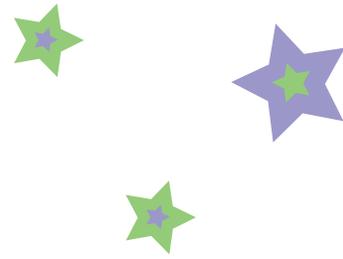


Coordinated School Health
Snapshot of the Field



**Executive
Summary**

2006

SNAPSHOT DESIGN

In May of 2006, School Health Connections contracted with Philliber Research Associates to conduct a follow-up to a needs assessment completed in 1998 to assess how school health has changed since the 1998 needs assessment and the release of *California's Blueprint: Building Infrastructure for Coordinated School Health (Blueprint)*. The purpose of the 2006 study was two-fold:

- To determine the progress made in strengthening Coordinated School Health (CSH) in California since the release of the *Blueprint*.
- To assist the State in determining future directions related to CSH.

This Snapshot of the Field looks at progress towards implementing the eight component model of CSH in California and the six goal areas described in the *Blueprint*.

The Snapshot of the Field was designed using three surveys — one for county offices of education (COEs), one for local health departments (LHDs), and one for key informants (KIs). When considering the findings, it is important to remember that a COE's primary purpose is supporting schools, whereas the core mission of LHDs is to promote and protect the health of the community. Therefore, although similar questions were asked of COEs and LHDs, the LHD responses will be different in scale and should not be compared directly to the COE responses.

Sample and Response Rate

The sample size and response rate was as follows :

COEs	49 of 58 COEs, yielding a response rate of 85%.
LHDs	49 of 61 LHDs, yielding a response rate of 80%.
KIs	23 of 23 KIs, yielding a response rate of 100%.

For a full report, email schoolhealth@cdph.ca.gov



CALIFORNIA'S BLUEPRINT:

BUILDING INFRASTRUCTURE FOR COORDINATED SCHOOL HEALTH GOALS

Goal 1: Coordinated school health policies and programs will support and contribute to the positive development of children and youth.

Goal 2: Policies at all levels will fully support coordinated school health for California's diverse populations.

Goal 3: Funds and resources will be allocated to support coordinated school health for California's diverse populations.

Goal 4: Closer collaboration and better coordination will be established within and between CDE and the CDHS, other state and local agencies, and business and community partners.

Goal 5: Personnel capacity in school health at the state and local levels will increase and will reflect California's diverse populations.

Goal 6: Use of state-of-the-art, research-based strategies to implement coordinated school health will increase.



EIGHT COMPONENT MODEL OF COORDINATED SCHOOL HEALTH

The CSH model consists of eight components. The components are:

- **Family and community involvement** – Partnerships among schools, parents and community groups to maximize resources and expertise in supporting the health of young people.
- **Health education** – Classroom instruction that addresses the physical, mental, emotional and social dimensions of health.
- **Physical education** – School-based instruction program that provides students with the skills, knowledge, attitudes and confidence to be physically active for life.
- **Health services** – Prevention services, education, emergency care, referrals and management of acute and chronic health conditions to ensure health of students.
- **Nutrition services** – Integration of nutritious, affordable and appealing meals, promotion of healthy eating behaviors, and reinforcement of classroom-based nutrition education.
- **Counseling, psychological and social services** – Activities that focus on cognitive, emotional, behavior and social needs in the school and home.
- **Healthy school environment** – The school's physical, emotional and social climate; providing a safe physical plant and a health, supportive environment for learning.
- **Health promotion for staff** – Assessment, education and wellness activities for school faculty and staff.



CONCLUSIONS AND RECOMMENDATIONS

Considerable progress has been made in CSH in the years since the initial needs assessment and release of the *Blueprint*. It is important to note that the 2006 Snapshot of the Field was not an evaluation of the School Health Connections' work directly, rather an update to the needs assessment that was done in 1998 to get a sense of the "state of the field" of CSH. School health issues are multi-faceted, ever changing and largely unpredictable, so progress comes through a convergence of factors, and is attributable to many programs and policies.

In summary, the key learnings from the snapshot surveys include:

- Awareness and activities around school health issues have increased.
- Collaboration among schools, county health agencies, state agencies, and non-profits has increased.
- Wellness policy requirements are currently driving change.

In order to expand and improve the implementation of CSH in California, School Health Connections should consider the following recommendations:

Provide more concrete technical assistance to schools and districts. Whether they are grappling with the implementation of new wellness policies with limited resources or trying to provide healthier student lunches in a cost effective way, schools and districts need guidance in the form of concrete tips, best practices, or tool kits. Statewide, there is a common set of problems that each school or district should not have to figure out individually.

Establish a lead contact person at local health departments for school health issues. While collaborative activities between schools, districts and local health departments have been increasing, there is still the need for greater connectedness. Establishing a key contact person on school health matters within each local health department is a critical step.

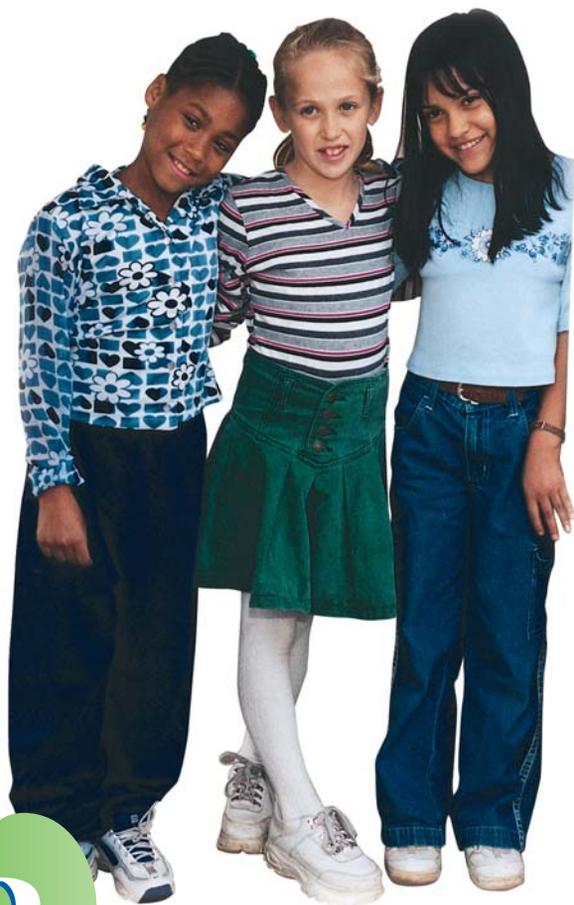
Provide oversight and monitoring of progress on implementing mandates. The promise of new school nutrition laws or physical education or physical activity requirements will not be realized unless they are accompanied by "teeth" — strong monitoring or oversight with attached incentives. Schools are stretched in so many directions that health-related matters often take a back seat to academic matters. The addition or continuation of consistent monitoring practices and incentives is necessary for progress.

Continue providing leadership at the state level. State agencies and statewide non-profit organizations should continue to provide leadership in the form of technical assistance, dissemination of information, conferences, and convenings. They should also take leadership in supporting new monies and legislation relating to school health. Additional groups within the California Department of Health Services, such as environmental health, epidemiology, and maternal and child health should expand their leadership to address school health issues. School Health Connections has provided statewide leadership that should continue to evolve to meet the challenge of continuing to expand and improve upon the implementation of CSH in California in the years to come.



**“CDE and CDHS should continue to play the role of facilitators.
I have never seen such cooperation between two state departments.”**

(KEY INFORMANT RESPONDENT)



PROGRESS IN IMPLEMENTING BLUEPRINT GOALS

SELECTED FINDINGS

Goal One: Youth Development

Youth Development Being Implemented

Two-thirds of KIs stated that their promotion or implementation of a youth development, youth resilience or assets-based approach in their work had increased. Similarly, three-quarters of COEs and slightly more than half of LHDs reported that they were advocating that schools and districts more frequently include a youth development approach.

A large majority of both COE (90%) and LHD (72%) respondents reported that they “often” or “sometimes” advocated that schools and districts with which they worked include a youth development approach in their school health policies and programs.

Goal Two: Policy Development

Increased Involvement in Policy Development

Large majorities of both COE respondents (72%) and LHD respondents (68%) reported increased contributions to policy development related to school health issues in the past five years. Three-quarters of the COE and LHD respondents reported that their office/department now frequently contributes to policy development. Examples included developing wellness policies, testifying at school board meetings, meeting with decision makers, or assisting with setting standards.

Many respondents mentioned serving on committees that had recently completed or were currently in the process of developing local wellness policies. Additionally, a large majority of KIs (69%) said that their organization had provided “a lot” of professional development or training on this topic.

Impact of California’s Nutrition Legislation

An overwhelming majority of KIs thought that new school nutrition standards (83%) and school beverage standards (79%) have “significantly” strengthened efforts in school health. Three-quarters of COE and LHD respondents also thought that the new legislation governing food and beverage standards (Senate Bills 12 and 965) was “very” or “somewhat” effective.

Health Education and Physical Education Policy Documents Being Used

Three-quarters of the COE respondents reported using the *Health Framework for California Public Schools*. Also, about half of the COEs reported using the *Physical Education Framework and Physical Education Model Content Standards for California Public Schools*. About a third of the LHD respondents had used the *Health Framework for California Public Schools*. Less than a quarter of the LHD respondents reported using the *Physical Education Framework and Physical Education Model Standards for California Public Schools*.

Technical Assistance on Policy Development and Implementation is Helpful—and Needed

Survey respondents indicated the continued need for supports for policy development. One clear example of such a support that has been well received is the *Guidance for the Development of California School Wellness Policies*, which was developed collaboratively by a diverse group of organizations and disseminated by CDE. Two-thirds of the COE respondents reported using at least a part of the *Guidance for the Development of California School Wellness Policies* document in their work.

“State agencies should better utilize professional organizations in order to provide standards workshops and trainings.”

(KEY INFORMANT RESPONDENT)

Goal Three: Funds and Resources

A Call for Greater Investment in School Health

Three-quarters of the LHD respondents felt that lack of funding hindered their work with schools and districts. This is considerably higher than the results of the 1998 needs assessment when just half of the LHD respondents had identified lack of funding as a barrier.

Two-thirds of KIs reported being very successful in collaborating with other organizations/agencies to leverage resources for school health. Examples of successful collaboration included working with other agencies on a variety of grant-funded programs, launching coalitions, and seeking collaborative funding to establish school health clinics.

Goal Four: Coordination and Collaboration

Increased Collaboration at the Local Level

A majority of respondents from COEs and LHDs reported increased collaboration in working together to jointly develop and implement programs, work on policies, participate on committees, and share data. Additionally, the vast majority of both COE and LHD respondents reported increased collaboration with schools to implement programs.

Noteworthy Collaboration at the State Level

Approximately half of the KIs reported that collaboration among state staff and between state and local agencies had increased. KIs expressed recognition for enhanced collaboration between CDE and CDHS. One described a “real bond between the CDE and CDHS staff” that had not existed previously.

Goal Five: Personal Capacity

A Call for More Training and Qualified Staff

Results from all three surveys reflected the critical need for expanded personnel capacity in order to achieve school health objectives. Respondents described a need at the school level for nurses, health center staff, and teachers qualified to instruct in health education topics. Respondents also described a need at the district and county level for planning, implementing, and overseeing health-related projects.

Staff Development Provided in Many Areas

A majority of KIs reported that they provided “a lot” of professional development or training in the areas of local school wellness policies (69%), physical

education/physical activity (61%), healthy school environment (52%), and family and community involvement (52%). In follow-up questions, a majority of KIs also reported disseminating best practices, particularly in the areas of physical education/physical activity (65%) and local school wellness policies (61%).

Goal Six: Researched-Based Strategies

Research-Based Materials Being Utilized

COE and LHD respondents were asked to what extent they had used specific resources: *The Health Framework for California Public Schools*, *California Guidance for Wellness Policies*, *California Physical Education Standards*, *California Physical Education Framework*, *Blueprint, and School Nutrition...By Design*. A majority of COE respondents had utilized most of these materials in their work. About a third of LHD respondents had used the *California Guidance for Wellness Policies* and the *Health Framework for California Public Schools*. The other research-based documents were used less frequently by LHDs.



"The School Health Connections staff deserves a lot of credit. They have been helpful, resourceful and constantly share information."

(KEY INFORMANT RESPONDENT)



P

PROGRESS TOWARDS IMPLEMENTING THE EIGHT COMPONENT MODEL OF COORDINATED SCHOOL HEALTH

School Health Connections promotes the eight component model of CSH. This model involves the entire school system, home, and community collaborating to support the health of young people in a school setting and to eliminate duplication and gaps.

Increased Levels of Commitment for CSH

Forty-two percent of the COE respondents and just over half of the LHD respondents reported that there was either a "high" or "very high" level of commitment or support from their office or department to work on coordinated school health. Additionally, about 60% of COE and LHD respondents reported that this level of commitment and support towards working on CSH had increased in the past five years.

Working with Schools or Districts— Emphasis on Nutrition, Physical Education/Activity

During the past five years, COEs and LHDs experienced the greatest increase in focus in the areas of nutrition services, physical education/activity, and healthy school environments. More than half of respondents also reported an increase in focus in the areas of health education, health services, family and community involvement and the coordination of the eight CSH components.

Programs and Services Are Being Delivered by Most Schools or Districts

At least two-thirds of COE respondents reported that nearly all or most of their schools and/or districts provided physical education and other physical activities, health services, counseling and social services, and a healthy school environment. Most COE respondents reported an increase over the past five years in providing high quality nutrition services to promote healthy eating (57%), providing counseling and social services (56%), and providing programs or policies to ensure a healthy school environment (82%).

Significant Barrier for LHDs Working with Schools—Time Limitations

Virtually all of the LHD respondents (92%) reported that the greatest barrier in working with schools and districts is that "school staff are overextended or have no time for anything but the basics." At the time of the 1998 needs assessment, just two-thirds of the LHD respondents thought over-extended staff was a barrier, although it was at the top of their list of barriers at that time as well.



F

FUTURE DIRECTIONS

Greatest Needs for Future Work

The most frequent responses from KIs, COEs, and LHDs, on what needs to happen in order to move forward as a state on issues of school health were related to funding, increased technical assistance/training, improving health services at school sites, and connecting health issues to student academic performance.

The Role of CDE and CDHS

KIs were asked what role CDE and CDHS could play in strengthening or improving school health. Similarly, COE and LHD respondents were asked how the state could better support CSH programs in their counties. Many comments emphasized ways the state agencies could provide greater leadership, advocacy, and funding. Additional comments focused on expanded roles the state agencies could play in providing training and technical assistance, monitoring, and continuing to convene key players in the coordinated school health field.

Acknowledgements

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