School Wellness Policies: Promoting School Health Councils and Local Wellness Policy Implementation

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Background

• Written Local Wellness Policies (LWPs) are federally mandated in school systems to enhance opportunities for healthy eating/physical activity among students1,2.
• Schools are encouraged to form school-level School Health Councils (SHCs) or wellness committees to oversee LWP implementation.
• Little is known about how SHCs are operationalized or relations between having an active SHC and LWP implementation.

Objective

To examine factors associated with having an active SHC and to determine if having an active SHC is associated with greater school-level LWP implementation.

Hypothesis: schools are more likely to implement wellness policies and practices when they have an active school health council that:
• sets goals for healthy eating and physical activity
• meets at least 4 times per school year
• has at least 3 of the following on their school health council: administrator, PE teacher, cafeteria manager, school nurse
• has a parent or student on their school health council
• informs stakeholders of activities through a website, newsletter, or PTA meetings

Methods

• 2012-2013 Maryland Active Living/ Healthy Eating in Schools Wellness Policies & Practices Survey
• Online survey on 2012-2013 activities, based on the School Nutrition Policies and Practices Survey (Schwartz, 2011). Maryland Wellness Policy Implementation Checklist (MSDE), SMART administrative review (USDA), Alliance for a Healthier Generation School wellness criteria, and wording from the Healthy Hunger Free Kids Act
• Sent via e-mail to school administrators (n=1349, response rate=55%)

• Sample: 42% had a SHC
• School-level implementation of wellness policies and practices
  • 17-item scale
  • Cronbach's alpha=0.923
  • Scored in 3 categories—low, mid, high implementation

School demographic data provided by State Department of Education

• “Active SHC score”
  • 5 constructs (scored 0/1), summed, higher score=more activities
  • set goals for healthy eating and physical activity
  • meet ≥24 times during 2012-2013 school year
  • members include: 2 administrator, PE teacher, cafeteria manager, school nurse
  • members include parent and/or student
  • activities publicly available (website, PTA meetings, or e-mail).

Results

• Mean active SHC score 2.6 (SD=1.4, range 0-5). LWP implementation categories: no (19.6%), low (36.0%), high (44.4%).
• 26% of schools majority low-income (>75% of students eligible for Free- or-Reduced-Price Meals).

Table 1: School-level implementation based on SHCs meeting certain criteria

| Criteria: 1 point if met | % endorsed (%) | School-level LWP Implementation | Score
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<tr>
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<tbody>
<tr>
<td>Goals for healthy eating and physical activity</td>
<td>Yes</td>
<td>66.9% (61.0%)</td>
<td>low</td>
</tr>
<tr>
<td>How frequently did you meet?</td>
<td>4x/year</td>
<td>45.8%</td>
<td>19.5%</td>
</tr>
<tr>
<td>Composition: school &amp; SHC</td>
<td>3 out of 7 of the following: administrator, PE teacher, cafeteria manager, school nurse</td>
<td>40.9%</td>
<td>22.3%</td>
</tr>
<tr>
<td>Composition: families</td>
<td>3 out of 6 of the following: Parent, student, school nurse</td>
<td>31.2%</td>
<td>24.4%</td>
</tr>
<tr>
<td>How public is information?</td>
<td>Online, newsletter, PTA meetings</td>
<td>71.4%</td>
<td>67.5%</td>
</tr>
<tr>
<td>TOTAL SCORE</td>
<td>Mean=2.64, SD=1.40</td>
<td>2.41</td>
<td>2.51</td>
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</table>

• Based on the chi-squared analyses schools that met more criteria were more likely to be in the high implementation group. Each of the 5 criteria had a significant correlation to LWP implementation. (Table 1)

Figure 1: School-Level Implementation of Wellness Policies and Practices by Having a School-Level SHC in Place

Results (Continued)

• Adjusted multi-level models revealed for every one-unit increase in SHC score, schools are 39% more likely to be in high implementation group (p=0.006). (Table 2)

Table 2: SHC score based on school-level implementation with adjusting for clustering

<table>
<thead>
<tr>
<th>Likelihood Ratio</th>
<th>p-value</th>
<th>95% C.I.</th>
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<th>p-value</th>
<th>95% C.I.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHC Score</td>
<td>0.96</td>
<td>0.789</td>
<td>0.76, 1.21</td>
<td>0.39</td>
<td>0.006</td>
</tr>
<tr>
<td>Majority Low-Income Student Body</td>
<td>1.48</td>
<td>0.269</td>
<td>0.75, 1.21</td>
<td>2.05</td>
<td>0.035</td>
</tr>
</tbody>
</table>

• Schools without a majority low-income student body are 2.05 times more likely to be in the high implementation group compared to the no implementation group. (Table 2)

Conclusions/Implications

• Schools with an active SHC have a higher likelihood of LWP implementation.
• Interventions that focus on the formation and maintenance of active SHCs are likely to increase LWP implementation.
• Federal/State Departments of Education and school systems should support the establishment of school-level school health councils to enhance implementation of LWPs in schools.
• School systems can encourage LWP implementation in schools through promoting school-level actions (setting goals, having SHCs meet frequently, communicating to the community, etc.).
• Schools with majority low-income student body are less likely to implement LWPs, and may benefit from assistance in establishing active SHCs.

References