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The Healthy Class of 2010: Utilization of the School Health Index to Build Collaboration Between a University and an Urban School District

James Butler, DrPH, MEd,

Assistant Professor, Department of Public & Community Health, Associate Director, University of Maryland Center for Health Equity, School of Public Health, University of Maryland College Park, 2320 SPH Building #255, College Park, MD 20742-2611, Phone: 301-405-0757, Fax: 301-314-9167, jbutler9@umd.edu

Craig S. Fryer, DrPH, MPH,

Assistant Professor, Department of Public & Community Health, Associate Director, University of Maryland Center for Health Equity, School of Public Health, University of Maryland College Park, 2324 SPH Building #255, College Park, MD 20742-2611, Phone: 301-405-0818, Fax: 301-314-9167, csfryer@umd.edu

Ernestine A. Reed, MEd, and

Executive Director (retired) of Middle Schools Operations, Board of Public Education, School District of Pittsburgh, 341 South Bellefield Avenue, Pittsburgh, PA 15213-3552, Phone: 412-622-3500, Fax: 412-622-3695, sjw1207@verizon.net

Stephen B. Thomas, PhD, FAAHB

Professor, Department of Health Services Administration, Director, University of Maryland Center for Health Equity, School of Public Health, University of Maryland College Park, 3302E SPH Building #255, College Park, MD 20742-2611, Phone: 301-405-8357, Fax: 301-405-2542, sbt@umd.edu

Abstract

BACKGROUND—Insufficient attention has been paid to the process of conducting the Centers for Disease Control and Prevention’s School Health Index (SHI) to promote collaboration between universities and urban school districts when developing adolescent health promotion initiatives. This article provides an overview of the real world contextual challenges and opportunities this type of collaboration can pose.

METHODS—The SHI and selected collaboration principles were used to facilitate partnership and increase stakeholder buy-in, which led to developing and implementing an eight year health promotion campaign, The Healthy Class of 2010 (HC 2010).

Correspondence to: James Butler.

Human Subjects Approval Statement

This study was approved by the Institutional Review Board at the University of Pittsburgh, Pittsburgh, PA.

RESULTS—The focus on planning brought together key stakeholders and allowed for HC 2010 programming to take place despite the competing demands on the schools. The SHI allowed for input from stakeholders to develop campaign activities and inform school- and district-wide policy. Universities and school districts desiring to develop and implement school-based, adolescent health promotion programs should: 1) identify the hierarchical structure of the school district; 2) establish credibility for the program and the university staff; 3) emphasize the benefits to all partners; 4) maintain a cooperative partnership with teachers and administrators; 5) appreciate the need for planning; and, 6) provide as many resources as possible to an already overburdened school system.

CONCLUSIONS—Promoting healthy behaviors among students is an important part of the fundamental mission of schools. HC 2010 underscored the significance of collaboration using the SHI in the development and implementation of this health promotion campaign with input from students, teachers, administrators and university partners.

Keywords

adolescent health; school health; school health index; collaboration; physical activity; nutrition

INTRODUCTION

Adolescence is a critical time for the development of lifestyle practices, attitudes, and beliefs related to health and wellbeing.¹ Many adolescent health behaviors, including dietary practices, physical activity habits, and weight control have been previously described.^{2,3,4} Yet evidence suggests there may be cause for concern, not only about the current health status and behaviors of adolescents, but also about their future health status as adults.¹ Comprehensive school-based initiatives that target these behaviors can help sustain healthy lifestyles through the adolescent years and after the initiatives have ended.⁵ However, insufficient attention has been paid to the process of conducting the Centers for Disease Control and Prevention's (CDC) School Health Index (SHI) to promote collaboration between a major public university and an urban school district to develop adolescent health promotion initiatives, and the real world challenges and opportunities this type of collaboration can pose. The social and physical environments of schools are considered significant factors that affect adolescent food consumption habits, physical inactivity practices, and subsequent obesity rates^{6,7,8} that are all risk factors for adult-onset conditions among adolescents (e.g., cardiovascular disease, hypertension, and type 2 diabetes).¹ This, in turn, may suggest that: 1) adolescents are not receiving or implementing health promotion messages designed to contribute to optimal health throughout the lifespan;¹ 2) their communities lack resources to maintain areas and facilities to promote physical activity;⁹ and, 3) adolescents lack access to healthy foods in their schools and neighborhood.^{7,10}

In recognition of the growing prevalence of obesity and to promote the overall health and wellbeing of adolescents, the CDC's Division of Adolescent and School Health developed the School Health Index (SHI). The SHI is an adolescent and school health planning tool designed to help schools and school districts assess and improve their health policies and programs in the context of a coordinated school health program. The SHI currently addresses several adolescent health behaviors including physical activity and nutrition

education.¹¹ In this article, we describe use of the SHI as a road map, guided by selected collaboration principles (building on partners' strengths and resources, reciprocal learning, cultural humility, and long-term commitment),^{5,12} to deconstruct an eight-year collaboration (2002–2010) that occurred between an urban school district and a major public university, which resulted in the launching of a comprehensive health promotion campaign, The Healthy Class of 2010 (HC 2010). HC 2010 was designed to impact the school environment, school policy, and potentially the health behaviors of students attending all of the 10 public high schools in Pittsburgh, Pennsylvania.

LITERATURE REVIEW

Health promotion has been concerned with program settings for many years – most commonly in terms of carrying out comprehensive health promotion initiatives within a particular setting, for example, the workplace, community, and in schools.¹³ The school-based setting offers opportunities for health promotion initiatives to be directed at individual health behavior change as well as environmental change to achieve improved health outcomes for school-aged youth, school administrators, and school staff.¹⁴ Additionally, by using a “settings approach” to adolescent health promotion provides an all-inclusive framework within which to work, encourages multi-stakeholder ownership of health, and is suitable for collaborations between universities, public school districts, and individual schools.¹⁵

Most U.S. public schools provide some type of nutrition and physical activity programs; however, multiple countervailing pressures (e.g., budget cuts, increasing demands on teachers' time, and political pressures to improve student performance on standardized tests) act on school leaders to impede a sustained focus on the health of students.¹⁶ For example, due to budgetary concerns and testing requirements the transfer of school food services to outside vendors, the reliance on vending machine revenues for extracurricular activities, and the elimination of physical education activities have all contributed to a less-than-optimal school environment where adolescents spend their formative years.^{17,18,19,20}

Nonetheless, schools still remain ideal settings for implementing comprehensive health promotion initiatives²⁰ including physical activity and nutrition education as they are an important context in which adolescents develop, grow, and spend time.¹⁷ Additionally, school-based interventions that focus on healthy eating and exercise have been shown to significantly impact adolescent health behaviors.^{21,22} These interventions are especially relevant in racial and ethnic minority communities characterized by social and economic disadvantage.²²

Recognizing the potential for schools to provide more healthful nutrition and physical activity environments for the nation's young people, the CDC's School Health Index was designed to enable schools to identify strengths and weaknesses of their health education, safety policies and related programs.^{23,24} Additionally, the SHI enables schools to develop action plans for improving student health and promotes the engagement of teachers, parents, students, and the community in advancing healthy behaviors.^{4,16,25} Although research demonstrates the use of the SHI in the assessment of adolescent school health

promotion,^{4,16,25,26} there is a dearth of literature about the processes employed by university faculty and external collaborators to engage teachers, parents, students, and the community in health promotion initiatives. More importantly, to our knowledge, this process has less often been examined in urban public school settings.

THE HEALTHY CLASS OF 2010: AN OVERVIEW

Since 2000, The Center for Minority Health (CMH) at the University of Pittsburgh has invested significant time and resources into building trust and creating partnerships with local community-based organizations. In 2001, CMH led a city-wide initiative, including partners across health, social service, media, and faith-based institutions to address a local crisis, the looming suspension for approximately 12,000 children in the city's schools because they had not complied with a new state law that required a second measles, mumps, and rubella vaccination.²⁷ By responding to this urgent community need and teaming up with a diverse set of partners, 97% of the children were immunized. The success of this immunization campaign, known as Booster-Booster, allowed CMH to build tremendous credibility and trust in the community. It also laid a foundation for a formal collaboration with the Pittsburgh School District, upon which HC 2010 would draw sustenance, take root, and grow.^{27,28,29}

Also during that time, increased national attention was given to issues of overweight and obesity among children. According to the U.S. Department of Health and Human Services, nine million children, or 16%, were overweight and the rate of overweight children in Pennsylvania was 18%.³⁰ These statistics were particularly alarming for urban youth, as many were already overweight or at-risk for overweight and gender, age, race, and individual levels of poverty were associated with their increased weight gain.^{31,32}

Programmatic Development of The Healthy Class of 2010

The Pittsburgh School District along with its 18 middle schools and 10 high schools faced unique challenges related to its limited resources as it attempted to address the overweight epidemic among its students. Having firsthand knowledge of these challenges and a positive prior working relationship, the School District Superintendent requested formation of a collaborative effort with the University of Pittsburgh, Center for Minority Health to address this critical health issue. Identifying and addressing these challenges while modifying school policies and curricula¹³ related to school-based health promotion initiatives like HC 2010 became essential. Thus, HC 2010 was developed and guided, in part, by the CDC's Coordinated School Health Program (CSHP) model, of which the School Health Index is anchored as a critical planning tool for adolescent and school health assessment.

Originally proposed in 1987, Allensworth and Kolbe^{33,34} provided a model with an "expanded" perspective, encouraging linkages and coordination among a broader number of supports to ensure achieving healthy students. Thus, the CSHP model consists of eight interrelated components that constitute a coordinated school health program including systematic communication and collaboration between students, families, teachers, and school administrators in an effort to impact the overall school environment as well as school health policies.^{11,35} As a result, a CSHP that works meets the health needs of the students

and increases the use of actions that improve student health; while also making better use of health promotion and disease prevention tools like the School Health Index.¹¹

The CSHP model asserts that schools by themselves cannot – and should not be expected to – solve the nation’s most serious health problems that affect students. Still, schools could provide a facility in which university faculty might work together with parents and school personnel to develop programs aimed at maintaining the health and well-being of adolescents.^{12,23,24} This type of interagency cooperation between a university and a school district harnesses the imagination, innovation and mutual support that can come from working across professional and organizational boundaries.¹³

The Birth of The Healthy Class of 2010

From September to December 2002, the School District Superintendent held a series of meetings with district administrators, teachers, and principals to introduce the SHI in all 18 middle schools. The primary aim was to select which SHI modules would be included in the planning process, and to gain buy-in from these key stakeholders. University faculty were also invited and attended these meetings to gain further understanding of the SHI and how it can be used in comprehensive adolescent health initiatives.

The initial activity of these meetings was having the stakeholders engage in a collaborative process to create healthier students and schools by completing the eight SHI self-assessment modules, which correspond to the eight components of a coordinated school program¹¹ with special attention paid to the Physical Education and Nutrition Services modules. Completion of the modules provided the framework for utilizing a “whole school approach”¹⁵ for engaging the schools in the process of planning regarding healthier school environments. Additionally, the SHI provided the framework for a “whole child approach”,³⁶ which we addressed by creating school health teams and identifying student role models to participate in leadership development, an important component of a coordinated school health program’s sustainability.³⁷ After completing the eight SHI self-assessment modules, the stakeholders posed the question, “How can we address physical activity and nutrition education in our schools?” From this simple question and its subsequent discussion, the concept of HC 2010 was born specifically with the idea of following a cohort of students scheduled to graduate in the year of 2010. More importantly, this approach was inclusive of the entire school district and directly tied the campaign to their graduation year.

As buy-in of the idea of HC 2010 emerged, discussions quickly began among the stakeholders about developing committees whose responsibility would be the “promotion of HC 2010 activities” in the schools. Using the SHI recommendations for establishing school-level health advisory boards,^{11,30} the school district administrators, teachers, parents, students, and university faculty worked collaboratively to identify existing school health policies’ and programs’ strengths and weaknesses as the initial step in developing and implementing this new health campaign. According to the SHI, these boards can promote life-long wellness by supporting a healthy learning environment, which impacts adolescent health and well-being; enabling the students to become healthy and productive adults.³⁰ Thus, we instituted three advisory boards to guide the development and implementation of HC 2010: 1) a Planning and Advisory Committee (school district representatives and

university faculty); 2) School Health Teams composed of teachers, staff, and parents; and, 3) a Peer Health Council (student representation from each school).

In September 2003, HC 2010 was officially launched as a health promotion campaign and ambitiously targeted all sixth grade students (approximately 2,000) attending the 18 Pittsburgh middle schools. To jump start the campaign, HC 2010 “Back-to-School Rallies” were organized at every school. During the rallies, presentations were given by both university faculty and school teachers on the importance of healthy eating and physical activity and students were provided with pedometers and strategies to build these activities into their daily lives. The aim was to introduce concepts of healthy eating and physical activity and spark the students’ interest in the HC 2010 campaign, and stress the importance of having them as collaborators with the university-school district partnership. After graduation, these same students were then followed as they transitioned from middle school to the 10 Pittsburgh Public High Schools listed in Table 1.

Once the students transitioned into high school, the advisory board membership changed and new advisory boards had to be developed and reestablished. The former administration of the middle schools that comprised the initial advisory boards requested to remain involved with the HC 2010 campaign. As a result, university faculty worked diligently to find tangible ways for them to remain connected to the campaign. An important component of the transition was that former advisory board members’ (e.g., administrators and teachers from the middle schools) testimony regarding the importance of HC 2010 garnered interest from the high school administrators and teachers. The former middle school administrators played a pivotal role in obtaining buy-in from the new high school administrators and teachers. Thus, their assistance created a more prudent process in the development of the new advisory boards and the transition of the campaign.

The HC 2010 advisory boards continually met and engaged its members, especially the students, in collaborative partnerships with The University of Pittsburgh, Center for Minority Health (CMH) to develop HC 2010 activities. For example, CMH conducted mini-grant writing workshops with the students and teachers on how to write and submit a competitive grant application. Subsequently, each school applied to CMH for a mini-grant of \$1500 each year to design their own health-related initiatives (e.g., purchasing a microwave to heat lunch meals brought from home and exercise equipment to increase physical activity during after school programs). Table 2 presents selected HC 2010 activities. Some of which focus on increasing physical activity and nutrition practices during an academic school year.

COLLABORATING WITH THE SCHOOL DISTRICT

The Pittsburgh Public School District is the largest of 43 school districts in Allegheny County and the second largest in Pennsylvania. The district serves approximately 28,000 students in Kindergarten through Grade 12 in 65 schools, and is composed of 10 high schools each with unique academic programs (see Table 1). Although the University of Pittsburgh’s Center for Minority Health (CMH) and the Pittsburgh School District had a prior positive work relationship, District policy mandated that formal administrative

approval must be obtained before any university-initiated health promotion program could be implemented. This process necessitated understanding the levels within the hierarchical framework of the Pittsburgh School District that included a Superintendent of Schools, Development Coordinators – who serve as liaisons between the district and external organizations who enter into collaboration with the district, Coordinator of Health Services, and the Institutional Review Board Office. Considering the school district receives numerous requests from outside agencies for programming and other activities, several efforts, including a formal letter describing the prior endeavors and the desire for collaboration regarding the HC 2010 campaign, were made to ensure the collaboration would become firmly established.³⁸ In addition, the HC 2010 staff expertise further aided in establishing the collaboration.³⁹ The HC 2010 staff consisted of a doctoral level educator (project director) and masters level school district liaison; who had more than 30 years of combined teaching and school district administration experience with the Pittsburgh Public Schools.

Additional meetings with specific district personnel (e.g., Coordinator of Health Services and the Development Coordinators) were arranged during the fall of 2002 to ensure the roles of the HC 2010 staff and HC 2010's components were consistent with district policy. At this time, a formal application of request to conduct a health initiative in the school district was submitted and approved by the School District's and the University of Pittsburgh's Institutional Review Boards. This endorsement was based on scientific merit, consistency with district objectives for collaboration with outside agencies, and potential benefit to the students.

Collaborating with the High Schools

An early sustained focus on the school district liaison was critical to ensure that district needs and interests were gauged correctly.⁴⁰ In districts with several high schools, communication with outside agencies usually requires trained school-base personnel to act as a designated intermediary.⁴⁰ Our school district liaison filled an important role in providing a communication link between the university faculty and staff, the school district administration, and the schools.

The high school principals provided the school district liaison with a list of teachers, collectively known as the HC 2010 facilitators, to initiate contact with the teachers, students, and staff of their respective schools. The facilitators were biology, health and physical education, and English teachers who were interested in the HC 2010 campaign and partnering with the university. It was important to make HC2010 a program which integrated the health theme across the curricula. At this time, an initial meeting at each school, arranged through its HC 2010 facilitator, included the principal, vice principal, interested teachers, and HC 2010 staff. Its purpose was to obtain buy-in to conduct the campaign and to determine campaign-specific activities. The facilitators further arranged meetings between HC 2010 staff and the students and began developing health-related activities (e.g., evening cooking classes with students and their parents).

COLLABORATION PRINCIPLES

The literature describes principles to identify and guide collaborations between universities, school district personnel, schools, and communities.^{5, 12,13,15,40} These principles are congruent with the SHI, which stresses the need for people interested in adolescent health to become involved and work together to create healthier students and healthier schools.^{11,15} Although many of these principles can be applied to interactions with both participants and partners, our focus was on collaborations with our partner organizations – the schools and school district. For the purposes of this article, we chose to focus on four particular collaboration principles that are consonant with the settings approach to health promotion¹³: building on partners' strengths and resources; reciprocal learning; cultural humility; and long-term commitment.

Building on Partners' Strengths and Resources

This principle encourages university faculty to build on partners' strengths and maximize the equitable exchange of resources rather than focus on deficits.^{13,41} In our case, the school district provided access to the students, facilities to conduct the campaign, and the investment of various school staff members with dedicated time and effort devoted to implementation of the HC2010 campaign as part of their jobs. The CMH provided dedicated staff support, professionally designed campaign materials, and financial resources for each school in the form of a \$1500 mini-grant to develop innovative health promotion initiatives driven by each school and designed to increase physical activity and advance nutrition education to increase consumption of fruit and vegetables.

In addition to a mutually valued goal and a favorable exchange of resources, another significant aspect of readiness to collaborate is the characteristics of the partner's leadership.⁴² The school district was led by experienced administrators committed to finding ways to better respond to adolescent health issues. Moreover, these administrators embraced the university assistance as a means to address the challenges from a public health perspective. These district administrative strengths were important assets facilitating the collaboration.

Reciprocal Learning

Through the process of reciprocal learning,⁴³ the university faculty and the school district gained a deeper understanding of each other and the fundamental issues of nutrition education and physical activity among adolescents. The process required faculty to understand the culture of the school district, each individual school³⁹, and orient the partners to the culture of a public university.⁴⁴

Advisory boards are a mechanism increasingly used by universities in collaboration with targeted groups to reciprocally learn from one another.^{45,46} As noted above, HC 2010 was guided by three advisory boards that represented the views and interests of the students, teachers, parents, school district representatives, and university faculty. The HC 2010 advisory boards informed the faculty about culturally sensitive and effective recruitment strategies. The boards also provided insight into the development of campaign materials and

how to obtain district-wide support and overcome barriers via conflict resolution.^{13,47} Currently, the literature describing advisory boards tends to place more emphasis on one-way information flow, from advisors to university faculty.⁵ Our experience is best described as a two-way, reciprocal, communication and learning model between both partners.

Cultural Humility

University faculty should demonstrate what Tervalon and Murray-Garcia⁴⁸ refer to as cultural humility, which involves respecting the strengths, expertise, and organizational culture of collaboration partners. Practicing cultural humility serves to minimize potential power imbalances between faculty and partners. Although a university and an urban school district are institutions of education, it was clear from the outset that each institution had its own unique culture of operation. We tried to demonstrate cultural humility by consulting with the advisory boards to learn about each school's practices that may impact the implementation of the HC 2010 campaign. For example, university faculty had to humble themselves and respect the existing meeting culture of the school district and not push its own meeting agenda based on convenience. As a result, one direct outcome from this experience was that HC 2010 planning meetings were integrated into the standing Board of Education meetings with principals.

Long-term Commitment

Collaboration calls for a strong commitment by university faculty to the long-term, iterative processes of human and social capital development in school districts and to sustaining effective school-based health initiatives.^{13,47} HC 2010 began its first year of implementation with limited resources and later received a grant from a local philanthropic organization. Although financial support of any program is critical, sustained efforts require buy-in from stakeholders. Our experiences indicated the philanthropic organization gained confidence in our strategy of collaborating with the school district and provided us with a substantial multi-year grant, which is longer than their traditional one-year-at-a-time grant funding. Notwithstanding, our school district partners continued to demonstrate their commitment to the campaign by informing us of culturally sensitive practices, effective implementation strategies, development of materials, and solutions to overcoming barriers in the achievement of our goals.

Formal projects in which representatives from public schools and universities work together to resolve common problems is critical in planning school district and university collaborations.^{49,50} These collaborations can pose several challenges especially in terms of the "sweat equity" time investment; the tension between conducting research versus providing service; adhering to state laws and school district policies; and the limits of time in a school day where "no child left behind testing" shapes school priorities. In our case, the SHI was the medium that allowed for inclusion of all stakeholders⁵¹ – from school district administrators to students – to make meaningful contributions, strategically plan and implement the HC 2010 campaign, and collaborate with university faculty.

DISCUSSION

Brener et al²⁵ found that few schools nationwide are addressing the entire breadth of SHI items and a more coordinated approach to school health is needed to reinforce health messages. Moreover, Staten et al²⁶ reported that most schools have made one immediate change in their school environment, yet require planning and perhaps the assistance of subcommittees in the development of district-wide health curricula. Our work highlights the process and the use of the SHI in the formation, development, and implementation of an adolescent health promotion campaign. Thus, our work fills a gap in the literature by examining *how* to collaborate and form important partnerships. Furthermore, this work demonstrates *how* the SHI can be used both at the micro-level (students) with emphasis on the planning process and collaboration instead of just at the macro-level (schools); where the majority of published literature has limited its focus.^{25,26} The successful collaboration reported here would have been nearly impossible without the use of the SHI as an organizing tool through which the planning process could flow and adapt to the cultural norms present within a school district.

Urban school districts are complex organizations complete with public debates over policy and funding priorities. During the course of our work, the school district went through a major re-organization with school consolidations, closings and staff reductions. This resulted in political controversy, public demonstrations, and charges of racism and discrimination that spilled out into the social and political environment. This was the real world context in which we collaborated with an urban school district and its implementation of an adolescent health promotion campaign. For example, programs that appeared to detract from “academic areas of study” were viewed by the teachers and administrators as being of “marginal importance.” Use of the SHI, however, provided a framework from which to address these and other challenges.

We discovered that the focus on *planning* put teachers, students, parents, and the university faculty on the same level of mutual respect for the process, as they had control over the development of HC 2010. The SHI also allowed for flexibility to use input – from the school district administrators to the students in the classroom – to develop campaign activities and to inform district-wide and local school policy related to health promotion and disease prevention. We also believe that the mini-grant program added value to the process so that schools received financial support to implement their shared vision on how best to improve the school environment. This approach resulted in the integration of health promotion activities across the school curricula including, but not limited to, English, math, social studies, and health and physical education classes.

Implications for School Health

Creating a school environment conducive to promoting healthy behaviors among students is an important part of the fundamental mission of schools: to provide young people with the knowledge and skills they need to become healthy and productive adults.³ Improving student health can lead to increased capacity to learn, reduced absenteeism, and improved physical fitness and mental alertness.¹¹ HC 2010 underscored the significant need for an adolescent health promotion campaign that specifically addressed physical activity and

proper nutrition using the SHI as a planning instrument, rather than an assessment tool, and facilitated the use of collaboration principles. HC 2010 highlighted the importance of developing a carefully organized plan to build collaborations that were necessary to effectively implement this school-based campaign across the entire school district. Thus, the school district, its schools and students took ownership of HC 2010's processes and outcomes to successfully implement the campaign.

To guide future university and school district collaborations, we recommend addressing the following critical areas when developing *and* implementing school-based, adolescent health promotion initiatives. First, determine the hierarchical structure of the school district before approval is sought. Second, establish credibility for the initiative and the university faculty and staff. Third, emphasize the benefits of the program to the school district, schools, parents, and students. Fourth, maintain a cooperative partnership with teachers, liaisons, and administrators to ensure effective implementation of the initiative. Fifth, appreciate the need for meticulous schedule planning and changes that will affect program implementation. Finally, provide as many resources as possible rather than making requests on an already overburdened and underfunded school system.

By utilizing the School Health Index and selected collaboration principles, we believe there are useful strategies and lessons learned from HC 2010 that may benefit urban school districts, and outside organizations seeking to work together to potentially change student health behaviors, the school environment and policies. In our case, the need for district-wide changes in the types of food options offered at the schools was stressed by the students via mini-grants and the Peer Health Councils that informed policy. This led to overall changes in food service by providing healthier food and drink options in the cafeteria and vending machines. It is both the students' and partners' ownership of the process that makes use of the School Health Index a tool that continues to yield positive results.

The Healthy Class of 2010 partners served as champions of the campaign until its end in June 2010. The planning process served as the foundation for establishing this critical partnership between a public university and an urban school district. Our experience utilizing the School Health Index and selected principles of collaboration within an urban public school district confirms our belief that universities can play an important role in shaping the healthy behaviors of our youth and impact the social and physical environments of the neighborhoods where these youth live.

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Table 1

A Description of the 10 Pittsburgh Public High Schools

School	Description	Total Enrollment	% African American	% White
A	The largest of the 10 schools; offers programs at the gifted, scholars, and standard academic levels.	1,402	37	56
B	This school provides comprehensive academic programs to accommodate student needs.	1,124	38	55
C	Students receive a quality education in an atmosphere that nurtures their individual artistic talents.	551	32	61
D	The school provides Special Programs in Business and Health Technology.	918	37	58
E	A Teaching, Horticulture/ Landscaping, Health, and Robotics Academies are located within this school.	493	67	29
F	The Law and Public Service and the Junior ROTC are two magnet programs offered to students.	575	82	13
G	The Robotics Technology and Public Safety programs and the Health Careers, Information Technologies and Culinary Arts academies are housed here.	492	93	4
H	This school provides students with opportunities to learn scientific research procedures through its Math and Science Program.	736	63	32
I	The school is home to two magnet programs: The International Baccalaureate and Robotics Technology.	684	70	23
J	The only school with a 100% African American population. Students can receive professional certifications and science and mathematics academy scholarships upon completion of four years of school.	335	100	0

Table 2

Selected HC 2010 Activities

Date	Activity	Description
September 2003	Pedometer distribution to track physical activity	>3,000 pedometers provided to students attending the 18 public middle schools.
October 2004 and 2005	HC 2010 Let's Just PLAY Day	A local park was the site of physical activity sessions (e.g., trail walks, relay races, dancing) to encourage students to make some extra time in their day to PLAY and celebrate PLAY based on the Nickelodeon® Television Channel's annual World Wide Day of Play.
April – May 2006	HC 2010 Writing Anthology Project	The anthology of student work represented an effort to highlight the school district's commitment to integrating health and wellness across the curricula.
October – December 2006	High School Mini-grant Proposals	Eight proposals were approved. Students from one high school used a portion of their funding to develop an Afro-Latino Dance Troupe to promote physical activity.
January 2007	HC 2010 Art Poster Contest	Winning posters were converted into billboards, providing increased visibility in the city of Pittsburgh for HC 2010 priority goals: physical fitness and nutrition education. See: http://www.cmh.pitt.edu/pdf/capa.pdf and http://www.cmh.pitt.edu/pdf/allderdice.pdf
February 2007	Evening Cooking Classes	The first of five HC 2010 Evening Cooking Classes for parents and students was held to promote healthy food choices.
February 2007	High School Mini-grant Proposals	These proposals focused on nutrition education and increasing physical fitness. One school used part of their mini-grant funding to rent bikes for their students to use on a local bike trail.
May 2007	"Be Active" and "Be Healthy" Day	This event was planned by the HC 2010 Advisory Committee and Peer Health Councils and held at a local amusement park to promote awareness of the importance of daily physical activity.
October – December 2008	HC 2010 Meetings	The HC 2010 project director and school district liaison visited each school to continue the collaboration process, promote HC 2010, and engage the HC 2010 facilitators and students.
November 2009	HC 2010 Poster Presentation	A poster, based on the university-school district collaboration to develop and implement HC 2010, was presented at a national public health meeting.
January – May 2010	Yearbook Ads	High school yearbook ads were taken out to congratulate the HC 2010 graduates.
May – June 2010	HC 2010 T-shirts	Final distribution of HC 2010 T-shirts to students.