 3: Students will demonstrate the ability to **access valid information, products, and services** to enhance health.

Standard 4: Students will demonstrate the ability to **use interpersonal communication skills** to enhance health and avoid or reduce health risks.

Standard 5: Students will demonstrate the ability to **use decision-making skills** to enhance health.

Standard 6: Students will demonstrate the ability to **use goal-setting skills** to enhance health.

Standard 7: Students will demonstrate the ability to **practice health-enhancing behaviors and avoid or reduce health risks**.

Standard 8: Students will demonstrate the ability to **advocate for personal, family, and community health**.

The health education standards are centered around Standard 1, which is the *knowledge or content* standard. This standard defines what knowledge students should have and incorporates the topics or health content within the discipline, including:

- Prevention of alcohol, tobacco, vaping, opioids and other substance use and awareness and safe use of over-the-counter and prescription substances
- Disease prevention and control
- Promotion of healthy eating
- Promotion of physical activity
- Promotion of social, emotional, and mental health
- Promotion of personal health and wellness
- Safety and injury prevention
- Promotion of sexual health
- Violence prevention

⁷ Joint Committee on National Health Education Standards. (2007). *National Health Education Standards, Second Edition: Achieving Excellence*. Washington, D.C.: The American Cancer Society. Joint Committee on National Health Education Standards. (2007). *National Health Education Standards, Second Edition: Achieving Excellence*. Washington, D.C.: The American Cancer Society.

Standards 2-8 are *skill standards* and focus on the introduction, practice, reinforcement and mastery or proficiency of the focus skill in the context of one of the aforementioned health content areas. Examples might be:

- a health education teacher introducing the skill of boundary setting within Interpersonal Communication (Standard 4) using scenarios related to peers experimenting with alcohol.
- a student practicing the skill of advocacy when promoting disease prevention by creating posters for the school hallway about proper handwashing techniques.
- a student demonstrating proficiency in accessing valid and reliable resources when finding the dietary guidelines to create a healthy holiday menu.

Curriculum Development and Selection

What is 'Curriculum'?

A common misconception about school curricula is the belief that a curriculum is primarily the collection of resources used to teach a specific course or subject. A high-quality curriculum is much more than this. RIDE has previously defined curriculum as a “standards-based sequence of planned experiences where students practice and achieve proficiency in content and applied learning skills. Curriculum is the central guide for all educators as to what is essential for teaching and learning, so that every student has access to rigorous academic experiences.” Building off this definition, RIDE also identifies specific components that comprise a complete curriculum. These include the following:

- **Goals:** Goals within a curriculum are the standards-based benchmarks or expectations for teaching and learning. Most often, goals are made explicit in the form of a scope and sequence of skills to be addressed. Goals must include the breadth and depth of what a student is expected to learn.
- **Instructional Practices:** Instructional practices are the research- and evidence-based methods (i.e., decisions, approaches, procedures, and routines) that teachers use to engage all students in meaningful learning. These choices support the facilitation of learning experiences in order to promote a student’s ability to understand and apply content and skills. Practices are differentiated to meet student needs and interests, task demands, and learning environment. They are also adjusted based on ongoing review of student progress towards meeting the goals.
- **Materials:** Materials are the tools and resources selected to implement methods and achieve the goals of the curriculum. They are intentionally chosen to support a student’s learning, and the selection of resources should reflect student interest, cultural diversity, world perspectives, and address all types of diverse learners.
- **Assessment:** Assessment in a curriculum is the ongoing process of gathering information about a student’s learning. This includes a variety of ways to document what the student knows, understands, and can do with their knowledge and skills. Information from assessment is used to make decisions about instructional approaches, teaching materials, and academic supports needed to enhance opportunities for the student and to guide future instruction.

Another way to think about curriculum, and one supported by many experts, is that a well-established curriculum consists of three interconnected parts all tightly aligned to standards: the intended (or written) curriculum, the lived curriculum, and the learned curriculum (e.g., Kurz, Elliott, Wehby, & Smithson, 2010)⁸. Additionally, a cohesive curriculum should ensure that teaching and learning is equitable, culturally responsive and

⁸ Kurz, A; Elliot, S.N.; Wehby, J.H.; & Smithson, J.L.(2010) Alignment of the intended, planned and enacted curriculum in general and special education and its relation to student achievement. *The Journal of Special Education*, Vol 4, Issue 3. <https://doi.org/10.1177/0022466909341196>.

sustaining, and offers students multiple means through which to learn through Universal Design for Learning.

The written curriculum refers to what students are expected to learn as defined by standards, as well as the HQCMs used to support instruction and assessment. This aligns with the 'goals' and 'materials' components described above. Given this, programs and textbooks do not comprise a curriculum on their own, but rather are the resources that help to implement it. They also establish the foundation of students' learning experiences. The written curriculum should provide students with opportunities to engage in content that builds on their background experiences and cultural and linguistic identities while also exposing students to new experiences and cultural identities outside of their own.

The lived curriculum refers to how the written curriculum is delivered and assessed and includes how students experience it. In other words, the lived curriculum is defined by the quality of instructional practices that are applied when implementing the HQCMs. This aligns with the 'methods' section in RIDE's curriculum definition. The lived curriculum must promote instructional engagement by affirming and validating students' home culture and language, as well as provide opportunities for integrative and interdisciplinary learning. Content and tasks should be instructed through an equity lens, providing educators and students with the opportunity to confront complex equity issues and explore socio-political identities.

Finally, the learned curriculum refers to how much of and how well the intended curriculum is learned and how fully students meet the learning goals as defined by the standards. This is often defined by the validity and reliability of assessments, as well as by student achievement, their work, and performance on tasks. The learned curriculum should reflect a commitment to the expectation that all students can access and attain grade-level proficiency. Ultimately, the learned curriculum is an expression and extension of the written and lived curricula and should promote critical consciousness in both educators and students, providing opportunities for educators and students to improve systems for teaching and learning in the school community.

Having access to high-quality curriculum materials is an important consideration for increasing equitable access to a rigorous education that prepares every student for college and careers. Through this national movement to increase access through high-quality materials, in 2019, RIGL§ 16.22.30-33 was passed, which requires the Commissioner of Elementary and Secondary Education and RIDE to accomplish the following:

- Develop statewide academic standards and curriculum frameworks
- Identify at least five (5) examples of high-quality curriculum and materials for each of the core subject areas (English Language Arts, Mathematics, & Science). Support LEAs in the selection and implementation of curriculum materials.

Health education is not explicitly included in this legislation; however, this effort is directly aligned with the requirements and intent of this legislation.

Quality health education curriculum is more than a syllabus. It should be aligned with the National Health Education Standards and incorporate best practice methods and materials that are inclusive and meet the needs of every learner. These include inquiry-based, problem-centered teaching approaches that encourage the active participation of students in the learning process through dialogue, role-play, group projects and discussion. Effective instruction ensures the provision of solid functional information in the early grade levels, creating the foundation for more complex reflection, analysis and evaluation in later grades. According to cognitive researchers, meaningful learning is reflective, personally and socially constructed, and self-regulated. Knowledge is more than just receiving information; the information must be interpreted and related to previously acquired knowledge. Standards-based health education requires multiple instructional methods to meet the diversity of student learning styles via a Universal Design for Learning.

The curriculum selection process is a critical step in ensuring that students receive high quality health education. The [Health Education Curriculum Analysis Tool \(HECAT\)](#) can be helpful during the selection process. The HECAT is an assessment tool that helps to conduct a clear, complete and consistent analysis of the alignment of health education curricula based on the [National Health Education Standards](#) and the CDC's [Characteristics of an Effective Health Education Curriculum](#). This tool may also be utilized when a district is developing its own health education curriculum scope and sequence.

HECAT results help districts/schools select or develop appropriate and effective health education curricula, enhance existing curricula, and improve health education instruction. It can be customized to meet local needs and conform to state or local curriculum requirements.

The HECAT features:

- Guidance on how to use the HECAT to review curricula and make health education curriculum decisions.
- Customizable templates for recording important descriptive curriculum information for state or local use during the curriculum review process.
- Tools to analyze preliminary curriculum considerations, such as accuracy, acceptability, feasibility, and affordability.
- Tools to analyze curriculum fundamentals, such as teacher materials, instructional design, and instructional strategies and materials.
- Specific health-topic concept and skills analyses.
- Guidance on using the HECAT for developing a health education scope and sequence.

Section 3: Implementing High Quality Instruction Skills-Based Health Education

“Skills are critical to maintaining and adopting health behaviors, and a skills-based approach supports both health outcomes and 21st century skills and learning outcomes (Benes, 2016).”⁹

As mentioned on page 11, a majority of the Rhode Island Health Education Content Standards are skills standards. Skills-based health education emphasizes the importance of skills practice over instruction that solely focuses on content and information. If the goal of health education is to create health literate students, they need the skills to implement healthy living throughout their lifetimes. Dedicating a substantial amount of time in K-12 health education to the practice and reinforcement of the seven health skills and using health content as the situational vehicle for how students practice these skills, can achieve our goal in health education. For example, if students just know that secondhand smoke might harm them or that getting enough sleep at night is healthy, it does not help them actually practice and adopt health-promoting behaviors.

Effective health education provides students with the ability to acquire knowledge, foster healthy attitudes, develop skills, and adopt behaviors to promote personal, family, and community health. A skills-based health education program includes a curriculum that is implemented through participatory methods to ensure that students develop the skills, attitudes, and beliefs to lead healthy lives.¹⁰

Skills-based health education, which should also be standards-based, refers to “the written curriculum, instructional style, and implementation” which focuses on skill development and proficiency.¹¹ Skills-based health education incorporates the use of participatory instructional methods that allow students to develop skill proficiency, address attitudes toward healthy decision-making, and build functional knowledge that will enable them to make decisions regarding their own health, wellness, and safety. A skills-based approach to health education also supports the integration of social and emotional learning (SEL) due to the overlapping nature between the five SEL competencies and seven health education skills standards. The Collaborative for Academic, Social, and Emotional Learning (CASEL) has developed a Framework for Systemic Social and Emotional Learning that identifies the five core competencies of social and emotional learning: 1) Self-awareness; 2) Self-management; 3) Responsible decision-making; 4) Relationship skills; and 5) Social awareness.¹²

⁹Benes, S., & Alperin, H. (2016). *The Essentials of Teaching Health Education Curriculum, Instruction and Assessment* (First ed.). Human Kinetics.

¹⁰ Benes, S., & Alperin, H.

¹¹ Benes, S., & Alperin, H.

¹² Collaborative for Social and Emotional Learning. (n.d.). *What is SEL*. CASEL, 2021. Retrieved August 16, 2021, from <https://casel.org/what-is-sel/>

Additionally, the National Health Education Standards and the World Health Organization (WHO) both provide models for skills development in health education. Figure 6 combines these two models and gives a framework for how each step is integrated into each skill taught in the curriculum.¹³ Although the steps are listed in order, previous steps can be addressed at any time, as needed.

Figure 6. Steps of Health Education Skill-Development



The Intersection between SEL Core Competencies, Health Education Standards and 21st Century Skills

The 21st Century Skills are very similar to the health education skills standards in that they prepare students for the future. The 21st Century Skills include performance indicators around life and career skills, learning and innovation skills and information, media and technology skills.

Health education offers an opportunity to intersect with both SEL Core and 21st Century Skills competencies. The following table shows the alignment and intersection between them and the Health Education Standards. You can see a direct link of how health education addresses these other skill measures. We address Standards 2-8 since these are the standards focused on skills development.

¹³ Benes, S., & Alperin, H. (2016). *The Essentials of Teaching Health Education Curriculum, Instruction and Assessment* (First ed.). Human Kinetics.

<u>Health Education Standards</u>	<u>SEL Core Competencies</u>	21st Century Skills
Standard 2: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.	Self-awareness Social awareness Responsible decision making	Access and evaluate information Use and manage information Analyze media Apply technology effectively
Standard 3: Students will demonstrate the ability to access valid information, products, and services to enhance health.	Self-awareness	Apply technology effectively
Standard 4: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.	Relationship skills Social awareness	Interact effectively with others Work effectively in diverse teams Communicate clearly Communicate with others
Standard 5: Students will demonstrate the ability to use decision-making skills to enhance health.	Responsible decision making Relationship skills	Reason effectively Make judgements and decisions Solve problems
Standard 6: Students will demonstrate the ability to use goal-setting skills to enhance health.	Self-management	Manage goals and time
Standard 7: Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.	Self-management	Flexibility and adaptability Initiative and self-direction Manage products
Standard 8: Students will demonstrate the ability to advocate for personal, family, and community health.	Self-awareness Social awareness Responsible decision making	

Positive Youth Development and Connections to Skills Based Health Education

According to the CDC, [positive youth development](#) programs are a public health strategy to connect youth with a network of supportive adults. Positive youth development strategies focus on enhancing the positive characteristics and opportunities of individuals and their school/community environment. Research on positive youth development approaches have yielded benefits across a range of health and academic outcomes. Community service and civic engagement provide rich opportunities for positive youth development as it provides opportunities to connect youth with supportive adults and make positive contributions to their school community.

Effective Practices in Health Education

There is a growing body of health education research that articulates effective practices for health education programs. The research pinpoints practices associated with improved student health literacy and adoption of positive health behaviors and attitudes. This section shares criteria to consider when developing health education programs.

[SHAPE America](#) has also developed a summary of best practices for health education in their publication, [Appropriate Practices in School Based Health Education](#) that include:

- Creating a positive and inclusive learning environment that engages students in learning the skills they need to live healthy lives.
- Implementing a sequential, comprehensive curriculum —aligned with the National Health Education Standards and other relevant frameworks —that is skills-based, with an emphasis on developing health literacy.
- Employing instructional practices that engage students in learning and in developing their health-related skills.
- Using assessments that measure student growth, knowledge and health-related skill development.
- Advocating for a positive school culture toward health and health education.
- Maintaining high standards of practice.

Characteristics of Effective Health Education Curriculum

More specifically, experts and the evidence base suggest that effective health education programs and curricula:

1. Focus on clear health goals and related behavioral outcomes.
2. Is research-based and theory-driven.
3. Address individual values, attitudes, and beliefs.
4. Address individual and group norms that support health-enhancing behaviors.

5. Focus on reinforcing protective factors and increasing perceptions of personal risk and harmfulness of engaging in specific unhealthy practices and behaviors.
6. Address social pressures and influences.
7. Builds personal competence, social competence, and self-efficacy by strengthening skills
8. Provide functional health knowledge that is basic, accurate, and directly correlates to health-promoting decisions and behaviors.
9. Use strategies designed to help students personalize information.
10. Provide age- and developmentally appropriate information, learning strategies, teaching methods, and materials.
11. Incorporate learning strategies, teaching methods, and materials that are culturally responsive and sustaining.
12. Provide adequate time for instruction and learning.
13. Provide opportunities to reinforce skills and positive health behaviors.
14. Provide opportunities to make positive connections with influential others.
15. Include teacher information and plans for professional development and training that enhance effectiveness of instruction and student learning.

Using Youth Health Behavior Data in Health Education

Youth health behavior data can be a very effective tool in planning health education curricula and developing students' understanding of and attitudes towards positive health behaviors. These data can be used by districts and schools in planning the timing of addressing key topics. For example, if data suggest that youth are initiating use of tobacco or vaping products in middle school, then it would be advisable to introduce these issues in elementary school and reinforce them in middle and high school. Youth behavior data can also be used to help shape students' understanding and knowledge about health behaviors. For example, students tend to overestimate how many of their peers are using substances or are sexually active. Data can be used to help students recognize that the majority of middle and high school youth are not using substances or sexually active.

State and National Data Resources

There are a number of reliable and comprehensive sources for youth health behavior data.

The Centers for Disease Control and Prevention is the premiere federal source for health data. Some key CDC resources include:

- The [Division of Adolescent and School Health](#) offers many data resources on school health and youth risk behaviors.

The [Youth Risk Behavior Surveillance System \(YRBSS\)](#) monitors health-risk behaviors among adolescents and young adults at the national, state, territorial, tribal, and local levels. Data are available on issues, such as dietary behaviors, weight, physical activity, tobacco and alcohol use, and other health topics.

- [School Health Profiles \(Profiles\)](#) monitors school health policies and practices in states, large urban school districts, territories, and tribal governments.
- More generally, CDC offers comprehensive data and statistics on health issues for people at all ages on their [data & statistics page](#).

[Monitoring the Future](#) is an ongoing study of the behaviors, attitudes, and values of Americans from adolescence through adulthood.

The [Rhode Island Department of Health](#) maintains state and local data on a variety of health issues, including child and adolescent health. The Rhode Island Department of Education (RIDE) hosts [SurveyWorks](#), an education survey suite containing data from annual surveys of students, parents, teachers/staff, and administrators as part of a coordinated effort to improve schools.

Section 4: High Quality Learning Through Assessment

Health Education Assessment

Assessment linked to health education standards, performance indicators, curriculum, and instruction is critical to students' mastery of health knowledge and skills. RIDE's [Comprehensive Assessment System \(CAS\) - Assessment - Instruction & Assessment World-Class Standards](#) can guide that work at the district and school levels. Both formative and summative assessments in the educational process are vital to reaching the level of health literacy that will ultimately support students in practicing healthy behaviors. There are a variety of valid assessments that range from a simple check for understanding to proficiency-based performance tasks. Assessment use should be matched to a purpose, and clearly defined rubrics should be used to help guide students in their learning from the beginning of a task to its final appraisal.

Alignment of Standards-Based Assessment, Curriculum, and Instruction

A guiding principle of quality assessment is the alignment between standards, curriculum, and instructional design and the assessment tools and measures. This alignment can be thought of as a continuous data cycle in which:

- the assessment of standards and performance indicators informs curriculum;
- curriculum informs instruction;
- instruction informs assessment; and
- assessment results, once again, informs curriculum.

Backwards Design

One approach to standards-based assessment, curriculum, and instruction is backwards design – or an approach in which the planning begins with the end (standards) in mind. In other words, educators will design their instruction around the performance indicators (what students should know and be able to do) that students must meet by the end of the grade or course, versus completion of a particular activity or project, chapters in a book, or a packaged curriculum.

Clarifying curricular priorities is a key component of backwards design. Curriculum and assessment decisions are made based on the desired end result. The desired end result in health education is the set of health concepts and skills so that students become health literate and practice healthy behaviors.

Backwards design calls for the following three-step approach to aligning standards, assessment, curriculum, and instruction with a specific goal in mind:

1. Use health standards and performance indicators to identify what knowledge and skills students need.

2. Identify assessments that will measure students' level of mastery of the intended knowledge and skills. Key questions for this step are "How will we know if students have achieved the desired results and have met the standards? What will we accept as evidence of student understanding and proficiency?"
3. Plan learning experiences and instruction that give students the opportunity to practice and master health knowledge and skills. A key question to ask for this step is "What instructional activities will we need in order to match the selected learning goals and planned assessments?"

Practicing backwards design requires that teachers, administrators, and other school personnel approach teaching and learning in five key ways:

1. The assessments that are used to measure students' health knowledge and skills performance must be well thought out prior to the development of lessons.
2. Existing instructional activities and projects may need to be revised or eliminated in order to ensure that all instruction is aligned with national, state and local standards and performance indicators.
3. The methods and materials used for teaching health knowledge and skills are chosen after teachers, administrators, and other school personnel have established student performance indicators.
4. Resources used to support health education instruction may draw from a variety of sources, such as the internet, governmental agencies and health organizations, in addition to textbooks.
5. The pedagogy is designed to enable students to develop their own proficiency related to the health skills.

Professional Development

We are all lifelong learners. Ongoing, high-quality professional development is crucial for supporting effective health education. Districts should ensure that all health educators have a programmatic plan for continual professional development designed to help them deliver quality instruction in support of the health standards, best practices, and a safe and inclusive teaching practices in the classroom environment. A quality professional development program will be multi-faceted and ongoing. The program should include formal training, as well as opportunities to observe successful teachers and be coached by experienced colleagues. Further, teachers should be provided with ongoing opportunities to consult with colleagues through sharing at conferences, planning sessions, in-service opportunities and by electronic communications. Because health education requires teachers to deal with sensitive issues, continuing professional development is necessary to maintain and build their commitment, understanding, skills and attitudes around equity, diversity and inclusion, social and emotional learning, and trauma-informed practices.

It is essential that teacher preparation (preservice) programs are aligned with current health education standards and best practices. Beginning teachers should have mentors to help them deal with the complexities of their first year. An accountability structure should be put in place to assess the impact of both preservice education and continuing professional development.

Currently, the federal Every Student Succeeds Act (ESSA) Title II supports professional development and districts submit their PD plans to RIDE for approval. ESSA also recognizes health education as a core topic. ESSA's Title IV Part A can provide additional support to schools related to social emotional learning and health education. Health educators are encouraged to meet with their building and district leadership on specific opportunities and are strongly encouraged to participate in and contribute to their school's needs assessment and school improvement processes. These processes and related products drive the use of federal funds and ensure that all efforts support academic achievement as described in the needs assessment. Additionally, Title 1 funds can be a source of support in schools that meet the needs-based criteria for the funds.

Title I-A Funds: Improving the Academic Achievement of the Disadvantaged

Title I-A funds can be used to support initiatives and activities that support student academic achievement in Title I schools. Activities must be reasonable, necessary, allocable, allowable and aligned to one or more goals in each school's schoolwide plan.

Title II-A: Building Systems of Support for Excellent Teaching and Leading

Title II-A funds can support professional development activities that provide the knowledge and skills necessary to enable students to succeed in a well-rounded education and to meet challenging state standards. Professional development means activities that are: sustained (not stand-alone, 1-day, or short-term workshops), intensive, collaborative, job-embedded, data-driven, and classroom focused. Allowable activities may include professional development that:

- Helps all students develop the skills essential for learning readiness and academic success;
- Helps educators understand when and how to refer to students affected by trauma, children with, or at risk of, mental illness; and
- Addresses issues related to school conditions for student learning, such as safety, peer interaction, drug and alcohol abuse, and chronic absenteeism.

Title III – Language Instruction for English Learners and Immigrant Students.

These funds can support supplemental interventions (such as social worker or counselor supports) for family and student engagement for students with refugee status or interrupted formal schooling. Please note that Rhode Island uses the term Multilingual Learner in place of English Learner.

Title IV-A: Student Support and Academic Enrichment Funds

Title IV-A funds can be used for a wide array of supplemental programs and activities that directly support student health and wellness as well as professional development and training for school personnel. Schools that support the physical and mental health of their students increase the likelihood of students’ academic success. Allowable activities must improve student outcomes and address the opportunity gaps identified through the Local Education Agency (LEA) needs assessment, and may include:

- Implementing programs that support a healthy, active lifestyle (nutritional and physical education);
- Implementing systems and practices to prevent bullying and harassment;
- Developing relationship building skills to help improve safety through the recognition and prevention of coercion, violence, or abuse;
- Providing school-based mental health services and counseling;
- Promoting supportive school climates to reduce the use of exclusionary discipline and promoting supportive school discipline;
- Establishing or improving dropout prevention; or
- Supporting re-entry programs and transition services for justice involved youth.

IDEA – Individuals with Disabilities Act

IDEA could support excess costs of special education related to supporting student health as part of functional goals on IEPs. Additionally, school psychologists and social workers are sometimes supported through IDEA grants. The Early Intervening Services reserve in IDEA Part B can support SEL tier 2 and 3 interventions, progress monitoring, training for staff, teaming, and behavioral evaluations for students without IEPs when addressed in a districts IDEA Part B grant application.

State Policies and Regulations

The following are key state laws, regulations, and policies that support the implementation of quality and comprehensive health education programs.

Basic Education Program Regulations

Basic Education Program (BEP) is a set of regulations promulgated by the Board of Education, Council on Secondary and Elementary Education pursuant to its delegated statutory authority to determine standards for the Rhode Island public education system and the maintenance of local appropriation to support its implementation. Safe and supportive learning environments are an imperative.

Health Education and State Mandated Content Areas

Rhode Island State Law requires that the administrative head of school(s) ensure that a comprehensive school health program is in place. This law applies to all schools, public and private. A comprehensive health education program consists of three (3) components: health education; health services; and a healthful school environment. Specifically, a comprehensive school health program is required to:

1. Develop a manual of procedures (protocols) governing health education, health services and a healthful school environment. This manual must be available at the Superintendent's office and at each school. Procedures must address the statutory and regulatory requirements and include provisions pertaining to, but not limited to, the following:

- Students and/or employees infected with HIV/AIDS or hepatitis;
- Substance abuse;
- The use of alcohol and tobacco products on school premises and at authorized school activities;
- Suicidal behavior;
- The prevention and management of injuries and violent behaviors for the protection and safety of students on school premises and at authorized school activities; and
- Provisions regarding the three (3) statutory waivers for exemption of a student from health education curricula pursuant to R.I. Gen. Laws §§ [16-22-18\(c\)](#) sexuality and family life; [16-22-17\(c\)](#) HIV/AIDS; and [16-21-7\(a\)](#) the characteristics, symptoms or treatment of disease.

School administrators must also provide an adequate number of personnel for a comprehensive school health program in accordance with statutory requirements. Required personnel include no less than a school physician, dentist, certified health educator and certified school nurse-teacher. Superintendents and Administrative Heads of Schools submit an annual school health report to RIDE documenting compliance with regulation, legislation, etc. pertaining to the comprehensive school health program.

Instruction in Health Education- Title 16

All children in grades Kindergarten through twelve (K-12) attending public schools, or any other schools managed and controlled by the state, except as provided in § 16-100-3(d), shall receive in those schools' instruction in health and physical education under rules and

regulations the department of elementary and secondary education may prescribe or approve during periods that shall average at least twenty (20) minutes in each school day.

Mandated Health Instructional Outcomes

Pursuant to R.I. Gen. Laws § [16-22-4](#), the health education curriculum must be based on the standards set forth in the Rhode Island Health Education Framework: Health Literacy for All Students and consistent with the mandated health instructional outcomes. These outcomes must pertain to no less than the following required content area topics appropriate to grade or developmental level:

1. Alcohol, Tobacco and Other Substance Abuse: the causes, effects, treatment and prevention of the use of tobacco and abuse of alcohol and other drugs, , including but not limited to information that mixing opioids and alcohol can cause accidental death, pursuant to R.I. Gen. Laws §§ 16-22-3, 16-22-4, 16-22-12, [16-1-5\(14\)](#), and [35-4-18](#)
2. Cardiopulmonary Resuscitation (CPR): the procedures and proper techniques for CPR, automated external defibrillator (AED), and the Heimlich maneuver, pursuant to R.I. Gen. Laws §§ [16-22-15](#) and [16-22-16](#)
3. Child Abuse: the signs, symptoms and resources available for assistance
4. Community Health: the significance of the relationship between the individual and the community, and the impact that individual health has on the community's health within a framework of geographical, social, cultural, and political factors
5. Consumer Health: the factors involved in decision-making, selecting, evaluating, accessing and utilizing health information, products and services
6. Environmental Health: environmental factors that affect the health of individuals and society, strategies to minimize the negative effects of the environment on the community and its members, and the importance of protecting and improving all aspects of the environment
7. Family Life and Sexuality: responsibilities of family membership and adulthood, issues related to reproduction, abstinence, dating and dating violence, marriage, parenthood, information about sexually transmitted diseases, the law and meaning of consent, sexuality and sexual orientation, as part of comprehensive sexuality education pursuant to R.I. Gen. Laws § [16-22-18](#)
8. HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immune Deficiency Syndrome): the causes, effects, treatment, and prevention, pursuant to R.I. Gen. Laws § [16-22-17](#)
9. Human Growth and Development: growth and development as a process of natural progression influenced by heredity, environment, culture, and other factors and which encompasses the continuum from conception to death
10. Mental Health: the emotional, behavioral, and social factors that influence both mental and physical health

11. Nutrition: the role of nutrition in the promotion and maintenance of good health
12. Physiology and Hygiene: the basic structure and functions of the human body systems, health habits, and sanitary practices for the preservation of health, pursuant to R.I. Gen. Laws § [16-22-3](#)
13. Physical Activity: the relationship of physical activity to health and physical fitness
14. Prevention and Control of Disease: the causes, effects, treatment, and prevention of chronic and communicable diseases, with exclusion of instruction thereof pursuant to R.I. Gen. Laws § [16-21-7\(a\)](#)
15. Safety and Injury Prevention: the causes, effects, treatment, and prevention of behaviors that can result in unintentional or intentional injury, and:
 - a. Suicide Prevention: the causes, effects, and treatment of behaviors related to suicide, and information that mixing opioids and alcohol can cause accidental death, pursuant to R.I. Gen. Laws § [16-22-14](#).
 - b. Teen Dating Violence (grades 7 through 12): defining dating violence, recognizing dating violence warning signs and characteristics of healthy relationships, as stipulated in R.I. Gen. Laws § [16-22-24](#).

The health education curriculum must:

- Be sequential and comprehensive for grades Kindergarten-12;
- Be evidence-based;
- Be medically accurate;
- Be aligned with the Rhode Island health education standards;
- Include standards-based goals, objectives, examples of teaching and learning strategies and materials, and assessments;
- Address the mandated health instructional outcomes; and
- Be developmentally appropriate so that all students can achieve high standards.

A curriculum team consisting of representatives from the school district teaching and administrative staff, parents, and community members including health professionals must periodically review and revise, as necessary, the health education curriculum. The health education curriculum of each school district must be available for review by RIDE upon request.

[District Health and Wellness Subcommittee](#)

Since 2005, as per [RIGL 16-21-28](#), every district school committee is required to establish a District Health and Wellness Subcommittee, chaired by a member of the full school committee. Membership must include more than 50% “non-school” members, including parents, student, and community based representatives. District Health and Wellness Subcommittees are responsible for making recommendations regarding the district’s health education curriculum and instruction, physical education curriculum and instruction, and nutrition and physical activity policies to enhance the health and wellbeing of students and employees.

State of Rhode Island-SAFE SCHOOL ACT

This statewide bullying policy is promulgated pursuant to the authority set forth in §16-21-34 of the General Laws of Rhode Island. Known as the Safe School Act, the statute recognizes that the bullying of a student creates a climate of fear and disrespect that can seriously impair the student's health and negatively affect learning. Bullying undermines the safe learning environment that students need to achieve their full potential. The purpose of the policy is to ensure a consistent and unified statewide approach to the prohibition of bullying at school.

Resources

Federal

CDC Healthy Schools

- [Promoting Healthy Behaviors-Whole School, Whole Community, Whole Child](#)
- [National Health Education Standards](#)
- [Health Education Curriculum Analysis Tool \(HECAT\)](#)
- [Data and Research](#)
- [Characteristics of Effective Health Education Curriculum](#)
- [Parents for Healthy Schools](#)
- [Health and Academics](#)

[School Health Profiles](#) A CDC developed system of surveys assessing school health policies and practices in states, large urban school districts, territories, and tribal governments. Profile surveys are conducted every 2 years by education and health agencies among middle and high school principals and lead health education teachers. Profiles monitors the status of:

- School health education requirements and content
- Physical education requirements
- School health policies related to HIV infection/AIDS, tobacco-use prevention, and nutrition
- Asthma management activities
- Family and community involvement in school health programs

[School Health Policies and Practices Study](#): The School Health Policies and Practices Study* (SHPPS) is a CDC national survey periodically conducted to assess school health policies and practices at the state, district, school, and classroom level. The SHPPS has not been conducted at the state level since 2014. Data collection alternates every two years between the district and school levels. The 2014 survey focused on school and classroom level data only. Survey respondents come from a national random sample of 850 schools.

[Youth Risk Behavior Survey](#): Biennial survey of student health risk behaviors administered by random sample in RI high schools and middle schools.

SHAPE America

- [Appropriate Practices in School Based Health](#)
- [Appropriate Instructional Practice Guidelines](#)
- [Monitoring The Future](#)

State

[RIDE Strategic Plan Transforming Education in Rhode Island](#) The five priorities include: ensure educator excellence, accelerate all schools toward greatness, establish world class

standards and assessments, develop user-friendly data systems, and invest our resources wisely.

[Rules and Regulations for School Health Programs](#) Statutory based minimum requirements for school in the area of health education, health services and healthy school environment. School administrators communicate their plans to meet the requirements.

[Basic Education Program](#) The Basic Education Program (BEP) is a set of regulations promulgated by the Board of Regents pursuant to its delegated statutory authority to determine standards for the Rhode Island public education system and the maintenance of local appropriation to support its implementation.

[Annual School Health Report](#) A tool to ensure that different policies and programs that are required within the Rules and Regulations are being implemented. This is a self-report assessment. This includes review of the health education curriculum which should happen yearly.

[Health Education Frameworks](#) and [Comprehensive Health Instructional Outcomes](#) Rhode Island sets the standards in collaboration with local communities and informed by best practice. The RI Comprehensive Instructional Outcomes are required by statute to frame comprehensive health education including personal health, mental and emotional health, injury prevention, nutrition, sexuality and family life, disease prevention and control, and substance use and prevention. The Health Education Framework is based on National Standards and break down what types of information should be taught within the standard framework that is relevant and developmentally appropriate. The Frameworks and mandated Rhode Island Comprehensive Health Instructional Outcomes can be used to guide district-level review, revision, and development of local health education curricula that is based on high standards.

[District Health and Wellness Subcommittees](#)- Since 2005, as per [RIGL 16-21-28](#), every district school committee is required to establish a District Health and Wellness Subcommittee, chaired by a member of the full school committee, Membership must include more than 50% “non-school” members, including parents, student, and community based representatives. District Health and Wellness Subcommittees are responsible for making recommendations regarding the district’s health education curriculum and instruction, physical education curriculum and instruction, and nutrition and physical activity policies to enhance the health and wellbeing of students and employees.

[Infoworks](#) RI Education data site including Information on state district and school data in the areas of: Student Achievement, Teaching, Students & Families, Safe & Supportive Schools and Funding & Resources.

[SurveyWorks](#) is Rhode Island's education survey suite. RIDE conducts these annual surveys of students, parents, teachers/staff, and administrators as part of a coordinated effort to improve schools.

[DataHUB](#) The RI DataHUB is a central data resource. The DataHUB brings together data sets from multiple federal, state and local sources. The ability to see relationships between data sets sheds light on important details and allows for new insights into policy or programmatic questions about the well-being of Rhode Islanders.

[Thrive](#)- RI's coordinated school health program

[Rhode Island Association for Health, Physical Education, Recreation and Dance](#) The state professional organization for school health professionals, which offers professional development and advocates for strong communities.

[Rhode Island Certified School Nurse Teacher Association](#) is a non-profit, specialty nursing organization for school nurses throughout the state.

Glossary of Terms

Disciplinary terms are used throughout this document. This glossary provides definitions and descriptions of these terms.

Assessment in a curriculum is the ongoing process of gathering information about a student's learning. This includes a variety of ways to document what the student knows, understands, and can do with their knowledge and skills. Information from assessment is used to make decisions about instructional approaches, teaching materials, and academic supports needed to enhance opportunities for the student and to guide future instruction.

Comprehensive sexuality education: Includes age-appropriate, medically accurate information on a broad set of topics related to sexuality, including human development, relationships, decision making, abstinence, contraception and disease prevention. Comprehensive sexuality education provides students with opportunities for developing skills as well as learning. In Rhode Island schools, sexuality education is a component of comprehensive health education.

Curriculum: is a standards-based sequence of planned experiences where students practice and achieve proficiency in content and applied learning skills. Curriculum is the central guide for all educators as to what is essential for teaching and learning, so that every student has access to rigorous academic experiences. The structure, organization, and considerations in a curriculum are created in order to enhance student learning and facilitate instruction. Curriculum must include the necessary goals, methods, materials and assessments to effectively support instruction and learning (RIDE, 2021)

Functional information/knowledge: Basic, accurate and relevant information/knowledge that relates directly to achieving health-promoting behaviors.

Goals within a curriculum are the standards-based benchmarks or expectations for teaching and learning. Most often, goals are made explicit in the form of a scope and sequence of skills to be addressed. Goals must include the breadth and depth to which a student is expected to learn.

Health behavior outcomes: The anticipated or expected health behaviors that should guide the development and delivery of PK-12 school health education.

Health Education Curriculum Analysis Tool (HECAT): A resource developed by the Centers for Disease Control & Prevention (CDC) that provides guidance and tools to improve curriculum selection and development.

Health literacy: The degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Methods are the instructional decisions, approaches, procedures, and routines that teachers use to engage all students in meaningful learning. These choices support the facilitation of learning experiences in order to promote a student's ability to understand and apply content and skills. Methods are differentiated to meet student needs and interests, task demands, and learning environment. Methods are adjusted based on ongoing review of student progress towards meeting the goals.

Materials are the tools selected to implement methods and achieve the goals of the curriculum. Materials are intentionally chosen to support a student's learning. Material choices reflect student interest, cultural diversity, world perspectives, and address all types of diverse learners.

National Health Education Standards: Written expectations for what students should know and be able to do by grades 2, 5, 8 and 12 to promote personal, family and community health. The standards provide a framework for curriculum development and selection, instruction and skills-building, and assessment of student knowledge in health education.

National Sex Education Standards: Designed to provide clear, consistent and straightforward guidance on the essential minimum, core content for sexuality education that is developmentally and age-appropriate for students in grades K–12.

Skills development: A planned, sequential, comprehensive and relevant curriculum that is implemented through participatory teaching and learning methods to help students develop the skills, attitudes and functional knowledge needed to lead health-enhancing lives.

Skills-based curriculum: Curriculum goals developed with an emphasis on skills that use content as a context through which the skills are developed and uses participatory teaching and learning.

Social and emotional learning (SEL): SEL is the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions, achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions.