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USING A MULTIPLE-CASE STUDY DESIGN TO
EVALUATE THE IMPLEMENTATION
OF THE HEALTHY SCHOOLS PROGRAM
AT SELECT NEW JERSEY CHARTER SCHOOLS

By

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ABSTRACT OF THE DISSERTATION

Using a Multiple-Case Study Design to Evaluate the Implementation of the Healthy

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Background: Childhood obesity is a public health problem in the United States. Schools have been identified as organizations that can combat childhood obesity in communities nationally. As such, federal acts such as the Federal Child Nutrition and WIC Reauthorization Act of 2004, and the Healthy, Hunger-Free Kids Act of 2010, have mandated that schools participating in federal meals programs develop a School Wellness Policy that outlines guidelines for nutrition consistent with those of the USDA, and also for physical activity. The Healthy Schools Program (HSP), created by the Alliance for a Healthier Generation (an organization founded by the Clinton Foundation and the American Heart Association), is both a policy planning tool and a program to help schools comply with these federal mandates. To date, HSP implementation has been evaluated in traditional public schools. Charter schools, a unique and growing type of public school, have organizational, financial, and academic performance differences that may affect HSP implementation differently than in traditional schools. **Objective:** To determine the extent to which HSP is being implemented in select New Jersey charter schools, and factors impacting implementation. **Methods:** Using a multiple-case study design, research was conducted at four K-8 independent, New Jersey charter schools. Three types of data collection were used: 1) interviews; 2) document review; and 3) school environment

observations. Level of HSP implementation was measured by the six steps of HSP implementation. The characteristics of an innovation (relative advantage, compatibility, complexity, trialability, and observability) of the Diffusion of Innovation theory were used as the analytical framework to explain how and why implementation had occurred in the manner it had. **Results:** All schools were partially implementing HSP, but no school was fully implementing the program. Schools were more successful at meeting the HSP/USDA nutrition guidelines, but were not meeting the HSP/New Jersey state guidelines for physical activity. This was due to not having time to schedule physical activity or lacking the infrastructure (gym or playground) or the staff to manage physical activity. Using the Diffusion of Innovation analytical framework, all study schools stated that HSP was compatible with their school mission and charter. However, sources of incompatibility were due to: 1) lack of leadership support for HSP due to prioritizing academics over HSP implementation; 2) lack of cultural relevance in HSP content; and 3) lack of parental support due to culture, economics, and education. In terms of complexity, participants at all study schools stated that HSP's templated format was easy to follow but that schools needed more support—both a person with health expertise to guide program implementation and evaluation, and more people generally, as HSP is designed for implementation at larger traditional public schools that have district-level, central office support. Participants at all study schools stated that HSP was better than other obesity prevention programs (relative advantage). Schools were also implementing HSP in pieces (trialability). Participants stated they had observed the nutritional value of school meals had improved since implementing HSP and students had more energy. There were also broader social and environmental factors in the community (e.g., poverty, violence,

infrastructure) that affected HSP implementation. **Conclusions:** The two factors most affecting HSP implementation were school leadership support and parental support. HSP was being most implemented in schools that already a culture of health promotion, with a school leadership that already prioritized health. In schools that did not have a culture of health, senior leadership prioritized academics over health promotion. Program developers should consider developing an integrated curriculum to bridge the gap between health and academics. HSP did not fit the needs of these independent charter schools. HSP needs to be tailored to better fit the cultural needs and organizational structures of independent charter schools. Schools also needed more support. HSP developers should consider providing in-person technical support to independent charter schools, similar to the support offered to traditional public schools. Future research should be conducted to better understand the social and environmental factors affecting implementation, with particular focus on understanding parent health behaviors, education, and needs. Future research should also be conducted at more schools in New Jersey and in other states to determine if this study's findings hold in other populations. Findings could guide further program development more compatible with this unique population of public schools.

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CHAPTER ONE:

INTRODUCTION

a. Statement of the Problem

Child and adolescent obesity is a public health problem in the United States. The obesity rate for children ages 2 to 19 tripled over the period from 1980 to 2010 (Fryar et al., 2012). Poor nutrition and insufficient physical activity have been linked to the increase in obesity prevalence among children (Troiano, Berrigan, & Dodd, 2008). In addition to physical ailments, obese children may experience negative psychological and emotional outcomes, including low self-esteem, depression, bias, and stigmatization (French, Story, & Perry, 1995; Hollar et al., 2010). Obesity does not end at childhood, as research shows that overweight children are more prone to becoming overweight adults, particularly at higher body mass indexes (BMIs; Graversen et al., 2014).

Research indicates schools, as the environment in which children spend the majority of their time outside of the home, can play a critical role in combating childhood obesity by implementing evidence-based strategies and policies that promote student health (Tortura et al., 2015). Federal policies focused on improving child nutrition and increasing physical activity in schools date back decades, with mixed effects. With respect to nutrition specifically, the U.S. federal government has been providing financial assistance to enable schools to offer nutrition education and food service to students since the 1940s. Taking federal involvement in student wellness a step further, the 2004 federal Child Nutrition and WIC Reauthorization Act required school districts participating in federally funded school meals programs to develop school wellness policies promoting proper nutrition and physical activity by the 2006-

2007 school year. The 2004 Act did not dictate the contents of the school wellness policies, but noted that policies should include input from parents, teachers, administrators, school food service staff, school boards, and the public. Some school districts began to develop wellness policies to meet these requirements; however, the policies were found to be ineffective in changing school nutrition and physical activity environments, due to the lack of specific guidelines and funding for implementation (Belansky et al., 2009, 2010; Moag-Stahlberg, Howley, & Luscri, 2008).

In 2010, the Healthy, Hunger-Free Kids Act (HHFKA) was enacted, and is still in effect today. HHFKA includes local wellness policy provisions requiring school districts to develop and implement wellness policies with specific goals for nutrition and physical activity, and to also measure, track, and publicly report progress. Despite the federal mandate of HHFKA, many public schools that participated in the National School Lunch Program, a federal government program that subsidizes school lunches offered to students based on financial need, found implementing a local School Wellness Policy challenging due to lack of obesity prevention expertise, lack of resources, and competing educational priorities (Budd et al., 2012; Madsen et al., 2015).

While both the Child Nutrition and WIC Reauthorization Act of 2004 and the HHFKA of 2010 were ineffective in instituting school wellness policies, some evidence indicates that school-based obesity prevention programs can be effective in implementing wellness policies. Research has shown school-based obesity prevention programs are effective in enabling schools to promote nutrition education and physical activity and meet the requirements of implementing wellness policies (Katz et al., 2008; Kropski et al., 2008; Peterson & Fox, 2007; Thomas, 2006). Specifically, research suggests that

multicomponent school-based obesity prevention programs can be effective instruments for 1) implementing school wellness policies; 2) positively impacting student dietary and physical activity behaviors (Coleman et al., 2005; Foster et al., 2008; Gortmaker et al., 1999); and 3) decreasing or maintaining student BMI within normal ranges (Katz et al., 2008; Kropski et al., 2008; Nigg et al., 2016; Peterson & Fox, 2007; Thomas, 2006). The Healthy Schools Program (HSP), developed by the Alliance for a Healthier Generation, is a program that has been shown to be effective in helping schools to implement school wellness policies and positively influence student eating and physical activity behaviors (Beam et al., 2012a). However, HSP has not demonstrated an effect on reducing student obesity (Madsen et al., 2015).

b. Study Rationale and Significance

Currently in more than 31,000 schools nationally and reaching 19 million students, the Healthy Schools Program (HSP) is the largest school-based obesity prevention program that helps schools to meet federal wellness policy guidelines at the local school level (The Alliance for a Healthier Generation, 2017). HSP implementation and health outcomes have been primarily examined in traditional public schools run directly by school districts. Implementation of HSP in charter schools, which are considered a segment of public schools as they are publicly funded, but are not run directly by school districts, has not been examined, even though HSP has been implemented in this school setting.

Charter schools are an important and growing segment of the public school population. Since the first charter in 1991, 6,700 charter schools in 43 states and Washington, D.C. have been established, and are serving nearly 3 million students. By

2020, that number is expected to grow to nearly 10,000 charter schools serving more than four million students (National Alliance for Public Charter Schools, 2017). Given the growth in number of charter schools over the last two decades, a better understanding of how HSP is being implemented in this growing segment of the public school population is important in involving all public schools in the fight against childhood obesity.

There are 88 charter schools serving 45,172 students in the state of New Jersey (National Alliance for Public Charter Schools, 2017). This dissertation study used a case study design to examine the extent to which HSP is being implemented in select independent New Jersey charter schools and the factors impacting program implementation, such as: 1) the level of fidelity of HSP implementation at independent New Jersey K-8 charter schools; and 2) the impact of charter school context (e.g., charter school mission, organizational structure, and performance metrics) on program implementation fidelity. This study is unique in that most school-based childhood obesity prevention research has been conducted at traditional public schools, while little research has been conducted on how school-based obesity prevention programs are being implemented in charter schools. A recent HSP evaluation study highlighted that fewer than 5% of schools included in the study were charter schools, and future research is needed to better understand how HSP is being implemented in charter schools (Madsen et al., 2015).

To add to its value, this dissertation study focused on independent charter schools instead of those that are part of a charter school network. Network charter schools differ from independent charter schools in that they function more like traditional public school

districts, implementing policies across schools within their networks. Therefore, studying the independent charter school population contributed to the body of knowledge on HSP implementation in this unique segment of public schools.

As this dissertation study focused on factors that impact HSP implementation in select New Jersey charter schools, current literature on wellness program implementation in schools was used to guide the evaluation methodology of this dissertation study. Wellness program barriers and facilitators, in combination with factors unique to charter schools, provided the foundation for probative questions that sought to examine how and why HSP was being implemented in select New Jersey charter schools.

CHAPTER TWO:

LITERATURE REVIEW

The literature includes several studies on wellness program implementation in schools generally, as well as studies on HSP implementation and outcomes. These studies highlight several facilitators and barriers to wellness program implementation that provide content areas to explore when seeking to identify factors that may impact HSP implementation in independent New Jersey charter schools.

a. Facilitators and Barriers to School-Based Wellness Program Implementation

The current literature highlights real-life facilitators and barriers observed in implementing school-based wellness programs. These factors, as well as factors unique to charter schools, may also impact HSP implementation in New Jersey charter schools. Studies on school wellness program facilitators and barriers have focused primarily on traditional public schools. The literature highlights three factors that facilitate school wellness program implementation:

- 1) **Engaging Key Stakeholders** in program development and policy adaption (Hoelscher et al., 2001; Wiecha et al., 2004).
- 2) **Consistent, Intensive Training** on program and policy components for key personnel (Franks et al., 2007; Hoelscher et al., 2001; Wiecha et al., 2004).
- 3) **Templatized Format** that enables programming to be easily and widely disseminated; however, programs also need to be flexible in order to allow tailoring to the specific school environment or classroom (Baranowski et al., 2002).

In terms of barriers to school wellness program implementation, several studies

have highlighted five factors that hinder School Wellness Policy implementation:

- 1) **Lack of Time and Resources**—Limited budget and a focus on testing make it difficult for teachers and administrators to find time for designing and implementing health promotion programs (Franks et al., 2007; Kelder et al., 2003; Osganian, Parcel, & Stone, 2003; Wiecha et al., 2004).
- 2) **Limited Staff Training and Expertise**—Training is critical to successful program implementation, as teachers and administrators lack health and wellness expertise (Bauer et al., 2006 2006; Beam et al., 2012a; Franks et al., 2007; Staten et al., 2005). Staff turnover is also cited as a barrier to program implementation (Franks et al., 2007; Osganian et al., 2003; Wiecha et al., 2004).
- 3) **Low Leadership Commitment**—School administrator commitment is critical to successful School Wellness Policy implementation. Without this commitment, policy implementation initiatives may flounder. Additionally, without support, teachers may feel other school initiatives take priority.
- 4) **Lack of Momentum**—Policy and environmental changes in schools are a slow process; the average duration of a school-based obesity prevention program is three to five years (Caballero et al., 2003; Kropski et al., 2008; Luepker et al., 1996). Celebrating small victories is key to maintaining program commitment and enthusiasm (Bauer et al., 2006; Pearlman et al., 2005; Wiecha et al., 2004). Milestone celebrations can help the teachers, administrators, and students to stay engaged in these programs; without these milestone celebrations, teachers and administrators may lose enthusiasm and momentum.

5) **Lack of an Outside Expert**—Outside experts can successfully guide policy implementation via their content knowledge and ability to focus group efforts (Austin et al., 2006; Baranowski et al., 2002; Katz et al., 2008; Kropski et al., 2008; Pearlman et al., 2005; Peterson & Fox, 2007; Staten et al., 2005).

Without an outside expert, schools may not have the expertise or resources to push wellness policy initiatives forward.

b. The Healthy Schools Program (HSP)

i. Overview

Founded by the American Heart Association and the William J. Clinton Foundation in 2005, the Alliance for a Healthier Generation developed the Healthy Schools Program (HSP), a national evidence-based obesity prevention program that is a mechanism for local School Wellness Policy implementation. HSP is both a program and a local wellness policy implementation tool that helps schools to meet the federal mandate of the Healthy, Hunger-Free Kids Act of 2010 (HHFKA). HSP provides schools with the content expertise, planning, and training resources needed to enable schools to make their environments healthier. The overall goal of HSP is to address student health behavior change on a systemic level and enable students to develop lifelong healthy habits.

ii. Theoretical Foundations of the Healthy Schools Program

Research indicates school-based obesity prevention programs have been most effective, in terms of implementation and improved health outcomes, when a social-ecological approach (a framework that includes the interconnected relationships among an individual, a system, and environmental changes) is the theoretical underpinning of

program development (Stokols, 1996). As such, HSP employs a social-ecological approach to address child health holistically through social and environmental factors, and incorporates other theories into the HSP framework. These program theories include Social Cognitive Theory (Bandura, 1986), which guides program content development, and Diffusion of Innovation (Rogers, 2002), which guides program implementation.

Social Cognitive Theory posits that behavior change is influenced by the person (individual factors), social, and environmental factors, in a dynamic triad that influences behavior (Bandura, 1986). Social Cognitive Theory underpins HSP content that targets student, teacher, and parent health behavior change, and leverages input and support from the broader community. In a study that examined teachers' perceptions of school-based obesity prevention programs and their perceived roles in these programs, teachers recognized themselves as important health role models for students (Griffin et al., 2015). Parents can also impact childhood obesity through their health attitudes, behaviors, and support of their children's health behaviors (Bois et al., 2005; Edwardson & Gorely, 2010; Gustafson & Rhodes, 2012).

Diffusion of Innovation addresses the process through which individuals within a system communicate, decide about, and act on innovations (Rogers, 2002), and is the theory underlying dissemination strategies of several effective school-based obesity prevention programs, including HSP (Franks et al., 2007; Thomas, 2006). Characteristics of an innovation (such as HSP) that facilitate adoption include 1) the innovation's **relative advantage** over existing programs in use; 2) the innovation's **compatibility** with the current environment; 3) **complexity vs. simplicity**, that is, the ease with which

the innovation is understood and used; 4) **trialability**, that is, incremental adoption over time; and 5) **observability**, that is, the results of the innovation are observable (Rogers, 2002). In designing HSP, program developers leveraged constructs of Diffusion of Innovation theory to facilitate program implementation in the following ways: 1) creating holistic comprehensive tools to meet wellness policy guidelines (relative advantage); 2) modifiable program components (compatibility); 3) templated content (complexity vs. simplicity); 4) ability to implement over time (trialability); and 5) urging celebrations of success (observability).

iii. HSP Implementation and Evaluation

When working with schools, an HSP relationship manager trains school staff and administrators over a four-year period to facilitate health policy and program implementation by building school capacity. To facilitate program implementation, HSP outlines a six-step assessment, planning, and evaluation framework, with health content targeted to students and staff. The HSP six-step process includes 1) Formation of a School Wellness Council; 2) Completion of the HSP School Health Environment Assessment (the HSP Inventory); 3) Local Prioritization and Action Planning; 4) Technical Resource Development and Brokering; 5) Take Action; and 6) Monitoring and Evaluation of Progress, based on changes in the HSP Inventory (Healthy Schools Program Framework, 2017).

The HSP Inventory, also known as the HSP School Health Environment Assessment, enables schools to assess eight content areas: 1) School Health and Safety and Environmental Policies; 2) Health Education; 3) Physical Education; 4) Nutrition Sciences; 5) Health Services; 6) Counseling, Psychological, and Social Services; 7)

Health Promotion for Staff; and 8) Family and Community Involvement. In traditional public schools, HSP is deployed through a district-level implementation model; if a school district signs up for HSP, every traditional public school in that district is automatically enrolled. The district is assigned an HSP relationship manager who leads traditional public schools through nine in-person training sessions over the course of the four-year program. HSP has a templated format with standardized content to facilitate implementation across multiple district schools.

There have been a small number of studies that examined HSP effectiveness as a wellness policy implementation tool and the program's effectiveness in positively impacting student health outcomes. Across these studies, results showed HSP to be an effective mechanism for local wellness policy implementation. By using HSP, intervention schools implemented wellness policies and made their school environments healthier by making health-promoting changes in key areas of school nutrition and physical activity (Beam et al., 2012a). In a follow-up study, researchers explored the role of technical assistance in facilitating wellness policy implementation and found it to be positively associated with school progress toward implementation (Beam et al., 2012b). In terms of its impact on obesity, the most recent study on HSP examined the effect of HSP on the prevalence of overweight and obesity in California Schools, 2006-2012 (Madsen et al., 2015). The study found that HSP did help schools to make their school environments healthier and improved student health behaviors. However, HSP did not have an effect on the prevalence of obesity; no significant decrease was found in student weight or BMI in HSP schools as compared to non-HSP schools.

c. Charter Schools

Charter schools are public schools with some key differences that may impact HSP implementation. Organizationally, charter schools in New Jersey are their own district, operating separately from a traditional public school district, which means they have more autonomy. However, because of their autonomy New Jersey charter schools may have less access to resources. Because New Jersey charter schools operate separately from the district, they do not fit into the HSP implementation model that provides support for district-level implementation from a district-level HSP relationship manager. Instead, New Jersey charter schools may receive HSP technical assistance only via online and telephone.

In addition to the differences in HSP training and technical assistance received by charter schools versus traditional public schools, other unique factors may also impact HSP implementation in New Jersey charter schools. Charter schools have a charter agreement, or a contract, with its sponsoring organization. Charter agreements differ by state and the governing bodies eligible to sponsor them. In New Jersey, the New Jersey Department of Education (NJDOE) is the only sponsoring agency for a charter school (Schwenkenberg & Vanderhoff, 2015). The NJDOE outlines specific goals and expectations in a sponsored school's charter. If these goals are not met, the charter can be revoked (Schwenkenberg & Vanderhoff, 2015; Troiano et al., 2008). Charters are granted for a period of time; every four to five years a school must go through a rigorous charter renewal process (Schwenkenberg & Vanderhoff, 2015). While traditional public schools provide general education, charter schools have a mission that speaks to an educational philosophy or content expertise, such as math and

science or the arts (National Alliance for Public Charter Schools, 2017). This mission is incorporated into the charter agreement. Charter schools operate separately from the school district and must manage their own budgets. The traditional public school district pays the charter school a fee per student, but this fee often does not cover the full cost of educating the student, which means charter schools are in a constant cycle of fundraising to cover the shortfall (National Alliance for Public Charter Schools, 2017). Finally, charter schools are schools of choice; parents *choose* to enroll their children in charter schools versus automatic enrollment in a school based on geography.

HSP implementation may unfold differently in charter schools because of these unique factors of charter schools. These unique factors, referred to as the charter school context, are listed and described in the “Methods—Analytical Framework” section of Chapter 3. There are two main types of charter schools: independent and network. Independent charter schools are standalone organizations, while network charter schools are part of a group of charter schools that may share curricular and administrative resources. This dissertation study focused on independent charter schools in the state of New Jersey only, and sought to examine how the charter school context and the role of technical assistance impacted HSP implementation in select, independent New Jersey charter schools.

CHAPTER THREE:

METHODS

This study sought to examine the factors impacting HSP implementation at select, independent New Jersey charter schools.

a. Study Aims/Research Questions

HSP research, and school-based obesity prevention research more generally, has focused primarily on traditional public schools. As a growing segment of the public school population, independent charter schools can potentially play an important role in the fight against childhood obesity, but little is known about factors influencing implementation of obesity prevention programs in independent charter schools. In order to better engage independent charter schools in the fight against childhood obesity, research is needed to better understand factors that may impact obesity prevention program implementation in independent charter schools. These factors may be found to be unique to independent charter schools only, or to be consistent with factors identified as impacting wellness program and policy implementation in public schools more generally. In better understanding factors unique to independent charter schools that affect wellness policy and program implementation, HSP administrators may be more able to tailor HSP to meet charter schools' needs, and potentially make it a more effective program for this school setting.

This dissertation study focused on independent, New Jersey charter schools only. As charter school operations differ by state, findings may not be generalizable to other states. However, findings from this dissertation study may be used as a basis for future

research regarding HSP implementation in independent charter schools in other states.

The aims and research questions of this dissertation study are outlined below.

a-1 Study Aim 1: Determine how HSP has been implemented in select New Jersey charter schools.

Research Question 1: At select, independent New Jersey charter schools, to what extent is the Healthy Schools Program being implemented based on the Healthy Schools Program six-step process for improving school wellness?

a-2 Study Aim 2: Determine the factors affecting HSP implementation in select, independent New Jersey charter schools.

Research Question 2a: How does the specific context of the independent charter school system shape program implementation? What factors help or hinder program implementation?

[For purposes of this dissertation study, the dimensions of the charter school context are categorized into six categories: 1) Fiscal and Organizational Factors; 2) Educational Philosophy and Educational Environment; 3) Charter Cycle Status; 4) Staffing and Retention; 5) Performance; and 6) Perceived Charter School-Unique Challenges.]

Research Question 2b: What role does technical assistance play in program implementation? To what extent has it been utilized? How has it been utilized?

a-3 Study Aim 3: Determine if and how HSP needs to be modified to facilitate program implementation.

Research Question 3: From the perspective of key stakeholders (school administrators, teachers, and school vendors), what additional supports or

resources are needed to help independent charter schools better implement HSP?

How do program components need to be modified to better meet the needs of the school?

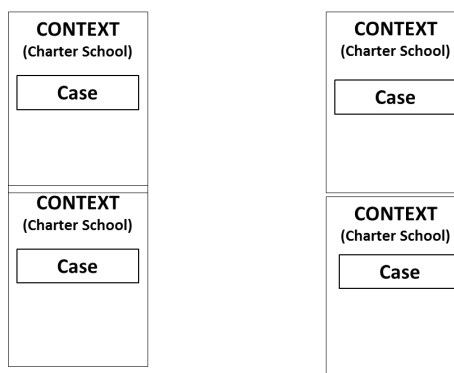
In answering these questions, this dissertation study sought to generate hypotheses about how HSP should be modified to be more effective, both as a wellness policy implementation tool and in improving student health outcomes. These hypotheses may be tested in future research.

b. Research Design

The research design of this dissertation study was an exploratory, multiple-case study, which included four case studies of HSP implementation at select independent New Jersey charter schools (see Figure 3-1). Each charter school served as a case, based on data collected from HSP stakeholders regarding how HSP was being implemented in each select charter school. Each school case report can be found in Appendices 3-1, 3-2, 3-3, and 3-4.

Figure 3-1:

Multiple-Case Design

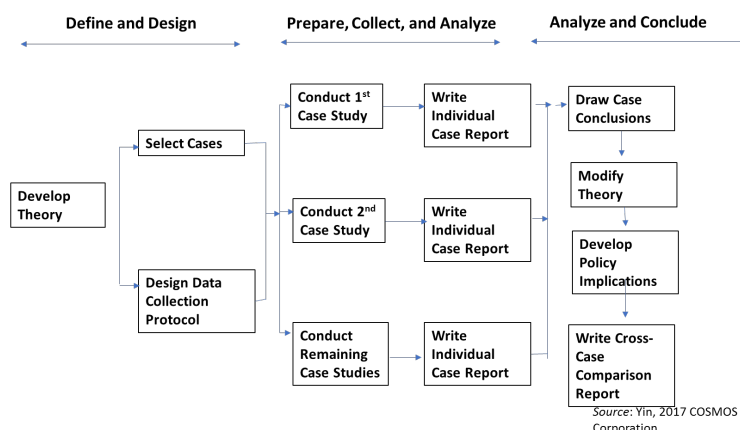


Source: Yin, 2018

This dissertation study is a cross-case comparison report that summarizes findings

across all cases in accordance with Yin's Phases of Multiple Case Design (see Figure 3-2). The case study design of this dissertation study allowed for a comprehensive evaluation of HSP implementation, identifying which aspects of the program have been implemented and factors that have impacted that implementation. Each case study includes descriptive information of the school roles of the individuals interviewed.

Figure 3-2:
Phases of the Multiple-Case Design



Case studies can serve as a tool for generating and testing theory, and can provide groundbreaking insights (Gibbert et al., 2008). A case study design was selected as it would be helpful in answering the questions of how and why HSP implementation occurred in the manner it did at select, independent New Jersey charter schools. Common themes emerged across all four cases that could lead to exploratory hypotheses for further research. Consistent with Yin's 2018 recommendation to use multiple sources for data collection, three types of methods were used to collect data for this dissertation study: 1) interviews; 2) observations; and 3) a review of documents (school mission, charter, student handbook, School Wellness Policy, meal menus, and the school's HSP online

dashboard, which tracked HSP implementation). Interviews were conducted with HSP stakeholders. Observations of the school environment were conducted to determine how healthy living was communicated in common areas of each school. Documents were reviewed to support or contradict interview data.

Components of a case study research design include 1) A case study's questions; 2) Its propositions; 3) Its cases; 4) The logic linking the data to the propositions; and 5) The criteria for interpreting findings. Regarding this dissertation study, the components of case study research design are applied as outlined below.

- **A case study's questions**—The research questions were developed based on the following: 1) data that indicate charter schools are different from traditional public schools in many ways and also differ by state; 2) research that indicates charter schools have been an understudied population with respect to health programming implementation; and 3) the literature which outlines barriers and facilitators to wellness programs, including HSP, in traditional public schools; these barriers and facilitators should be examined to determine if they play a role in HSP implementation in independent New Jersey charter schools as well.
- **The propositions**—*Proposition* is a term used by Yin, and is defined as something that should be examined within the scope of the study. The first proposition of this dissertation was to discover factors that impact HSP implementation in independent New Jersey charter schools and determine if these factors are specific to charter schools or are consistent with factors impacting wellness program implementation in traditional public schools more broadly. The findings from this dissertation uncovered factors unique to charter schools that

impact HSP implementation. These factors are discussed in Chapter 4: Results.

The second proposition of this dissertation study was to create hypotheses about both HSP implementation in charter schools, and HSP content for charter schools, that may be tested in follow-up research.

- **Cases**—The case, or unit of analysis in this dissertation, was the study school.

This dissertation sought to understand how HSP has been implemented in select, independent New Jersey charter schools. Therefore, the evaluation of HSP took place at the school level.

- **Logic**—The logic linking the evaluation data to the propositions was the Diffusion of Innovation theory. Within the Diffusion of Innovation, dimensions of the charter school context and wellness program implementation barriers and facilitators highlighted in the literature are mapped to the theory's characteristics of an innovation.

- **Criteria for data interpretation**—Findings were interpreted using the characteristics of an innovation from the Diffusion of Innovation theory. Conclusions were drawn based on each case. These conclusions were then integrated into an overall summary across all four cases, and included in this dissertation study.

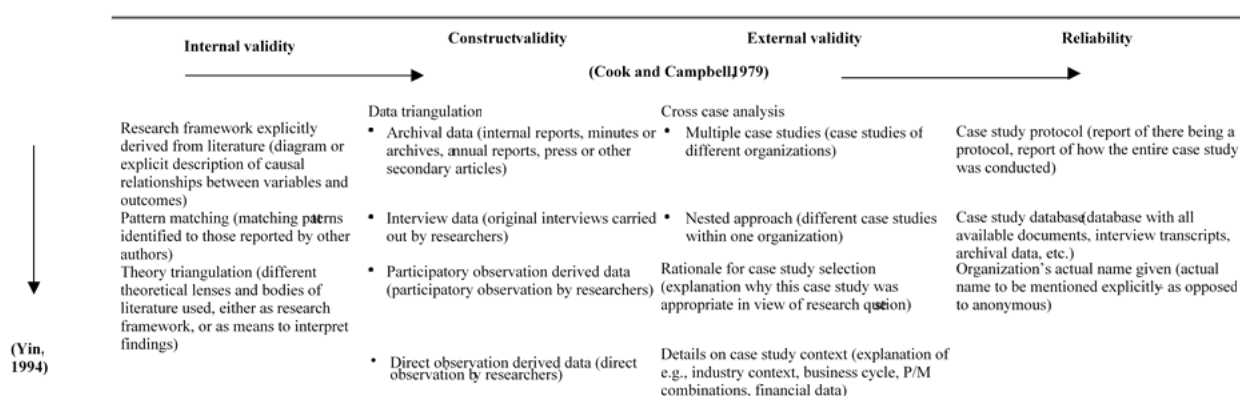
This dissertation study used qualitative (interviews) and observational (school environment) methods, as well as school document review, to determine 1) the extent to which HSP was implemented in select, independent New Jersey charter schools; and 2) why implementation had occurred in the manner it did, using the Diffusion of Innovation analytical framework. Interviews, which Yin states are one of the most

important sources of case study evidence, were utilized to collect data on individuals' roles in HSP, and their experiences and insights. These interviews attempted to explain the "hows" and "whys" of HSP implementation in select New Jersey charter schools. Interviews were conducted with representatives from various stakeholder groups. To provide deeper understanding of factors impacting HSP implementation, and to either support or illuminate contradictions in interview data, observations were conducted of the school environment common areas, including hallways, gyms, and cafeterias, as well as a review of school documents. Direct observations in common areas were used to understand the culture of an organization, and provide indications on how the school employees were embracing and messaging health promotion throughout the school.

To identify factors that impacted HSP implementation and to contribute to the current state of the science, the research design needed to support the different types of validity. The four criteria commonly used to assess the rigor of field research include internal validity, construct validity, external validity, and reliability (Gibbert et al., 2008). Figure 3-3 outlines how Gibbert et al. (2008) apply these four criteria in a case-study research design. To support internal validity, this dissertation used theory, in particular the Diffusion of Innovation theory, to guide the implementation evaluation. Literature was also used to guide interview protocol development. To support construct validity, three different forms of data collection were used: interviews, observations, and document analysis. In terms of external validity, this dissertation study was exploratory research; findings cannot be generalizable outside of this dissertation study but may be used for hypothesis generation and future research. Regarding reliability, study schools and study participants were a convenience sample, leading to potential

bias in the data results. However, study design aspects that supported reliability included the use of one researcher to collect all data, utilizing the same data collection instruments across all study schools, and interviewing representatives from multiple stakeholder groups to unearth consistency of perspectives. Documents were used to determine a neutral assessment of implementation, separate from participant responses.

Figure 3-3: Framework for an Investigation of the Methodological Rigor of Case Studies



Source: Gibbert et al., 2008

i. Analytical Framework—Diffusion of Innovation

To understand how the Diffusion of Innovation theory was employed as an analytical framework in this dissertation study, it is helpful to first outline the components of this theory. Diffusion is defined as “the process by which an *innovation* (any new idea, method or object) is *communicated* through certain channels over *time* among the members of a *social system*” (Rogers, 2003). In diffusion theory, an innovation is “an idea, practice, or object *perceived as new* by an individual or unit of adoption” (Rogers, 2003). The perception of newness not only indicates the relevance of the diffusion process when the innovation is first used, but also how the innovation moves through different contexts over time and is adapted. In the context of this

dissertation study, the innovation is HSP.

In comparison to other theories of change processes, adaptability is a characteristic of an innovation that is unique to the diffusion of innovation theory. Early studies of diffusion recognized adoption as the exact replication of an innovation. More recent studies have recognized that an innovation can be adapted and still be adopted (Ashley, 2009; Charters & Pellegrin, 1972; Rogers 2003). Adaptation of an innovation means the organization has modified the innovation to meet the organization's needs while still adopting it. In addition to adaptability, an innovation's attractiveness to an adopter is impacted by factors including perceived relative advantage, compatibility with current values and priorities, complexity to be understood and implemented, trialability before full adoption, and observability of use and utility.

The term *communication channel* refers to the process by which messages are transferred from one individual to another. Diffusion theory leverages communications theory, and identifies mass media and interpersonal networks as being effective categories of communication channels (Ashley, 2009). For purposes of this dissertation study, the communication channel that could be used to diffuse the HSP innovation might include school message boards, newsletters, emails, and discussions of the program among teachers and school administrators. *Time* is key to the diffusion process; the immediate uptake of a program is not expected. Rogers (2003) theorized the rate of adoption as an S curve, the cumulative number of adopters increasing over time. Change in the diffusion process materializes through the *adoption* of an innovation. Diffusion theory accounts for different reactions to the innovation, with some adopting the innovation immediately (innovators) and others waiting to see how the innovation works

before adopting (late majority or laggards). Those who adopt the innovation may *adapt* the innovation to make it more compatible with their specific context.

Diffusion theory underscores adoption as a process that has five stages: 1) Knowledge, when the individual or organization is initially introduced to the innovation; 2) Persuasion, where the individual or organization forms a positive or negative opinion about the innovation; 3) Adoption, which is making the determination to accept or reject the innovation; 4) Implementation, when the individual or organization uses the adopted innovation; and 5) Confirmation, where the individual or organization looks for evidence or information further supporting the decision made, and may reject the prior decision to adopt if presented with incongruous evidence. Implementation, the fourth stage of the adoption process, is the focus of this dissertation study. Specifically, this dissertation study examined the extent to which HSP has been implemented in select independent New Jersey charter schools and reasons for variations.

A *social system* is the contextual space within which the innovation is diffused—organizations, neighborhoods, or states (Ashley, 2009). Institutional, social, and environmental factors dictate how and if an innovation reaches the targeted audience. Factors highlighted in diffusion theory include prior conditions, characteristics of the adopter (person or organization), and the influence of change agents and opinion leaders in promoting the innovation (Ashley, 2009; Wolfe, 1994). For purposes of this dissertation study, each independent New Jersey charter school was considered to be a social system, and each charter school's specific context impacted HSP implementation. As previously outlined in Chapter 3: "Study Aims/Research Questions," independent charter schools are different from traditional public schools in many operational and

philosophical aspects, which this study refers to as “charter school context.” The role of school leadership commitment was also explored within the Diffusion of Innovation framework. School leadership can be change agents or opinion leaders. Change agents or opinion leaders can come from elsewhere in a school’s organization as well—teachers, the School Wellness Council, nurses, physical education/teachers of health. However, not having leadership support can negatively impact the diffusion of an innovation, in the case of this dissertation study HSP implementation, which is discussed in Chapter 4: Results.

Diffusion of Innovation theory has been used as the analytical framework in several studies. In “Innovation Diffusion: Implications for Evaluation,” Ashley (2009) states that the theory can help evaluators uncover patterns and factors that might otherwise be overlooked, and understand the factors that impact an intervention’s adaptation to a local context. The Diffusion of Innovation theory was used as the evaluation framework for the implementation of Treatment Improvement Protocols (TIPS) in substance abuse treatment programs (Hubbard et al., 2003). Using Diffusion of Innovation theory as the evaluation framework, recommendations were made to improve the development and dissemination of TIPS, as well as needed changes to the program itself.

In this dissertation study, to better apply the Diffusion of Innovation analytical framework to HSP program evaluation in charter schools, charter school-specific factors impacting the innovation’s (HSP’s) diffusion or implementation were examined within the Diffusion of Innovation framework. To answer Research Questions 2 and 3, the Diffusion of Innovation theory was operationalized by asking questions specific to HSP

implementation that corresponded to the five characteristics of an innovation.

Dimensions of the charter school context were integrated into questions matched to these five characteristics:

- **Relative Advantage**—Stakeholders were asked if they were familiar with other school-based childhood obesity prevention programs and initiatives, and if so, how HSP compared.
- **Compatibility**—This characteristic corresponds to the Fiscal and Organizational Factors, Educational Philosophy and Educational Environment, and Social Environment dimensions of the charter school context. Questions were asked about the extent to which HSP is consistent with the mission, charter, and organizational structure of the charter school.
- **Complexity vs. Simplicity**—This characteristic corresponds to the Charter Cycle Status, Staffing and Retention, Educational Philosophy and Educational Environment dimensions. Questions were asked about ease of implementation of HSP given school resources. Questions were also asked about the role of technical assistance, specifically if the school was using an expert for program implementation and, if so, how this expert was being used. These questions were matched to the Fiscal and Organizational dimension of the charter school context. For example, questions sought to determine if the school was using an expert for program implementation and, if so, the expert's impact on program implementation.

- **Trialability**—This characteristic corresponds to charter school context. Questions examined stakeholder attitudes about incremental implementation of HSP and, in this light, which program components are priorities.
- **Observability**—Questions examined the extent to which effects of HSP were observable and if stakeholders felt this impacted program implementation. Questions also examined if study participants had observed any other school using HSP or similar program.

To examine stakeholder perceptions of HSP compatibility, complexity, and trialability, questions using dimensions of the charter school context were used to guide the interview protocols for Research Questions 2a and 3, previously outlined in Chapter 3: “Study Aims/Research Questions.” Regarding Research Question 2b, the role of technical assistance was explored within the Diffusion of Innovation framework as it relates back to HSP complexity, that is, how easy or difficult is it for the charter school to implement the program. As previously stated, charter schools are not assigned an HSP program manager to guide them through the program, nor do they receive hands-on technical assistance delivered on site by HSP; charter schools have access to HSP technical assistance only through online tools and telephone assistance. Schools may also choose to use outside, non-HSP consultants and experts to help with program implementation. Research Question 2b will explore if and how outside, non-HSP consultants are being used by mapping questions back to the complexity characteristic of an innovation of the Diffusion of Innovation theory.

The previously outlined barriers and facilitators to wellness program implementation from the literature, as well as charter school context, are mapped to the

characteristics of an innovation of the Diffusion of Innovation theory and integrated into this analytical framework to guide the evaluation of HSP implementation in select independent New Jersey charter schools. The analytical framework created for this dissertation study is highlighted in Table 3-1.

**Table 3-1: HSP Implementation Evaluation Analytical Framework
the Diffusion of Innovation**

	Diffusion of Innovation—Characteristics of Innovation				
	Relative Advantage	Compatibility	Complexity	Trialability	Observability
Charter School Context		<ul style="list-style-type: none"> • School Culture/Mission/Charter Agreement • NJDOE Academic, Fiscal, and Operational Performance • Charter School Age and Charter Renewal Cycle Stage • Organizational Structure and Autonomy • Instructional Conditions and Educational Innovations • Teacher Staffing Recruitment and Retention • Funding • School Demographics and Ethnic Culture • Parental Engagement 	<ul style="list-style-type: none"> • School Culture/Mission/Charter Agreement • NJDOE Academic, Fiscal, and Operational Performance • Charter School Age and Charter Renewal Cycle Stage • Organizational Structure and Autonomy • Instructional Conditions and Educational Innovations • Teacher Staffing Recruitment and Retention • Funding • School Demographics and Ethnic Culture • Parental Engagement 		
Barriers & Facilitators	<ul style="list-style-type: none"> • Engaging Key Stakeholders • Leadership Support 	<ul style="list-style-type: none"> • Engaging Key Stakeholders • Leadership Support • Use of an Outside Expert 	<ul style="list-style-type: none"> • Engaging Key Stakeholders • Leadership Support • Training • Use of an Outside Expert • Templatized Format 	<ul style="list-style-type: none"> • Engaging Key Stakeholders • Leadership Support • Use of an Outside Expert 	<ul style="list-style-type: none"> • Engaging Key Stakeholders • Leadership Support • Momentum

ii. Study Population and Sample Selection

The study population was independent K-8 New Jersey charter schools. Consistent with other school-based obesity prevention programs, this study was conducted at the school level. Schools were identified for potential inclusion in this study based on their inclusion in the HSP online database, which lists schools that have registered for the program. A database search was conducted for charter schools in the state of New Jersey that had been registered for the program for at least a year. This search yielded nine charter schools within a 50-mile radius. The rationale for choosing at least one year of program participation was that a year was deemed enough time to have completed some of the steps in HSP program implementation and identified potential barriers and facilitators. The rationale for focusing only on charter schools in the state of New Jersey was to eliminate potential differences in state environments that could impact results. The 50-mile radius was used to assure that all of the selected schools were from the same region. Of the nine schools, one school was closed, and another was middle through high school (covering Grades 6-12) and therefore was eliminated because it covered a segment of the population not consistent with the rest of the sample (K-5, K-8, or 6-8). Seven schools were then deemed eligible to participate in the study. The first K-8 charter school that agreed to participate helped to recruit other charter schools. After this initial school made first contact with a prospective school, the study investigator made a follow-up call to ask the school administrator a series of screening questions. These questions were used to verify 1) that the school was an independent charter school; 2) the grade levels covered; 3) how long the school had been in existence; 4) that the school was participating in the National School Lunch Program; 5) that the school was signed up for

HSP; and 6) that the school had taken specific actions in implementing key components of HSP (e.g., had set up a wellness council, had made or planned to make a specific plan to make changes to nutrition and increase physical activity opportunities throughout the school day). The target sample size for this dissertation study was five schools. Outreach via phone and email to the seven schools eligible for inclusion occurred over a 9-month period. Four schools agreed to participate, and ultimately participated, in this study. Two potential schools declined, stating it was not the right time. Seven recruitment attempts via phone and email were made to the seventh school, with no response. Each study school had a school liaison who helped to set up interviews, collect documents, and facilitate school environment observations.

Introduction to Schools

All study schools were elementary (K-8) schools, located in New Jersey within a 50-mile radius. Study schools ranged in age from 5 to 20 years old. Demographically, the schools were ethnically diverse: School A was predominantly Hispanic and African American; School B was almost entirely Hispanic, with most students having Hispanic-immigrant parents; School C was predominantly African American; and School D was the most ethnically diverse with a mix of Asian, Hispanic, and African American students (predominantly Asian and Hispanic). All study schools had low-income student populations. School D had a higher income student population with 46% of its students qualifying for school lunch, a relatively low percentage as compared to the other three study schools, whose free/reduced lunch population ranged from 86%-88% of the school population. Schools C and D had the highest student/teacher ratios. An overview of study schools is highlighted in Table 3-2

Table 3-2: Study Schools Overview

School Population	<u>School A</u>	<u>School B</u>	<u>School C</u>	<u>School D</u>
City Population	150,000	500,000	250,000	250,000
% of City Population Living Below Poverty Line	30%	36%	17%	17%
School Age	10 years (founded 2008)	20 years (founded 1998)	7 years (founded 2011)	5 years (founded 2013)
Grade Levels	K-8	K-8	K-8	K-7 (expanding to Grade 8 upcoming school year)
# of Students	800	350	380	434
Student/Teacher Ratio	19:1	11:1	17:1	21:1
NJ State Student/Teacher Ratio	12:1	12:1	12:1	12:1
Ethnicity	Hispanic (64%) African American (33%)	Hispanic (82%) (Spanish dual-language school) African American (11%) White (4%)	African American (89%) Hispanic (9%)	Asian (44%) Hispanic (38%) African-American (12%) White (5%)
Income Status	Low-income	Low-income	Low-income	Low-to-middle income
% of Students Qualify Free/Reduced Lunch	87%	86%	88%	46%

iii. Interviews

This dissertation study employed qualitative and observational methods to collect data, as well as a review of documents. The qualitative mode of data collection were interviews. There were five interview protocols in total, each for a different stakeholder, including 1) Food and Beverage Vendor; 2) Food Service Administrator; 3) School Administrator; 4) Teacher; and 5) School Wellness Council Focus Group. Interview protocols may be found in Appendices 3-1, 3-2, 3-3, 3-4, and 3-5. To answer Research Question 1, the School Administrator protocol (Appendix 3-3), which was based on a questionnaire used in a previous study (Beam et al., 2012a), was used for data collection. Interviews were the primary data collection method for this dissertation study. Interviews were scheduled at the convenience of the school. All interviews were conducted at study school locations, with the exception of two interviews conducted via telephone, and were completed within a 60-day window for each study school. The goal was to conduct 10 interviews with a duration of 45 minutes to 60 minutes per each study school. Overall, 26 interviews and one focus group were conducted across all four study schools. Interview durations varied from 45 minutes to 90 minutes.

Stakeholder Interviewee Selection

The liaison at each charter school served as the point person. The school liaison identified people within the school who would be most appropriate for the study interviews. School A was the only school at which a focus group was conducted. The focus group was with the School Wellness Council, which included two school nurses (one of whom was also a parent at the school), and the Student Support Services Administrator. The Physical Education/Health Teacher was also a member of the School

Wellness Council, but she left School A at the beginning of this study and did not participate in the focus group. The Food Staffer was also a member of the School Wellness Council but was not able to attend the focus group. Repeated attempts to contact these two missing members were unsuccessful.

In addition to the focus group, an interview was conducted with the Dean of Students of School A. She is the administrator for the building housing 5th grade. Repeated attempts were made to contact other School A administrators, including the CEO and Chief Academic Officer, but were unsuccessful. At School B, 10 interviews were conducted—four administrators (Education Director, Dean of Students, Family Coordinator, Business Administrator [who was also a parent at the school]); two teachers (3rd Grade Teacher, Physical Education /Health Teacher); Food Staffer (who was also a parent at the school); Food Vendor; School Nurse; and the School Social Worker. At School C, eight interviews were conducted—three administrators (CEO, Principal, Director of Development); three teachers (4th Grade Teacher, Science Lab Teacher, Physical Education /Health Teacher); Food Service Staffer; and School Nurse. At School D, seven interviews were conducted—two administrators (CEO, Principal); three teachers (4th Grade Teacher; two Physical Education/Health Teachers); Food Staffer; and the School Nurse.

Table 3-3: Study Participants Overview

	<u>School A</u>	<u>School B</u>	<u>School C</u>	<u>School D</u>
Total Number of Interviews	1	10	8	7
Administrators	1 (Dean of Students)	4 (Education Director; Dean of Students; Family Coordinator; Business Administrator [also a parent])	3 (CEO, Principal, Director of Development)	2 (CEO, Principal)
Teachers		2 (3 rd Grade Teacher, Physical Education /Health Teacher)	3 (4 th Grade Teacher, Science Lab Teacher, Physical Education /Health Teacher)	3 (4 th Grade Teacher, 2 Physical Education /Health Teachers)
Food Vendor	0	1	0	0
Food Staffer	0	1	1	1
School Nurse	0 (2 nurses participated in the focus group)	1	1	1
Social Worker	0	1	0	0

iv. Observations

The second part of data collection included observing each school environment to assess if it supported HSP implementation through health communications in the school. For all schools, common areas such as school hallways, cafeterias, and gyms were observed and photographed to see if and how messages were displayed. A challenge in collecting observation data on health messaging involved the timing of the study. The study was conducted during standardized testing. Some schools had removed all postings from walls to ensure information posted would not change test score outcomes. It was also noted if the school had a gym and playground. Menus were reviewed to assess if healthy options were being served.

v. Documents

The third part of data collection included a review of school documents, such as the school charter agreement, mission statement, student handbook, School Wellness Policy, and menus, to provide additional information about each school's context. Document review was used to corroborate findings in interviews. Menus were reviewed to determine if healthy options were being served. Additionally, a review of each school's HSP online dashboard, the official tracking measurement tool, was reviewed.

vi. Instrumentation—Instruments for Interviews and Observations

Research Question 1—*At select, independent New Jersey charter schools, to what degree is the Healthy Schools Program being implemented?*

This research question was factual in nature, determining the current status of HSP implementation in the charter school. The interview protocol included specific, fact-based questions that corresponded to the HSP six-step process for wellness policy

implementation and nutritional and physical activity program components: 1) Formation of a School Wellness Council; 2) Completion of the HSP Health Environment Assessment; 3) Local Prioritization and Action Planning; 4) Technical Resource Development and Brokering; 5) Take Action; and 6) Monitoring and Evaluation of Progress.

Research Question 2a—*How does the specific context of the charter school shape program implementation? What factors help or hinder policy implementation?*

To answer Research Questions 2 and 3, interview protocols were designed to address charter school context within the Diffusion Innovation analytical framework. Research Question 2a examined the impact of the charter school context on HSP implementation and sought to provide an understanding of the HSP implementation process. Interviews followed the data collection format previously outlined in Chapter 3: “Research Design—Interviews,” and charter school context integrated into the Diffusion of Innovation framework to guide questions (Appendices 3-1, 3-2, 3-3, 3-4, 3-5).

Research Question 2b—*What role does technical assistance play in program implementation?*

The literature demonstrates that technical assistance can play a role in facilitating wellness program implementation in schools. In addition to online tools and telephone assistance, traditional public schools receive hands-on technical assistance and training through an HSP relationship manager. Charter schools have access to HSP online tools and telephone assistance only. Research Question 2b sought to understand limitations imposed by the lack of technical assistance on HSP implementation, how schools made use of available tools, and whether schools used their own outside experts (e.g., nurse,

dietician) to facilitate program implementation. Dimensions of the charter school context were integrated into the Diffusion of Innovation framework to guide interview protocol creation. Previously identified barriers and facilitators to wellness program implementation and information on the role of technical assistance in wellness program implementation found in the literature were used to guide interview protocol development.

Research Question 3—*From the perspective of key stakeholders (the school administrators, teachers, and vendors) what additional supports or resources are needed to help schools implement HSP?*

Research Question 3 sought to examine stakeholder views on needed implementation components of HSP that could help schools implement a local wellness policy. This question specifically focused on the helpfulness of the HSP six-step wellness process in making the school environment healthier. This research question also sought to shed light on other tools and resources needed—but not currently provided—for program implementation.

The Diffusion of Innovation theory guided development of the interview protocols for Research Questions 2 and 3. Using the theory, the interview protocol included questions corresponding to the following characteristics of an innovation:

Relative Advantage—How does HSP compare to other school-based childhood obesity prevention programs and initiatives the school has implemented or is currently implementing? How could HSP be improved to be better than existing school-based childhood obesity prevention programs and initiatives?

Compatibility—To what extent is HSP compatible with the charter school context (e.g., school charter, mission, accountability and performance metrics, organizational structure and autonomy, instructional context and innovation, teacher staffing [recruitment, selection, and retention], age of the charter school, and where it is in the charter renewal cycle)? How could HSP be altered to be more compatible with the charter school context? Is HSP compatible with some aspects and not others?

Complexity vs. Simplicity—Is it difficult or easy to implement HSP? Do charter schools use non-HSP outside consultants, experts, or staff to assist with program implementation? How do charter schools use the HSP online and telephone technical assistance tools, if they use at all? How are these tools helpful in program implementation? How does the school use outside experts, if any? What staff or teachers are involved in implementing HSP? Is there a way HSP could be simplified that would facilitate implementation?

Trialability—Was the program implemented incrementally? To what extent is it easy to try HSP without being fully committed to the program?

Observability—To what extent are the outcomes of HSP observable to program stakeholders and how does this observability impact program buy-in and further support for program implementation? Observable outcomes may include: 1) systemic/environmental outcomes (e.g., changes in the cafeteria menu, visible messaging supporting healthy behaviors, vending machines serving only healthy options); or 2) reductions in child BMI, increases in child physical activity, improvements in child eating habits. How could HSP outcomes be more observable? Does observability influence acceptability or support for the program? Do teachers and administrators

perceive that parents know about HSP? If so, do teachers and administrators think parents think HSP is beneficial? Questions were asked not only about how health messages were communicated but also how they could be better communicated.

Charter School Context

The charter school context guided development of interview questions that examined two of the characteristics of an innovation of the Diffusion of Innovation theory: compatibility and complexity. The dimensions of the charter school context are:

- **Fiscal and Organizational Factors;**
- **Educational Philosophy and Educational Environment;**
- **Charter Cycle Status;**
- **Staffing and Retention;**
- **Social Environment;**
- **Performance;** and
- **Perceived Charter School-Unique Challenges.**

Fiscal and Organizational Factors

Charter Agreement—A school's charter is its contract with the state that outlines very specific guidelines the school must follow. If the school violates its charter agreement, this could result in charter revocation, which closes the school. Charter obligations may impact HSP implementation because HSP may or may not align with the school's charter (direct conflict), or implementing HSP may result in an opportunity cost of diverted resources the school *perceives* to be critical to fulfilling its charter obligations (indirect conflict).

Key Interview Questions:

- How do charter obligations impact HSP implementation?
- Where do childhood obesity prevention and HSP implementation fall in terms of charter obligation priorities?
- Is childhood obesity prevention, or child wellness, addressed within the school's charter?

Organizational Structure and Autonomy—Independent charter schools operate separately from the school district and are separate from a charter school network. A benefit of autonomy is flexibility. However, a negative aspect is that independent charter schools do not have the benefit of scale (shared resources and back-office functions) that traditional public schools or network charter schools have. Lack of resources due to autonomy may impact HSP implementation.

Key Interview Question:

- What roles do organizational structure and autonomy play in HSP implementation?

Educational Philosophy and Educational Environment

Charter School Mission—As compared to traditional public schools, most charter schools have a mission or guiding ethos that informs their educational approach and focus. The school mission may impact HSP implementation because the overall school mission may or may not be aligned with HSP content.

Key Interview Questions:

- How does the charter school mission impact HSP implementation?
- Is HSP consistent with charter school mission?

Instructional Conditions and Educational Innovations—Instructional

conditions and environment may include curriculum, leadership practices, teacher expectations, and teaching philosophy and approach (Berends et al., 2010). Evidence suggests charter school teachers have more educational autonomy than their traditional public school counterparts. In terms of HSP implementation, charter school teachers may or may not view HSP content as being aligned with their educational philosophy.

Key Interview Question:

- How do the school's instructional conditions impact HSP implementation?

Charter Cycle Status

Charter School Age and Charter Renewal Cycle—The age of a charter school may impact HSP implementation two ways: 1) academic performance and 2) resource prioritization. In terms of academic performance, newly established charter schools have been found to perform poorly (Bifulco & Ladd, 2006; Booker et al., 2007; Hanushek et al., 2007). Additionally, less-established schools may not have the resources to dedicate to HSP implementation. Similarly, schools that are going through the very intense and rigorous renewal process may not have the resources to dedicate to HSP implementation.

Key Interview Question:

- How does the age of the charter school or stage in the charter renewal cycle impact HSP implementation?

Staffing and Retention

Teacher Staffing Recruitment and Retention—Charter school advocates argue that the independent charter autonomy reduces bureaucratic encumbrances (particularly union pressures and collective bargaining agreements), enabling charter schools to adopt more effective teacher selection, assessment, and salary policies (Finn et al., 2000;

Hassel, 1999; Stuit & Smith, 2012). Research is inconclusive and does not strongly support this position. Several studies have found that charter schools tend to hire younger, less experienced teachers with fewer masters degrees and more uncertified teachers as compared to traditional public schools (Burian-Fitzgerald et al., 2004; Cannata & Penaloza, 2012; Carnoy et al., 2006). Studies also have found staff turnover rates are higher at charter schools versus traditional public schools. High staff turnover is cited in the literature as being a barrier to school wellness program implementation in general. Teacher inexperience and high turnover could negatively impact HSP implementation specifically, because new teachers may not know about the program; additional training and onboarding is constantly needed.

Key Interview Question:

- How does teacher turnover/teacher experience impact HSP implementation?

Social Environment

School Demographics—Studies have sought to examine the effect of charter schools on segregation of students by race and socioeconomic status, with results showing charter schools can increase or decrease the percentage of Black students in the student body (Bifulco & Ladd, 2007; Booker et al., 2005; Garcia, 2008; Ritter et al., 2012; Weiher & Tedin, 2002; Zimmer et al., 2009).

Key Interview Question:

- If there are higher levels of segregation in charter schools that increase the level of low-income Black students, could this lead to ethnic or cultural factors that could impact program implementation via parental support and

buy-in stemming from differences in cultural norms, attitudes, and beliefs about diet and exercise?

Parental Engagement—Advocates argue charter school parents are more likely to be involved with a school if they have chosen to enroll their children there. Moreover, some states and charter schools mandate parent involvement through a variety of ways, including approving the establishment of a charter school, serving on the school’s governing board, and committing to a specific level of involvement. Innovation, less bureaucracy, accountability, choice, and a more tailored educational experience have been touted as reasons to favor charter schools. These elements are all vehicles for helping improve academic performance.

Key Interview Questions:

- If parents are more engaged with the school more generally, are they also more engaged with HSP implementation specifically?
- From the perspective of teachers, is parental engagement in HSP impacted by or related to parental engagement in school activities more generally?

Performance

Academic, Operational, Financial Performance—Charter school performance is measured by the New Jersey Department of Education (NJDOE) Performance Framework, which includes the academic, operational, and financial standards charter schools must meet. Research indicates most New Jersey charter schools fail to meet these standards due to poor test scores (Schwenkenberg & Vanderhoff, 2015).

Key Interview Questions:

- Does a school’s current academic performance and standing impact HSP

implementation, that is, do schools in “academic crisis” feel HSP implementation is not a priority?

- How does the school’s current academic performance status impact HSP implementation?

Perceived Charter School-Unique Challenges

Perceived Financial and Academic Performance Challenges—Some charter school supporters lament that charter schools are underfunded and receive less funding per pupil than traditional public schools (Speakman & Hasset, 2005). A counterargument is that local school districts often have expenses and service responsibilities charter schools do not (Bifulco & Bulkley, 2014). In terms of accountability, charter schools must undergo a rigorous charter application process and are granted a charter for a period of four or five years. At the end of the charter term, administrators must apply for charter renewal and undergo another rigorous process, after which the charter may be renewed or revoked. Charter schools must also undergo a rigorous performance review annually and are held accountable to strict performance metrics. The NJDOE’s Performance Framework outlines clear academic, financial, and organizational performance expectations; charter renewal is dependent upon meeting those expectations. Public schools are held to the same academic standards as charter schools. However, the consequences of not meeting those standards are potentially greater for charter schools (i.e., charter revocation). Whether the magnitude and type of challenges charter schools face are greater than those of traditional public schools is commonly debated.

Key Interview Question:

- How do school administrator and HSP stakeholders *perceive* these issues, and do their perceptions impact HSP implementation?

vii. Data Analysis

This case study research method was designed to support the exploratory nature of this dissertation study and focused on identifying factors impacting HSP implementation in select, independent New Jersey charter schools. Interviews were recorded and transcribed by the principal investigator within 72 hours of the interview. Interview data were then coded manually in Microsoft Word. Data were organized and coded using deductive methods based on theory (the Diffusion of Innovation, characteristics of an innovation), and review of implementation findings in the literature (barriers and facilitators to school wellness program implementation), as well as those specific to the charter school context. The three categories of a priori codes included 1) Codes mapped to one of the constructs found in the Diffusion of Innovation theory (the overall analytical framework for this dissertation study); 2) Codes mapped to barriers or facilitators to wellness program implementation; and 3) Codes describing charter school context. In addition to using deductive codes derived from scientific literature and theory, because of the exploratory nature of this study codes were also derived inductively to allow for factors impacting HSP implementation arising from interviews. Analysis of both deductive and inductive codes helped to develop hypotheses about HSP implementation that can be tested in future studies. Inductive coding was also used to categorize and analyze common themes that emerged across interviews at the same school and across schools. Illustrative codes were identified. Data were categorized based on these codes for each individual school case summary, and then a cross-case

comparison summary across all schools was created. All codes were integrated into the Diffusion of Innovations framework as outlined in Chapter 3: “Methods—Analytical Framework.” Some codes were listed in more than one category. Content also could be categorized by multiple codes. Codes, and their definitions, are shown in Tables 3-4, 3-5, and 3-6.

Table 3-4: Diffusion of Innovation Codes

CODE	DESCRIPTION
Relative Advantage	A comparison of HSP to other school-based childhood obesity prevention programs and initiatives.
Compatibility	The compatibility of HSP with the charter school context (e.g., school charter, mission, accountability/performance metrics, organizational structure and autonomy, instructional context and innovation, teacher staffing including recruitment, selection, and retention, age of the charter school and where it is in the charter renewal cycle).
Complexity vs. Simplicity	Level of difficulty in implementing HSP, and the ability of HSP to fit within the charter school context.
Trialability	The ability to succeed with HSP without being fully committed to the whole program.
Observability	The extent to which HSP outcomes are observable to program stakeholders and how this might impact program buy-in and support for program implementation. Observable outcomes may include 1) systemic/environmental outcomes (e.g., changes in the cafeteria menu, visible messaging supporting healthy behaviors, vending machines serving only healthy options; or 2) reductions in child BMI, increases in child physical activity, improvements in child eating habits.

Table 3-5: Facilitators and Barriers to Program Implementation Codes

CODE	DESCRIPTION
School Culture	School values, social functioning (e.g., health-promoting, community-oriented both within and outside of the school in the broader community).
School Leadership	The extent to which school leadership is supportive of HSP implementation and health promotion.
Amount of Training	The extent to which the school has engaged in training that supports HSP (e.g., has the school received training from HSP administrators, used HSP online training tools, engaged in other health promotion training that would support HSP implementation?).
Perceptions of Staff Training and Expertise	The extent to which school staff feel they have the adequate training and expertise to support HSP implementation.
Time and Resources	The extent to which school staff feel they have enough time, enough resources, and the right kind of resources to implement HSP.
Perceptions of the Program Format	The extent to which HSP is customizable to meet school needs. The extent to which HSP content is templated for easier implementation across the school.
Parents	The extent to which parent factors play a role in HSP implementation, both in and out of school (e.g., parent engagement in school activities in general and health promotion specifically; parent education of proper nutrition and the importance of physical activity; parent work schedules and parents' ability to be present to monitor what their children are eating and their physical activity; parents' ability to attend health events at the school).
Social and Environmental Factors	The extent to which the physical environment impacts HSP implementation, both inside and outside of school walls (e.g., access to public outdoor spaces to engage in physical activity, safety, access to grocery stores with healthy food options). The extent to which cost plays a role in students eating healthier foods.

Table 3-6: Charter School Context Codes

CODE	DESCRIPTION
School Culture	The extent to which school values, social functioning (e.g., health-promoting, community-oriented both within and outside of the school in the broader community) are compatible with HSP implementation.
School Charter	The extent to which a school's charter agreement is compatible with HSP implementation.
Mission	The extent to which a school's mission is compatible with HSP implementation.
Accountability (NJDOE Performance Framework)	The extent to which school staff feel that meeting the standards set by NJDOE impact how the school functions and HSP implementation (e.g., charter schools feel they are held to a higher, different standard as compared to traditional public schools and meeting this standard negatively impacts HSP implementation).
Organizational Structure and Autonomy	The extent to which being an independent charter school negatively impacts or supports HSP implementation.
Instructional Context and Innovation	The extent to which innovation is a part of a school's culture, which can negatively impact or support HSP implementation (e.g., curriculum innovation may support health promotion integration into core subjects).
Teacher Staffing (Recruitment, Selection, and Retention)	The extent to which teacher turnover impacts HSP implementation.
Charter School Age/Charter Renewal Cycle	The extent to which a charter school's age and where it is in its renewal cycle impacts HSP implementation (e.g., a more mature school has more stable processes which support HSP implementation; a school that has a recently renewed charter may have more time to implement HSP).
Student Demographics	The extent to which culture, race, and ethnicity impact HSP implementation.
Staff Perception of Parental Engagement	The extent to which staff think parent engagement in health initiatives impacts HSP implementation (e.g., parent engagement is high or low, which negatively or positively impacts implementation).

Based on the findings of each individual case and the overall cross-case comparison report, hypotheses were generated about the reasons for success or failure of HSP implementation in select New Jersey charter schools, as well as ways to modify HSP to better fit the independent charter school context in New Jersey in order to be more effective as a wellness policy implementation tool. Findings are highlighted in Chapter 4: Results.

CHAPTER FOUR:

RESULTS

The purpose of this dissertation study was to determine the extent to which the Healthy Schools Program (HSP) has been implemented in select, independent New Jersey charter schools, and explore factors impacting implementation. Factors explored included each charter school's context (e.g., school mission, charter, and organizational, social, and demographic factors), barriers and facilitators related to school wellness program implementation cited from the literature, and additional factors impacting implementation discovered through the research process. This dissertation study also examined what additional supports are needed to further facilitate HSP implementation, and how, if at all, HSP could be modified to better suit the needs of independent New Jersey charter schools.

This chapter reports the results of the research and seeks to answer the research questions using the study's analytical framework. A detailed data analysis of study interviews, observations, and documents, using charter school context and barriers and facilitators to HSP implementation within the Diffusion of Innovation framework, helped to explain how and why HSP implementation has occurred in the manner it has, is provided.

Research Questions and Study Findings

Study Aim 1: Determine how HSP has been implemented in select New Jersey charter schools.

Research Question 1: At select, independent New Jersey charter schools, to what extent is the Healthy Schools Program being implemented based on the Healthy Schools Program six-step process for improving school wellness?

Findings: For this dissertation study, the level of HSP implementation was measured by the HSP six steps of implementation (see below). All four study schools had taken actions toward implementing the six HSP implementation steps. However, no school had implemented all of the steps and none had implemented the sixth step of monitoring and tracking. Table 4-1 summarizes the steps each study school had taken in HSP implementation based on interview data and review of each school's HSP online dashboard.

Table 4-1: Level of Implementation Measured by the HSP Six Steps

	<u>School A</u>	<u>School B</u>	<u>School C</u>	<u>School D</u>
Step 1: School Wellness Council Formation	Formed; Active	Formed; Not Active	Formed; Not Active	Formed; Not Active
Step 2: School Health Environment Assessment	Online Health Assessment: Partially completed Meeting USDA/HSP nutrition requirements Not meeting state/HSP physical activity requirements; not meeting for Grades K-5 (66%), not meeting for Grades 6-8 (44%)	Online Health Assessment: Partially completed Meeting USDA/HSP nutrition requirements Exceeding state/HSP physical activity requirements for Grades K-5 (160%); not meeting for Grades 6-8 (60%)	Online Health Assessment: Partially completed Meeting USDA/HSP nutrition requirements Not meeting state/HSP physical activity requirements; not meeting for Grades K-5 (96%); not meeting for Grades 6-8 (64%)	Online Health Assessment: Partially completed Meeting USDA/HSP nutrition requirements Exceeding state/HSP physical activity requirements for Grades K-5 (143%); not meeting for Grades 6 and 7 (75%)
Step 3: Local Prioritization/Action Planning	Formal Planning School Wellness Policy: Created; conditionally enforced	Informal Planning School Wellness Policy: Created; strictly enforced	Informal Planning School Wellness Policy: Created; conditionally enforced	Informal Planning School Wellness Policy: Created; conditionally enforced
Step 4: Technical Resource Development (HSP Training/ Technical Support)	Trained with school district and HSP relationship manager	No Training	Trained with school district and HSP relationship manager	No Training
Step 5: Take Action	Partial Implementation	Partial Implementation	Partial Implementation	Partial Implementation
Step 6: Monitoring	No Monitoring	No Monitoring	No Monitoring	No Monitoring

- **Step 1**—Formation of a School Wellness Council. All study schools had formed a School Wellness Council; however, only School A's Council was active. School B participants stated they did not need to formally meet; those involved in health initiatives spoke informally daily. School C had a School Wellness Council on paper, but also was not meeting; health efforts were being done individually, versus being coordinated as school-level initiatives. School D had not had the time to structure formal wellness council meetings.
- **Step 2**—School Health Environment Assessment. All study schools had taken some steps in evaluating the health environments of their schools. However, the amount of school health environment assessment completed, and the results of that assessment, varied by school. In terms of the nutrition assessment, all study schools were implementing the USDA/HSP nutritional guidelines for meals served under the federal meals program; however, schools had varying degrees of monitoring and enforcing wellness policies supporting healthy nutrition for snacks and other non-federal program foods. In terms of physical activity and Physical Education, some study schools (B and D) were exceeding New Jersey's or HSP's recommended amount of physical activity for students in Grades K-5 (150 minutes per week), but none of the study schools were meeting these requirements for Grades 6-8 (225 minutes per week).
- **Step 3**—Local Prioritization/Action Planning, including creating a School Wellness Policy. All study schools engaged in informal planning of health initiatives and HSP implementation; however, only School A engaged in formal

planning through its School Wellness Council. All study schools had a School Wellness Policy, with varying degrees of enforcement.

Documents: In terms of Step 3 (Local Prioritization/Action Planning), all schools had a written School Wellness Policy in accordance with the Healthy Hunger Free Kids Act (HHFKA of 2010), highlighting guidelines for school nutrition, physical activity, monitoring and tracking of the policy enforcement, and outcomes. Menu review showed that all schools were serving foods meeting the USDA/HSP guidelines for meals served under the federal meals program.

- **Step 4—Technical Resource Development.** Schools A and C received HSP training with their local traditional public school district because of existing special relationships with individuals at these districts. In-person HSP training occurred twice a year over four years, with online and telephone support in between training sessions. Training ended in 2016 when HSP grant funding for training ended and before this dissertation study research was conducted. It is unusual for independent charter schools to receive in-person HSP training from a relationship manager and train with the traditional public school district.
- **Step 5—Take Action.** All study schools had taken HSP implementation actions to implement HSP recommendations for school nutrition and physical activity. Overall, schools were successful at implementing the USDA/HSP nutrition guidelines for school meals but in general were not meeting New Jersey's or HSP's recommended amount of physical activity for all students. School environment observations (summarized below) and document review were data collection methods for seeing how study schools had taken action to make their

school healthier; observations also supported participant statements about how they utilized the school infrastructure to support health promotion.

School A Observations: Observations at School A revealed water fountains and water coolers in hallways at all three of its campuses. In terms of health-related messages, there were images of students playing and eating healthy foods throughout all three campuses. There was also a nutrition board with images of healthy foods, encouraging students to eat these foods, as well as nutrition information and recipes for making healthy foods. A countdown of days to statewide testing, which was a critical focus of School A at the time, was prominently displayed. Related to the time of year and testing, the Dean of Students noted that normally there would be more images and information posted on walls in general and related to health specifically, but School A was preparing for testing and the administration did not want students to be prompted by any information posted in hallways or classrooms that might affect test scores. In addition, it was also observed that none of School A's three campuses had a gym and only one of the three had a playground. This supported interview data that suggested the lack of infrastructure decreased the amount of physical activity students were engaging in.

School B Observations: At School B, the school's mission and vision were prominently displayed, but health promotion messages as part of Step 5 (Take Action) were not. Academic-related content (e.g., word of the week) and photos highlighting the school community were placed on the walls. School B did not have a cafeteria, so there were no health messages to observe in that area.

School B had a gym as well as a large playground and soccer field for student physical activity. The school physical infrastructure was consistent with interview data in which teachers stated they would sometimes take students outside to the playground and soccer field for brain breaks.

School C Observations: School C had taken action in posting health messages and images promoting healthy eating and engaging in physical activity in hallways and outside classrooms on every floor. Nutrition messages were also posted in the cafeteria. School C also had a gym and a playground in which students could engage in structured physical education and physical activity, respectively.

School D Observations: School D did not have a playground or gym, due to a lack of space. Not having a playground or gym was cited by the administration as a barrier to students engaging in physical activity. The administrators stated they wanted to support their students engaging in more physical activity and had explored potential solutions to the lack of space issue, including exploring building a play area on top of the school. These plans had not come to fruition due to logistics and lack of funding to support the initiative. Health messages were posted in an area used for physical activity and physical education classes. Because School D's cafeteria was a rented, shared space with the local church, neither messages or posters could be displayed. The Principal of School D noted they would have displayed health messages in the cafeteria if they were allowed to do so.

Document Reviews: In general, for all study schools, a review of documents showed a consistency with interview data related to the planning and action steps study schools had taken in implementing HSP. For example, all participants stated HSP was consistent with their school's mission and charter; document review supported these statements. Only School B's student handbook included the School Wellness Policy and guidelines for school-approved nutrition; other study schools' student handbooks did not. This was consistent with interview data in which School B participants stated that health promotion was an integral part of the school culture, and all parents in School B were made aware of the School Wellness Policy and its strict enforcement. This was also consistent with interview data at Schools A and C, where participants stated HSP implementation was not supported by the administration as much as it could be; academics were the priority. School D's administration supported HSP but had not yet integrated the policy into the student handbook. Factors impacting dissemination of the School Wellness Policy and integration into the student handbook are explored in Research Question 2. More information on documents reviewed can be found in the individual case reports, appendices 4-1, 4-2, 4-3, and 4-4.

- **Step 6—Monitoring of Implementation Progress.** None of the study schools were actively monitoring or tracking HSP implementation progress or outcomes (e.g., student behaviors or anthropometric measurements).

Study Aim 2: Determine the factors affecting HSP implementation in select New Jersey charter schools.

Research Question 2a: How does the specific context of the independent charter school system shape program implementation? What factors help or hinder policy implementation?

Findings: A charter school's context impacts HSP implementation. The Diffusion of Innovation theory was used as the analytical framework to explain why implementation occurred in the manner it has at study schools. As previously discussed in Chapter 3: Methods, there are five characteristics of an innovation in the Diffusion of Innovation theory: 1) relative advantage—is the innovation better than what previously existed? 2) compatibility—does the innovation correspond to existing social or organizational values? 3) complexity—is the innovation easy to use or understand? 4) trialability—can the innovation be done on a trial basis or in phases? and 5) observability—are the effects of the innovation observable? Of the five characteristics, the compatibility and complexity characteristics were most relevant to findings of this dissertation study. Table 4-2 outlines the analytical framework with these characteristics.

**Table 4-2: HSP Analytical Framework
The Diffusion of Innovation**

	Diffusion of Innovation—Characteristics of Innovation				
	Relative Advantage	Compatibility	Complexity	Trialability	Observability
Charter School Context		<ul style="list-style-type: none"> • School Culture/Mission/Charter Agreement • NJDOE Academic, Fiscal, and Operational Performance • Charter School Age and Charter Renewal Cycle Stage • Organizational Structure and Autonomy • Instructional Conditions and Educational Innovations • Teacher Staffing Recruitment and Retention • Funding • School Demographics and Ethnic Culture • Parental Engagement 	<ul style="list-style-type: none"> • School Culture/Mission/Charter Agreement • NJDOE Academic, Fiscal, and Operational Performance • Charter School Age and Charter Renewal Cycle Stage • Organizational Structure and Autonomy • Instructional Conditions and Educational Innovations • Teacher Staffing Recruitment and Retention • Funding • School Demographics and Ethnic Culture • Parental Engagement 		
Barriers & Facilitators	<ul style="list-style-type: none"> • Engaging Key Stakeholders • Leadership Support 	<ul style="list-style-type: none"> • Engaging Key Stakeholders • Leadership Support • Use of an Outside Expert 	<ul style="list-style-type: none"> • Engaging Key Stakeholders • Leadership Support • Training • Use of an Outside Expert • Templated Format 	<ul style="list-style-type: none"> • Engaging Key Stakeholders • Leadership Support • Use of an Outside Expert 	<ul style="list-style-type: none"> • Engaging Key Stakeholders • Leadership Support • Momentum

To answer Research Question 2A, findings are divided into three sections: 1) study data categorized by the Diffusion of Innovation characteristics of an innovation; 2) a priori barriers and facilitators to implementation from the literature; and 3) additional empirical factors uncovered affecting implementation.

Study Data Categorized by the Diffusion of Innovation Characteristics of an Innovation

Relative Advantage—All study participants stated that HSP was helpful in making their school environments healthier. Most study participants did not have experience with other health programs that would allow for comparison with HSP; however, study participants stated HSP was a useful tool in helping to meet the guidelines of the Healthy Hunger Free Kids Act (HHFKA) of 2010. The Director of Development at School C stated, “HSP is excellent. It’s an excellent tool to help implement the School Health Index of the CDC [Centers for Disease Control and Prevention].” Participants at School B stated HSP was better than the wellness programs being implemented in their own children’s schools. Study participants felt HSP was helpful in making their school environments healthier. Participants at School B thought HSP was valuable. The Dean of Students stated the value of HSP was being able to see where School B ranked in relation to other schools with implementing HSP and filling out the school environment health assessment.

Compatibility—All study participants stated that HSP was compatible with their school charters, mission, and vision. Sources of incompatibility were lack of support from school leadership for HSP implementation, and placing academics ahead of HSP implementation. The priority of school leadership for both Schools A and C was

academics, to the detriment of HSP implementation and health promotion more broadly. Study participants at these schools stated that school leadership thought that focus on HSP implementation and health promotion took focus away from academics. The priority of academics over HSP implementation was exhibited by the administrations' focusing on academics in communications with parents and not including information about HSP. This incompatibility is discussed further in this section in the "Leadership Support" dimension of charter school context. Participants also stated HSP was designed for larger, traditional public schools versus smaller, independent schools. Another source of incompatibility was the lack of cultural relevance in HSP content, which was cited as an implementation barrier.

Complexity—All study participants stated that HSP was easy to implement due to its templated format. HSP is templated in that it employs a standard six-step implementation format for all schools, with health content that is the same for all schools. Being templated also served as a barrier to implementation because program content was not tailored to fit an individual school's needs. Another barrier was not having enough staff to implement HSP.

Trialability—All study schools were implementing HSP in phases; study participants thought prioritizing was important to achieving wellness goals. Nurse 1 at School A stated, "You have to do a piece. You have to focus in on a piece and I think that's how it will be better served rather than trying to do too much."

The Dean of Students and Education Director at School B made similar statements. Due to limited resources, the Dean of Students at School B stated they needed

to prioritize. The Dean of Students at School B stated, “The school is very focused on the nutrition piece as a priority.”

The CEO at School C also thought prioritizing and focus were important to HSP implementation and any school initiative. The CEO at School C stated that it was important to get small victories that led to the big victory. Similarly, the School Nurse at School C felt health and wellness could be done in pieces, stating, “Everything takes time. Every day we implement. When it comes to healthy eating, we’re always having a conversation. But doing it in stages.”

The CEO at School D also stated the school was implementing HSP in phases. This was attributed to the young age of the school and being overwhelmed with managing school operations. According to the CEO, “We participate in [HSP], but we’re not fully implementing because we’re a charter, so we have to do so many other things. It’s one of those things that unfortunately, is the last item on the to-do list if you get to it.”

Observability—None of the study schools were tracking HSP implementation or measuring outcomes. However, all study participants stated that they had seen students eating better and having more energy since implementing HSP. All study participants thought HSP had made their school environments healthier, especially in the foods the schools were serving. The Dean of Students at School A stated, “Students have more energy. They eat better here and because of the way [the Food Staffer] has everything set up, the healthy foods, they interact with their peers better, they have more energy.” At School B the effects attributable to HSP were unclear because the school had a strong culture of health promotion before HSP was implemented. The Education Director of

School B stated, “It’s hard to tell the effects [of HSP] because being healthy was such the norm for the school.”

At School C, the School Nurse stated,

The lunches that they’re serving are so much healthier now. We’re exposing our kids to healthy eating and understanding why it’s so important to eat fruits and vegetables in our school. So now instead of people rewarding our kids with cupcakes for those parties for good behavior, we’re providing fruits and vegetables.

At School D, participants stated that they saw positive changes in the menu and school-approved snacks since implementing HSP. The School Nurse at School D stated that students who used to come to her with hunger-related health issues were no longer doing so. She attributed this change to HSP implementation.

Table 4-3 summarizes interview data organized by the characteristics of innovation of the Diffusion of Innovation theory.

**Table 4-3: Participant Perceptions of HSP Using the
Diffusion of Innovation Theory**

Constructs	<u>School A</u>	<u>School B</u>	<u>School C</u>	<u>School D</u>
Relative Advantage	Made the school environment healthier.	HSP better than other programs.	“Excellent”; made school environment healthier.	Made the school environment healthier.
Compatibility	Compatible: -School mission & charter. Incompatible: -School leadership prioritizing academics; administration’s placing academics over health promotion. - Lack of culturally relevant content was also viewed as barrier.	Compatible: -School mission & charter. Incompatible: -HSP is designed for large traditional public schools and for schools with “idyllic” conditions.	Compatible: -School mission & charter. Incompatible: -School leadership prioritizing academics; administration’s placing academics over health promotion. - Lack of culturally relevant content was also viewed as barrier.	Compatible: -School mission & charter. Incompatible: -School age; early stage of school development; focus on other primary school operations; understaffed.
Complexity	Easy to implement, but challenge to implement physical activity; lack of space.	Easy to implement, but challenge to implement physical activity; lack of time.	Easy to implement, but challenge to implement physical activity; needed more people and time.	Easy to implement, but challenge to implement physical activity; lack of space.
Trialability	Implemented in phases.	Implemented in phases.	Implemented in phases.	Implemented in phases.
Observability	Students were eating healthier; more energetic; able to learn better.	Students were eating healthier; more energetic; able to learn better.	Students were eating healthier; more energetic; able to learn better.	Students were eating healthier; more energetic; able to learn better.

Mapping the dimensions of charter school context to the five characteristics of an innovation of the Diffusion of Innovation highlighted in Table 4-3, most data could be categorized by the compatibility and complexity characteristics. Study findings revealed some dimensions of charter school context mapped to both the compatibility and complexity characteristics. These characteristics, and the various dimensions of charter school context, are discussed in more detail below.

School Culture/Mission/Charter—This dimension maps to the *compatibility* characteristic. All study schools viewed HSP as compatible with their school's mission and charter. However, the importance of health promotion in the school's culture differed across schools. These differences affected implementation. For example, at School B, administrators stated that health was a part of the culture of the school; even if School B was not signed up for HSP, they would be promoting healthy eating and the importance of engaging in physical activity to students. Study participants from School A's School Wellness Council and the Dean of Students also felt health promotion was compatible with their school's mission and charter; however, wellness initiatives were not fully supported by School A's leadership. School C had an overall sustainability initiative, of which health promotion and HSP were key components. School D's mission also emphasized the crucial importance of health in promoting the well-being of students. The CEO and Principal worked together to implement elements to make their school healthier, such as hiring a new food vendor who made healthier, better quality food to meet the USDA guidelines, and making room in the school curriculum for a dedicated health class.

Documents were reviewed to shed light on the dimensions of charter school context (school mission, charter, vision) that could impact implementation. A review of documents obtained found school missions and charter agreements to be compatible with HSP. (School A's charter agreement could not be obtained despite repeated requests.)

NJDOE Academic, Fiscal, and Operational Performance—This dimension maps to *compatibility* in terms of schools' perceptions of alignment between HSP implementation and the factors on which they are measured to maintain their charters, and to *complexity* in terms of ease of implementation, given these performance metrics. Meeting the New Jersey Department of Education (NJDOE) performance standards and needing to outperform their traditional public school counterparts with academic testing were cited by all study schools as pressures they constantly felt. In some cases, study participants felt that this pressure caused school leaders to prioritize academic performance over health promotion and HSP implementation. For example, the Dean of Students at School A stated the school was performing better than its traditional public schools counterparts, but needed to perform even better. The Dean of Students of School A stated, "Academics and testing are the priority. The administration cares about health but we have to keep our test scores up or we won't stay open." The entire School Wellness Council echoed similar thoughts.

School C participants also felt that academics took priority over health in their school. Although the Principal at School C stated that health was important and there was a connection between health and academic performance, communications with parents via open houses and in the student handbook focused primarily on academics, according to other study participants at School C. School B had also been challenged in keeping test

scores up as its student population changed over the years to include more English as a Second Language (ESL) students. However, in contrast to Schools A and C, School B's leadership commitment to health has never waned; the administration did not view health and academic performance as an "either/or" but rather viewed them as "interconnected," as stated by both the Dean of Students and the Education Director. School D's leadership stated that health promotion was important to overall child well-being, in addition to academic performance.

Charter School Age and Charter Renewal Cycle Stage—This dimension maps to *compatibility* in terms of HSP implementation aligning with where schools were in their overall life and charter renewal cycles, and to *complexity* in terms of ease of implementation given these cycles. At School D, the administration and staff stated they were "overwhelmed" with dealing with issues related to the school being a young, growing, school. Specifically, at the time of this study, School D was a K-7 school that had received approval to add an 8th grade class in the upcoming school year, and the CEO and Principal noted they "were trying to figure out where we are going to put the class" physically within their existing school structure. Operational issues took up a significant amount of administrator time. School C (7 years old) was still putting processes in place for its educational curricula and school operations. This had consumed considerable time and resources. Regarding the charter renewal process, all study schools stated the process was "stressful," "grueling," and "intense," and was the critical focus of the teachers and administration at the time of renewal. All study schools went through the charter renewal cycle while implementing HSP. Study participants stated this charter renewal process consumed enormous amounts of all school resources.

Organizational Structure and Autonomy—This dimension maps to *compatibility* in terms of HSP implementation aligning with the school’s independent, autonomous structure, and to *complexity* in terms of ease of implementation given this structure, and the pros and cons of independence. Operating separately from the traditional public schools had both advantages and disadvantages which impacted HSP implementation. All study school participants felt their independence afforded them more freedom to implement curricula, policies, and systems tailored to their school, including how they chose to implement HSP. A disadvantage of independence was being understaffed, as was noted by the participants. All study schools, except for School B, had student/teacher ratios much higher than the state average. Being understaffed meant teachers were often serving multiple roles at the school. According to study participants, this made it difficult to have staff dedicated to HSP implementation. Another disadvantage of HSP implementation was that study participants felt HSP was designed for larger, traditional public schools, operating with the support of a district central office. The Dean of Students at School B stated, “HSP seems to be designed for larger, traditional public schools. They ask us to do things that we cannot do because we don’t have the people or are not set up that way.” This program design served as a barrier to HSP implementation, and one of the factors that led to School B staffers needing to adapt HSP to better fit their smaller school environment. For example, HSP recommends high school students model healthy behaviors by engaging in healthy activities with the lower grades. School B does not have a high school. Instead, administrators and teachers model healthy behaviors for their K-8 students.

Instructional Conditions and Educational Innovations—This dimension maps

to *compatibility* in terms of HSP implementation aligning with the school's flexibility with educational content and instruction techniques, and to *complexity* in terms of ease of implementation given this flexibility. All study schools thought that charter schools had more flexibility with instructional curriculum and had more freedom to innovate in their classrooms. Study participants felt this innovation extended to how they implemented HSP and served as HSP implementation facilitators. All study schools incorporated "brain breaks," 10- to 15-minute physical activity breaks, into the classroom. HSP recommends integrating physical activity into the classroom and encourages the use of activity breaks. Specifically, School C staffers were implementing an overall sustainability initiative, which included integrating sustainability concepts regarding the environment and health into classroom curricula across all subjects. HSP was a part of this curricula.

Teacher Staffing, Recruitment, and Retention—This dimension maps to *compatibility* in terms of level of stability in the school's staff for continuity of instruction, school policy knowledge and dissemination generally, and HSP specifically, and to *complexity* in terms of ease of implementation given stability or instability. Teacher turnover was cited as a disruption in educational continuity generally across all study schools, and was cited as an implementation barrier specifically at Schools B and C. The Education Director at School B stated, "Some new teachers struggle with our nutrition policies. It takes time for them to transition, to get it." School C had momentum with HSP implementation and was on pace to receive HSP Bronze level recognition, but the change in school principal also brought a change in teachers. This led to differential awareness and support of HSP among teachers. The CEO stated, "You would get

different responses or knowledge levels” if teachers were randomly asked about HSP or School C’s nutrition policies.

Funding—This dimension maps to *compatibility* in terms of HSP implementation aligning with the school’s overall funding status as a result of its independent charter school status, and to *complexity* in terms of ease of implementation given funding status, in this case participants stating their schools were underfunded for HSP implementation. Lack of funding to support school operations was a problem for all study schools, in general, and specifically in relation to supporting HSP implementation and other health initiatives. Employees from Schools A and C trained in-person with the traditional public school district and district HSP relationship manager. After this training ended, HSP implementation efforts at both Schools A and C subsequently stalled. The Education Director at School B, Dean of Students at School B, and PE/Health Teacher at School C each noted that programs need to be sustainable and funding needs to be consistent and stable. The PE/Health Teacher at School C stated, “Programs start. And then the money runs out and they just end.” Lack of funding was also cited by the 3rd Grade Teacher and the Dean of Students at School A as a cause for high teacher turnover and difficulty in attracting more teachers.

School Demographics and Ethnic Culture—This dimension maps to *compatibility* in terms of HSP content being aligned with the school’s demographic and culture, and to *complexity* in terms of ease of implementation given this demographic, that is, staffers needing to modify HSP to make it more culturally relevant, and therefore easier to implement, with their respective populations. Lack of cultural relevance was cited as a barrier to implementation by Schools A and B. These study school participants

in particular stated HSP lacked focus on culture and content; not only a lack of materials in Spanish, but also a perceived lack of cultural relevance to a Hispanic population. All four of the study schools were ethnically diverse, and, with the exception of School C, had high percentages of Spanish-speaking students. School A's student population was 60% Hispanic. School B's student population was 82% Hispanic. School D was the most ethnically diverse, with 44% Asian and 38% Hispanic populations. Study participants at Schools A and B stated HSP did not take into account ethnicity/culture and language and thought their schools needed to adapt HSP to address both language and culture. Nurse 1 at School A described the HSP curriculum as "Generic. It needs to be more specific. I'm Puerto Rican. We like to eat rice. We need help in showing parents healthier alternatives." Similarly, the Family Coordinator at School B stated, "In the Hispanic culture we have a lot of carbohydrates in our diets. We need to teach parents how to cook healthier."

Most study schools were also low-income. HSP's curriculum and program do not include strategies to address social and economic factors. These include domestic violence and incarceration (Schools B, C, and D) and immigration status (School B). Students and parents from all schools were dealing with the threat of family deportation, which not only created emotional stress that impacted student well-being, but also meant that because of their undocumented immigration status some parents did not have drivers' licenses to drive to grocery stores where healthier food options might be sold. According to the Business Administrator/Parent 1 at School B, the threat of deportation also meant parents tended to stay very close to home for fear of being "picked up" by law enforcement. At School D, administrators had to manage domestic violence issues. The

CEO at School D stated that two students had seen their mother murdered by their father. She and other teachers had taken time to make sure these students were coping with this trauma; managing situations like this took precedence over monitoring students' diet and exercise. At School C, the CEO, Principal, and the 4th Grade Teacher all noted the students were dealing with social traumas that negatively affected emotional well-being and the ability to effectively learn in school, including learning about and engaging in healthy behaviors.

Parental Engagement—This dimension maps to *compatibility* in terms of level of parental engagement at study schools more broadly and with respect to health promotion specifically, and to *complexity* in terms of ease of implementation given parental engagement, that is, higher parent engagement in health promotion facilitates HSP implementation. Overwhelmingly, participants stated that parents were the key to having healthier students. Every study participant stated that health started at home; health started with the parents. All study participants felt that the biggest hurdle to having healthier students and more support for HSP was the need to reach parents. Study participants felt tools to better educate and engage parents in student health was the critical piece missing from HSP. The School Nurses at Schools B and D stated, “The relationship between eating poorly and bad health was too long-term and not real to them. Unless it’s a critical health problem, parents will not respond. We need to make the problem real to parents.” Both school nurses made these statements based on conversations they had had with parents about the importance of healthy eating to supporting student health.

Lack of knowledge about nutrition on the part of parents was cited as a problem.

Parents working multiple jobs that prevented them from being home to monitor what their children were eating was also seen as a barrier. Because parents were not home, often older siblings were taking care of younger siblings. A further concern was the problem of obesity among parents themselves. Nurses at Schools B, C, and D stated it was hard to have a conversation about a child being obese when the parent was also obese. At School D, parent reactions to the school policies around nutrition differed in terms of culture and ethnicity. Specifically, according to school administrators, their perception was that the South Asian and White parents seemed to be more accepting of the School Wellness Policy, which promoted healthy eating at school, as compared to the Hispanic and African American parents, who were more resistant and less compliant with the policy.

A Priori Barriers and Facilitators to Implementation from the Literature

The literature reveals several factors that can serve as barriers or facilitators to wellness program implementation in schools, including the engagement of key stakeholders, leadership support, training, momentum, use of an outside expert, and templated format. Training, momentum, and use of an outside expert are addressed later in the chapter. These factors also map to one or more of the characteristics of an innovation of the Diffusion of Innovation theory. For example, engaging key stakeholders and leadership support intersected with all five characteristics—relative advantage, compatibility, complexity, trialability, and observability. Use of an outside expert intersected with the compatibility, complexity, and trialability characteristics of an innovation.

Engaging Key Stakeholders—Engaging stakeholders is connected to the *compatibility* characteristic of an innovation. Lack of stakeholder engagement served as a barrier to HSP implementation. For example, all study school participants stated that parents, a part of key stakeholders, needed to be engaged in order to support HSP implementation but were not enforcing plans to do so. For example, School A parents were invited to attend School Wellness Council meetings and had attended them in the past. For unknown reasons, these parents stopped attending the meetings. Schools B, C, and D had school wellness policies calling for parents to attend meetings, but this was not possible because these schools did not hold formal wellness council meetings.

Leadership Support—Leadership support varied across study schools and was related to the *compatibility* characteristic. The presence or absence of leadership served as either a facilitator or a barrier HSP implementation. At Schools A and C, school leadership was more focused on academics, which served as a barrier to HSP implementation.

At School A, members of the School Wellness Council stated that academics was the priority and that school leadership could be more supportive of health. At School A, Nurse 1 of the School Wellness Council stated, “I think the harder thing is for the administration to make this a priority because...it’s at the bottom of their priority list, so they don’t really enforce it. They want us to, but we don’t carry the weight. They need to be at the forefront, the face of the program.” Consistent with these comments, the Dean of Students at School A stated, “Academics is number one. Culture is two, and health would be number three.” Members of the School Wellness Council made suggestions for greater support, which included giving them the opportunity to present their initiatives at

the open house at the beginning of the school year, where they could highlight ways in which parents, teachers, and students could get involved in health promotion activities. Another suggestion for more support from school leadership was incorporating health promotion and HSP into teacher professional development. In a review of School A's handbook, the School Wellness Policy was not included. It was a separate document that existed on School A's website only. Observations revealed the majority of posted messages focused on academics and School A's values, consistent with interview data that highlighted academics were the priority at School A.

Similar to School A, study participants at School C thought HSP was compatible with the school's mission and charter but the new school administration's support of academics over health made HSP incompatible with School C's current context. The Food Staffer stated, "We try to do our part individually but without support from higher up, there's only so much we can do." School C study participants stated that they met with the administration to ask for support in continuing their mission of health promotion at the school but were told by the school principal that academics was the priority. Participants from School C similarly felt there was a lack of leadership support for HSP implementation. Although the CEO had a vision for School C to be a healthy school, operationally the pieces were not in place to support this vision. School C study participants stated they had met with the school administration to ask that they continue their mission of health, to no avail. School C had a School Wellness Policy, but it was a separate document, not included in the student handbook, and therefore not widely distributed or known. The policy was also conditionally enforced. Participants felt they

were trying to support health promotion and HSP on an individual level; however, without top-down support or enforcement, they felt their efforts were not as effective.

In contrast to Schools A and C, at Schools B and D study participants stated that school leadership facilitated HSP implementation through being engaged and supportive. School B's leadership fully embraced the health of their students as being important, and connected good student health to academic performance and overall student well-being. This support was demonstrated in that the School Wellness Policy was published in the student handbook, the policy was actively enforced by teachers, and the school leadership modeled healthy behaviors in front of students and used opportunities to engage in health education with students throughout the school day. School B's leadership also supported healthy initiatives by securing a grant to fund free breakfast for all students. The administration incorporated breakfast into the school day, calling it "advisory." At School D, participants stated that school leadership was supportive of HSP and health promotion. PE/Health Teacher 1 stated, "They really try to communicate the health policy to the parents, and make it easy to follow. The administration is also open to any new ideas for health initiatives we might want to do."

Templatized Format—Training (discussed in Research Question 2b) and a templatized program format (standardized content and implementation steps) connected to the *complexity* and *compatibility* characteristics of an innovation of the Diffusion of Innovation theory. All study participants thought HSP was easy to implement. This was due to the implementation of clear steps to follow and, in part, to implementing HSP in phases, which intersects with the *trialability* characteristic. Members of the School Wellness Council of School A and the Director of Development at School C thought the

HSP online implementation tools were easy to follow. School D administrators thought HSP was easy to implement in that it could be implemented in phases, and the principles of HSP were consistent with those of the school. All study participants felt HSP's templated format facilitated HSP communication throughout the school and organized implementation steps for schools to follow. However, study school staffers were also adapting HSP implementation to fit their school context. This connects back to the previously discussed *compatibility* characteristic of an innovation of the Diffusion of Innovation theory.

Having a templated format was both a barrier and a facilitator to HSP implementation. Templating made it easy for schools to follow the implementation steps. However, templating produced cookie-cutter implementation processes and content that did not always fit each school's context. The Dean of Students at School B stated that it seemed HSP content focused on implementation in large, traditional public schools, which was not aligned with implementation at smaller, independent charter schools. For example, the Dean of Students at School B stated that HSP called for use of district level, central office traditional public school staff to implement program components that School B did not have.

In terms of content compatibility, study school participants saw benefits of HSP and the program consistent with their school's mission and charter, but thought the program was not necessarily tailored to the specific needs of the school, the physical environment, or the school's demographic.

Additional Empirical Factors Uncovered Affecting Implementation

Additional charter school context factors were uncovered during the research which impacted the implementation of HSP that were not originally included in this dissertation study's analytical framework nor the literature cited.

- **Lack of Time and Infrastructure for Physical Education/Physical Activity—**

Meeting nutrition guidelines for federal meals appeared to be the easiest component for schools to implement. But all study school staffers found it difficult to meet the New Jersey state guidelines for physical activity. This was due to lack of time in the day for all study schools, and in the cases of Schools A and D, lack of physical infrastructure (e.g., not having a gym or a playground). School C's PE/Health Teacher stated, "Kids have to eat. That doesn't take time away from anything. PE does. It takes time away from academics and you need someone to oversee it."

Other Social Issues Negatively Impacting Healthy Living

- **Lack of Transportation—**According to study participants, lack of access to cars to drive to grocery stores was cited as a barrier to parents obtaining healthy foods.
- **Immigration Status—**Parents having undocumented status negatively impacted HSP implementation and healthy habits outside of the school. Not having cars was connected to undocumented immigration status. Additionally, multi-family living conditions (also connected to immigration status) sometimes limited access to kitchens for cooking healthy meals at home. These issues were cited in particular at School B. Study participants also stated that parents were often afraid to go to public parks, where their children could engage in physical activity, because of a fear of deportation.

- **Community Environment**—All study schools were located in low-income, unsafe communities offering easy access to unhealthy foods. Across the study schools, the prevalence of corner stores serving unhealthy, inexpensive processed foods was cited as a barrier to supporting students in eating healthier foods. Participants from Schools B, C, and D all noted unsafe local neighborhoods as a barrier to increasing student physical activity outside of school. Interview participants stated that parents did not feel their environments were safe for outdoor play. These factors map to the *compatibility* and *complexity* characteristics of an innovation of the Diffusion of Innovation theory. The Principal at School C stated, “We are in the most violent section of our city. Literally, there was a murder just down the street in the park yesterday as I was leaving. So we’re in a traumatized neighborhood.”

Study Aim 2 (continued): Determine the factors affecting HSP implementation in select New Jersey charter schools.

Research Question 2b: What role does technical assistance play in program implementation? To what extent has it been utilized? How has it been utilized?

Findings—Use of HSP technical support varied across study schools and impacted implementation. Consistent with the literature, all study school participants stated they needed more support.

Training—Staffers at Schools A and C trained with the traditional public school district and the district HSP relationship manager, which was atypical for charter schools, and used HSP online implementation tools more. Both groups of staffers found the HSP training, when they were doing it, to be “excellent” and “really helpful.” These were the only two of the four study schools in which staffers received in-person training. They

also had access to the district relationship manager via email and phone for implementation help, and accessed the HSP online dashboard for the online school health environment assessment and tracking action items based on those assessments.

Employees at Schools A and C eventually stopped using the online dashboard support tool and the momentum behind implementation waned when the funding for in-person support ended in 2016.

In contrast to Schools A and C, staffers at Schools B and D did not train with an HSP relationship manager. School B's Dean of Students, who was most actively involved with the implementation of HSP, was aware of the online dashboard and had completed some of the online assessments. Staffers at School D were unaware of the online dashboard and, therefore, were not using it to track implementation. Participants from both Schools B and D stated that having a person to help them with implementation would be helpful, provided this support person understood the context of the school and its goals and priorities. The Director of Education of School B stated, "Having an outside person come in would be helpful provided what they're doing doesn't take over what we're doing."

Across all study schools, having more support was deemed important to facilitating implementation. For participants from Schools A and C, having online tools only after the in-person implementation support was not enough. As Nurse 1 in School A suggested, they needed a person to facilitate greater focus, accountability, and "to keep the momentum going." The Dean of Students at School B said they checked the dashboard "from time to time to see how we're doing versus other schools and look for grant opportunities," but accessing the dashboard regularly was not deemed critical in

implementation. The following highlights the factors related to training categorized by the barriers and facilitators impacting implementation, as well as the complexity construct:

Momentum—HSP implementation momentum waned due to lack of training support and changes in school leadership at some study schools. For example, at Schools A and C, implementation momentum was lost due to HSP training support ending and the new principal prioritizing academics over health promotion and HSP implementation. School C was on track to receive HSP Bronze level recognition for its implementation efforts, but after the new principal joined the school, implementation efforts effectively ceased. Original staff who were part of the school under the previous principal and who were at School C when the school initially signed up for HSP still tried to carry on HSP implementation in their own way but without leadership support; the whole-school momentum behind HSP implementation had dissipated at School C.

Use of Outside Expert—A broader concept that incorporates training is the use of outside experts to facilitate implementation. None of the study schools were using outside experts to facilitate HSP implementation. However, all study school participants said they needed a person dedicated to health to push initiatives forward. This person could either be hired to facilitate HSP implementation and lead other wellness initiatives, or be an outside person/entity who could facilitate school wellness initiatives, if they were sensitive to the school's context and priorities, according to the Dean of Students and the Education Director of School B. Study participants stated they needed a person with specific health expertise to help with health education of both parents and students.

In addition to expressing a need for health education support, participants shared that none of the study schools were evaluating HSP effectiveness. The employees did not have the time or expertise in program evaluation to do so. All study school participants thought it would be helpful to know how HSP was impacting their school's health environment in a more structured manner.

Study Aim 3: Determine if and how HSP needs to be modified to facilitate program implementation.

Research Question 3: From the perspective of key stakeholders (school administrators, teachers, and school vendors), what additional supports or resources are needed to help independent charter schools better implement HSP?

Findings—Feedback from study schools on how HSP could be improved or modified fell into two categories: 1) ways to improve program content and 2) ways to improve implementation. In terms of content, study school participants felt there needed to be more content regarding and targeted to the health education and health behaviors of parents. Study participants also felt HSP content needed to be more culturally relevant, available in both English and Spanish, and cultural factors needed to be better incorporated into the content. In terms of implementation, participants felt they needed more people to facilitate implementation. Specifically, consistent with the literature, participants stated that they needed a dedicated, knowledgeable person to lead health initiatives in their schools. This person could be from an outside organization or from within the organization, hired to focus on health. Also consistent with the literature, all study participants stated that school employees lacked the time and expertise to focus on program implementation and evaluation.

Recommendations from Study School Participants on Improving HSP

In explaining how and why HSP was being implemented, study school participants offered detailed feedback on ways to improve HSP and also better support their desire to improve student health. Improving content and improving implementation intersected in that better content will help study schools with their implementation efforts.

1) Improving HSP Content

Target Parents—The need to improve parent health education and engagement around health was cited across all study schools. While participants in study schools felt they were reaching the students because they were a captive audience, they felt they needed to do a better job of reaching parents. They believed that parents needed more education on proper nutrition. The Food Staffer at School C stated,

To get parents involved. To get them to say, “Let me try to continue this at home and to get involved and participating.” Because the parents put the food in front of the children. It’s not the children that are going to the grocery store buying it...the parents are bringing it home saying, “Okay, this is what you get to eat.” So to me, you must change the parents.

All study participants at School C stated there needed to be more programs that involved parents and were targeted to increasing parent health education and changing parent health behavior. At School B, participants stated that family fitness events had garnered strong turnout at the school and that parent modeling was important for changing student health behavior. The Family Coordinator suggested cooking classes for parents, using the school’s kitchen infrastructure, would be beneficial in getting families to eat more healthily. She stated parents would definitely come to this type of class if the school had the stoves and they could cook. The Food Staffer/Parent 2 stated, “Health

must start at home, because if the parents don't know, or they're not aware of healthy meals, they're not going to encourage their students to eat healthy. So there needs to be more education of the parents. A program must start with the parents."

Content Incorporating Language, Culture, Social Context—All study schools were ethnically diverse, with Schools A and B having higher percentages of Hispanic, Spanish-speaking students as compared to Schools C and D. HSP developers did not take school culture or language into account. Nearly all of the content on the HSP website was in English, with only a handful of documents in Spanish. These documents had been translated from English, but did not take into account Hispanic culture. According to participants from both Schools A and B, HSP is a generic program that does not take school culture or language into account. The 3rd Grade Teacher at School B stated,

Health programs need to be tailored to individual school needs and the community. It would make it better if the program were tailored to the community. If you tell this community to eat healthy and exercise more generally without tailoring it to their culture it's not going to work because they are immigrants. They're used to eating their foods. They're scared to go the park for exercise.

The 3rd Grade Teacher at School B suggested the need for an assessment of parents, teachers, and administrators to inform program design; there needed to be more cultural relevance in health programming and health communication, which HSP currently does not have. The Education Director at School B stated that health messages and content should include people that look like the school's demographic, saying, "Health message content needs to be culturally relevant and delivered in the school population's native language. Spanish is the norm."

Based on interview data, it appears both the message and the messenger are important in terms of connecting parents and children to wellness and changing health

behaviors—the right message, to the right person. The Food Staffer/Parent 2 at School B stated, “Culture is very important in terms of the foods people eat and the content of the activities people do at the school. How food tastes, how it’s made, it connects people to where they come from.”

Incorporate a Mental Health Component and a Focus on Healthy Behavior Change—HSP does not address mental health or the cognitive components of health coaching that underlie health behavior change. Participants pointed out that mental health is key to physical health for both students and parents. It would be helpful if mental health support services were on school premises versus parents having to go through a referral process to other locations. Healthy lifestyle building skills incorporated into program content would also be helpful.

2) Improving HSP Implementation

Change HSP Implementation Structure to Better Fit the Needs of Smaller Independent Schools—Lack of tailoring for a small, independent school served as a barrier to implementation. The Dean of Students for School B stated, “I don’t think the designers of HSP really know what a small school looks like. It would be valuable if they tailored it and marketed it towards smaller schools in smaller districts.” An example of this is HSP recommending that district-level personnel facilitate implementation. Independent charter schools do not have additional district-level staff to facilitate implementation because independent charter schools are their own district.

Need for Outside Resources to Facilitate Program Implementation—All study school participants felt they needed additional support. The Education Director at School B suggested, “It would be helpful to have someone come in from the outside

(outside company or person) to spend time at the school, get to know our culture, operations, and priorities and help us to set realistic goals, then help the school transition to managing on our own.” Schools A and C both had staffers train with the district and an in-person HSP relationship manager. They felt this was helpful to program implementation and wished support could have been ongoing. The CEO of School C thought partnerships were key to improving HSP implementation and making the environment of the school healthier. The CEO stated:

Sometimes you have to think more broadly about your approach and your strategy. The reflex answer is always “give me more money,” right, and then I can go buy the resource that I need. It’s not always just that. Sometimes it’s taking a step back and saying, well, maybe we can accomplish what we want to accomplish via collaboration.

An idea the CEO discussed was to create a consortium of independent charter schools engaged in wellness initiatives that could share resources (funding and people), programs, and services.

Build School Capacity for Sustained Support of Wellness Initiatives—

According to the Education Director of School B, lack of sustainability was a barrier to HSP and health program implementation: “The other issue is that initiatives start but then the grant runs out and then they stop. And if the school doesn’t have the capacity to take it on, then that’s the end of the program.” The PE/Health Teacher at School C also stated initiatives stop because grant funding ends.

Need for a Dedicated Health Leader/ Health Educator—Participants from all study schools identified the need for a dedicated health leader to coordinate and lead school wellness initiatives, as well as provide more health education. Health initiatives were being led by multiple people with competing responsibilities within study schools.

They were not a part of a cohesive master wellness strategy. The only school that had a more formal approach to wellness initiative execution was School A, which had a functioning School Wellness Council. At School B the School Nurse identified the need for more consistency in programming:

Being able to offer programs more consistently throughout the year and having a person who's in charge is important; right now, everybody's doing a little bit here and there, but there isn't like a person where health and wellness is their focus, where their sole function is managing health and wellness in the school.

At School C, the CEO, Principal, School Nurse, Director of Development, School Staffer, and PE/Health Teacher all felt the school needed a health educator. As suggested by the Food Service Staffer, the school "Needs a new person who can help change behavior of the parents...someone to help guide me in working with them." The CEO and Principal at School C felt there needed to be someone to manage health initiatives in the school. The PE/Health Teacher stated,

I feel like if we had a concentrated health teacher that would help. We don't have one. I am a teacher of health but that's not what I'm doing. Somebody said, "Can you do this?" And I said, "I can, but unless you can make a clone of me, I don't have the time in the day to do it."

The Principal of School C stated, "I need the project manager to take these ideas that have already been established before I got here, and then let's project manage." The School Nurse at School C stated the school needed a dedicated resource with expertise in health:

We need a health educator. I am a teacher of health also. The thing is I can't put myself in the classroom on a daily basis because of what happens here. I have a mini ER here. So I really feel that we need to get a teacher of health to come in and teach our kids more. We could use more people. And the more knowledgeable in health, the better we do as a school.

Increased Access to Healthy Foods—Participants at School B felt that HSP did not provide content or tools to help economically struggling families address concerns about putting food on the table. The Family Coordinator at School B said the food she was able to get from a local food bank for their family food pantry was not enough: “Most of the time what the main food bank sends is not enough.” The 3rd Grade Teacher at School B suggested that food subsidies would be helpful: “If there were a way to subsidize healthy eating so there was another option beyond (a local store) this would help.”

Technology as an Implementation Tool—HSP does not have a digital application targeted to parents, which would allow parents to access health content. All study participants felt that mobile apps, particularly those optimized for mobile phones, could be used to better engage parents. Content would need to be in Spanish as well as English and culturally relevant. Study participants stated this content should be distributed via mobile apps, as parents did not necessarily have internet access at home. The Dean of Students of School B stated online tools may be a solution for engaging parents: “They may not have internet at home, but all of the parents have phones. They also know every free Wi-Fi place in town. Having online videos and health information available via mobile would be the best.” The Business Administrator/Parent 1 of School B thought online tools targeted to parents might help wellness implementation, but only if they are introduced to it by someone they know and it is culturally relevant and complementary to school activities:

Fitness videos and tools online/app may be helpful and interesting to parents, but people have to be introduced to something new by someone they know and trust; it has to be something they can do together with other people in the community.

More personal. Let's try this together. Otherwise it's intimidating, especially when many parents don't speak English.

School B participants also stated that social media could be better used to connect parents to each other and the school. The Food Staffer/Parent 2 at School B thought that technology could be used for better health communication and connecting people to each other, the school, and wellness information. He stated, "The school could send out a text message about health and wellness events that are happening at the school and in the community. Things that will connect people and bring them together." At School C, the CEO stated that it would be helpful to offer health and wellness content that parents could access through Parent University, the online resource School C used to help empower parents with technology.

In summary, there were many factors that impacted HSP implementation in study schools. Using concepts found in the Diffusion of Innovation theory and incorporating charter school context and barriers and facilitators to wellness program implementation helped to organize and explain these factors. Chapter 5 offers an interpretation of the results of this dissertation study, with the goals of providing more insight into factors affecting HSP implementation, recommendations for HSP developers, and guidance for future research.

CHAPTER 5:

DISCUSSION

Childhood obesity has been identified as a global health crisis. In the United States, schools have been identified as playing a pivotal role in the fight against childhood obesity. Federal policies governing school nutrition and physical activity have been created to ensure schools take an active role in creating school environments that support healthy behaviors in students. Childhood obesity prevention programs, such as the Healthy Schools Program (HSP), have been designed to help bring schools into compliance with these federal policies.

The purpose of this dissertation study was to determine the extent to which HSP is being implemented in select independent New Jersey charter schools, as well as factors impacting implementation. This study focused on charter schools, which are a type of public school with a growing student population. Understanding factors affecting HSP implementation in charter schools may help HSP developers to revise or adapt program elements or provide more or different implementation supports to improve HSP effectiveness in charter schools.

Chapter Five, divided into four sections, provides a discussion of the study findings relevant to the research questions and the implementation of the study. The first section discusses the findings relevant to the research questions. The discussion seeks to interpret study findings in an attempt to explain the level of implementation at study schools. Section 2 provides recommendations for HSP developers. Section 3 discusses study strengths and limitations and Section 4 provides recommendations for future research.

a. Research Questions Discussion

The aims of this dissertation study were to determine the extent to which HSP was being implemented in select, independent New Jersey charter schools and factors impacting implementation. Overall, study school participants thought HSP was a helpful program that was compatible with their school's mission and charter. None of the study schools were implementing HSP fully; they were implementing pieces of HSP and had adapted the program to fit their unique school context. Participants in all study schools expressed a need for more support in terms of implementation—more people with health expertise, more partnerships, and more funding—to enable implementation in a more sustained and consistent manner. Study findings revealed that schools were implementing parts of HSP to varying degrees. All study schools were meeting the nutrition guidelines for federal meals but none of the study schools were meeting the state and HSP guidelines for physical activity for Grades 6-8; Schools A and C were not meeting the physical activity requirements for any grade level. HSP nutrition and guidelines are the same as those for the USDA for federal meals, and HSP physical activity guidelines are the same as those for state requirements. However, it is easier for schools to implement the nutrition guidelines for various reasons discussed in the next section.

In-School and Out-of-School Factors Impacting Implementation

There were in-school and out-of-school factors that affected implementation. The main in-school implementation factor was school leadership support for health promotion and HSP. The main out-of-school factor affecting implementation was lack of parent engagement. Consistent with the literature, lack of school leadership was a barrier to HSP implementation among some study schools. Without leadership support from the top

down, health advocates within the schools felt unsupported, and that their efforts were not having as much impact as they believed that they could. In some study schools, the administration believed supporting HSP implementation would take time and focus away from academics. It is possible that in these schools, academics was the priority above all other programs, not just HSP. However, participants only commented on academics being the priority over HSP and health promotion. Some schools managed to both emphasize academics and support HSP. School B was a school that was struggling to keep test scores up, but the administration was still committed to health promotion, had incorporated it into the daily operations of the school, and never sacrificed health promotion for academics and improving test scores. For School B's administration, health and academics were not an "either/or" but rather were interconnected, where the overall well-being of the student was interconnected with the student's academic performance. Although a school may have passionate health advocates among its staff, without leadership support those staffers' efforts will not be as effective as they could be. A key factor in improving HSP implementation appears to be getting school leadership on board to make health promotion a priority, consistently communicated, with policy enforcement, stemming from the top.

The biggest out-of-school barrier to HSP implementation was the level of understanding and engagement of parents. Overwhelmingly, participants from all study schools said they needed to better educate and engage parents. Lack of parent education not only impacted student health behaviors outside of school but also the kinds of foods students were bringing into the school. Another external barrier to implementation was the broader school environment. The ubiquitous corner store, with its cheap, accessible

junk foods, was noted across the study schools as a barrier to implementation. All study school participants stated they were dealing with social issues that impacted health, and that as a school they were forced to address these issues in order to create environments conducive to student learning. “Schools are not just schools; they’re community centers,” the Dean of Students of School B stated. Schools therefore need more resources that support student and community health. What is clear from this study is that a program targeting obesity prevention in a school, such as HSP, must take into account both the individual context of that charter school and the broader social environment in which that school exists in order to be successful. Student health behavior is a product of those two contexts and should therefore be considered in the program design.

Implementation Status as a Function of Implementation Barriers and Facilitators

Implementation Barriers

Although study school participants thought HSP was compatible with their missions and charters, there were sources of HSP incompatibility with the schools’ contexts. These sources included 1) school leadership focusing on academics to the detriment of HSP implementation; 2) the templated program format, which had two broad issues: content focused on large school implementation and lack of cultural relevance; 3) lack of time for PE/physical activity; and 4) lack of infrastructure to support physical activity. Due to these sources of incompatibility, school employees were adapting HSP, including prioritizing particular steps within the broader HSP implementation template, and modifying the program to better fit school size and culture. For example, in terms of prioritizing HSP implementation steps, School B had formed a School Wellness Council (Step 1) but was not meeting formally because staff felt that

their informal communications were effective in implementing HSP and formal meetings were not necessary. In terms of taking action (Step 5), School B was also prioritizing nutrition over physical activity.

Lack of leadership support for HSP implementation was cited as a program implementation barrier at Schools A and C. Study participants at these schools were health advocates within their schools and champions of HSP, but they felt their efforts were unsupported by school leadership. According to study participants, this lack of support manifested itself in lack of enforcement of school wellness policies, and the absence of a platform from which advocates of HSP and wellness initiatives could present their ideas and initiatives to school leadership, parents, and teachers. The focus on academics (specifically the need to improve test scores) was another factor cited as a barrier to HSP implementation. Administrators at both Schools A and C felt they needed to improve their test scores. School A had a new principal who had been in his position only six months at the time this dissertation study was conducted. His focus had been on academics and improving test scores. Several unsuccessful attempts were made to interview the School A principal. Similarly, School C had had a change in school leadership where the new school principal prioritized academics over health promotion.

Lack of cultural relevance was cited as an implementation barrier at Schools A and B, both schools with high percentages of Hispanic students. School D's largest barrier to implementation was the school's (relatively new) age and a school leadership which was overwhelmed with managing growing pains and being understaffed. In terms of out-of-school factors, lack of parent engagement and health education was described as a barrier across all study schools.

All study schools faced social and environmental issues outside of school in the broader local community that affected implementation. For example, the prevalence of corner stores serving inexpensive, unhealthy foods was cited as a barrier. School B faced larger sociopolitical concerns related to its undocumented immigrant population and their fear of deportation, lack of access to transportation to drive to grocery stores, and multi-family living conditions which limited access to kitchens for cooking.

Another barrier cited in implementing the nutrition guidelines across the study schools is student tastes. The schools could put healthy foods in front of students, but if the students did not like the taste or had not been exposed to the food before, they would not eat it. The study school participants stated student education and exposure to healthy foods was important to get students to actually eat the healthy foods served to them.

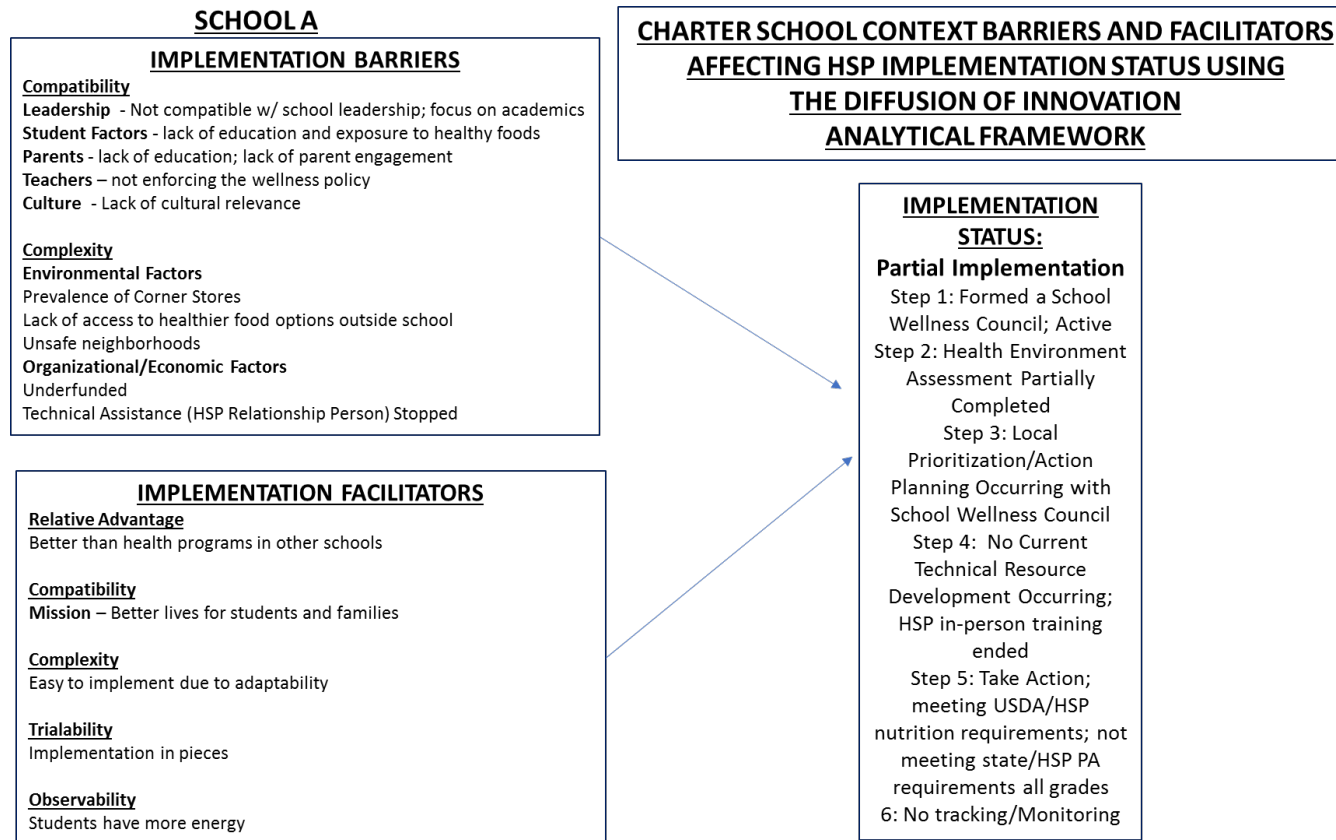
Last, study participants stated administrators and teachers often must contend with social and family issues the students experience outside of school, which can impact their behavior and well-being within the school. Making sure the students were healthy emotionally and behaviorally were also on the list of school administrator's priorities.

Implementation Facilitators

As previously mentioned, all study school participants stated that HSP was consistent with their school's mission and charter. School leadership support for HSP implementation was the biggest in-school implementation facilitator. Of the four study schools, School B had adopted HSP the most. This appears to be due to School B already having a strong culture of health promotion. Implementing HSP was already compatible with School B's existing culture and, therefore, was not as difficult to implement. HSP implementation appears to benefit from an existing climate of health promotion. Study

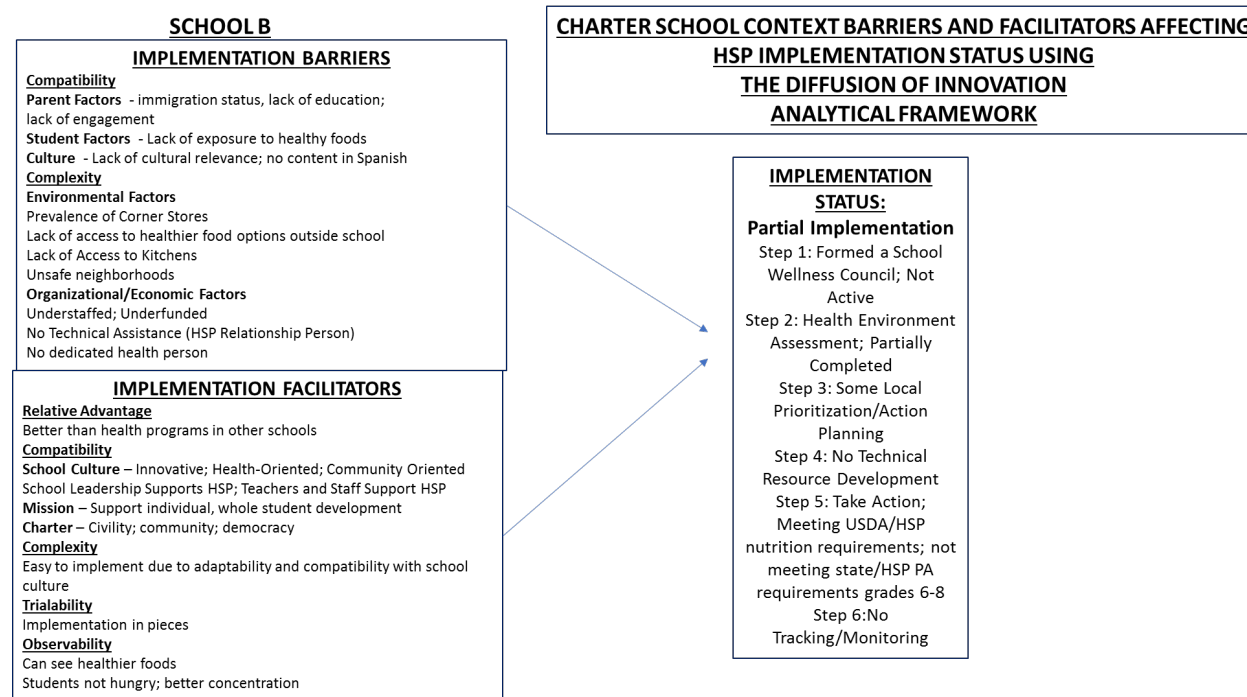
participants stated other factors facilitating implementation included flexibility and innovation in the curriculum that allows teachers to be innovative in integrating HSP concepts into their classrooms. The ability to implement HSP in phases and to prioritize initiatives were also cited by study participants as a program implementation facilitator. Figures 5-1, 5-2, 5-3, and 5-4 outline level of implementation as a function of the previously discussed factors.

Figure 5-1: Implementation Status—School A



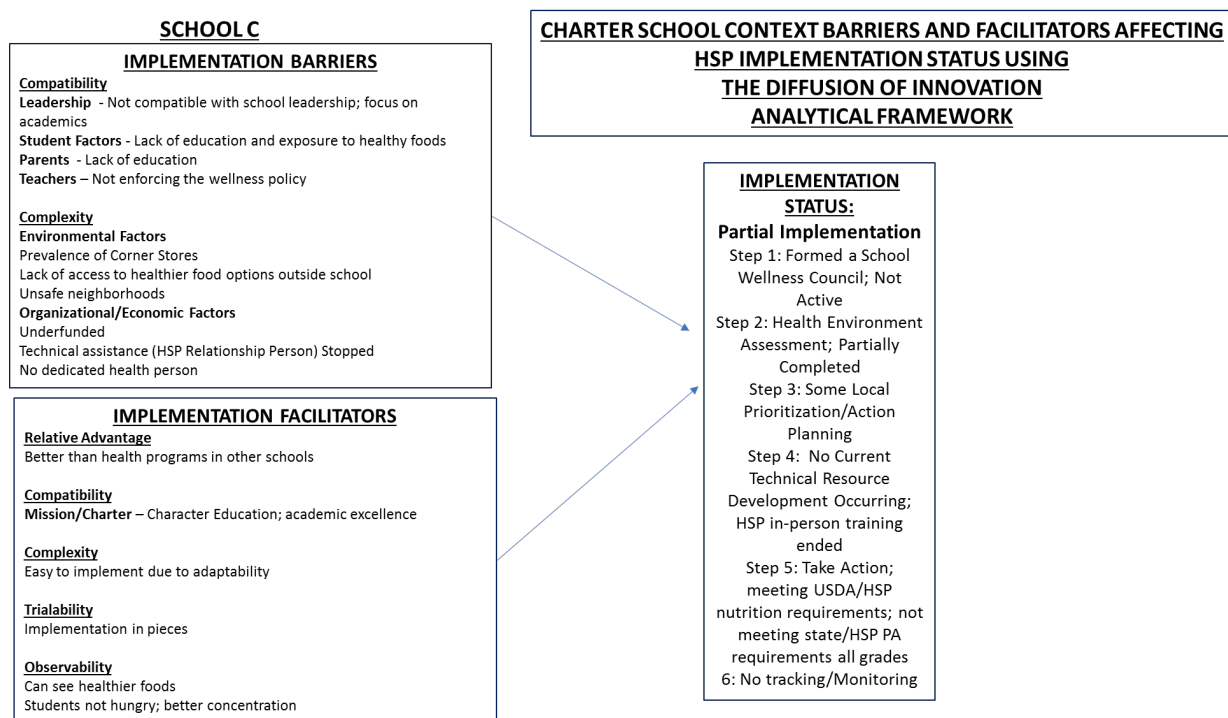
For School A, the main barriers to HSP implementation were 1) lack of leadership support; 2) lack of parent engagement; and 3) lack of cultural relevance. School A had adopted HSP with respect to forming an active School Wellness Council and planning health events, but without leadership support HSP implementation was not as integrated or as effective as it could be.

Figure 5-2: Implementation Status—School B



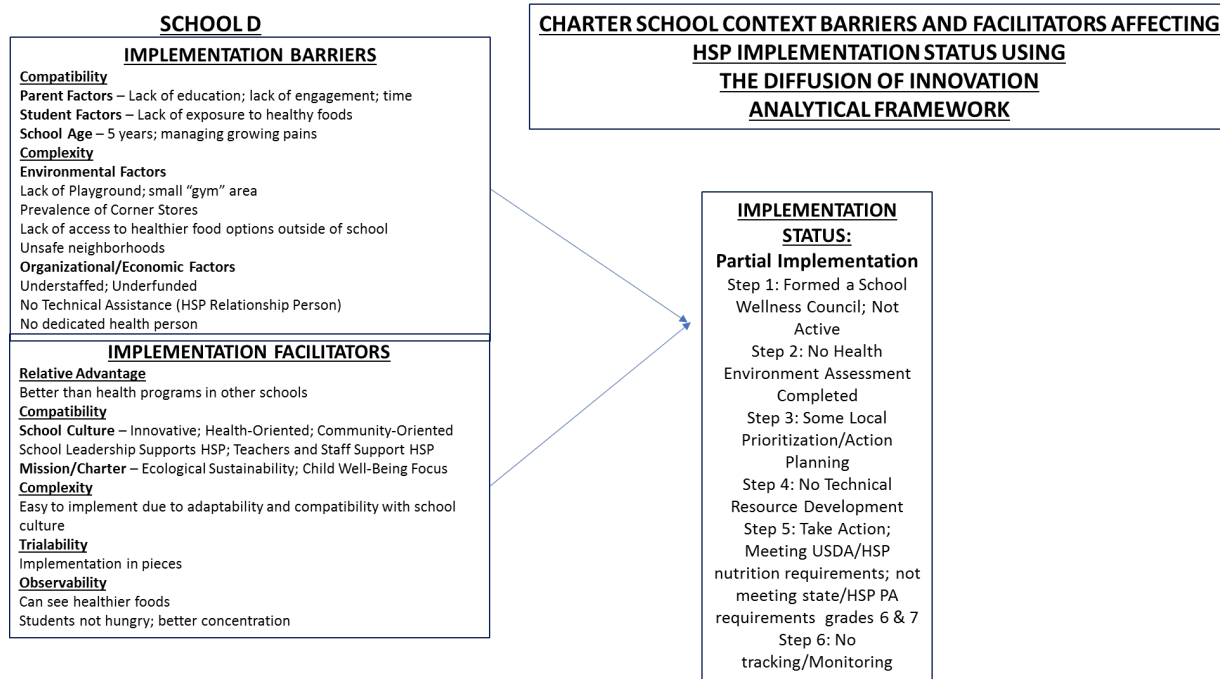
For School B, the main barriers to implementation were 1) lack of cultural relevance; 2) lack of understanding of the broader social and environmental context of School B's mostly Hispanic immigrant population; 3) lack of funding to do more programs; and 4) lack of parent engagement. Of all study schools, School B had adopted HSP the most. This appears to be because HSP was already very compatible with the school's context and, therefore, easy to implement.

Figure 5-3: Implementation Status—School C



For School C, lack of school leadership support was the main barrier to implementation. School C was initially on track to adopt more of HSP, but without leadership support, implementation efforts had waned. Currently, implementation is only occurring in pockets by individual people versus being a coordinated school-wide initiative.

Figure 5-4: Implementation Status—School D



For School D, the main barriers to implementation were 1) School D's young age and dealing with growing pains; 2) being understaffed; and 3) lack of parent engagement. School D has the leadership support to adopt more of HSP. With more time, as School D stabilizes its operations with more people and resources, HSP will likely be more fully adopted. In contrast to the other three study schools, School D had school leadership committed to health, but being a young school, the school staff was still implementing overall school systems and policies. School D was also the most understaffed of the study schools. Time and School D's age impacted HSP implementation. With time, it is possible school operations will become more stable and the school will hire more staff, freeing up more time for School D's administration and teachers to devote to HSP. Also, per the Diffusion of Innovation theory, more time may help in increasing knowledge of HSP throughout School D, which would facilitate implementation.

Additional Factors Impacting Implementation

School HSP Knowledge, Adoption, and Communication. Schools A and C did not have leadership support for HSP, which impacted HSP awareness and communication throughout these study schools. School B had a culture of health promotion; its leadership ensured School B's program was consistently communicated internally to school staff, as well as externally to parents.

Pressure to Perform. All study school participants stated they needed to perform better academically than their traditional public school counterparts and were held to a higher standard; all were acutely aware of the pressure to perform and the threat of closure. Whether charter schools must actually perform better than their traditional public school counterparts is open to debate; however, the charter schools' *perception*

that this is true is what is relevant to this study and potentially impacts HSP implementation. Although all study school participants had this perception, school leadership at study schools did not react the same way to this pressure in terms of HSP implementation. At Schools B and D, these schools did not view the decision as academics *or* health promotion; they viewed the decision as academics *and* health promotion. As previously stated, study school leadership may have prioritized academics above other programs, but in the context of this dissertation study, participants commented only on school leadership's focus on academics to the detriment of HSP implementation and health promotion more broadly. Because the administrations at Schools B and D both thought health promotion was complementary to and supportive of academic performance, HSP implementation at Schools B and D was better in terms of consistency of HSP messaging throughout the school and to parents at home, as well as wellness policy enforcement. Conversely, Schools A and C study participants felt school leadership made academics the priority to the detriment of HSP implementation. Although School C leadership stated health was important, according to School C study participants there was a disconnect between what the administration was saying and what was actually happening in the day-to-day support and enforcement of the School Wellness Policy. The policy to not allow junk foods at School C was not enforced. School B was also struggling to keep test scores up. This was due to a change in the makeup of the school's local community. In recent years, School B's student population had become more Hispanic with English as a second language. Test scores dropped, and school leadership cited this as a concern. According to the Education Director of School B, "The school becoming more of an immigrant Hispanic population led to "White,

bright flight,” which has negatively impacted test scores because the population has come more ESL. As a charter school, our test scores can’t go down. If our scores sink below the local TPS [traditional public schools], then we get shut down.” However, health promotion and HSP were compatible with the School B culture; the administration maintained its commitment to promoting overall student well-being, even in the face of academic and testing challenges. As an example of the administration’s commitment to health promotion, School B secured a grant to enable all students, irrespective of economic status, to eat free breakfast together in the morning. Serving healthy breakfasts is aligned with the USDA/HSP guidelines. However, in most schools, only students who qualify for school meals served under federal programs are served breakfast at school. School B’s administration thought that eating a healthy breakfast was important for all students’ well-being and therefore secured funding to provide one.

b. Recommendations for HSP Developers

The third of aim of this study was to determine if and how HSP needed to be modified to facilitate HSP implementation in New Jersey charter schools. This study’s findings suggest several modifications to HSP which would improve implementation and effectiveness. Although this study focused on independent, New Jersey charter schools, some of this study’s findings may be applicable to all schools. For example, lack of school leadership, cultural relevance, training, and health expertise were cited as barriers to HSP implementation in this study. These barriers are also consistent with wellness program implementation barriers found in the literature. This study also found lack of parent engagement and support for HSP to be an implementation barrier. Although not explicitly cited in the literature as a barrier to wellness program implementation,

consistent with Social Cognitive Theory and the literature, parents can also impact childhood obesity through their health attitudes, behaviors, and support of child health behaviors. Therefore, it is plausible that increasing parent health knowledge and engagement in students health, as well as improving parent health behavior, would also facilitate HSP implementation in all schools, not just the schools included in this dissertation study.

Other findings from this study that may be applicable to all schools include the need for schools to have a dedicated person with health expertise to push health initiatives forward and facilitate program evaluation. Schools in lower-income and underprivileged communities may also benefit from having more resources to support both student and parent health, and to better address broader social issues that may impact overall student health. Finally, all schools may benefit from a better mechanism or mechanisms to build school capacity to support HSP implementation on a sustained basis. Based on these findings, the following are recommendations for HSP developers to consider for all schools, not just independent New Jersey charter schools:

1) Change Starts at the Top: Provide school administrators with more information on the correlation between academic performance and health.

School A had health advocates on its staff. The School Wellness Council was active and committed to making the school environment and students healthier. Providing them with more information about the correlation between health and academics may help to better focus the school leadership on health. School C also had health advocates. However, in both cases, implementation efforts were not being fully supported by school leadership. In contrast, Schools B and D had

strong leadership support for HSP, and HSP was more effectively implemented in these study schools.

- 2) More Focus on Understanding the Social and Environmental Contexts of the School.** Study school participants stated there were social and environmental factors that affected implementation. All study schools had many social challenges that affected HSP implementation, both in school and out of school, when students went home to their communities. An issue noted across all study schools was the easy access to inexpensive junk foods sold via ubiquitous corner stores near study schools. HSP administrators could work with school, city, and state leadership to discuss policies and economic subsidies to help place healthy foods in these corner stores.

In addition to taking into account a school's physical, community environment, a school's cultural context should also be taken into consideration when designing content and programs. Culture should also be taken into account when designing content targeting both students and parents; HSP would be more effective if it reflected the culture of the school's students.

- 3) Better Communication of Wellness Benefits to Staff.** Across Schools A, C, and D, teachers could have been better educated about HSP and the benefits of eating healthily and engaging in physical activity. Arming health advocates with tools and information to be better educated champions of the program will facilitate HSP implementation. HSP and health and wellness need to be incorporated into teacher professional development. There need to be more opportunities to show staff games and activities they can do with students. School leadership support

will facilitate taking this recommendation. At School B, the school leadership had clearly outlined to staff the school's wellness policy and insisted upon its enforcement. Because School B already has a strong culture of health promotion, more communication about health benefits to staff is not as necessary. For a school with a pre-existing culture of health promotion, HSP administrators should put more focus on implementation support.

- 4) **Develop an Integrated Health Curriculum.** To help narrow the divide between the emphasis on academics and health promotion, HSP should develop an academic curriculum that both enhances math and reading skills and also conveys important health messages.
- 5) **Provide Schools with a Health Consultant and Health Educator.** This position could be filled by an HSP relationship manager and/or by offering additional HSP health experts as resources. There may be ways to share resources across multiple independent charter schools in the same geographic area. For example, leveraging a common health educator and/or an HSP implementation resource across independent charter schools may assist with providing schools with access to experts.
- 6) **Provide More Programs Targeted to Parents.** "Health starts at home" was a common theme across all interviews at all study schools. A better understanding of parents (their health behaviors, work schedules, cultures, and life stressors) may help to better inform content development targeted to them. This will potentially increase their health knowledge, level of engagement, and support for HSP with students at home, and impact the kinds of foods brought into the school.

7) **More Resources to Support Schools as Community Centers, Including**

Mental Health. Schools needed more services to better support student academic learning and development. The Dean of Students at School B stated, “Schools are not just schools; they’re community centers.” The CEO of School C stated, “We’re dealing with social gaps where other departments have failed. We have to fill those gaps because they affect our students and their families.” Health promotion and HSP implementation were intertwined with all study schools’ social environments. HSP administrators should advocate for additional funding for more health support services to be offered at charter schools. Although the concept of schools being community centers was explicitly stated at Schools B and C, participants at Schools A and D also stated that student health was connected to the socioeconomic status of the broader community. Participants at all study schools stated that part of the role of charter schools was to serve the community.

Related to the concept of schools being community centers, offering general wellness services to the broader community, study participants stated there needed to be a focus on health behavior, and mental health was cited as being important. HSP does not address mental health or the cognitive components of health coaching that underlie health behavior change. The Dean of Students at School B thought bringing in different professionals to talk about mindfulness and how to decompress the mind would be helpful: “Mental health is balance. Stress management supports eating healthy and engaging in exercise.” The Dean of Students of School B also stated that practical, healthy lifestyle skill-building

would be helpful. This Dean stated, “Skills supporting a healthy lifestyle would be helpful. Time management skills, financial management skills, organizational skills are really important.”

7) More Tools to Enable School Capacity Building. Schools need to find ways to sustain wellness initiatives in the face of limited funding. If resources outside of the school are going to be used, they need to be used in ways that build school capacity, so wellness initiatives can be sustainable. According to the Education Director at School B, “Initiatives start but then the grant runs out and then they stop. And if the school doesn’t have the capacity to take it on, then that’s the end of the program. So it needs to be something that is continuing and sustainable.” Capacity building includes building people resources as well as a consistent source of funds to help with implementation. When the grant for in-person training ended for School A and School C, both schools lost momentum with their implementation efforts. Schools need help to figure out ways to be more economically self-sufficient.

Another finding from this dissertation study was that HSP is designed for larger, traditional public schools that have support from a central office, and the current implementation format does not work as well in the context of smaller, independent charter schools. A recommendation to HSP developers, specific to charter schools, is to design a program that is tailored to smaller schools that do not have the benefit of a central office for implementation support. Charter schools also tend to be understaffed; in this dissertation study, all but one study school had student-teacher ratios significantly higher than the state average. HSP

developers should take this lack of staff into account more broadly when designing content and implementation best practices for charter schools. Charter schools also tend to have higher staff turnover in comparison to their traditional public school counterparts. HSP developers may want to acknowledge this issue and consider developing tools that teachers and administrators can use to help with on-boarding new staff to HSP and the school's health policies and practices. Perceptions of academic performance were also different in charter schools. Whereas all schools need to meet academic performance metrics, charter school employees feel extra pressure to not only meet the same standard as their traditional public school counterparts, but to exceed these standards. This pressure was cited across all study schools, and for those study schools that did not already have an ingrained culture of health, this pressure to perform negatively impacted HSP implementation. For schools that do not already have a culture of health, HSP developers should create implementation support content that recognizes this pressure to perform and helps internal HSP advocates to highlight to senior leadership how HSP is aligned with the goal of improving academic performance. Last, all study school participants felt the schools needed in-person support. HSP developers should re-think their model of providing only online and telephone support to charter schools, and investigate efficient ways to provide this unique and growing population of public schools with the same level of support as their traditional public school counterparts by assigning them HSP relationship managers as well.

c. Study Strengths and Limitations

This dissertation study had several strengths and limitations. In terms of strengths, the qualitative case study design, which included multiple sources of data (interviews with key HSP stakeholders, school observations, and school document review) allowed for a deep understanding of program implementation in select independent New Jersey charter schools. Study schools also varied in terms of demographics and challenges, providing different perspectives for factors impacting HSP implementation as well as opportunities to reveal commonalities.

This dissertation also had several limitations. The first limitation was that study participation, at both the school and the individual participant level, was voluntary. As a result, only a limited number of interviews could be conducted, specifically at School A. At this study school, several attempts were made to schedule interviews with the CEO, administration, and other staff, but no response was received. The amount of data collected varied by school. For example, the most interviews were conducted at School B; the fewest number of interviews was conducted at School A. Document collection was also subject to a school's willingness to provide this information. In some cases documents could not be obtained, for example School A's charter agreement. In general, less information was obtained from School A than from the other study schools.

The sample size of the dissertation study was small, with only four study schools. In addition to small sample size, the convenience sample both at the school and the participant level introduced bias into the results. Schools that opted to be included in the study may be different from those that did not. The school liaison's selection process for interviewees was biased. In order to gain more insight into factors impacting HSP

implementation, the school liaison reached out to teachers and staff they thought could offer more insight into HSP implementation and the school's wellness efforts. There may have been differential levels of knowledge between teachers and staff selected to participate in the study from those who were not selected, which resulted in bias. Further, the staff who were contacted by the liaison and who chose to participate may have been different from those who did not choose to participate. Due to the voluntary nature of the study, the number of documents collected, and how interviews were conducted, were subject to the school's cooperation.

This study focused on the main stakeholders at study schools implementing HSP, some of whom were also parents. Participants offered their perspectives on parent factors affecting HSP implementation. However, only two study participants, who were also parents of children attending a study school, were able to offer direct parent perspectives. Better direct understanding of parent perspectives on health—health knowledge and health promotion barriers and facilitators—is needed to draw more conclusions about how and why parents are impacting student health. Another limitation was that only one interviewer conducted interviews and reviewed transcripts and documents. There was no check for reliability of conclusions from quotes or other views or input included in data collection or analysis. Last, this dissertation study focused on independent, New Jersey charter schools only; results are not generalizable to other school populations.

d. Future Research

This dissertation study focused on factors affecting HSP implementation within study schools; research conducted focused on HSP stakeholders within the school. However, this dissertation study revealed factors outside of study schools that impacted

HSP implementation. Future research should be conducted to better understand these external factors that affect HSP implementation. Specifically, parents were found to have an impact on HSP implementation. As a follow-up to this dissertation study, future research focused on parents should be conducted. This research should focus on gaining a better understanding of parental health education and behaviors and factors, from the parent perspective, that facilitate or hinder supporting HSP for their children. Findings from this research could then serve as the basis for programs targeted to parent health behaviors, and incorporated into the overall Healthy Schools Program.

This dissertation study was exploratory; the results of this dissertation study are not generalizable to other populations, but study findings can potentially serve as a basis to potentially guide HSP developers in improving both HSP implementation and program content for independent New Jersey charter schools. Findings from this dissertation study can also be used as the basis for a larger study with more New Jersey charter schools and potentially schools in other states. Research should be conducted with a larger sample of independent New Jersey charter schools to better determine if findings from this dissertation study are also applicable to other New Jersey independent charter schools. It may also be illuminating to conduct similar research in other states.

APPENDIX 3-1
FOOD AND BEVERAGE VENDOR INTERVIEW PROTOCOL

To be read by interviewer:

Thank you for taking the time to talk with me today. My name is Jennifer Turner and I am a doctoral candidate at Rutgers School of Public Health, pursuing a Doctor of Public Health, specializing in Health Education and Behavioral Science. My dissertation focuses on evaluating the implementation of a school-based childhood obesity prevention program. As part of my dissertation, I am conducting an evaluation of the Alliance for a Healthier Generation's Healthy Schools Program (HSP) in a small sample of New Jersey charter schools to gain an understanding of the extent to which the program is being implemented, and the barriers and facilitators to program implementation. My evaluation includes conducting interviews with a key school staff (teachers and administrators), parents and community leaders at different New Jersey charter schools. The information I collect will help me to understand the points of view from multiple stakeholders' points of view, and the successes and challenges schools experience in developing and implementing their Healthy Schools Program. This interview will take 45-60 minutes.

I'm going to take notes while I talk with you, but I would also like to audiotape the interview to confirm that my notes are accurate. May I have your permission to audiotape this interview?

[Note: Do not audiotape the interview without the respondent's permission.]

General Background Questions

School Tenure

- 1) *How long have you been a vendor for the school? What food or beverage services do you provide to the school?*

General School Health Initiative Awareness

- 2) *What school health (diet and exercise) initiatives are you aware of?*
- 3) *Are you aware of steps the school is taking to improve the nutritional quality of the reimbursable meals served? Who on the school staff has been communicating these steps and guidelines to you?*

Healthy Schools Program Awareness

- 4) *Are you aware of the Healthy Schools Program (HSP)?*

- 5) *If so, are you aware of the HSP nutritional guidelines regarding food and beverages? These are the same guidelines outlined by the USDA?*

Healthy Schools Program Implementation

Healthy Hunger Free Kids Act (HHFKA) gives the USDA the authority to set nutritional standards for all foods regularly sold in school during the school day, including vending machines, the “a la carte” lunch lines, and school stores.

- 6) *In terms of nutrition in compliance with USDA guidelines of HHFKA, does your school offer or use:*

- a. Only 1%, ½% or fat-free milk (flavored or unflavored; flavored milk must contain no more than 150 calories per 8 oz.)
- b. Half of all grains offered daily, at breakfast and lunch, are whole grains
- c. At least one fruit (fresh, canned or frozen in fruit juice or light syrup) is offered at breakfast
- d. At least four non-fried, no-added-sugar fruit and/or vegetable options daily (salad can serve as one of the four)
- e. At least one low-fat entree choice at lunch with $\leq 35\%$ calories from fat, $\leq 10\%$ calories from saturated fat, 0 g trans fat and ≤ 480 mg sodium
- f. Only unsaturated (no more than 1 g saturated fat), zero trans fat oils during on-site (post-manufactured) food preparation
- g. Serve only non-fried food products (food products that have not been pre-fried, flash fried, or par-fried during the manufacturing process) and uses no deep fat frying in food preparation
- h. Non-fried fish at least one time per week

- i. Only lean protein products such as lean red meat, skinless poultry, lean deli meats, fat-free or low-fat cheese, beans, tofu, etc. (Lean: less than 10 g fat, 4.5 g or less saturated fat, and less than 95 mg cholesterol per serving and per 100 g.)
- j. A daily salad with three fruits or vegetables in addition to lettuce/lettuce mix. If dressing is offered, must be portion controlled, 1 oz. low-fat or no-fat dressing
- k. Only desserts that meet the Alliance Competitive Foods Guidelines

7) As a vendor, what challenges have you faced in following these guidelines?

How are you addressing those challenges?

8) With respect to implementing the HSP nutritional guidelines regarding food and beverages, what factors do you think help with program implementation?

What factors do you think serve as barriers to program implementation?

9) From your perspective, what challenges has the food services program encountered serving fruit and vegetables, lean protein, low-fat foods, and unsweetened beverages to students?

10) What limitations have you encountered offering fresh produce?

11) How do you see the eating of fruit and vegetables and other nutritious foods promoted to students?

12) Do you know who is responsible in your school for evaluating and reporting progress on the implementation of the HSP nutritional guidelines regarding food and beverages?

- a. *Are your services evaluated? If so by whom, how often, and what are the evaluation criteria?*

Diffusion of Innovation - Compatibility

13) Do you think youth being overweight is a problem in the school?

14) Do you supply foods or beverages for the school's reimbursable meals offerings? (i.e. school lunch and breakfast meals as part of the National Schools Lunch Program and National School Breakfast Program)

- a. *If yes, are you satisfied with the offerings or are the shortcomings in terms of variety and quality?*

15) Do you supply foods or beverages for the school's competitive foods offerings?

A competitive or "alternative food" is defined as any foods or drinks sold or served on school grounds other than meals served by the school food service program (e.g., a la carte offerings; food and beverages in vending machines, snack bars, school stores and concession stands)

- a. *If yes, are you satisfied with the offerings in vending machines or a la carte? If not, what are the shortcomings?*

16) Are you familiar with the HSP Competitive Foods Guidelines (USDA)?

- The school should not advertise or market foods and beverages to students that do not meet the Smart Snacks criteria.
- The school also only does fundraisers with foods that meet the USDA Smart Snacks criteria.
- If foods and beverages are sold to students on the school campus at events outside of the school day (e.g., sporting event, after-school

activities, award ceremonies) then water, fruit, and/or vegetables are also offered and promoted as options.

17) In the school, what are the healthy food selections which reflect the cultural demographics of the student population?

18) How does menu planning reflect the preferences of the cultures represented by the students in the school or district? How have recipes for culturally preferred foods been adapted to address the standards of healthy food selections?

Diffusion of Innovation - Simplicity vs. Complexity

19) During the current school year, have you received any technical assistance or training? If yes, who provided training? How did you receive this training? What topics did the technical assistance or training sessions cover? In what ways was each of the technical assistance or training sessions you participated in helpful?

20) During the current school year, what types of technical assistance or training on school wellness or obesity prevention has your school received from outside consultants or other persons not associated with the Healthy Schools Program? How helpful was this assistance to your school in terms of improving the health of students and staff?

Diffusion of Innovation – Observability

21) Have you been able to observe the impacts of HSP on the school? For example, the changes in the menu, changes in student and staff health behaviors, if healthy messages are communicated in the school environment.

HSP Overall Perceptions

- 22) *What components of the Healthy Schools Program do you find helpful?*
- 23) *Are there areas of the Healthy Schools Program that could be improved?*
- 24) *Are there additional program components or resources the Healthy Schools Program does not offer but you think would be helpful to offer?*
- 25) *What questions, if any, do you have about the overall approach of the Healthy Schools Program and what the program is asking schools to do?*

APPENDIX 3-2:
FOOD SERVICE ADMINISTRATOR INTERVIEW PROTOCOL

To be read by interviewer:

Thank you for taking the time to talk with me today. My name is Jennifer Turner and I am a doctoral candidate at Rutgers School of Public Health, pursuing a Doctor of Public Health, specializing in Health Education and Behavioral Science. My dissertation focuses on evaluating the implementation of a school-based childhood obesity prevention program. As part of my dissertation, I am conducting an evaluation of the Alliance for a Healthier Generation's Healthy Schools Program (HSP) in a small sample of New Jersey charter schools to gain an understanding of the extent to which the program is being implemented, and the barriers and facilitators to program implementation. My evaluation includes conducting interviews with a key school staff (teachers and administrators), parents and community leaders at different New Jersey charter schools. The information I collect will help me to understand the points of view from multiple stakeholders' points of view, and the successes and challenges schools experience in developing and implementing their Healthy Schools Program. This interview will take 45-60 minutes.

I'm going to take notes while I talk with you, but I would also like to audiotape the interview to confirm that my notes are accurate. May I have your permission to audiotape this interview?

[Note: Do not audiotape the interview without the respondent's permission.]

General Background Questions

School Tenure

1. *How long have you been an administrator at the school?*

School Meals Program

2. *Does your school participate in the National School Breakfast and Lunch Programs or in independent breakfast and lunch programs that meet USDA nutrition standards?*
3. *Do school breakfast and lunch programs meet USDA School Meals Initiative (SMI) standards for reimbursable meals?*
4. *Do you know if your school offers only whole grains daily at breakfast and lunch?*

5. *Does your school conduct annual training covering techniques such as reducing fat and sodium in food preparation, and portion control, for your food service staff?*
6. *Is your school meals program sensitive to the cultural needs of your school population?*
 - a. *How does menu planning reflect the preferences of the cultures represented by the students in the school or district? How have recipes for culturally preferred foods been adapted to address the standards of healthy food selections?*

General School Health Initiative Awareness

7. *What school health (diet and exercise) initiatives are you aware of?*
8. *What steps is your school taking to improve the nutritional quality of the reimbursable meals served?*
 - a. *What steps is your school taking to improve the nutritional quality of the competitive foods served? What has worked well? Why do you think it worked? What did not work? Why do you think it did not work?*
9. *Does your school have a School Wellness Policy?*
 - a. *If yes, who is responsible in your school for district for evaluating and reporting progress on the implementation of the wellness policy? Please tell me more about that process. How often will evaluating and reporting be conducted?*

Healthy Schools Program Awareness and Implementation

10. *Do you know about the Healthy Schools Program?*

- a. *If yes, do you have a role in implementing the School Wellness Policy?
What is your role?*
- b. *With respect to HSP implementation more broadly, what factors do you think help with program implementation? What factors do you think serve as barriers to program implementation?*
- c. *If you are involved in implementing School Wellness Policy, what challenges have you faced in your school or community in implementing the policy? How are you addressing those challenges?*

The Healthy Hunger Free Kids Act (HHFKA) gives the USDA the authority to set nutritional standards for all foods regularly sold in school during the school day, including vending machines, the “a la carte” lunch lines, and school stores.

- 11. *In terms of nutrition in compliance with USDA guidelines of HHFKA, does your school include use of healthy options such as fat free milk, half of all grains being whole grains, at least one fruit at breakfast, at least four non-fried, no-added-sugar fruit and/or vegetable options daily, only unsaturated fat and non-trans fat, and lean proteins?*
- 12. *Do you know if all beverages offered for sale to students outside of the school meals program during the regular and extended school day meet or exceed the HSP Beverage Guidelines? The HSP Beverage Guidelines state plain water and carbonated water are in compliance; regular soda, juice drinks (not 100% juice); sports drinks (full calorie); sweetened tea; energy drinks; other sugar sweetened beverages are not in compliance.*
- 13. *Do the beverages served to students outside of the school meals program*

during the regular and extended school day, including school and classroom parties, meet the HSP Beverage Guidelines?

14. Ensured all new Requests for Proposals and/or Requests for Quotes that contain competitive foods and are issued during this school year (even if effective for future school years) include only competitive foods that meet the HSP guidelines

15. Have you taken actions to encourage students eating and drinking healthier options such as:

- a. Lowered the price of compliant competitive foods and raised the price of non-compliant foods in all areas where competitive foods are sold
- b. Substituted at least two non-compliant food fundraisers with non-food alternatives or with only products that meet the Guidelines
- c. Conducted one or more initiatives with an evaluation component to engage students in leading change toward healthier competitive foods at the school
- d. Conducted a marketing campaign with evidence of input from students, school staff, administration and food service staff to promote nutritious snack choices in all areas where competitive foods are sold

Competitive Foods

A competitive or “alternative food” is defined as any foods or drinks sold or served on school grounds other than meals served by the school food service program.

Competitive foods include a la carte offerings; food and beverages in vending machines, snack bars, school stores and concession stands; food and beverages sold

as part of school-sponsored fundraising activities; and refreshments served at parties, celebrations and meetings.

The HSP Competitive Foods Guidelines (same as USDA) state:

- The school should not advertise or market foods and beverages to students that do not meet the Smart Snacks criteria.
- The school also only does fundraisers with foods that meet the USDA Smart Snacks criteria.
- If foods and beverages are sold to students on the school campus at events outside of the school day (e.g., sporting event, after-school activities, award ceremonies) then water, fruit, and/or vegetables are also offered and promoted as options.

16. Do you know if all competitive foods offered for sale to students outside of the school meal program during the regular and extended school day meet or exceed the HSP Competitive Foods Guidelines?

17. Do all competitive foods served to students outside of the school meals program during the regular and extended school day, including school and classroom parties, meet the HSP Foods Guidelines?

18. Has your school completed an inventory of all competitive foods currently offered in vending machines, on a la carte lines, as fundraisers, and school stores and on snack carts to identify which meet the HSP Competitive Foods Guidelines? Have you created a list of vendors that meet the HSP Competitive Food Guidelines?

19. Have you developed a written policy stating that all competitive foods will be

compliant with the HSP Guidelines within 12 months and sent this policy to parents and guardians?

Diffusion of Innovation - Compatibility

20. How does health fit into your school's charter and school mission?

21. Do you think youth being overweight is a problem in your school?

22. Are you satisfied with the variety and quality of your school's reimbursable meals offerings? (i.e. school lunch and breakfast meals as part of the National Schools Lunch Program and National School Breakfast Program) If yes, in what ways are you satisfied? If no, what are the shortcomings in terms of variety and quality?

a. What about competitive foods and beverages offered in vending machines, if applicable?

23. What contracts does your school have with beverage manufacturers or distributors and food vendors for the right to sell their products in your school (through vending machines or the cafeteria)? Does your school receive a flat fee, or an amount based on sales? How much money did your school receive from these contracts last year? Roughly what percentage of your school budget do these contracts represent? What is this money used for? Has the school or the district renegotiated the contracts to meet Healthy Schools Program school recognition criteria?

24. What is your perception of the amount of money your school earns overall by selling food or beverages on school grounds that do not meet Healthy Schools Program criteria?

25. *What, if anything, would your school gain or lose if it were to align all food and beverages sold in all school venues, including the cafeteria and vending machines, to Healthy Schools Program criteria?*
26. *What challenges has the food services program encountered serving fruit and vegetables, lean protein, low-fat foods, and unsweetened beverages to students?*
27. *What limitations have the food services program encountered buying fresh produce?*
28. *How do you as the food services director promote the eating of fruit and vegetables and other nutritious foods by students?*
29. *How are student health and wellness efforts publicized at the school? Is student health and wellness a standing agenda item for school or district meetings?*

Diffusion of Innovation - Simplicity vs. Complexity

30. *During the current school year, have you received any technical assistance or training? If yes, who provided the training? How was it provided?*
31. *What topics did the technical assistance or training sessions cover? In what ways were each of the technical assistance or training sessions you participated in helpful?*
32. *During the current school year, what types of technical assistance or training on school wellness or obesity prevention has your school received from outside consultants or other persons not associated with the Healthy*

Schools Program? How helpful was this assistance to your school in terms of improving the health of students and staff?

HSP Overall Perceptions

33. *What components of the Healthy Schools Program do you find helpful?*
34. *Are there areas of the Healthy Schools Program that could be improved?*
35. *Are there additional program components or resources the Healthy Schools Program does not offer but you think would be helpful to offer?*
36. *What questions, if any, do you have about the overall approach of the Healthy Schools Program and what the program is asking schools to do?*

APPENDIX 3-3: **SCHOOL ADMINISTRATOR INTERVIEW PROTOCOL**

To be read by interviewer:

Thank you for taking the time to talk with me today. My name is Jennifer Turner and I am a doctoral candidate at Rutgers School of Public Health, pursuing a Doctor of Public Health, specializing in Health Education and Behavioral Science. My dissertation focuses on evaluating the implementation of a school-based childhood obesity prevention program. As part of my dissertation, I am conducting an evaluation of the Alliance for a Healthier Generation's Healthy Schools Program (HSP) in a small sample of New Jersey charter schools to gain an understanding of the extent to which the program is being implemented, and the barriers and facilitators to program implementation. My evaluation includes conducting interviews with a key school staff (teachers and administrators), parents and community leaders at different New Jersey charter schools. The information I collect will help me to understand the points of view from multiple stakeholders' points of view, and the successes and challenges schools experience in developing and implementing their Healthy Schools Program. This interview will take 45-60 minutes.

I'm going to take notes while I talk with you, but I would also like to audiotape the interview to confirm that my notes are accurate. May I have your permission to audiotape this interview?

[Note: Do not audiotape the interview without the respondent's permission.]

Charter School General Information

General Background Questions

1. School Role - *What is your role at the charter school?* school administrator (e.g., CEO, principal, manager/director)
2. School Tenure - *How long have you been working at the school?*
3. School Background Questions
 - a. *Is your charter school a brand, new school or conversion from a previous school structure?*
 - b. *How long have you been a charter school?*
 - c. *Do you know when your school is up for charter renewal?*

4. General School Health Initiative Awareness - *What school health (diet and exercise) initiatives are you aware of?*
5. Perceptions of Overweight and Obesity - *Do you think youth being overweight is a problem in your school?*

General HSP Implementation Questions

HSP Awareness

6. *Do you know about the Healthy Schools Program?*
7. *How did you become aware of the Healthy Schools Program?*
8. *How was it decided that your school would participate in the Healthy Schools Program?*
9. *Do you know when your school started implementing the Healthy Schools Program? Is HSP implemented the same across all grade levels?*
10. *Do you know if your school has gone through the charter renewal process since implementing the Healthy Schools Program?*

HSP Management

11. *Who in your school is responsible for developing, implementing and overseeing the Healthy Schools Program?*
12. *What is your role in the Healthy Schools Program?*
13. *Are you involved in the development, implementation, and oversight of the Healthy Schools Program? Is there an opinion leader?*

Before proceeding with asking questions about implementation of specific HSP implementation components, the following questions will be asked, relating back to the HSP six-step implementation process: 1) Formation of

a school wellness council; 2) Completion of the HSP school health environment assessment; 3) Local prioritization and action planning; 4) Technical resource development; 5) Take Action; 6) Monitoring and evaluation of progress

Formation of a school wellness council (HSP Six-Step Process Step#1)

14. Has your school formed a school wellness council? Why or why not?

15. If yes, how often does the wellness council/committee meet?

16. Does your school wellness council/committee include at least one student-family member representative as an active member? What is parental or guardian involvement? Are parents or guardians involved in the planning of school wellness activities? Do students have the opportunity to provide input into the development and implementation of school health and wellness activities?

17. If your school wellness council/committee has been established, how does your school wellness council/committee represent the varying linguistic, cultural and socio-economic backgrounds of your student population?

Completion of the healthy schools assessment – (HSP Six-Step Process Step#2)

18. Has your school completed the HSP (same as the School Health Index) school health assessment in the health content areas? Why or why not?

Which, if any, of the content area assessment pieces have you completed? Why?

Content areas of the School Health Index

- i. School Policies and Environment
- ii. Health Education

- iii. Physical Education
- iv. Nutrition Services
- v. Health Promotion for Staff
- vi. Family and Community Involvement

Local prioritization & action planning (HSP Six-Step Process Step#3)

19. If you have completed the school health assessment, have you started to prioritize findings and develop an action plan? Why or why not?

Technical resource development and brokering (HSP Six-Step Process Step#4)

20. Have you received any technical assistance or resource support from HSP/The Alliance or from outside consultants or subject matter (e.g., nutrition, physical education, medical) experts?

Take Action (HSP Six-Step Process Step#5)

21. Has your school received any HSP implementation support?

Monitoring and evaluation of progress (HSP Six-Step Process Step#6)

22. Have you been tracking your school's progress in HSP implementation, e.g., making your school environment healthier and/or tracking the health outcomes of students and staff?

a. If yes, how have you been tracking progress? What data collection measures are used and what metrics are tracked? (e.g., child BMI, weekly minutes engaged in child PA, weekly minutes engaged in employee PA?)

23. Does your school have a School Wellness Policy?

- a. If so, what is your role in implementing the School Wellness Policy?***
- b. How are wellness policy initiatives communicated to students,***

families and school staff?

- c. Who in your school is responsible for evaluating and reporting progress on the implementation of the School Wellness Policy? How often are evaluating and reporting conducted? What process is in place to ensure that the School Wellness Policy is followed? Who is responsible for monitoring compliance?*
- d. Has your school secured funds to implement school health/wellness action plan if such a plan has been developed?*

Diffusion of Innovation Protocol Framework

Relative Advantage - Is HSP better than existing health programs?

- 24. To communicate benefits of the program and plan implementation throughout the school, what parties were included in that process?*
- 25. How committed has senior leadership (or you if CEO/principal) been to HSP implementation?*
- 26. How do you feel about HSP, both the content and as a tool for local wellness policy implementation? How does HSP compare to other school-based childhood obesity prevention programs and initiatives the school has implemented or currently implementing?*
 - a. With respect to HSP content, how do you feel about the content targeted to students, teachers, parents/families?*
 - b. How do you feel about the tools/curriculum provided to teachers?*
 - c. How can HSP be improved to be better than existing school-based childhood obesity prevention programs and initiatives?*

- d. Is HSP better than other community-based childhood obesity prevention programs? If yes, in what ways?*

27. Have you implemented employee wellness programs?

- a. If yes, what are the key components of your school's Staff Wellness Program? For example, weight management (physical activity and healthy eating opportunities), health screenings, stress management, tobacco cessation.*
- b. Who is responsible for its implementation and what activities have taken place?*
- c. If you have a school employee wellness action plan, how often is it evaluated? (annually, semiannually, quarterly?)*
- d. Do you know if food and beverages sold and served in the staff lounge are in line with HSP?*
- e. What types of formal or informal support does the school provide to promote staff wellness messages in a language and cultural context that is meaningful to staff of various cultural backgrounds?*

Overall Perceptions of HSP

28. How do you see the Healthy Schools Program complementing your school's overall school improvement efforts?

- a. What elements of the Healthy Schools Program do you find helpful?*
- b. What elements of the Healthy Schools Program do you think need improvement? How would you improve them?*

- c. *Are there additional or different resources or elements you think should be added to the Healthy Schools Program?*

29. *What would facilitate the implementation of the Healthy Schools Program at your school?*

- a. *What would impede/is impeding the implementation of the Healthy Schools Program?*
- b. *What areas of your Healthy Schools Program do you need assistance with?*
- c. *Do you feel you have the right resources (e.g. health expertise and time) to implement the Healthy Schools Program?*

30. *Do you think you will be implementing HSP long-term? How long do you think HSP will continue to be a part of your school environment?*

Compatibility - To what extent is HSP compatible with the charter school context?

Charter School Context Questions

31. School charter - *Is student health and wellness aligned with the obligations your school charter?*

32. Mission - *Is student health and wellness aligned with your school charter?*

33. Accountability (NJDOE Performance Framework) - *How does public accountability and the NJDOE Performance Framework impact the school's ability to implement HSP?*

- a. *How would you classify your school's financial performance? Meeting expectations, below expectations, exceeding expectations?*

- b. *How would you classify organizational performance? Meeting expectations, below expectations, exceeding expectations?*
 - c. *How would you classify academic performance? Meeting expectations, below expectations, exceeding expectations?*
- 34. Organizational structure and autonomy - *Do you think being an independent charter school helps or hinder with HSP implementation?*
- 35. Instructional context and innovation- *How does HSP fit with the school's educational approach and philosophy? What are some of the barriers or facilitators to integrating HSP into the school curriculum?*
- 36. Teacher staffing (recruitment, selection, and retention) - *How is teacher turnover? How many teachers who have been at the school for less than 2 years are currently on staff? How do you think turnover affect HSP implementation? Do you know how new teachers learn about HSP/are on-boarded? How easy is it for a new teacher to integrate HSP into their classroom?*
- 37. Charter school age – *How long has your charter school been in existence? Do you think the charter school age impacts HSP implementation?*
- 38. Charter renewal cycle – *Where are you in your charter renewal cycle? Have you gone through the charter renewal process since implementing HSP? Do you think the charter renewal process has impacted HSP implementation? If so, how?*
- 39. Student demographics - *What is the ethnic and racial composition of the student body? How do cultural factors impact program implementation? Are students included in food and physical activity choices within the school?*

40. Parental engagement - *In general do you feel parents are engaged – not just with health initiatives, but with school activities in general? What role do you see parents playing in HSP implementation?*

41. HSP improvement - *How could HSP be altered to be more compatible with your school?*

Complexity vs. Simplicity – Is it difficult or easy to implement HSP and why?

42. *During the current school year, what types of technical assistance or training on school wellness or obesity prevention has your school received from outside consultants or other persons not associated with the Healthy Schools Program? Does your school use non-HSP outside consultants, experts or staff to assist with program implementation?*

43. *If your school uses outside consultants not associated with HSP, how helpful was this assistance to your school in terms of improving the health of students and staff?*

44. *Have you ever received training or technical assistance from an HSP relationship manager?*

45. *Does your school use HSP online and telephone technical assistance tools? How are these tools helpful in program implementation?*

46. *If so, what topics did the technical assistance or training sessions cover? In what ways was each of the technical assistance or training sessions you participated in helpful?*

47. *Were key personnel trained on program and policy components? Do key personnel engage in ongoing training to sustain the momentum?*

48. Do you think the program is templated for easier implementation? Do you think program components can be easily changed to meet the specific needs of your school?

49. Do you feel you have the time and resources to implement HSP?

50. Is there a way HSP could be simplified that would facilitate implementation?

Trialability – Can the program be implemented incrementally?

51. Do you think HSP can be implemented in parts or do you think HSP needs to be implemented in totality?

- a. If HSP can be implemented in parts, which components are the easiest for you to implement and why?*
- b. Which program components are priorities?*

Observability – To what extent are the outcomes of HSP observable?

52. Have you seen the impact of HSP? For example, changes in the school environment such as cafeteria menu changes, visible messaging supporting healthy behaviors, vending machines serving only healthy options

- a. Changes in student BMI, increases in child PA, improvements in child eating habits.*
- b. How could HSP outcomes be more observable?*

Overall Perceptions of the School Wellness Environment

Food and Beverage

53. Are you satisfied with the variety and quality of your school's food and beverage offerings (e.g., cafeteria and vending machine foods and beverages)? If yes, in

what ways are you satisfied? If no, what are the shortcomings in terms of variety and quality?

54. What steps is your school taking to improve the nutritional quality of the meals served?

55. What steps is your school taking to improve the nutritional quality of the competitive foods served? What worked well? Why do you think it worked? What did not work well? Why do you think it did not work?

56. Is drinking water is available to all students free of charge at all times during the school day?

Physical Activity

57. Do all students have the opportunity to participate in physical activity breaks on a daily basis? If yes, what kind of activities do they participate in?

58. Are you satisfied with the quantity and quality of your school's physical activities and physical education classes? If yes, in what ways are you satisfied? If no, what are the shortcomings in terms of quantity and quality?

59. Are you satisfied with the quantity and quality of your school's extracurricular physical activity offerings? If yes, in what ways are you satisfied? If no what are the shortcomings in terms of quantity and quality?

60. What attempts has your school made to improve students' physical activity? What worked well? Why do you think it worked? What did not work well? Why do you think it did not work?

61. In what ways do your school's physical activities and physical education and health education programs respond to the needs and interests of the various cultures represented by the student population?

Health Education

62. Do you have a health education program?

- a. If yes, is health education taught by trained teachers?*
- b. Do all teachers who teach health education receive annual professional development on effective practices for health education, including physical activity and healthy eating? If yes, how many hours of training do they receive?*
- c. Are healthy eating and physical activity messages integrated into other subject areas?*

63. Are you satisfied with the quantity and quality of your school's health education classes? If yes, in what ways are you satisfied? If no, what are the shortcomings in terms of quantity and quality?

Before and After-School Programs

64. Does your school offer before and after school programs?

65. If so, do before and after school programs how much time is dedicated to physical activity? (e.g., 20%, 50%)

66. Do your before and after school programs offer a healthy snack as part of the After-School Snack Program reimbursed through the USDA and compliant with the HSP Competitive Food and Beverage Guidelines? Are you familiar with these guidelines?

67. Do your before- and after-school programs offer a variety of physical activity opportunities that reflect the diversity and needs among students, families and the community? Are students encouraged to connect with physical activity opportunities in the community?

APPENDIX 3-4: **TEACHER INTERVIEW PROTOCOL**

To be read by interviewer:

Thank you for taking the time to talk with me today. My name is Jennifer Turner and I am a doctoral candidate at Rutgers School of Public Health, pursuing a Doctor of Public Health, specializing in Health Education and Behavioral Science. My dissertation focuses on evaluating the implementation of a school-based childhood obesity prevention program. As part of my dissertation, I am conducting an evaluation of the Alliance for a Healthier Generation's Healthy Schools Program (HSP) in a small sample of New Jersey charter schools to gain an understanding of the extent to which the program is being implemented, and the barriers and facilitators to program implementation. My evaluation includes conducting interviews with a key school staff (teachers and administrators), parents and community leaders at different New Jersey charter schools. The information I collect will help me to understand the points of view from multiple stakeholders' points of view, and the successes and challenges schools experience in developing and implementing their Healthy Schools Program. This interview will take 45-60 minutes.

I'm going to take notes while I talk with you, but I would also like to audiotape the interview to confirm that my notes are accurate. May I have your permission to audiotape this interview?

[Note: Do not audiotape the interview without the respondent's permission.]

General Background Questions

School Tenure

- 1) *How long have you been a teacher at the school? How long have you been a teacher?*

General School Health Initiative Awareness

- 2) *What school health (diet and exercise) initiatives are you aware of?*

Healthy Schools Program Awareness

- 3) *Do you know about the Healthy Schools Program?*

Diffusion of Innovation Protocol Framework

Relative Advantage - Is HSP better than existing health programs?

- 4) *How does HSP compare to other school-based childhood obesity prevention programs and initiatives the school has implemented or currently implementing?*
 - a. *How do you feel about HSP, both the content and as a tool for local wellness policy implementation? Is it better than other school wellness programs? Is HSP better than other community-based childhood obesity prevention programs?*
 - b. *With respect to HSP content, how do you feel about the content targeted to students, teachers, parents/families? Are you aware of this content?*
 - c. *Are you aware of the employee wellness component? If so have you participated in HSP employee wellness initiatives? How do you feel about HSP content targeted to teachers/employees?*
- 5) *To communicate benefits of the program and plan implementation were you or other teachers included in that process?*
- 6) *In your opinion, how committed was senior leadership to HSP implementation?*
- 7) *Has HSP impacted your own personal wellness? If yes, how?*
- 8) *How can HSP be improved to be better than existing school-based childhood obesity prevention programs and initiatives?*
- 9) *How do you feel about the tools/curriculum provided to teachers?*
- 10) *Overall, how could HSP be improved to be better in comparison to existing school-based childhood obesity prevention programs and initiatives, and better generally?*

Compatibility - To what extent is HSP compatible with the charter school context?

Charter School Context Questions

- 11) School charter - *Is student health and wellness aligned with the obligations your school charter?*
- 12) Mission - *Is student health and wellness aligned with your school charter?*
- 13) Accountability (NJDOE Performance Framework) - *How does public accountability and the NJDOE Performance Framework impact the school's ability to implement HSP?*
- 14) Organizational structure and autonomy - *Do you think being an independent charter school helps or hinder with HSP implementation?*
- 15) Instructional context and innovation- *How doe HSP fit with the school's educational approach and philosophy? What are some of the barriers or facilitators to integrating HSP into the school curriculum? How do you integrate HSP into your classroom? Is HSP aligned with your educational philosophy? Do you feel you have flexibility and autonomy in your classroom to implement HSP?*
- 16) Teacher staffing (recruitment, selection, and retention) – *What is your perception of teacher turnover? How do you think turnover affect HSP implementation? Do you know how new teachers learn about HSP/are on-boarded? How easy is it for a new teacher to integrate HSP into their classroom? How did you learn about HSP?*
- 17) Charter school age – *How long has your charter school been in existence? How do you think the charter school age impacts HSP implementation?*

18) Charter renewal cycle – *Where are you in your charter renewal cycle? Have you gone through the charter renewal process since implementing HSP? Do you think the charter renewal process has impacted HSP implementation? If so, how?*

19) Student demographics - *What is the ethnic and racial composition of the student body? How do cultural factors impact program implementation? Are students included in food and physical activity choices within the school?*

20) Parental engagement - *In general do you feel parents are engaged – not just with health initiatives, but with school activities in general? What role do you see parents playing in HSP implementation?*

21) HSP improvement - *How could HSP be altered to be more compatible with your school?*

Complexity vs. Simplicity – Is it difficult or easy to implement HSP?

22) *Does your school use non-HSP outside consultants, experts or staff to assist with program implementation? If so have you worked with these consultants? Do you feel they were helpful in implementing HSP?*

23) *Have you used HSP online and telephone technical assistance tools? Did you find these tools helpful in program implementation?*

24) *Were you trained on key program and policy components? Have you had continuing training since first being trained on the program?*

25) *Do you think the program is templated for easier implementation? Do you think you can change program components easily to meet the specific needs of your students?*

26) Do you feel you have the time, resources, and expertise to implement HSP?

27) Is there a way HSP could be simplified that would facilitate implementation?

Trialability – Can the program be implemented incrementally?

28) Do you think HSP can be implemented in parts or do you think HSP needs to be implemented in totality?

29) If HSP can be implemented in parts, which components are the easiest for you to implement and why?

30) Which program components are priorities in your opinion?

31) Is there a way HSP could be simplified that would facilitate implementation?

Observability – To what extent are the outcomes of HSP observable?

32) Have you seen the impact of HSP? For example, changes in the school environment such as cafeteria menu changes, visible messaging supporting healthy behaviors, vending machines serving only healthy options

33) Or changes in student BMI, increases in child PA, improvements in child eating habits.

34) Have you observed changes in your own health behavior or BMI, or that of your colleagues?

35) How could HSP outcomes be more observable?

APPENDIX 3-5:
SCHOOL WELLNESS COUNCIL FOCUS GROUP PROTOCOL

To be read by interviewer:

Thank you for taking the time to talk with me today. My name is Jennifer Turner and I am a doctoral candidate at Rutgers School of Public Health, pursuing a Doctor of Public Health, specializing in Health Education and Behavioral Science. My dissertation focuses on evaluating the implementation of a school-based childhood obesity prevention program. As part of my dissertation, I am conducting an evaluation of the Alliance for a Healthier Generation's Healthy Schools Program (HSP) in a small sample of New Jersey charter schools to gain an understanding of the extent to which the program is being implemented, and the barriers and facilitators to program implementation. My evaluation includes conducting interviews with a key school staff (teachers and administrators), parents and community leaders at different New Jersey charter schools. The information I collect will help me to understand the points of view from multiple stakeholders' points of view, and the successes and challenges schools experience in developing and implementing their Healthy Schools Program. This interview will take 45-60 minutes.

I'm going to take notes while I talk with all of you, but I would also like to audiotape the interview to confirm that my notes are accurate. May I have your permission to audiotape this interview?

[Note: Do not audiotape the interview without the respondent's permission.]

General School Wellness Council Background Questions

1. *What is the role of the School Wellness Council?*
 - a. *What are the roles and responsibilities of the School Wellness Council?*
 - b. *What role does the School Wellness Council have in implementing the school's Wellness Policy?*
 - c. *(For the coordinator) As the coordinator of the council, what are your specific responsibilities? Do you have other responsibilities within the school? If yes, what are they?*
2. *How long has the School Wellness Council been in existence?*
3. *How often does the School Wellness Council meet?*

4. *Are there any challenges in meeting? How do you address these challenges?*
5. *Who is included in the School Wellness Council? How are different school constituents represented in the School Wellness Council?*
 - a. *Does your school wellness council/committee include at least one student-family member representative as an active member?*
 - b. *What is parental or guardian involvement? Are parents or guardians involved in the planning of school wellness activities?*
 - c. *Do students have the opportunity to provide input into the development and implementation of school health and wellness activities?*
 - d. *How does the School Wellness Council represent the varying linguistic, cultural and socio-economic backgrounds of your student population?*
6. *What school health (diet and exercise) initiatives is the School Wellness Council is aware of and involved in?*
7. *Does the School Wellness Council think youth being overweight is a problem in your school?*
 - a. *If yes, what role should the school play in addressing this problem? What role should the School Wellness Council play?*
8. *How does health fit into your school's charter and mission?*

HSP Awareness and Implementation

9. *Does the School Wellness Council know about the Healthy Schools Program?*
10. *How did the School Wellness Council become aware of the Healthy Schools*

Program?

11. How was it decided that your school would participate in the Healthy Schools Program?

12. If the School Wellness Council is aware of the Healthy Schools Program, is the School Wellness Council involved in implementing the Healthy Schools Program? If yes, what role does the School Wellness Council play in Healthy School Program implementation?

a. Is the School Wellness Council involved in the development, implementation, and oversight of the Healthy Schools Program? Is there an opinion leader?

13. What challenges has the School Wellness Council faced in your school and community in terms of implementing the Healthy Schools Program? How is the School Wellness Council addressing these challenges?

a. What successes has the School Wellness Council achieved related to the Healthy Schools Program and childhood obesity prevention initiatives more broadly?

14. During the current school year, how many times did the School Wellness Council members observe Healthy Schools Program activities at [name of school]? What types of programs and activities were observed?

15. How are student health and wellness efforts promoted and publicized at the school? Is school health and wellness a standing agenda item for staff meetings or other meetings and the School Wellness Council?

a. How is the Healthy Schools Program messaged throughout the

school?

- b. How is healthy living more generally messaged throughout the school?*

16. During the current school year, has the School Wellness Council received any technical assistance or training? If yes, from whom? From the Healthy Schools Program's Relationship Manager? [May not be applicable to charter schools because in most cases, they are not assigned a Healthy School Program Relationship Manager]

- a. If technical assistance or training on school wellness or obesity prevention was received from outside consultants or other persons not associated with the Healthy Schools Program, what topics did this training cover? How helpful was this assistance to your school in terms of improving the health of students and staff? In what ways was each of the technical assistance or training sessions you participated in helpful?*

17. Has the School Wellness Council used the online tools and content the Healthy Schools Program offers to facilitate wellness council initiatives?

18. What elements of the Healthy Schools Program do you find helpful? What elements of the Healthy Schools Program do you think need improvement? How would the School Wellness Council improve them?

19. Are there additional or different resources or elements you think should be added to the Healthy Schools Program?

20. What factors does the School Wellness Council think facilitate Healthy

Schools Program implementation?

- a. What factors does the School Wellness Council think hinder Healthy Schools Program implementation?*

21. Does the School Wellness Council think the school has the resources (e.g., time, financial resources, expertise) to successfully implement the Healthy Schools Program?

22. Has senior leadership been an advocate of the Healthy Schools Program? What is the School Wellness Council's perception of school leadership's commitment to the program?

- a. What is the School Wellness Council's perception of school leadership's commitment to student health more generally? Where does student health rank among other school priorities?*

23. Does the School Wellness Council think the Healthy Schools Program could be implemented in parts or does it need to be implemented in totality? If implementation in parts is possible, what parts are key priorities?

24. Has the School Wellness Council observed the effects of the Healthy Schools Program? If so what are these effects?

- a. How could the Healthy School Program effects be more observable?*

25. Does the School Wellness Council think the Healthy Schools Program is compatible with the school's mission, charter, and organizational structure?

- a. Does being an independent charter school affect program implementation? If so, how?*

26. What questions, if any, do you have about the overall approach of the Healthy

Schools Program and what the program is asking schools to do?

27. What is the School Wellness Council's overall perception of the Healthy Schools Program?

APPENDIX 3-6:**SCHOOL ENVIRONMENT OBSERVATION INSTRUMENT****Observation Checklist – Common Areas to Observe Health Messaging**

*Digital photos will be taken

- School entryway
- High traffic hallways
- Message boards
- School cafeteria
- Gym
- Common area classrooms (if applicable)
- Menus

Message Classification

- Volume/Quantity
- Prominence
- Type of Health Messaging
- Edutainment or health facts
- Culturally/Ethnically relevant
- Messages sent home – email or newsletter

Message Classification

Location/Object Observed

	School Entryway	Hallways	Message Boards	Cafeteria	Gym	Other Common areas	
# of Health Messages							
Total # of messages							
Prominence							
Health Message Type (diet/PA)							
Edutainment							
Health Facts							
Cultural Relevance (features people who look like target audience)							

APPENDIX 4-1

Case Report—School A

SCHOOL INTRODUCTION

School A was located in a New Jersey city with a population of approximately 150,000 people, in which 30% lived below the poverty line. School A was created as an independent charter school in 2008. It served approximately 800 students in Grades K-8. School A served a low-income, predominantly Hispanic (64%) and African American (33%) population, with 87% of students qualifying for free and reduced lunch. The student teacher ratio was 19:1, as compared to the state average of 12:1.

School Wellness Council Focus Group

A focus group was conducted with the School Wellness Council, which included two school nurses and the Student Support Services Administrator. Nurse 1 was also a parent. The Physical Education (PE) Teacher was also a member of the School Wellness Council but left School A at the beginning of this study. Despite many attempts to contact her via phone and email, she could not be reached. The Food Staffer was also a member of the School Wellness Council but was unable to attend the focus group. Several attempts to contact the Food Staffer were made via email, but she also could not be reached. In terms of roles and responsibilities of the people who comprised the School Wellness Council, the Student Support Services Administrator had guidance counselor responsibilities, and also worked with the school social workers for student who needed help with family issues, Individualized Education Programs (IEPs), or support referrals. The School Nurses provided support services for general health, performed height/weight measurements and immunizations, and maintained student health records.

Interviews

An interview was conducted with the Dean of Students. The Dean of Students was primarily an administrative role. The Dean of Students stated she acted as the principal for the building since it did not have a principal or assistant principal. School A had the following organizational structure: CEO, Chief Academic Officer, Principal of the two campuses, and a dean for each of the three campuses. Repeated attempts were made to interview the CEO, Chief Academic Officer, and Food Staffer, but were unsuccessful.

School Environment Observations

Common areas such as school halls and cafeteria were observed at all three campuses. Water fountains and water coolers were observed in hallways at the three campuses. Photos were taken of health messages on walls. The majority (70%) of messages focused on academics and School A's values. There were images of students playing and eating healthy foods throughout all three campuses. There was also a nutrition board with images of healthy foods, encouraging students to eat these healthy foods, as well as nutrition information and recipes for making healthy foods. A calendar countdown of days to Partnership for Assessment of Readiness for College and Careers (PARCC) testing was prominently displayed in the front office on each campus. Participants stated PARCC testing was a critical focus of School A's at the time this dissertation study was conducted, which was in the weeks leading to PARCC testing. The Dean of Students stated there would normally be more images and information posted on walls in school hallways, both generally and related to health, but School A was going

into testing and the administration did not want students to be prompted by any information posted in hallways, and classrooms that might affect test scores.

Documents Reviewed

Mission—School A’s mission stated the school sought to inspire and empower its students, their families, and the staff with opportunities to be life-long learners, to better their lives and their community, and feel good about themselves. Some of the characteristics School A deemed important included respect, self-esteem, excellence, and integrity. Although health was not directly mentioned in School A’s mission, participants felt the Healthy Schools Program (HSP) and improving student health were connected to students living better lives; therefore, HSP was compatible with the school’s mission.

School Wellness Policy—The School Wellness Policy addressed School A’s health environment in the eight school health assessment areas outlined by HSP. The School Wellness Policy called for the convening of a School Wellness Council to implement and monitor the policy. Stakeholders were to include at least one administrator, school nurses, teachers, parents, students, and any other interested members of the school community. The School Wellness Council was tasked with providing school environments that supported healthy eating and physical activity, which, in turn, ultimately supported student well-being and students’ ability to learn. School A’s School Wellness Policy outlined the following directives:

- **Nutrition**—All reimbursable meals and reimbursable after-school snacks (free and reduced-cost) were to meet the federal nutrition standards as required by the USDA/HSP. All snack and beverage items sold or served anywhere on school property during the school day, including items sold in a la carte lines, vending

machines, snack bars, and school stores, as well as for fundraisers, birthdays, and holiday celebrations, were to meet USDA/HSP standards. School A was also to regulate foods sold or offered outside of federally funded meals. No high-sugar or foods of minimal nutritional value were to be served, sold, or given out as a free promotion anywhere on school property at any time.

- **Physical Activity**—All students enrolled in Grades K-8 were required to participate in physical activity consistent with the New Jersey Department of Education Core Curriculum Standards. The School Wellness Policy stated that the State Board of Education required that elementary schools provide 150 minutes per week and middle schools provide 225 minutes per week of physical activity. Physical activity could include teacher-led, classroom level physical activity linked to curriculum other than physical education.
- **Policy Implementation**—The Principal/Chief Advocate was tasked with developing regulations consistent with the School Wellness Policy, including a process for measuring the effectiveness of its implementation, and designating personnel within each school with operational responsibility for ensuring School A was complying with the policy. The School Wellness Council was also tasked with developing an action plan to assist in the full implementation of the School Wellness Policy. This action plan would identify goals and steps that needed to be taken each year. Action plans would be submitted to the Principal/Chief Advocate by June 30th of each year for implementation at the start of the new school year.

Student Handbook—The student handbook included detailed information about school operations and expectations of students and parents. In terms of health, information about immunization and medical records, the administration of medication, health screenings, EPI pens, and substance abuse was included. The student handbook did not include the School Wellness Policy or any information about School A's policies on nutrition.

Menus—Menus including three lunch and one breakfast menu were reviewed. The menus showed lean proteins, fruit, vegetables, whole grains, and skim or 2% milk.

Charter Agreement—Requests were made to school administrators to obtain a copy of School A's charter agreement, but were unsuccessful.

I. HSP IMPLEMENTATION

LEVEL OF IMPLEMENTATION—MEASURED BY THE HSP SIX STEPS

Implementation Step	Action Taken
Step 1: School Wellness Council Formation	Formed; Active
Step 2: School Health Environment Assessment	Online Health Assessment: Partially completed Meeting USDA/HSP nutrition requirements Not meeting state/HSP physical activity requirements; not meeting for Grades K-5 (66%), not meeting for Grades 6-8 (44%)
Step 3: Local Prioritization/Action Planning	Formal Planning School Wellness Policy: Created; conditionally enforced
Step 4: Technical Resource Development (HSP Training/Technical Support)	Trained with school district and HSP relationship manager
Step 5: Take Action	Partial Implementation
Step 6: Monitoring	No Monitoring

The six steps involved in HSP implementation include: 1) Formation of a School Wellness Council; 2) Completion of the HSP School Health Environment Assessment; 3) Local Prioritization and Action Planning; 4) Technical Resource Development; 5) Take Action; and 6) Monitoring and Evaluation of Progress. In terms of level of implementation as defined in this study (i.e., number of HSP implementation steps taken by a school, with six being the maximum number), School A had taken some steps but not all. School A had partially completed or taken action in Steps 1, 2, 3, 4 and 5, and done none of Step 6.

School A's Implementation of the HSP 6 Steps to Making School Environments Healthier

Step 1 Formation of a School Wellness Council—School A had formed a School Wellness Council. It was active and met every third Monday of the month. They had been meeting since 2013. In terms of teacher participation, Nurse 1 stated,

We try to include as much as possible, so any teacher is always welcome to join, but from time to time we usually just have the teacher leader for the grade. They're responsible for disseminating the information. So usually we do that. The health teachers and nurses are by default members of the School Wellness Council.

In terms of other participants, Nurse 1 stated,

The food person, from our food department meetings she's in meetings, and then the administrators, they kind of come and go. But we send out an email of the notes so even if they're not here, they get minutes or what the meeting entailed and what we're working on. When we come back to school we let the teachers know we have a wellness council.

The Student Support Administrator stated, “We put like five or 10 people on the email, saying do you guys want to participate, and whoever wants to can.” Nurse 1 was also a parent at School A. Nurse 1 stated,

So parents are in here. We used to have another parent that used to come. We used to be a part of it. This year, it’s just us. We don’t have another external parent, but we do have certain parents that sometimes they’ll volunteer like our parents, our PTO [homeschool counsel], our homeschool counselors, is what we call it here. So they do come out and they support our events.”

Nurse 1 stated, “They are aware, and we let them know when they have their meetings. We’d go through our parent liaison and she lets them know what we have going on.”

Role of the School Wellness Council—Council members were asked the role of the School Wellness Council. Their responses included:

Awareness—The Student Support Administrator stated,

Awareness because without us nothing would change. The menu would stay the same. We do the health and wellness program. We do fundraisers for different causes. We did autism this month. Bloodwork for leukemia the last time. Try to get everyone aware, participating in being healthy.

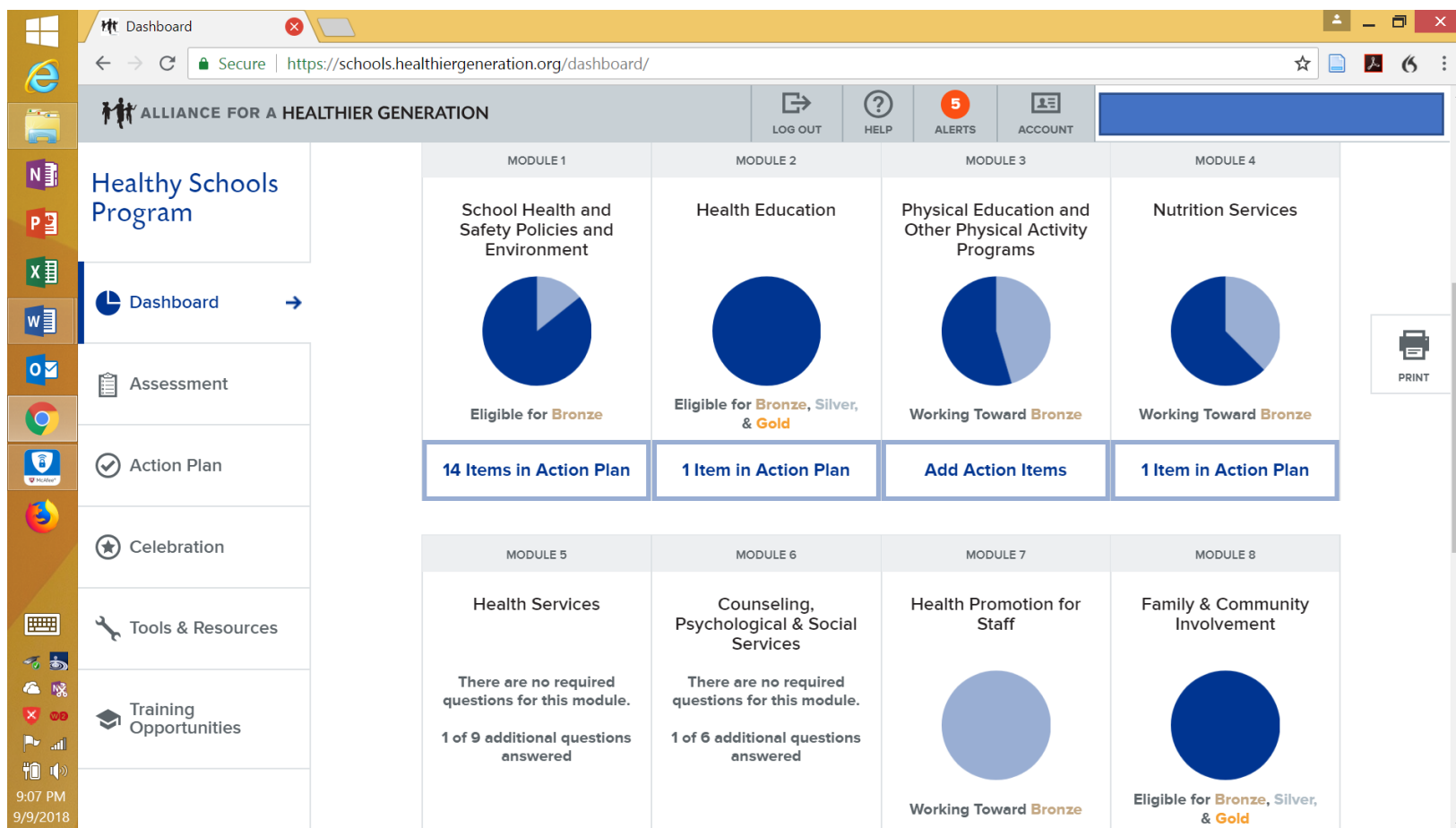
Encourage Healthy Behaviors—Nurse 1 stated,

We also try to encourage on within the school, I try to encourage the children to bring water bottles to school to try to limit their snacks and things. We do have policies. We did make policy changes about two years ago. We’re still working on actually implementing a lot of those. We’ve been doing it slowly. Introducing the different policies and things as far as like what’s allowed at birthday parties. So this year we implemented at least in the lower grades that do the birthday parties, only one birthday party a month, so that they pick like the last Friday of the month, and then they have birthday parties as opposed to multiple birthday parties. So we’ve just been doing it little by little to try to get the buy-in, not only from the parents but more so the staff.

- **School Wellness Policy**—The School Wellness Council had input in the School Wellness Policy, which was on School A’s website.

- **Step 2 School Health Environment Assessment**—Regarding Step 2, School A had completed some School Health Environment Assessments content areas online: 1) School Health and Safety and Environmental Policies; 2) Health Education; 3) Physical Education; 4) Nutrition Sciences; 5) Health Services; 6) Counseling, Psychological, and Social Services; 7) Health Promotion for Staff; and 8) Family and Community Involvement. Based on the assessments, School A had created action items in School Health and Safety and Environmental policies, of which 90% of the action items had been completed; 35% of the action items in Physical Education and Other Physical Activity Programs had been completed; 66% of the action items in Nutrition Services had been completed; none of the action items in Health Promotion for Staff had been completed; 100% of the action items in Family and Community Environment had been completed; and 100% of the action items in Health Education had been completed. The assessments for Health Services and Counseling, Psychological, and Social Services had not been completed and no action items had been created. School A's dashboard had not been updated since May 2015. However, consistent with interview data that stated School A had focused on implementing nutrition and community involvement, School A was eligible for Gold HSP recognition in Community Involvement and Gold HSP recognition in Health Education.

EXHIBIT A-1



Interviews with stakeholders reflected the school was doing the following on the HSP assessment areas:

- **Assessment Area 1—School Health and Safety and Environmental Policies**
 - No vending machines. Only water was offered via water fountains and refill stations.
- **Assessment Area 2—Health Education**
 - The Physical Education Teacher also taught health. She left the school at the beginning of this study and could not be interviewed.
- **Assessment Area 3—Physical Education and Physical Activity**
 - K-5 got physical education twice a week and recess every day. Middle school students (Grades 6-8) did not have recess, but had gym four times a week. School A also incorporated brain breaks throughout the school day to integrate fitness into the school day.
- The New Jersey State Board of Education requires elementary schools (K-5) to provide 150 minutes per week and middle schools provide 225 minutes per week of physical activity. These are the same PA recommendations as in HSP. Physical activity may include teacher-led, classroom level physical activity linked to curriculum other than physical education. For Grades K-5, School A was providing 100 minutes per week, or 66%, of the HSP/state requirement. For Grades 6-8, School A was providing 44% of the HSP/state requirement.

- **Assessment Area 4—Nutrition Services**

- School A was implementing the USDA guidelines, which are the same as the guidelines for HSP nutrition. The Dean of Students for School A stated, “We offer water, 100 percent apple juice or 100 percent orange juice, and milk, and it’s fat free milk.”

- **Assessment Area 5—Health Services**

- School A had two full-time nurses who provided health services as uncovered in interviews. However, the school had not yet filled out this section of the assessment online. School A did have a food allergy management plan that was coordinated through the School Nurses and the Food Staffer.

- **Assessment Area 6—Counseling, Psychological, and Social Services**

- School A had social workers who offered counseling services. This was uncovered in interviews. However, the school had not yet filled out this section of the assessment online.

- **Assessment Area 7—Health Promotion for Staff**

- School A did not offer wellness programs for the staff. The Dean of Students stated, “We don’t. That’s something that we need to look into. Actually when you said it I’m like wow, that would be nice.” In the focus group it was uncovered that School A had offered Zumba to parents and teachers, but it was not consistently offered.

- **Assessment Area 8—Family and Community Involvement**
 - School A involved family and community in family fitness events and the school’s annual Health Fair.
- **Step 3 Local Prioritization and Action Planning**—The School Wellness Council planned events such as family fitness (e.g., Zumba and yoga classes), an event on autism, and an annual Health Fair. The School Wellness Council also helped School A to offer free eye exams and low-cost eyewear, dental exams, and free hearing screenings. The School Wellness Council mobilized volunteers, as needed, to help implement these events. However, School A was not using an overall wellness plan or strategy document to guide these wellness activities. School A did have a School Wellness Policy that outlined the school’s requirements for student nutrition and physical activity. The federal free and reduced breakfasts and lunches provided by the school met the USDA/HSP requirements and adhered to School A’s Wellness Policy. However, the School Wellness Policy was conditionally enforced by teachers and school administration for foods not offered under the federal program. Food from outside of School A was allowed in the school and it was not enforced that this food meet the guidelines of the School Wellness Policy. Nurse 1 stated, “They [students] can bring in outside food. We just ask they be cautious about bringing in, for the peanuts and things like that.”
- **Step 4 Technical Resource Development**—Independent charter schools are not usually assigned an HSP relationship manager and do not normally receive in-person training from HSP. However, through a relationship with the traditional public school district, School A allowed to train with the traditional public school’s relationship

manager, in person, at the local district. School A received HSP in-person training for 4 years, which included in-person meetings twice a year, as well as phone and online support. The grant funding training lasted 4 years, and in-person training until 2016.

Nurse 1 stated she still used the HSP online dashboard:

We still have access to their dashboard and to their website. So I can still log in. We can still update it. I try to go back in and update our little board so that, hopefully when we have everything in order, we can maybe apply and then maybe they'll see, oh they got that certificate. The money that can come in if you do certain steps...that all ties in. If you fill out one, you get the state, you can get awards and things like that, that can come to the school and then that gets noticed and that might push the administration. So that's what I'm hoping for. If you fill it out through them, it links you to different grants. By filling that in, it automatically links you to different grants that you can apply and get for the school for say equipment for the gym teacher or whatever it might be.

A review of School A's action items, the next steps School A needed to take to show progress in the assessment area, had not been updated on the dashboard since May 2015.

- **Step 5 Take Action**—School A was implementing the USDA/HSP guidelines for nutrition for federally funded meals. However, enforcement of the School Wellness Policy for non-federally funded meals and adherence to HSP recommendations for healthy snacks and outside foods were inconsistent. Regarding physical activity, School A was also meeting only 66% of the HSP/state requirement for PA for Grades K-5, and only 44% of the state/HSP requirement for Grades 6-8.
- **Step 6 Monitoring and Tracking of Progress**—School A was not actively measuring and tracking the effectiveness of HSP in terms of changing the school health environment and student health outcomes/behaviors. School A was not also actively tracking its level of implementation of HSP, specifically the number of HSP

steps the school was implementing, and School A's current status with the school environment health assessments.

FACTORS IMPACTING IMPLEMENTATION:

BARRIERS AND FACILITATORS TO HSP IMPLEMENTATION

There were several in-school and out-of-school barriers and facilitators that impacted HSP implementation. In-school factors included the content of the USDA guidelines, student behaviors, teacher enforcement of the School Wellness Policy, and school leadership support for HSP implementation. Out-of-school factors impacting implementation included parent health education and engagement, and social and environmental issues in students' family lives and their broader communities. In terms of relative difficulty of implementation, comparing diet to exercise, participants had mixed responses. Nurse 1 thought physical activity was more difficult to implement because School A had more control of students' diets. Nurse 1 stated,

Physical activity I think is the hardest because for us here, I think physical acts because the kids when they go home, they're on video games. Once it's raining, there's no way. I think for the most part we are providing their diet, I mean if they eat it, because we provide their breakfast and we provide their lunch. Encouraging them to do more physical activity, that aspect, we don't totally have.

Nurse 2 felt students playing video games negatively impacted their physical activity.

Nurse 2 said, "How many kids come in and say, 'Oh, I'm so tired. I was playing whatever until like 11 o'clock.'" The Student Support Services Administrator disagreed, thinking getting students to eat healthier was more difficult. She stated, "But diet is all day long."

EXHIBIT A-2

In-School

Out-of-School

Barriers	Facilitators	Barriers
<p>USDA Guidelines:</p> <ul style="list-style-type: none"> • Guidelines seemed outdated—Allergies, like gluten, not taken into account • Culture—Not taken into account <p>Physical Education/Physical Activity:</p> <ul style="list-style-type: none"> • None of School A's three campuses had a gym. • Two of School A's three campuses did not have outdoor playground or gym. 	<p>USDA Guidelines:</p> <ul style="list-style-type: none"> • Knowledgeable Food Staffer—School Food Staffer was knowledgeable on the HSP/USDA guidelines 	<p>Parents:</p> <ul style="list-style-type: none"> • Parent Education—not knowing what healthy eating was; not understanding the relationship between obesity and health problems; obesity-related diseases were too long-term and nebulous • Parent work schedule—not home to oversee student eating; not able to attend health events at school • Parent Engagement—was mixed around School A activities in general and low around student health
<p>Students:</p> <ul style="list-style-type: none"> • Not like the taste • Resistance to trying new foods • Lack of Exposure 	<p>School Leadership:</p> <ul style="list-style-type: none"> • Belief in Positive Relationship Between Student Health and Academics—School leadership believed there was a relationship between student health 	<p>Social and Environmental Issues:</p> <ul style="list-style-type: none"> • Lack of Transportation—Some families did not have cars, making it difficult to get to a grocery store with healthy food • Cost of Food—healthy food more expensive than junk food • Environment Infrastructure—

Barriers	Facilitators	Barriers
	<p>and better academic performance</p> <p>Teachers:</p> <ul style="list-style-type: none"> • Passionate Staff—Core group of teachers and staff believed in the mission of healthy students and were committed to supporting student healthy eating and PA <p>Kitchen Staff:</p> <ul style="list-style-type: none"> • Encouraged students to eat healthier 	<p>Corner stores selling junk were prevalent and easily accessible to students and parent</p> <ul style="list-style-type: none"> • Safety—unsafe neighborhoods served as a barrier to students playing outside
<p>School Context</p> <ul style="list-style-type: none"> • Lack of Leadership Support *Leadership was focused on academics and getting test scores up. New Principal joined the school less than 1 year before. *School leadership had not focused on disseminating information about the School Wellness 	<p>School Context:</p> <p>School Age/Charter Renewal—School A was 10 years old; it was relatively stable. School A went through charter renewal previous year and had a charter that would not have to be renewed for another 4 years.</p> <ul style="list-style-type: none"> • Mission—HSP consistent with School A’s mission and charter 	

Barriers	Facilitators	Barriers
<p>Policy; support and enforcement of Wellness Policies were not being diffused throughout the organization; staff felt health was not supported from the top consistently and unconditionally</p> <ul style="list-style-type: none"> • Academic Performance— School A was not on academic probation, but test scores were not as high as they needed to be in comparison to their traditional public school peers. Although test scores had improved, school leadership's priority was further improvement • Academics was the Priority—to the 	<ul style="list-style-type: none"> • Obesity Prevention— School A teachers/administrators/parents believed obesity prevention was a role • More Flexibility/Less Bureaucracy— Teachers felt empowered in their classrooms and for initiatives they would like to take for general education and health promotion *Easier to get things done *More staff input 	

Barriers	Facilitators	Barriers
<p>detriment of HSP support</p> <ul style="list-style-type: none"> • Pressure to Outperform Traditional Public Schools—School A felt they must prove their existence by outperforming traditional public schools on test scores and academics • Teacher Turnover—disrupted HSP information exchange • Teacher Enforcement Inconsistent <ul style="list-style-type: none"> *Teacher awareness of HSP was mixed *Teachers not consistently enforcing HSP due to confrontational parents; policy enforcement not mandated from the top 		

Barriers	Facilitators	Barriers
<ul style="list-style-type: none"> • Lack of Funding— Lack of overall funding impacted HSP implementation • Lack of People *Needed more people to oversee physical education and physical activity *Needed a health educator to teach health education to the students and help with educating the parents and staff *Needed a project manager to oversee all health initiatives 		

IN-SCHOOL BARRIERS

USDA Guidelines—Nurse 1 thought that the USDA guidelines were a little outdated in terms of being current with student allergies. She stated,

To me it's kind of like a catch-22 because there's a lot of gluten allergies and they're all about grains and different things, so it's a catch-22 where I'm seeing an increase in the kids with the gluten stuff. So we are providing all this with whole wheats and this and that, they can't particularly have it. I think the guidelines need to include that factor, for the schools to implement in the schools. For those that do have the gluten stuff going on.

Lack of Play Space or Formal Gym—School A was located on three different campuses. Not all campuses had a playground or access to outdoor space, which limited School A's ability to support PA for its students. Among its three campuses, only the K-4 school had a playground. This campus had no formal gym but used a designated area for gym. The 5th Grade and 6th-8th Grade campuses did not have a playground or gym. Nurse 1 stated all grades were attempting to implement the PA and nutritional components of HSP and were doing their best with the infrastructure they had. Nurse 1 stated,

Every grade participates in their own way. So like the middle school doesn't really get outdoor recess. They might be allowed to walk around in the cafeteria or do different little things that they can do. Each grade modifies physical activity for their building. The elementary school has a playground. Here for the 5th graders, they go right outside here on the end of our driveway. The 5th grade is just by themselves. If it's a nice day, they can go out there and they'll play with the ball, soccer or they'll play football or a jump rope, hopscotch, read a book, or they'll walk around. But the middle school, 6-8, they just go into the cafeteria or whatever else they do for them. So I was thinking for that building, maybe doing those bikes, maybe getting like a WiFit where they can go in a certain area, where they can project it into the wall and then they can all do like a Wifi class.

Student Resistance to Trying New, Healthy Foods—Nurse 1 stated that student resistance to trying new, healthy foods served as a barrier to the nutrition components of HSP. Nurse 1 stated,

Students need to be better educated to make better health choices. They need more exposure to begin to like healthy foods. Given the choice between a candy bar and a banana, the kids always go for the candy bar. So it's just about reprogramming them to try to encourage them to try different foods.

School Leadership—The Student Support Services Administrator and Nurse 1 both stated the difficulty of getting the administration to make HSP implementation a priority. Nurse 1 stated, “We need more time with the teachers, but I think the harder thing is for the administration to make this a priority because it's there, but it's at the bottom of their priority list, so they don't really enforce it.” The Student Support Services Administrator agreed, “I mean they care about it but on the list of priorities it's not top. They would like us to do it.” Nurse 1 stated,

They want us to, but we don't carry the weight. But they need to be the forefront. The face of the program. This is what we want. This is what needs to happen. So when we have our back to school night they need to mention it. Like hey, we're not going to tolerate having this [unhealthy food]. If this is brought in. They need to be the ones to say it to the parents.

Nurse 2 stated, “So people will listen. Because then if you say it to the parents and you say it to the teachers, the teachers are the ones in the classrooms that have to follow the rules. So I can say it, but if the principal's not going to follow, make it a mandate.”

Nurse 1 stated, “This is what we're doing. It's just the nurses, they're the Food Nazi. That's what they call us.” The School Wellness Council thought the reason for School A's administration placing a lower priority on health promotion and HSP implementation was due to a focus on testing and academics.

Nurse 1 stated, “I think for them it's about getting the kids at a certain level, at a certain time with the PARCC testing, with the scores, and academics and testing that

needs to get done.” The Student Support Services Administrator stated, “They don’t see the connection yet between healthy children and higher test scores.”

IN-SCHOOL IMPLEMENTATION BARRIERS

There were several factors within school walls which served as barriers to HSP implementation. The barriers fell into the categories of limited resources and lack of leadership support of HSP implementation and School Wellness Policy enforcement.

- ***Charter Schools are Held to a Higher Standard***—The School Wellness Council and the Dean of Students both felt that charter schools were held to a higher standard than traditional public schools . The pressure to outperform their traditional public school counterparts was a consistent theme across comments from the School Wellness Council and the Dean of Students. Their comments differed only in the amount of quantifiable difference in which charter schools needed to outperform their traditional public school counterparts. The Student Support Services Administrator of the School Wellness Council stated,

Charter schools are held to a higher standard than public schools. We have to score 10% higher than public schools in order to stay open. So every year they evaluate our test scores. And I believe we are scoring about 8% higher? So we’re not meeting the charter school standard, but we are performing higher than the public schools.

Nurse 1 stated, “We have to be 10% above regular schools to stay open. I think we’re performing about 8% higher than them right now.” In contrast to what was said in the School Wellness Council, according to the Dean of Students, School A did not need to perform 10% higher than their traditional public school

counterparts, but consistent with the School Wellness Council comments, School A did have to meet a higher standard. The Dean of Students stated,

We're held to a higher standard because, we are a school of choice. Whenever you are a private or a charter or any school that is outside of a regular traditional school, they expect that it's better. I know that with public schools, they have to meet a minimum goal for public schools, but when it comes to a charter school, they have to meet, not the minimum, but the standard before the highest. So we have to always meet that. We have to be right there. So we always have to be at least 10 steps ahead of the public schools.

- ***Less Resources***—In addition to having to outperform their traditional public school counterparts, School A employees felt they had to do so with less resources. The Dean of Students stated,

Doing more with less. That's the biggest downside of being a charter school is we have to do so much more. We are held to such a higher standard and we have less teachers, sometimes we have less materials, and we have to make it work. We have less teachers. In my public school experience, we're packed, we have teachers. We have them. We're never short of teachers, in my public schools. Except for in a shortage area, like a science or math, those areas are sometimes hard to fill in any school, a math or science position. Because if you're a science or a math major you tend to maybe do something in private industry. But I think there's not a lot of having to find a lot of teachers in public schools. They're coming to public schools in droves. We don't have a lot of teacher turnover. With charter schools sometimes the day's a little longer and it's harder to get a teacher to buy into staying to 4 p.m. Even though the day ends at four, sometimes when you're a teacher you might stay a little later to kind of help with students and you might be here to five, and sometimes it's harder to have teachers to buy into that. I think that's what it is. It's the longer days. The pay is comparable, but it's hard to get the longer day for them.

- ***School A's Priorities***—Participants thought health promotion was important to but not the top priority of School A's senior leadership. The Dean of Students stated,

Academics is number one. Culture is two, and health would be number three. We want to get health up there a little bit higher because it's very important for our kids to be healthy. But academics is definitely first and foremost, then culture, then health. Culture is how the school runs. Essentially what we expect from the staff, what we expect from the students, what we expect from everyone in the building. The culture determines how the school actually runs. If there is a negative student culture or negative staff culture, then that translates into how our school runs. So it's essentially everything in every way the school runs the culture, what we do, how we say things. The way we walk in the building, the way we talk, and building, the systems and routines that we actually do in the building. Culture is a priority because if there's no school culture, if the kids are doing what they want to do, then how can academics take place? A teacher can't teach if the culture is not there or if the culture has been breached, if there is no classroom control and things of that nature. So we have to have the culture in order for the academics to run. You can't learn in chaos.

Consistent with comments from the School Wellness Council, academics and School A's operational policies were the focus of the school's Back to School event, held at the beginning of the school year. School A's involvement in HSP and the School Wellness Policy were covered on the agenda but are lower priorities on the agenda. The Dean of Students stated,

The agenda includes usually academics, school structure, and our uniform policy. If we have any teacher or administrators inductions, like I was inducted as a new administrator, I think I think that we have to really make this [health] a priority. Letting the parents know, even though we have some adversities, we have some challenges in our lives, in particular, this is still very important. I know you're working two jobs, but if you can just still maybe, donate whatever you can to the healthy initiative program. So I think if we just kind of just make it as important, I think it may help. I mean I don't know the answers, when we were working from this perspective, but I do know that can be a way to help.

Summary of In-School Barriers Affecting HSP Implementation

The School Wellness Council thought academics were more of a priority than health promotion and supporting HSP. The Dean of Student's comments were consistent with the School Wellness Council's perceptions. The pressure to improve test scores and

outperform their traditional public school counterparts was a consistent theme across comments from all study participants. This negatively impacted HSP implementation in that the School Wellness Council members stated they were not getting the time with teachers to better educate them on HSP. The School Wellness Council members stated that communicating HSP to parents and teachers on Back to School night was not a priority. The School Wellness Council members stated the administration was counting on them to enforce HSP and the School Wellness Policy, but in order for effective enforcement to happen, the mandate needed to come from the top of school leadership, which was not occurring. Although the Dean of Students stated high teacher turnover was not a problem at School A, attracting teachers to School A was a challenge due to the longer school days for the same pay. The scarcity of teachers was not explicitly stated as being a barrier to HSP implementation, but it was cited as falling into the category of charter schools having to do more with fewer resources. The perception that School A had to do more with less generally could mean that School A felt they also had fewer resources to devote to HSP specifically.

IN-SCHOOL IMPLEMENTATION FACILITATORS

There were in-school factors that may have acted as HSP implementation facilitators. Some of these factors were general to independent charter schools, such as more flexibility in teaching curriculum. Other factors were more specific to School A's school context, such as teacher health behaviors.

More Flexibility—Being a charter school allowed more flexibility with how the school was run and the educational curriculum. The Dean of Students stated,

We have the freedom of choice in charters, so we can really create our own culture. The way we want the school to run, move, and look. As opposed to traditional school. When I worked in a traditional school, everything was very state-driven, state-oriented. Also in charter schools we have to, you know, operate the way the state wants us because we still get state funding, but we still have freedom to do a few more things, where in traditional public school, it is not, you know, is exactly what the state wants and that's that. It's very outlined.

In terms of HSP and other wellness implementation, the Dean of Students stated,

I have more freedom to be able to do more healthy initiative things. I was able to actually go around and implement more things. I get examples from teachers, get input for more staff, whereas when I was in the regular public school, I had to follow a set curriculum, and "This is how we had to do it." We let the teachers be as creative and innovative as they want to be. We allow them that space.

Teachers—Teachers supported HSP implementation through integration of PA in their classrooms and through modeling healthy behaviors for students.

- **Teachers integrated PA into the classroom**—The Dean of Students stated, "Each individual teacher does a brain break. It really depends on the teacher, but they have like brain breaks. They may have a stretch session, something of that nature."
- **Teachers modeled healthy behaviors**—Nurse 1 stated, "Fortunately we're pretty lucky. Most of the teachers do make healthy choices, as far as their meals; they bring shakes. Our staff is pretty good. Modeling, you know, they bring their salads and they bring their stuff. A lot of them, so the kids can see, oh the teacher's eating a salad, but it would be nice to be able to incorporate like a party where it's a salad; it doesn't have to be a cake or cupcakes."

The Dean of Students also stated, "The teachers we have here eat very healthy.

The ones in this building, they eat very, very healthy."

Charter School Age and Renewal Status—The Student Support Services Administrator stated, “We just got the 5-year renewal last year. We’re in our second year.” The Student Support Services Administrator stated that School A was approximately 10 years old and “pretty stable.”

Obesity—Obesity was perceived by members of the School Wellness Council as being a problem in the school and one the school should take a role in addressing with the parents. Nurse 1 stated,

Obesity is a problem in the school. It is, and you see it. I mean, I just call parents like, you know, your child says you said it’s okay to eat potato chips for breakfast. I’m just calling to confirm, because I’m sure you’re not allowing them to eat chips for breakfast, that it was probably a snack for later for breakfast. So that way they know the child knows they’re being held accountable.

Summary of In-School Facilitators Affecting HSP Implementation

Being an independent charter school allowed School A to have more flexibility with developing their own school culture and educational curriculum. This flexibility could have been an HSP facilitator in that it allowed the school to develop a culture that supported health promotion and HSP implementation. Having flexibility of curriculum design also offered an opportunity for School A to integrate health promotion and HSP content into School A’s curriculum. However, integration of health-promoting content into School A’s general curriculum would require buy-in and support from school leadership, something the School Wellness Council members stated they did not have. Another HSP implementation facilitator was teacher behaviors. Teachers integrating physical activity into their classrooms helped to increase student physical activity, a goal of HSP. Teachers modeling healthy behaviors also facilitated students eating healthier foods and supported students eating the healthy foods served to them by the school.

OUT-OF-SCHOOL IMPLEMENTATION BARRIERS:

SOCIAL AND ENVIRONMENTAL ISSUES

There were several social and environmental factors that served as HSP implementation barriers, both in terms of students continuing healthy behaviors outside of school, and the unhealthy behaviors students brought into the school.

Cost—The Dean of Students stated that the relatively higher cost of healthier foods than processed junk foods is a barrier to implementation. Parents were giving their kids what they could afford to buy. The Dean of Students stated,

The families not being on board with the healthy initiative because they feel like, you know what I have to buy what I can afford, that healthy stuff is not affordable. So if my son wants to eat cookies in the morning, I'm going to give him the cookies instead of giving him the fruit because maybe the fruit is more expensive, at least he had something to eat. So I think that's one of the barriers. We can have the initiative implemented, but if parents are still sending cookies for breakfast then that breaches our process. But if we can get parents to really understand and have them in for parent nights and things of that nature, which we do, I think it will help us to really push the initiative a lot further.

Safety—Some of School A's students lived in unsafe neighborhoods, which impeded their engaging in physical activity outside, and also impeded parents from coming to school health events. The Dean of Students stated,

Our particular neighborhood is...it can be tough living here for some of the students. So some of the students really need, well the parents need, to be in at a certain hour from a safety perspective to receive their children. So coming to something at the school, and we do it at five. For parents who have to work, it may be problematic for them. And money might also be a problem for some of our parents who are low-income, and they can't participate as well as maybe a wealthier parent from a wealthier county could maybe.

Convenience of Junk Foods—Nurse 1 and the Student Support Services Administrator both stated lack of access to healthier foods was not a barrier to parents obtaining

healthier foods for their kids, but the higher cost and convenience of junk foods made junk foods the easier dietary choice. Nurse 1 stated, “I don’t think it’s an access issue. I mean not for us. We have a farmer’s market that it’s available, but access to unhealthy food is even easier.” The Student Support Administrator stated, “I just think when they drop the kids off at school, right across the street at the bodega they can get they can get butter and whatever.”

Parents—Parents played a critical role in student health behaviors both outside of school, and what health behaviors students brought into the school. Parent engagement in student health promotion, parents’ personal health behaviors, and parent work schedules can undermine student health promotion and HSP implementation.

- ***Improving Parent Engagement***—Lack of parent engagement was a barrier to health promotion and HSP implementation. The Dean of Students stated,

I think one of the barriers would be maybe getting a word out to the families about our health initiative. Parent engagement is not as good as I would want it to be, I would want it to be 100%, it’s probably now at 50%. In terms of the healthy initiative in terms of, not with anything else, just in terms of the healthy initiatives. I want the parents to understand that a healthy kid translates into very healthy grades. I think that participation is only 50% because of the reality of their lives. Some parents work two jobs, and they just can’t get here because they go from one job to the next. I think what would help is if we could really drive it home a little more. I think just really drive it home as much as we drive home the academics, make it like number one on the list. The way we make academics number one on the list. Letting the parents know that this is just as important as your kid’s doing well on that exam or studying. I think I’m just really giving it to the parents, and letting them know this is very, very important.

In terms of parent reactions to students eating junk food for breakfast, Nurse 1 stated,

The students know they they’re not supposed to bring in Takis chips; we kind of banned them. They have no nutritional value at all; they’re really bad for their

health. So we told the principal we don't want that in their school. So I called the parents like please don't send them to school if you want to feed them at home, just know that they can cause ulcers and esophagus issues. So if you want to eat those at home, that's entirely up to you. But we asked they not bring them during the school day because then they'll come in with stomach aches. We want to avoid this because we don't want to interrupt the educational process. I have a lot of students who go to Burger King and bring in Burger King. So it's always, you know, the process of calling the parent, and saying, you know they do get breakfast here. And it's actually a healthy breakfast.

Nurse 1 stated School A tried to get parents to change their health behaviors so that parent health behavior would influence student health behavior. Nurse 1 stated,

I think we have to get to the parents to encourage them to try so that the kids will try. So that's I think where are; being able to send fruit home, the fruit so that the parents to try with them and try something. So that's what we try to do in the health fair and having different chefs try different things and give them different recipes. They cook it at home and kid will get used to it.

In terms of parent knowledge of HSP, Nurse 1 stated,

I don't think they really realize. Every chance we get, we try to let them know, I know when we do back to school I always tell them, this is some of the expectations we have. When I do the kinder reg [registration], I always try to bring that up to them. Just encourage them to look, to know so that they themselves become informed of some of the expectations or what shouldn't be brought into school. At the end of the day we realized that it's 25 cents for a bag of chips. It's dollars' difference. Parents may be aware, but cost is an issue.

- ***Parents Work Schedules***—Parents were busy working multiple jobs and were not always available to monitor their children's diet and exercise habits. Work schedules also made it difficult for some parents to make it to health events, and events more generally, at School A. The Dean of Students stated,

Parents are juggling a lot. Multiple jobs. And the neighborhood is hard. There are also cultural issues. We need to figure out how to bridge the gaps. Culture impacts

the perceptions of health. Sometimes we find that culturally, health is not at the top of the list for them. But they're getting there. I can say now that we have this healthy initiative program and we're really putting out flyers and we're doing all these different things, they're actually getting there, they're becoming more supportive. But you know culturally, healthy wasn't the way we ate or way we eat. It's not always the healthiest choices.

Summary of Out-of-School Barriers Affecting HSP Implementation

Participants felt parents played an important role in HSP implementation, both within school walls and continuing the tenets of HSP beyond school walls. Parent work schedules and health habits, as well as social and environmental issues such as the cost of food and neighborhood safety, served as barriers to HSP implementation. In-school HSP implementation was a function of not only what teachers and administrators implement within school walls but also what behaviors and external factors students and parents brought into the school, and the health behaviors they continued outside of the school.

IMPROVING HSP

More Financial Resources—If School A had more money, Nurse 1 stated, she would have liked to integrate more physical activity into the classroom. Nurse 2 said, “Just to get them moving.” Nurse 1 stated, “For the middle school, in my perfect world, I even sent it to our old CEO, like there was this article with an exercise bike and the kids were like reading in English class and using like a little fan bike in class.” Nurse 1 stated,

To have something like that where because space is an issue and we don't, they can't go outside and they don't have a playground to go out into, I mean middle schoolers, but at least I know for 15, 20 minutes they can alternate and have a little exercise thing and that might help with behavior. It might help with some other different aspects that they can have. I would like to get four special ed classes or whatever. Like the ones that classes that we do have maybe have all their chairs be bouncy chairs so that no one was singled out, so for that classroom,

those are the chairs. You're not getting regular chairs. Everybody's going to be on a bouncy chair, and that helps the core. That helps. That's my ideal world. The kindergarten teachers all do a little exercise, brain booster with exercise in the morning and in the afternoon.

Content Tailored to Culture—Nurse 1 stated,

I think they should have resources available specific to culture. So, for example, Hindi food, different things that would attract, that can attract a parent, like if I'm going to give information to a parent that I can say, "Oh, here's what, so within what you do eat, here are some of the better alternatives you can choose," as opposed to, you know, generic.

More Webinars—Nurse 1 stated that the school needed more webinars for support.

Nurse 1 had participated in webinars for another program (Action for Healthy Kids) and found it helpful. She stated, "That's separate from the Healthy Schools Program. It's just more ongoing. Now that we are no longer receiving support from the Alliance, we're on our own looking for different things to do. So we're constantly signing up for different things to help us."

CONCLUDING THOUGHTS

The biggest factors impacting HSP implementation in School A were 1) School leadership not fully supporting HSP; 2) Mixed teacher awareness of HSP and inconsistent policy enforcement; 3) The School Wellness Policy not being widely disseminated; 4) Lack of parent engagement and education; 5) Ease of access to junk foods via corner stores; and 6) Lack of funding for HSP training and wellness initiatives implementation. Lack of cultural specificity in menu design was also cited as a potential barrier.

School A participants stated that HSP training was excellent, when they had it. The grant ending, compounded with a change in School A's leadership focus to academic

to the detriment of HSP and health implementation, served to thwart the momentum School A had in making their school environment healthier.

For HSP program designers the recommendations are:

1) Provide School Administrators with more Information on the Correlation

between Academic Performance and Health—School A had health advocates on its staff. The School Wellness Council was active and committed to making the school environment and students healthier. Providing these health advocates with more information about the correlation between health and academics may help to better focus the school leadership on health.

2) Provide School More Support

- a. **Health Consultant**—School A needed a person to project manage health initiatives in the school.
- b. **Provide a Health Educator**—In addition to needing a project manager, School A also needed a dedicated person qualified in health education to help School A's staff as they help to educate students and parents on proper nutrition and how to engage in physical activity, as well as teach a health education class to students. The Physical Education Teacher also taught health to students. Having someone who could be a health educator for both students and parents would be helpful.
- c. **More Sustainable Financial Resources**—School A needed more opportunities for sustainable funding to support health initiatives in the school. It would be helpful if HSP administrators could either provide

more funding or help School A to identify sources of funds and secure them. That would sustain HSP implementation on an ongoing basis.

- 3) **More Content Targeted to Parents**—All study participants felt that lack of parent education was a barrier to program implementation. There need to be more programs and content targeted to parent education.
- 4) **More Focus on Understanding the Social and Environmental Context of School**—School A had many social challenges that affected HSP implementation both in School A and out of School A when students went home to their communities. An issue cited was easy access to cheap junk foods sold via ubiquitous corner stores. HSP administrators could work with school leadership, city, and state to discuss policies and economic subsidies to help place healthy foods in these corner stores. School A's cultural context should also be taken into consideration when designing content and programs. Culture should also be taken into account in programs designed for parents.
- 5) **More Culturally Relevant Content**—School A was 64% Hispanic and 33% African American. Health content should not only be translated into Spanish but be culturally relevant to a Hispanic population.
- 6) **Use of Technology**—More webinars and ways to view content remotely would be helpful. Use of apps and culturally relevant videos were used as ways to increase access to health content and improve HSP implementation. This content could be disseminated via mobile apps for phones.

In summary, for School A, the biggest factor impacting implementation was the lack of leadership support. Although School A had a functioning School Wellness Council, without leadership to back the Council on Wellness Policy enforcement and provide more of platform to discuss the policy, e.g., incorporate HSP and School Wellness Council initiatives into teacher professional development and include time at the beginning of the year Open House where the School Wellness Council could present the Wellness Policy, initiatives planned for the year, and ways parents, students, and teachers could get involved. Another method to increase HSP and health policy awareness would be to include the School Wellness Policy in the student handbook vs. just being on the school website. The first priority to improve HSP implementation would be to have health promotion be a top priority, consistently communicated, with policy enforcement, stemming from the top.

APPENDIX 4-2

Case Report—School B

SCHOOL INTRODUCTION

School B was located in a New Jersey city with a population greater than 500,000 people in which 36% lived below the poverty line. It was created as an independent charter school in the late 1990s. It served approximately 350 students in Grades K-8. School B served a predominantly Hispanic immigrant (82%) English as a Second Language (ESL), low-income population. The rest of the student body was African American (11%) and White (4%). According to school administrators, 86% of students qualified for free and reduced lunch. School B was a dual-language Spanish/English school. The student teacher ratio was 11:1 as compared to the state average of 12:1. Interviews were conducted with 10 key HSP stakeholders (a Parent, a 3rd Grade Teacher, Dean of Students, Education Director, Family Coordinator, Food Service Staffer, School Food Vendor, School Nurse, School Physical Education Teacher, and a School Social Worker). Documents (school charter, school mission, student handbook, meal menus, and HSP online school dashboard) were also reviewed. Additionally, School Health Environment Observations (access to gym, open spaces for physical activity, health messages) were also conducted.

Interviews —School B had many staff members who had been at the school for extended periods of time ranging from 4 years to 20 years, since the school was founded. A common theme across participant profiles was that many participants wore multiple hats in the organization.

Participant	# of Years at School B	Overall Role	HSP Role
Dean of Students	18 years; 8 years as volunteer; 10 years as employee	In charge of attendance; Discipline of the school; worked with students, guidance counselors; school to home outreach regarding discipline. Oversaw the meal program, the after-school program or enrichment clusters and the student volunteers. Worked with social workers on Special Ed program; IEPs (Individual Education Plans for special ed students), interventions, counseling	Spearheaded HSP; oversaw menu planning; worked with School Food Vendor; oversaw grant applications to support wellness.
Education Director	20 years; founding teacher; 5 years as administrator; 2 years as ED	Principal/Superintendent; Oversaw the Board, staff, all school operations	Enforced healthy eating in the school; looked to the Dean of Students to manage day-to-day and details
Family Coordinator	6 years; 5 years as Teachers Assistant; 1st year as FC	Link between school and families; Oversaw Family Learning Nights, Food Pantry and Backpack programs In charge of enrollment - did open houses in the school, managed the lottery, collected papers for registration; did kindergarten interviews, along with the teachers.	Wellness component to Family Learning nights; offered exercise and cooking classes to parents, students, community
3rd Grade Teacher	4 years	General education teacher; taught in both English and Spanish as part of Dual Language Program	Enforced HSP nutrition in classroom and on school grounds; incorporates PA into classroom "brain breaks"
Physical Education Teacher	10 years	Taught all students K-8 both gym and health class. Also was a parent of a child who attended the school who had since graduated. Tried to maximize the physical education time	Implemented the physical activity components of HSP; not only physical education class but providing teachers with ideas for integrating PE in the classroom

Participant	# of Years at School B	Overall Role	HSP Role
Social Worker	8 ½ years	Acted as school guidance counselor; worked with Dean of Students on Special Ed support services	Helped with the mental and behavioral parts of HSP, which she viewed as lacking from HSP
Business Administrator/Parent 1	13 years	Parent/Business Administrator; oversaw school office support	Acted as a parent adhering to School B's nutrition policies
Food Service Staff/Parent 2 (note Spanish/English translator used)	7 years	Member of the food service staff that served meals to students; also a parent	Served breakfast/lunch to the students; encouraged them to eat healthy and try new foods
School Food Vendor	5 years	Provided breakfast and lunch; Provided approximately 700 meals a day to School B.	Worked closely with Dean of Students on menu planning; followed HSP/USDA guidelines
School Nurse	1 year	Performed immunizations; took BMI measurements, general student health support	Communicated with parents about healthy eating and obesity

Documents—The school mission and charter agreement both reflected a commitment to students' overall well-being and a commitment to serving the community. Both of these documents were aligned with HSP. Additionally, school menus showed several healthy options—vegetables, lean proteins, whole grains, fruit—as well as evidence of student input on foods students liked, e.g., “Leah’s Tacos.” This was consistent with interview data. The student handbook clearly outlined the policies of what was and was not appropriate nutrition and foods for students to bring to

school for snacks or lunch. This document was consistent with what parents of students at the school, teachers, and administrators said in interviews about the nutrition policies being clearly stated. School B's online dashboard was also reviewed to determine how much of the HSP school environment health assessment completion School B had documented.

School Health Environment Observations—In terms of health messages, School B had some health messages displayed throughout the school; however, the school mission and vision were prominently displayed in multiple places. Academic-related content was also placed on the walls (e.g., word of the week), as well as photos highlighting the school community. The school did not have a cafeteria, so there were no health messages in that area. The school had a gym, as well as a large playground and soccer field for students to engage in physical activity. Photos were taken.

The combination of these data sources provided a deeper understanding of the factors that impacted HSP implementation and wellness program implementation more broadly at School B. Level of implementation in this study were measured by the six steps involved in HSP implementation: 1) Formation of a School Wellness Council; 2) Completion of the HSP School Health Environment Assessment; 3) Local Prioritization and Action Planning; 4) Technical Resource Development; 5) Take Action Implementation Support; and 6) Monitoring and Evaluation of Progress.

LEVEL OF HSP IMPLEMENTATION MEASURED BY 6 STEPS OF IMPLEMENTATION

LEVEL OF IMPLEMENTATION SCHOOL B

<u>Steps</u>	<u>Actions Taken</u>
Step 1: School Wellness Council Formation	Formed; Not Active
Step 2: School Health Environment Assessment	Online Health Assessment: Partially completed Meeting USDA/HSP nutrition requirements Exceeding state/HSP physical activity requirements for Grades K-5 (160%); not meeting for Grades 6-8 (60%)
Step 3: Local Prioritization/Action Planning	Informal Planning School Wellness Policy: Created; strictly enforced
Step 4: Technical Resource Development (HSP Training/ Technical Support)	No Training
Step 5: Take Action	Partial Implementation
Step 6: Monitoring	No Monitoring

In terms of level of implementation as defined in this study (i.e., number of HSP implementation steps taken by a school, with six being the maximum), School B had taken some steps but not all. School B had partially completed Steps 1, 2, 3, and 5, and done none of Steps 4 and 6.

Step 1 FORMATION OF A SCHOOL WELLNESS COUNCIL

School B had formed a School Wellness Council on paper, but it did not function as a formal body and have structured, regular meetings. Instead, health issues were divided across multiple people in the organization, who were informally in contact with each other every day. The Dean of Students stated, “I feel like we’re on top of it. Everybody

knows what they need to do. Everybody does their part. Health is a part of who we are. Even if we were not signed up to do HSP, it would change absolutely nothing.”

The Education Director stated, “Everyone in the school tries to support wellness in the school in their areas (teachers, the School Food Vendor, the Dean of Students, the Family Coordinator) but there isn’t one person leading the charge of the multiple initiatives.”

Step 2 COMPLETION OF THE HSP SCHOOL HEALTH ENVIRONMENT ASSESSMENT

There are eight School Health Environment Assessment areas: 1) School Health and Safety and Environmental Policies; 2) Health Education; 3) Physical Education; 4) Nutrition Sciences; 5) Health Services; 6) Counseling, Psychological, and Social Services; 7) Health Promotion for Staff; and 8) Family and Community Involvement. Of these, School B had completed School Health and Safety and Environmental Policies, Health Education, and Nutrition Services and completed 66%, 90%, and 40% of the action items based on these assessments, respectively. School B was eligible for Gold HSP recognition in Health Education and was working towards Bronze HSP recognition in School Health and Safety and Nutrition. However, based on interview data, School B exceeded USDA/HSP requirements in terms of the quality of the healthy foods offered. Therefore the assessment may not reflect reality. These numbers may not have accurately reflected what School B was actually doing in these areas, as the Dean of Students, the only one using the dashboard, only used it periodically. Exhibit B-1 highlights School B’s school environment assessment on the school’s HSP online dashboard.

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Dashboard

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ALLIANCE FOR A HEALTHIER GENERATION

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HELP
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ACCOUNT

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Assessment

Action Plan

Celebration

Tools & Resources

Training Opportunities

Your School's Assessment Progress:

MODULE 1	MODULE 2	MODULE 3	MODULE 4
<p>School Health and Safety Policies and Environment</p> <p>Working Toward Bronze</p> <p>Add Action Items</p>	<p>Health Education</p> <p>Eligible for Bronze, Silver, & Gold</p> <p>Add Action Items</p>	<p>Physical Education and Other Physical Activity Programs</p> <p>20,125 schools have started this module.</p> <p>Ready to join them?</p> <p>Start Module</p>	<p>Nutrition Services</p> <p>Working Toward Bronze</p> <p>Add Action Items</p>
MODULE 5	MODULE 6	MODULE 7	MODULE 8
<p>Health Services</p> <p>There are no required questions for this module.</p> <p>3 of 9 additional questions answered</p> <p>Add Action Items</p>	<p>Counseling, Psychological & Social Services</p> <p>There are no required questions for this module.</p> <p>6 of 6 additional questions answered</p> <p>Add Action Items</p>	<p>Health Promotion for Staff</p> <p>18,586 schools have started this module.</p> <p>Ready to join them?</p> <p>Start Module</p>	<p>Family & Community Involvement</p> <p>11,104 schools have started this module.</p> <p>Ready to join them?</p> <p>Start Module</p>

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Interviews with stakeholders reflected the school was doing the following on the HSP assessment areas:

- **Assessment Area 1—School Health and Safety and Environmental Policies**
 - No vending machines. Only water was offered via water fountains and refill stations.
- **Assessment Area 2—Health Education**
 - The Physical Education Teacher also taught health. He and another health teacher taught nutrition and healthy eating. With nutrition they taught moderation and portion control.
- **Assessment Area 3—Physical Education and Physical Activity**
 - Kindergarten through 5th grade students had a half hour recess every day and gym twice a week. Middle school students (Grades 6-8) did not have recess, but they had gym four times a week. School B also incorporated “brain breaks,” short periods of physical activity, throughout the school day to integrate fitness into the school day.
- **Assessment Area 4—Nutrition Services**
 - School B was implementing the USDA guidelines, which were the same as the guidelines for HSP nutrition.
- **Assessment Area 5—Health Services**
 - School B had a full-time nurse who provided health services as uncovered in interviews. However, the school has not yet filled out

this section of the assessment online. School B did not have a food allergy management plan coordinated through the School Nurse, Dean of Students, and School Food Vendor. The School Nurse was unaware of HSP specifically, but was aware of School B's nutrition policies and had participated, sporadically, in the wellness components of Family Learning Nights—events held at the school with wellness and educational opportunities for parents, students, and the broader community.

- **Assessment Area 6—Counseling, Psychological, and Social Services**
 - School B had two social workers who offered counseling services as uncovered in interviews. However, the school had not yet filled out this section of the assessment online.
- **Assessment Area 7—Health Promotion for Staff**
 - School B had offered yoga classes to teachers at \$5 a class and there was Zumba incorporated into Family Learning Nights, but there was no formal, cohesive, consistent wellness program targeted to teachers.
- **Assessment Area 8—Family and Community Involvement**
 - Family Learning Nights were highlighted as events held weekly throughout the school year that was open to parents and the community for learning in general, and health and wellness activities. This was School B's main way of involving parents and

communities in health and wellness at the school. These wellness activities included cooking classes and Zumba.

Step 3 Local Prioritization and Action Planning—School B had informally engaged in local prioritization and action planning to a certain extent. There was a select group that was involved in health initiatives at the school (Dean of Students, Education Director, Physical Education/Health Teacher, School Nurse [to a degree], Family Coordinator). The school mobilized these individuals as well as parent and community volunteers, as needed, for wellness initiatives. Because the school had limited people and financial resources, this select group prioritized or chose what initiatives to do. However, there was no master wellness plan guiding or documenting these activities. School B did have a School Wellness Policy that outlined the healthy foods that were allowed in the school. The policy was strictly enforced by teachers and school administration.

Step 4 Technical Resource Development—As an independent charter school, School B did not receive any formal support from HSP. The school was not assigned an HSP Relationship Manager to provide hands-on, in-person trainings as compared to their traditional public school counterparts, who did have access to this type of training. However, School B did have access to HSP online content and tools, and access to HSP health experts online and via telephone that they could use for implementation support, and were using sporadically. However, there was no structured mechanism for HSP technical resource development in place at School B.

Step 5 Take Action—School B was implementing the USDA/HSP guidelines for student nutrition. Consistent with HSP guidance for providing student with nutrition they like that meets the USDA guidelines, the Dean of Students actively involved students in the menu selection process. The Dean of Students stated, “Students are involved, and student feedback has been reasonable.” The Dean of Students named the lunch day after the kid who chose the entrée, i.e., “Blanca’s Day.” The School Food Vendor also tailored the food to be culturally relevant, e.g., having tortillas or quesadillas, but these foods were dispersed throughout the menus, working within the guidelines. They had Meatless Mondays. The School Food Vendor and Dean of Students were constantly looking for ways to offer foods the students would like that would also meet the guidelines; they shared information and ideas.

In terms of physical activity, School B was exceeding state/HSP physical activity requirements for Grades K-5 (160%), but not meeting the state/HSP requirements for Grades 6-8 (60%). Despite not having a formally functioning School Wellness Council, School B had been successful at implementing several wellness initiatives aligned with HSP. These initiatives included: 1) Providing breakfast to all of the students, as previously noted; 2) Formation and communication of a Wellness Policy regarding acceptable nutrition within the school, as previously noted; 3) Family Learning Nights; 4) Backpack Program; 5) Food Pantry; 6) Community Garden; 7) After-School Clusters; and 8) Local Wellness Events. The Family Coordinator oversaw Family Learning Nights, the Backpack Program, and the Food Pantry and enlisted volunteers as needed to help.

Family Learning Nights—Family Learning Nights were an opportunity for parents to learn about different topics related to parenting, take English As A Second

Language (ESL) classes, and do wellness activities such as cooking lessons and exercise classes. Cooking classes were initially offered to the students, but parents wanted to come too, so it was changed to a family activity. In terms of the wellness component of Family Learning Nights, School B tried to help families make healthier choices, like going for a walk as a family. Family Learning Nights were year-round events, September through May. The Family Coordinator stated,

On Family Learning Nights, we provide free childcare and light refreshment to whoever is coming. And when the classes are given in English only, we also provide interpreters. So we provide interpretation, childcare, and light refreshment. Our budget is very limited, so that's how we do it; we don't provide that many classes, but in an ideal world, if we have the resources to provide more classes for students, parents, students and families together, that would be fantastic.

Backpack Program—Through an outside grant secured through one of the community board member's organization, Blessings in a Backpack, the school offered students food they could take home on the weekends. Every Friday, the students who qualified for free and reduced lunch were given a bag full of food to take home. The Dean of Students had worked with the Family Coordinator, trying to get them to increase the healthy foods in the backpack. The Education Director stated,

The school has a backpack food program and the requirements for that are that the students need to be able to prepare everything in there themselves. Pros and cons to that: foods are simple to prepare but they're not always healthy, like mac and cheese, but the idea is that there should be no obstacles to eating healthy, or to reduce those obstacles.

Food Pantry—The food pantry consisted of both canned goods and fresh produce, and was donated by a larger, county-wide food bank. Because the program was nationwide, sponsored by the state, the Family Coordinator attended monthly meetings,

and was connected to the other food pantries in which they shared not only information but food.

Community Garden—The Education Director stated School B participated in a community garden where families paid \$20 and were given a small parcel of land to grow healthy foods. Transportation was an issue, which was related to parents’ undocumented status. The initiative was overseen by volunteers.

After-School Clusters—School B also had after school “clusters” or groups. Current clusters: soccer and Girls on the Run, where they ran around the neighborhood. There was also an after-school cluster (club), that focused on healthy snacks, and helping the students to learn how to prepare healthy snacks for themselves. This was also overseen by volunteers.

Local Fitness Activities—According to the School Nurse and The Education Director, School B participated in local health and wellness events that included running, walking, and cycling. School B also did an annual Walkathon to raise money for the school.

Step 6 Monitoring and Tracking of Progress—School B was not actively measuring and tracking the effectiveness of HSP, either in terms of changing the school health environment or in student health outcomes/behaviors.

FACTORS IMPACTING IMPLEMENTATION

In addition to helping school environments to be healthier and influencing student behaviors in school, a goal of HSP is to have these healthy behaviors continued and

supported when students go home. School B had been successful at implementing wellness policies, practices, and taking on initiatives that supported student health and created a healthier school environment. There were a number of in-school factors that facilitated HSP implementation. However, a goal of HSP is to continue these practices outside of the school. There were many social and environmental factors that served as barriers and facilitators to HSP implementation both within School B, and outside of the school when students went home.

IN SCHOOL IMPLEMENTATION BARRIERS AND FACILITATORS—SCHOOL B

<u>In-School</u>		<u>Out-of-School</u>	
Barriers	Facilitators	Barriers	Facilitators
USDA Guidelines: <ul style="list-style-type: none"> • Changing/Inconsistent • One-Way Mandates • Cost • Difficulty Finding Food 	USDA Guidelines: <ul style="list-style-type: none"> • Good School/Vendor relationship • Had Kitchen Infrastructure 	Parents: Parent Education—not knowing what healthy eating is; not understanding the relationship between obesity and health problems; obesity-related diseases were too long-term and nebulous Parent work schedule—not home to oversee student eating; not able to attend health events at school	Parent Engagement: Parents were highly engaged in the School B community and activities; parents were always at the school; wanted their children to be successful; wanted to help out in the community; School B was a focal point of their lives
Students: <ul style="list-style-type: none"> • Not like the taste • Resistance to trying new foods • Lack of Exposure 	Administration: <ul style="list-style-type: none"> • School leadership was committed to health as a school priority 	Social and Environmental Issues <ul style="list-style-type: none"> • Immigration status—many parents were undocumented; social stress associated with threat of deportation • Transportation—being undocumented made it difficult to get a car; grocery store with healthy food was not within walking distance • Ethnic Culture—predominantly 	

Barriers	Facilitators		Barriers	Facilitators
			<p>Hispanic; diet based on carbs</p> <ul style="list-style-type: none"> • Language—predominantly Spanish speaking; HSP content in English • Cost of Food—healthy food more expensive than junk food • Shared Housing/Lack of Access to Kitchen—families cohabitated with other families; didn't have access to kitchen • Environment Infrastructure—lack of sidewalks for walking • Safety—unsafe neighborhoods kept parents from letting students play outside • Lack of Awareness Places to engage in physical activity — Parents not familiar with local places to 	

Barriers	Facilitators		Barriers	Facilitators
			engage in physical activity	
School Context <ul style="list-style-type: none"> • Changing community demographic to Hispanic ESL population—took time/resources; changed to dual-language • Lack of overall funding impacted HSP implementation • Teacher Turnover disrupted HSP information exchange • Combating misconceptions about charter schools took school resources • Held to a higher academic standard than traditional public schools. Perception the threat of being closed down is greater for charter schools 	Teachers: Teachers supported the Wellness Policy; they confiscated non-compliant food; communicated the policy to parents; engaged in healthy behaviors in front of students; incorporated PA into classroom; teachers were highly engaged overall and in support the health of students			
	Kitchen Staff: <ul style="list-style-type: none"> • Encouraged students to eat healthier 			

Barriers	Facilitators		Barriers	Facilitators
	Obesity Prevention: <ul style="list-style-type: none"> School B teachers/administrators/parents believed obesity prevention was a role 			
	School Age/Charter Renewal: <ul style="list-style-type: none"> Stable school; 20 years old Charter renewal previous year 			
	More Flexibility/Less Bureaucracy: <ul style="list-style-type: none"> Teachers felt empowered in their classrooms and for initiatives they wanted to take for general education and health promotion 			

IN-SCHOOL IMPLEMENTATION BARRIERS

Nutrition Implementation—School Menu HSP/USDA Guidelines

Arbitrarily Changing and Inconsistent Guidelines—The Dean of Students stated that for USDA guidelines, which are the same as HSP nutrition deadlines,

the standards are not great. On the positive side, there's consistency—all public schools receiving free and reduced lunch are supposed to follow the guidelines. For schools who are struggling to feed their students healthy foods, and maybe they don't know what healthy looks like, it's better than nothing.

However, “in terms of negatives of the USDA guidelines, the guidelines don't make sense and often don't seem consistent with the spirit of what being healthy or nutritious is.” Examples of these inconsistencies that the Dean of Students cited included a training session where the session leader stated glazed donuts meet the requirements for sodium and a grain. Similarly, meat was declared as counting as a grain for breakfast. The Dean of Students stated:

For breakfast there needs to be a dairy portion and a fruit portion and a grain portion. It's three different elements as opposed to five elements for lunch. We were told bacon could count as a grain. The guidelines constantly change and they're contradictory. Feels like USDA can't make their minds up. The presenters at the training sessions only go by what the guidelines say.

The HSP/USDA guidelines have shortcomings in that schools can technically meet them, yet not truly be nutritious. Schools find ways to meet the USDA guidelines (these are the same as HSP nutrition guidelines) in ways that are not truly in the spirit of supporting healthy eating. The School Food Vendor stated:

For example, if there's pasta on the menu with tomato sauce in it, the pasta sauce could count as a vegetable. So for a school that is trying to nickel-and-dime and meet the USDA guidelines, then the guidelines work for them, but not for us; we're really trying to meet the spirit of healthy nutrition. We don't use salt in our cooking; we use spices. If you're a school that is feeding your students mostly frozen food, you really need to consider sodium.

The School Food Vendor also stated a challenge to HSP/USDA nutrition implementation is

frequently the state changes the rules and requirements. I work closely with the Dean of Students on this. They want to make sure that what the state is requiring, the school is providing it, and the students are happy because if the students won't eat the food, it doesn't matter what the state guidelines are. The state comes in once a year; maybe once every couple of years. Sometimes it's a surprise.

Guidelines are One-Way Mandates—According to the School Food Vendor, there was currently no mechanism for feedback. “It would be helpful to have input when they reevaluate the food process, the most helpful would be able to visit them or have a dialogue about the guidelines.” Her general perception of the guidelines was,

They make sense to a certain extent. The Dean of Students does a great job applying them. The concept is good in that students need proper nutrition in order to learn. The part that is most objectionable is how decisions get made, the drastic nature, and they come out of the blue, constantly changing. For example, no whole milk or 2% milk; only 1% milk is allowed and on a lot of cases students won't drink it. Changes are mandated; there is no forum for discussion.

Cost to Implementing the Guidelines—According to the School Food Vendor,

There is a cost to implementing the guidelines and providing certain types of food; some schools cannot afford to implement the guidelines. It changes the dynamic; in some cases, it makes it hard, if not impossible, to work with certain schools; and in some cases, schools will have to look elsewhere for food service. From an economic perspective, what the state is requiring is a hindrance in a lot of cases because a, the students enjoy the food that we prepare. [School B] is able to make the economics of meeting the guidelines work but it's a challenge.

USDA guidelines were mandated, but no additional funding was given to schools to implement. Depending on the community a child was coming from, the school may not have had the ability to cover the difference, and the child could not participate in the lunch program. This may have been especially the case when a child's parents made too much money for them to qualify. It created a situation where there was differential

quality of lunches within the same school population. When students brought food from home parents had to be careful about food allergies, like peanuts; the guidelines were behind the times in terms of keeping up with allergies. The vendor took direction from the Dean of Students in terms of what kinds of meals to deliver (e.g., vegetarian). The school had to let the vendor know.

Difficult to Find Foods that Meet the Guidelines—According to the School Food

Vendor,

Sometimes it's difficult to find the food that fits in the guideline. The guidelines are very specific. To source the food, the very limited staff have to go to multiple locations (Costco, Pathmark), Stop and Shop. I mean Aldi's. I mean he will go anywhere. And if one doesn't have it, he'll go to the next one. So he'll be up and down the road in different towns from one side of New Jersey to the other to obtain the ingredients and things that are needed to meet the guidelines.

Challenges with Delivering Fresh Produce—According to the School Food Vendor,

Fruit is the most difficult. It's the timing. It needs to ship a little under-ripe, so it will be ripe by the time it gets to the school. Some schools won't accept foods if they have bruising or in the case of the ripe banana have brown spots. Schools also need two servings of fruit. Certain things have to be pre-packaged and sealed. Apples and bananas have to have an unbroken skin.

Fruit delivery was especially difficult when the weather impacted supply. When suppliers moved or went out of business, this was also a challenge.

Limited Resources—In terms of the food preparation process, the School Food Vendor had a small staff; only two full-time and one part-time cook to prepare all food from scratch. It was a challenge to make fresh, healthy foods every day that met the guidelines.

Students Resist New Foods—Students didn't like to try new foods they didn't know. It was a challenge to get them to try something new. Food Staffer/Parent 2 said, "students want to eat like they're at home, so the foods that culturally they know." To add more dimension to this comment, The Dean of Students said students liked the food their

parents make, so when they tried to replicate it at school students didn't necessarily like it.

Students Will Only Eat What Tastes Good—It was really important that the food taste good. According to the Dean of Students, the students were very vocal in giving feedback to her directly regarding the menus, or indirectly to their parents when they went home. According to Food Service Staffer/Parent 2, food service staffers could see from the reaction of the students if they were happy:

The Dean of Students is walking the halls and can see it too. They also look into the garbage can to see if students threw the food away. Some students tell their parents and parents will send an email to the Dean of Students so she knows whether or not to choose it for the next month. Students are pretty vocal. They will say what they like and what they don't. Some of them think the food is cooked in the back and will say, "You cooked it real good today."

School B's Charter School Context That Serves as HSP Implementation Barriers

Changing Community Demographic Impacted School B's Educational Focus and

Resources—The neighborhood surrounding School B had changed significantly over the years. When the school was first started, School B was more diverse (White) and affluent, with several students being children of professors of a nearby university. Over the years, the community had become more of an immigrant, ESL Hispanic population. To better serve the community, over the last seven years School B had been transitioning to a dual-language Spanish/English school. According to the Education Director, this transition had taken an enormous amount of resources and led to teacher turnover in needing to find dual-language teachers. The 3rd Grade Teacher, Dean of Students, and Business Administrator/Parent 1 all commented on how much the school had changed over the years and how resource-intensive it had been for School B to transition from

being Montessori-based school to dual-language. More of School B's resources had been dedicated to this transition as opposed to other school initiatives, including health. Additionally, teacher turnover had led to retraining teachers, not only on education-related issues but also HSP and School B's wellness policies.

According to the Education Director, the school becoming more of an immigrant Hispanic population led to "White, bright flight," which negatively impacted test scores because the population had become more ESL. As a charter school, their test scores couldn't go down. If their scores sank below the local traditional public school then they would be shut down. Across all the schools in this study there seemed to be some debate about the amount by which charter schools had to outperform their traditional public school counterparts; however, the general consensus from all four charter schools included in this study was that they must outperform their traditional public school counterparts. According to the Education Director they needed to outperform their traditional public school counterparts "by 10-15%." The Education Director also stated,

Poverty has an impact. This isn't situational poverty, but generational poverty. Students are coming to the school who have uneducated parents and it has had an effect on test scores. Eighty-five percent of the student population are free reduced lunch students. The students are struggling, and the school is still held to the same standard. So it's a short-term/long-term situation where long-term the school is committed to having these ESL students learn English and be on par with their native English speaking classmates but short-term the school has to stay open by keeping test scores at a certain level. Charter schools often get criticized for cherry picking and not mirroring the community. [School B] mirrors the community and they are very proud of that. They go by a strict lottery system.

It was critical to School B maintaining their charter that test scores meet or exceed the test scores of their traditional public school counterparts. This had caused even more focus on education, again putting more school resources into things that supported education and testing vs. health specifically and HSP.

Lack of Funding—Across multiple interviews, the main challenge cited of being an independent charter school was financial. Across interviews there was the perception that charter schools were underfunded. Without hesitation and consistent with other interviews, School B’s Physical Education teacher cited salaries as a challenge for independent charter schools. According to the Physical Education Teacher, School B “is well below salaries of TPS [traditional public schools]. I could make a lot more if I were working at a neighboring public school. But I value the flexibility. I can have a flexible schedule if I need to attend my students’ sporting events.” The Dean of Students also felt they are underfunded: “For every dollar that the public school was getting in tax revenue for a student, we get, as a charter school, 75% of that dollar. [School B] was functioning on a much smaller amount of money than a public school.” School B felt they have to do more with less. This lack of funding served as a barrier to HSP implementation in that there was less money to devote to health promotion. Lack of funding also impacted the school’s ability to attract and retain teachers, which was also a barrier in continuous implementation of HSP.

Teacher Turnover—“Teacher turnover is high or low depending on who you ask,” according to the School Social Worker. Across interviews the perception of turnover was mixed. The 3rd Grade Teacher and School Nurse thought it was high, mostly due to funding. The Dean of Students thought turnover was low. The Education Director felt that sources of turnover were due to 1) the transition to dual-language and needing to hire different teachers; 2) teachers needing to commute far to the school due to the fact that there isn’t a deep generation of educated teachers from the community to source locally; and 3) life changes. The Education Director stated, “The teachers [School B] has right

now commute in; they could be working closer to where they live and making more money, but they love the school and the community; it speaks to their dedication. We feel incredibly lucky and grateful to have them.”

In terms of the impact of the transition to dual-language on teacher retention, the Education Director stated,

Changing to a dual-language school had a dramatic impact on [School B’s] staff. We had to diversify the staff. It was and is very difficult to find bilingual educators. It’s hard to find and hire bilingual educators. As a consequence, we are getting very young teachers who need a lot of shaping and molding, which is both exciting and overwhelming. The school has been finding a balance. Compared to the charter world, we have little turnover. We have great retention of our veteran staff, so our English world teachers have been here for a long time, so, it’s really hard for us to find and keep bilingual teachers. So that’s where we struggle. So there’s a big disparity, there’s a big disparity and, it’s really unfortunate because we’re getting new teachers and like I mentioned to you before, there are typically very young teachers, so you’re really starting off with a first-year teacher and there’s just this pattern of doing that. In education more generally, teacher retention is a problem. It’s a very overwhelming job. This is not really an issue specific to us. Hiring bilingual teachers is difficult. Poaching of qualified teachers by other schools is also a problem.

Teacher turnover heavily, negatively impacted HSP implementation and achieving school initiatives more generally. The Education Director stated,

The English world teachers are exhausted. They’re tired of training new teachers—it takes a lot to onboard a new teacher. The inconsistency is draining. It’s hard to find people with the proper credentials [bilingual certification], so the school is pretty flexible. The teachers need to show they are in the process of getting it or a plan to get it.

In terms of teacher onboarding and health, the administration touched upon health in the new-teacher orientation that was held in August. The Education Director stated,

We discuss that we practice what we preach. We believe in role modeling. We discuss healthy snacks. We discuss having an inclusive environment and our educational model of having special education students integrated with non-special education students. We discuss how we don’t celebrate holidays. We learn about them, but in the spirit of inclusion they don’t celebrate them, which is sometimes difficult for the staff to understand. People want to bring whatever

they want but cupcakes do not agree with the School Wellness Policy; it's hard for new teachers to understand this. When they do a celebration, they tie it to learning [a unit they're studying]. Or celebrations can be healthy with popcorn and strawberries. They have to reprogram children's palates to healthier eating. Pizza is okay every now and then but must be the exception, not the rule. Bake sales have healthy foods too.

But it was difficult to have consistent messaging communicated throughout the school if the staff turned over.

Combating Misconceptions About Charter Schools and Stigma—School B also had to dedicate time and resources to combating the misconceptions about charter schools. The School Social Worker stated,

People have a lot of misunderstandings about charter schools. They don't really understand how charter schools work, what it's like working with us. Going out and being a part of different community organizations and knowing people helps to bring more visibility and understanding of [School B]. We have the same students and are trying to connect them to the community.

The School Nurse also cited misconceptions: "There is also a lack of understanding what a charter school is and the purpose. I didn't really understand charter schools until I started working here." According to the Dean of Students, "There is a stigma associated with being a charter school. Misconceptions is a big part of it. This is a consistent theme across interviews." As a charter school, School B "has to prove its worth every five years—public schools don't have to do that. There is this attitude from public schools of 'you're taking money from us'; us vs. them mentality." School B was fortunate that their Education Director had formed a relationship with the traditional public school district superintendent. According to the Dean of Students, the Education Director was "very personable and has formed good relationships. Without those relationships, we can feel very islanded." She had spent a lot of time fostering relationships, which took time that could have been devoted to HSP.

IN-SCHOOL IMPLEMENTATION FACILITATORS

HSP IMPLEMENTATION-SPECIFIC FACILITATORS

School Menu Implementation—USDA Guidelines

Good Vendor/School Relationship—In terms of the School B/School Food Vendor relationship, each party felt they have a good working relationship and partnership in implementing the HSP/USDA Guidelines. According to the Dean of Students, School B was very happy with their food service vendor. They felt very fortunate to be working with them: “Really lucky to be working with them.” The School Food Vendor echoed, “We have a great relationship. The Dean of Students is very flexible and easy to work with. This partnership really helps the school to implement the guidelines.”

Good Relationship with Food Service Staff—School B’s School Food Vendor interacted with the kitchen staff, who were trained on how to serve the food. They controlled the flow of food. The School Food Vendor stated, “These are the people that can send food back and can be most difficult to work with. This is not the case with [School B].”

According to the School Food Vendor, she had a good relationship with School B’s Food Servers.

Has Kitchen Infrastructure—According to the School Food Vendor, “An issue is that schools need to have some kind of kitchen. In a lot of schools, trucks roll up with pre-packaged food in cardboard boxes, with plastic on top that will be microwaved. Other schools have figured out how to meet the USDA guidelines on this pre-packaged system.” This vendor had gone to tastings where vendors bid on contracts and there was the type of pre-packaged vendor.

Gone are the days where students go on a line and get served food on a plate; School B is in the minority. [School B] has kitchen and serves food family style.

To have a kitchen you have to have insurance, staff (with salaries), training, procuring food every day. Schools aren't willing to pay for it; the state will not fund it.

Although School B's food was cooked by the vendor off site, School B had a kitchen which allowed them to offer a broader range of healthy foods, in addition to being able to offer cooking classes to parents during Family Learning Nights. According the School Food Vendor, "With the right resources, it would be possible to provide what she provides to other schools in New York and New Jersey—food made from scratch, that's healthy and meets the USDA guidelines."

School B's Charter School Context as HSP Facilitator

Perception of Obesity and School B's Role —The perception of obesity being a problem in the School B was mixed. Some participants thought it was more of a problem; others thought it was limited to pockets of the population. Overall, participants thought obesity in a global sense is a problem and that School B should take a proactive role in addressing it, and specifically, do an even more vigilant job engaging parents. The 3rd Grade Teacher stated, "It's difficult to talk to the students about being obese when the parents are obese." This connects back to the consistent theme throughout interviews that parent health behaviors and their education needed to be better targeted through HSP or school wellness initiatives. In terms of combating obesity, from Business Administrator/Parent 1's perspective,

It's important that the school educate the parents. I wouldn't be the parent I am today if it weren't for a lot of programs that happened at [School B], and a lot of the things that I was exposed to. [School B] really guides the parents, gently, but encourage parents to engage in healthy eating. The food pantry is important in making food options available to our families that wouldn't necessarily be able to access them. The cooking classes where parents are learning how to cook something that maybe they're not that familiar with has been helpful.

Business Administrator/Parent 1 didn't know if it's the school's responsibility per se to fight obesity, but she was "very impressed with how much the school does around health and wellness with such limited resources. If there were more money it would be great if they could do even more things." These perceptions served as HSP implementation facilitators.

Also a positive to HSP implementation, which included involving the community in health initiatives in the school, was School B's perception that schools should take an important role in the community. School B teachers and administrators felt a deep sense of civic responsibility and felt they had a responsibility to serve the community. From the 3rd Grade Teacher's perspective, "the whole point of a charter school is to involve the community, to serve the community." The Education Director and the Dean of Students both viewed School B as a community center. It had to be the "hub" of a community. The Dean of Student stated, "schools are not just schools, they are community centers." This sense of community service was consistent across all interviews and was also supported in the school's charter and mission.

School B's strong sense of community served as a facilitator to HSP implementation in that everyone in the school was focused on bettering the lives of the school's children and their families. This was a consistent theme across interviews and with School B's vision statement, which was also consistent with HSP, in that the vision statement included involvement of family and community, one of the health environment assessment areas. The vision statement was also consistent with interview data from school administrators in that they felt a deep responsibility toward education, family, and

community. Parent involvement was also cited in the charter agreement as being critical to School B's success.

Teachers Support School B's Wellness Policies—Teachers modeled healthy behaviors for students, which was an HSP implementation facilitator. The School Nurse stated that the teachers appeared to be eating healthy. She had seen them eating salads in the teacher's lounge and had not seen them eating fast food. According to School B's Physical Education Teacher, some teachers engaged in healthy behaviors and others did not. In terms of modeling healthy behaviors, Food Staffer/Parent 2 stated, "A lot of the teachers don't do a lot of physical activity, but they encourage the students to eat vegetables and tell the students when foods are not good for them. Teachers also encourage students to try new, healthy foods if the child has not eaten before. Exposure to healthy foods is something teachers do." According to the 3rd Grade Teacher, the teachers were aware of School B's policies about nutrition and the teachers policed student lunches or confiscated junk food when they saw it. These comments were consistent with those made by Business Administrator/Parent 2.

The Kitchen Staff Also Encourages Students to Eat Healthier—According to Food Staffer/Parent 2, when students aren't familiar with a food, the staff encourages them to at least try it. This is helpful to HSP implementation when the Dean of Students has included a new, healthy food on the school menu that students are reluctant to try.

School Leadership is Committed to Health—School B has many champions of HSP and health promotion within the school. According to Parent 1, School B's administration is "very on top of making sure that everybody's making healthy choices." According to the Physical Education Teacher, "The administration is definitely committed to health;

everybody is so inundated with so many things that it's just another thing. Everyone is very concerned with the health of the students and the obesity levels. The previous nurse was very vigilant about it. She would also do outreach to the parents." According to the School Nurse, the administration "really tries to have their students eat healthy; spends a lot of time on the menus. Sometimes it's a challenge to get the students to eat it but in general they are very happy. They have to be encouraged to try different foods."

According to Food Staffer/Parent 2,

The school administration and school leadership really promote health and wellness in the school. Sometimes students at home struggle a little bit with the eating. Breakfast and lunch, which the school provides, are full nutrition, which helps the students as long as they're here in the school. That's two different times the students are eating. Once they go home, it's unclear what they are eating. They might not have enough food to eat so at least here they already ate twice a day and they're a little more full. This is a big help for the school, the parents, and students.

Consistent with these comments, the Dean of Students talks to students about healthy eating when she solicits their feedback on the menus. The Dean of Students also stated "I make a point of going around to younger classrooms, usually once a month, maybe once every other month, to sit with them and talk about our menus and I try to explain to all of the students why they eat the way we eat here." It was a big part of her message to them. She felt she covered a lot in health education.

Mature Charter School with Recently Renewed Charter—School B had been a charter school for 20 years. Although changing to a dual-language program had not been easy, the school itself was very stable. School B had also just had its charter renewed the previous year, so the school didn't have to worry about reapplying for another four years. The 3rd Grade Teacher was also aware that the school had had its charter renewed last year, and also referred to the school as "pretty stable." These factors were HSP

facilitators in that the school wasn't being distracted by the very rigorous renewal process. Teachers were not worried the school was going to go away and could feel more job security.

More Flexibility and Innovation; Less Bureaucracy—According to the School Social Worker, School B had “more flexibility to do what we feel is important. We still have to meet grade level expectations but are able to do more of what the school philosophically believes in.” There was “less bureaucracy,” the 3rd Grade Teacher commented, and it took “less red tape to get something done.” This is an HSP implementation facilitator, because the administration and staff felt they could incorporate wellness into the school environment and curriculum without having to jump through the bigger district hoops that their traditional public schools had to go through. The 3rd Grade Teacher stated that there was more flexibility with instruction and educational philosophy. This was consistent with comments made by the 3rd Grade Teacher. In terms of innovation it “is part of what the school does in certain things.” The school was more open to trying new ideas and programs that would help the students. The 3rd Grade Teacher commented that a lot of times she felt like they are “ahead of certain things,” e.g., doing movement breaks and doing a little bit of yoga.

More Collaboration—The 3rd Grade Teacher cited how teacher input was valued. The administration sought out teacher input through a review board that a teacher from each grade sat on. Changes were not mandated from the top. Teachers had an opportunity to share their ideas, not just on educational matters but also on any school matter, including health, through a teacher committee that met regularly with the administration. “There is lots of dialogue with the administration about how to do things differently and better.”

School administration valued the feedback and input of teachers. The 3rd Grade Teacher stated,

There is a school review committee. Two team leaders per grade—K1 has a team leader, K2 and K3 have a team leader, and so on. The teachers meet every month and talk about different ideas and different things the teachers want to implement. Everything is vetted through the teachers before anything is implemented. They read articles, sometimes have mentors and consultants who attend these meetings. Then everyone tries something different and then we talk about it again and then we'll move on.

The Physical Education Teacher also felt empowered to run his classes for health education and gym the way he wanted to, and his main goal was getting students to participate. This supported HSP implementation in that ideas for healthy initiatives were encouraged to come from anywhere. There was a core group running health within School B, but the administration welcomed new ideas.

High Teacher Engagement—School B's Nurse was new to charter schools but felt like there was a real desire and passion to help students learn be healthy and happy. There were not a lot of resources in comparison to traditional public schools, but the desire was there. She stated, "That same passion isn't seen in TPS." School B's Nurse taught in traditional public schools back in the late 1990s. The School Nurse stated that there wasn't as much caring in the traditional public schools as at School B. If School B had had more resources, they would have gone even further with what they offered.

According to the School Nurse, "The teachers invest a lot of time with the students. They really care about the students. The place is like a palace in terms of the attention students get. No wonder there's a waiting list." This was an HSP facilitator in that the school had a staff that fundamentally cared about the students being healthy, happy, and successful, not just in school but in the community, consistent with the school charter, mission, and

vision. More engaged teachers who cared about student well-being were more receptive to supporting HSP.

OUT-OF-SCHOOL IMPLEMENTATION BARRIERS AND FACILITATORS

HSP is designed to help schools support parents and students to eat healthy outside of the school. However, there were factors that posed challenges to making this intent a reality for School B's population.

OUT-OF-SCHOOL HSP BARRIERS

Parent Factors Affecting Student/Parent Healthy Eating

Parent Education—According to the Education Director parents didn't know what good nutrition was. For example, "not understanding that Gatorade is not something students should be drinking unless they're running a marathon." According to the Family Coordinator, parents were not familiar with vegetables. For example, "We had baby spinach and eggplant from the food pantry. Families didn't know what to do with it, how to cook it. Parents have not been exposed to fruits and vegetables." Business Administrator/Parent 1 also said, "parents don't necessarily know what is healthy or what is not." This could be a barrier to students eating healthy.

Both the School Nurse and School Social Worker stated parents didn't understand the cause and effect relationship of eating badly today with obesity and other health problems later. For example, Takis (a kind of junk food chip) came up in this interview and across multiple interviews within School B and across all schools included in this study as something the students ate; neither parents nor students connected eating them now with poor health and obesity later. The School Social Worker said,

The idea of consequences in general has to be taught. Sometimes it's just asking the question to get students to think about it. To better crystallize it for parents. Having a good speaker who provides culturally sensitive information can be helpful. The speaker must be engaging, interesting, and make sense to them.

The School Nurse said the idea of obesity and bad health as a consequence was too nebulous and long-term. Parents were dealing with immediate, real problems. The School Nurse stated,

Even though parents know conceptually to eat healthy, there's a lack of understanding the consequences of not eating healthy. They have a broad sense but not a specific sense of it so they can have a more of a hands-on grasping the issue because everybody's heard about healthy eating. If something acute is wrong with the child, the parents move right away on it. But if it's something to do with their weight or their blood pressure or their diet, then it's like a "mystical thing." It's something that's out there that it does not a concrete issue. It's also not a timely issue that has to be dealt with here and now. There is a consequence it's not immediate, so it doesn't feel real. There's a consequence to unhealthy eating and lack of physical activity but the effects may not be seen for years.

This lack of education and understanding could serve as barriers to HSP when they tried to support healthy behaviors outside of the school. The Family Coordinator had conducted workshops on how to prevent diabetes through cooking, and how families could cook healthier foods using the products in the food pantry. "It was very helpful to the families." According to the Food Staffer/Parent 2, School B's health policies had made him more aware about nutrition and changed his health behavior:

The school has made me more health conscious and changed my eating habits to be healthier and I want to share that impact with other parents and members of the community. I feel everyone, starting with himself, can make a big difference by starting with changing health behavior in their own house. At the end of the day, I believe parents are there to make a big difference in their child's life and their family's life. They should always try even if they don't succeed, in encouraging students to eat well. The school has been a big influence for my family and for me.

The Food Staffer/Parent 2's comments demonstrate the positive impact educating parents can have not just on one parent but a family, and potentially an entire community.

Parent Work Schedule; Parents Were Overwhelmed—According to the Education Director, parents working multiple jobs was an issue. Working multiple jobs is the norm; even parents who were at home were often watching other people's children, so they were not stay-at-home parents in the more traditional sense. Multiple jobs were definitely an obstacle for parents getting to events and also being able to be with their children to engage in physical activity at local parks, which was related to a perceived safety issue. According to the School Nurse, parents often went to work early (4:00 a.m.) and arrived home late. Students often had to get themselves up, get dressed, and go to school. The School Nurse stated,

Some students don't see their parents. It's hard to expect a child to change their behavior when the parental contact isn't there. The social issues are difficult to maneuver. The parents are all hard workers. A lot of them work around the clock. The students may seem a little neglected, but the parents work hard. It's really important to get to know the families.

The Food Staffer/Parent 2 also said,

Parents work a lot so they're not always home to monitor what their child is eating. Families aren't eating together. Because of working they don't know that what their kid is doing at home, or what their child is eating. Sometimes the students just sit down, watch TV, and they're just eating, and they don't even realize what they're eating. It's mindless eating of junk food. There are so many fast food restaurants in the community. The parents are working late and so they grab something fast to eat for themselves and their family to eat.

The Business Administrator/Parent 2 also stated, "Both parents are working multiple jobs; parents aren't home to police what their students are eating."

The School Nurse stated being able to engage parents was a

huge challenge. Parents want to be involved but they've got so many other commitments going on that they can't really, unless it's a pressing issue for their child. They've got their own stuff going on in terms of financial and trying to just keep a roof over their heads, and their other priority with respect to their students is academic, like making sure that the kid is doing well academically. Parents are overwhelmed. They want their students to be healthy but are overwhelmed with social issues and having their child do well in school and the academic portion of it. Unless it's a medical issue it's not on the parent's radar; not top of mind. Parents have bigger, more pressing issues to deal with.

Social and Environmental Barriers

Across interviews, there were many social and environmental issues that negatively impacted parents and students eating healthy:

Immigration Status—School B had a large undocumented population. According to the Education Director, parents limited where they went in their day-to-day activities, including those related to health. For example, the grocery store offering good produce was not within walking distance, so parents did not go there. This negatively impacted parents (and their students) from eating healthy. Being undocumented, or having families of mixed documentation status, caused a lot of stress on families. The Business Administrator/Parent 2 also stated,

Being undocumented is a source of stress for this population. Under this [presidential] administration in particular, family members are worried they will be deported. They call to make sure dad made it home from work. So much has changed over the last year for our families. So much more stress. The school is a safe place. If things were more accessible at the school then families wouldn't have to worry about going someplace, putting their families in jeopardy. Their world is basically within walking distance.

Transportation—Related to immigration status, not having access to transportation was a barrier to eating healthy, according to both the Education Director and Business Administration/Parent 1 Business Administrator/Parent 1 stated,

Transportation is an issue. A lot of our families don't have access to transportation. They can't drive to the grocery store and just take their bag of food

home with them. They have one grocery store in town but it's a glorified bodega. There is a real grocery store, but you would need to drive there. A lot of parents don't have cars due to cost and being undocumented. Most parents walk, or they carpool, or they pay for cabs or bus. The car issue is a financial issue and a documentation issue. People are afraid to go to a different area not too far away in fear they will be pulled over by the Police Department randomly.

Ethnic Culture—Ethnic culture was cited across all interviews as a barrier to healthy eating. Both the Education Director and the Family Coordinator stated the predominantly Hispanic population had a diet where carbohydrates were the staples in their culture. These were barriers to eating healthy and reducing caloric intake. The Family Coordinator stated, “Yucca, it's kind of potato. It's a root—or rice or corn. So this negatively impacts reducing caloric intake. It's cultural issue. They cook the same foods out of tradition.” The Physical Education Teacher, School Social Worker, and Business Administrator/Parent 1 all said culture served as a barrier to eating healthy. Business Administrator/Parent 1 stated, “No one wants to go outside of their comfort zone. The school does a good job of exposing people to different foods—e.g. baked sweet potato fries, BBQ chicken that's baked and the sauce that isn't sugary but still tastes good.” But in general, according to the School Nurse, there were no resources to help families cook healthy, more culturally relevant and appealing foods. The challenge was helping parents to cook appealing foods that didn't lead to hypertension and diabetes.

Language—A factor that affected the administration's and teachers' abilities to connect with parents was their ability to speak Spanish. Not being able to speak Spanish could serve as a barrier to the administration being able to connect with parents more generally and on health issues more specifically. The 3rd Grade Teacher felt that the ability to speak Spanish helped her to connect with the parents. Her relationship with the parents

“is different than that of the monolingual parents. The ability to speak Spanish is important in this school. Language is important. The parents know that there’s people who speak Spanish and they feel more welcomed and invited.” Similarly, with health content, it needed to not only be in Spanish but to be culturally relevant, not just Spanish translations of English. HSP content is not in Spanish. Moreover, the content is not culturally specific. According to program participants, it was not enough that content be translated into Spanish; it should also be content that had resonance with parents.

Cost of Food—According to the Family Coordinator, School B’s families were low-income; 80% to 85% of the students received either free or reduced lunch. “So I see that that is part of the problem. The fresh fruit being more expensive. So for them, it’s cheaper to take the students to McDonald’s than to cook at home.” According to Business Administrator/Parent 1, not everyone could get to supermarkets to buy fruits and vegetables, or even afford fruits and vegetables: “Parents are feeding their students what they can afford.”

Easy Access to Unhealthy Foods—This was a combination of both cost and transportation and the physical structure of local neighborhoods. According to Business Administrator/Parent 1,

Junk food is so accessible. At dismissal, you can watch the students walk across the street to the bodega and come out with their little black bag of junk that’s cheap. Students have money in their pockets and they go to the bodega and buy junk, Takis. There are big displays of chips, candy, soda, ice cream, just packaged.

Even though School B did a great job controlling what students were eating within the school to be healthy, the students could walk right across the street and eat unhealthy foods, undermining the work of HSP.

Shared Housing/Lack of Access to a Kitchen—According to the Family Coordinator,

There are sometimes two or three families living in a two-bedroom apartment and they take turns cooking. Sometimes it is not their time to cook, so they cannot cook fresh or homemade products every day. So as a result, they have unrefrigerated or get canned foods or eat outside or order fast food.

The Family Coordinator stated when she was a teacher's assistant at the school, “90% of the times when you ask the students what they ate outside school, and it was fast food.”

The Family Coordinator started a program for healthy eating with cooking classes:

It started with two students and ended up with 15 students. It was very successful. We taught students to cook, to make salads and things. The problem was when it wasn't that family's turn to cook, they could not make fresh or homemade products every day. Parents don't have the cooking infrastructure—no microwave, refrigerator, or oven. We take for granted that we can cook anytime we want and try out a new recipe. This is not the case for our families. They don't have that luxury. I have one family who told me that they can only cook, I think it was, twice a week. And on Sundays, they all agreed that nobody would cook.”

Physical Activity Barriers

Local Environment Infrastructure—According to the Education Director, the city needed to improve the safety of walking. This was born out of a tragic accident with one of their students. There were no crosswalks or crossing signs in certain places. There were no sidewalks in others. The Education Director was working with the city to address this issue.

Safety—Parents didn't feel the neighborhood outside of the school environment was safe, so they didn't want their students playing outside without them. But parents were often not at home because they were working multiple jobs. Safety interacted with social, environmental, and parent factors. The Physical Education/Health Teacher stated, “Some neighborhoods are unsafe, and parents do not feel comfortable having their students go out to play.”

Lack of Awareness of Local Places for PA—Food Staffer/Parent 2 stated he was not really aware of the activities or places students can go for physical activity locally, but he and his daughter would go running around the neighborhood. They felt safe going to areas around the nearby university. They usually went from home, walking or running. This lack of knowledge of local places to engage in physical activity was consistent with the Education Director’s desire to expose students and families to local fitness activities.

OUT-OF-SCHOOL HSP FACILITATORS

Parent Engagement—Although parents may have been busy working multiple jobs and did not fully understand the effects of unhealthy eating, which served as barriers to engagement around health, in terms of overall parental engagement, across interviews there was the perception that parents were really engaged in the school and really cared about their students and the community. According to the 3rd Grade Teacher, “there is a lot of parent involvement” at School B. According to the 3rd Grade Teacher, the Physical Education Teacher, and the Family Coordinator, “there are always parents at the school.” The Family Coordinator stated, “They volunteer at the school constantly. Parents want their students to be the best and they want their children to succeed. Parents are more available because they want to help. They offer help and help when asked. They know it’s important to attend events.” According to the 3rd Grade Teacher, parents in the charter school she previously had worked at

were focused on getting their child into college; parents in School B are involved because they feel they are a part of this community and want to help. There’s a greater sense of connection. Parents feel the school is homey and safe. They feel that connection and involvement. They hear about the neighborhood public school not being safe. That’s their perception, so they want their child to be able to continue coming to School B which is safe.

According to School B's Physical Education Teacher, one of the positives of being a charter school included family input:

Families around the building all the time. Most of the students get picked up by family members. Interaction with the parents a daily basis. The sense of community, family, sense of helping the other families in need in our community here. All the families want to pitch in and help. In other communities, people are islanded. Students are picked up by buses, so you don't see the parents; they're not outside the school communicating.

According to the Family Coordinator, parents were engaged and there was a desire to be healthy, but social issues, cost, lack of education, language barriers, documentation issues, and culture could serve as barriers. A silver lining of parents not being documented and having access to cars was that the school really was the anchor of their community. Parents wanted to go to the school.

According to the Family Coordinator,

We had family learning classes every day from Monday through Thursday, except Friday. Fridays, we don't have classes. And they come. We had parents who came three times a week. They come on Tuesday for cooking classes. Then they come back on Thursday for working with behavior for ESL. And then on Wednesdays, they came again and worship. So yes, they like to be here.

This desire to be at the school was a facilitator to HSP implementation. More health programs at the school targeted to this population could have an impact in changing their health behavior.

For HSP program designers the recommendations are:

The Education Director felt like what they currently had in terms of how they were using HSP "work[ed] for them." This was an adaptation of HSP, but there are things that would make the program work better for them. Below are recommendations for improving HSP

and, if they had the resources, to design a school-based obesity program that would better fit the needs of School B's environment.

School B's Participant Recommendations for Improving HSP Content

<u>Recommendation</u>	<u>Participant Comments</u>
Need More Programs Targeted to Parents	A critical weakness in School B's wellness initiatives was the need to better engage the parents in health
Need More Health Programs	Need more programs targeted to students, parents, parents and students, and the broader local community
Increased Access to Healthy Foods	HSP did not provide content or tools to help economically struggling families to put food on the table, to address these issues. Food subsidies would be helpful.
More Tailored Content Incorporating Language, Culture, Social Context	HSP does not take school culture or language into account. Nearly all of the content on the HSP website is in English with only a handful of documents in Spanish, which are translations from English and do not take into account Hispanic culture.

<u>Recommendation</u>	<u>Participant Comments</u>
Need a Mental Health Component and Focus on Healthy Behavior Change	HSP does not address mental health or the cognitive components of health coaching that underly health behavior change. Participants mental health was key to physical health for both students and parents. It would be helpful if those support services were on school premises vs. parents having to go through a referral process to other locations. Healthy lifestyle building skills would also be helpful.

Program Components

- 1) **Need More Programs Targeted to Parents**—Across interviews, a critical weakness in School B's wellness initiatives, whether participants knew the school was implementing HSP specifically or just aware of the school's health initiatives generally, was the need to better engage the parents in health. The Dean of Students, Education Director, School Social Worker, and 3rd Grade Teacher all said the school needed to engage parents at home. Specifically, participants cited a need to target parent health behavior with respect to diet and exercise and increase parent health knowledge with respect to diet and exercise. The School

Social Worker also said, “In this parent outreach, it is important for the school to think “about it [health] through their lens, through some of these issues that they’re dealing with, these social issues.” The 3rd Grade Teacher stated,

The school is their [parents’] safe place. The school does a lot of kid work but not enough parent work and how to bring it home. It would be great to get more parents involved. The parents want to be fit, it’s just difficult. The school offers Zumba classes and they like it. In this political environment, parents won’t even open their door if you came to them to talk to them about health. They want to be healthy. They are happy people with unfortunate circumstances.

The Education Director said, “Family soccer nights, family volleyball nights—great turnout for those. Modeling is really important in terms of changing health behavior.” The Family Coordinator stated cooking classes for the parents, with the kitchen infrastructure, would be beneficial in getting families to eat healthier. She stated,

Parents would definitely come if the school had the stoves and they could cook. The school only has an industrial oven. No open flame. Parents would definitely come if the school had the resources. If we would have a healthy program for the parents, cooking program, they will definitely come because they have already expressed interest in this.

Food Staffer/Parent 2 stated,

Health must start at home, because if the parents don’t know, or they’re not aware of healthy meals, they’re not going to encourage their students to eat healthy. So there needs to be more education with the parents. A program must start with the parents.

- 2) **Need More Health Programs**—Although the general framework of HSP, which focuses on nutrition and increasing PA, was helpful, across interviews, participants stated the school would have liked to expand the program and wellness initiatives within these categories in the school and broaden their reach into the larger community. Within the structure of HSP, School B would have

liked to have more wellness programs that involved the broader community socially and physical infrastructure. The school was viewed by teachers, parents, and administrators as a focal point of the community. It was important to have more events at the school around health to better engage parents, students, and the broader School B community as it was viewed as a safe place for parents and students. The Education Director said they wanted to have a more robust community garden:

The community garden is fabulous because there is this community connection. The school would like to have more conversations about growing your own foods, giving them spaces to grow their own foods, and also connecting them to more healthy activities in the community.

She also wanted to introduce more running and outdoor activities, which “just aren’t on the students’ radar,” to the School B population. The Education Director wanted “to make sure people are exposed to more things, even if they’re in their community. More field trips, more things that they could continue to do on their own.” A key component of this would be the ability to provide transportation, an issue for this population as previously cited. Food Staffer/Parent 2 also stated socializing wellness in the community was important:

We need to connect people. If there was a way to bring people together once a week (maybe at a farmer’s market) to weigh themselves, that would be a way to connect people and connect them to wellness. They could weigh themselves and then go get fresh fruits and vegetables. If they need to lose 20-30 pounds a person (maybe a nutritionist/dietician) could say eat these fruits and vegetables this week and see where your weight is next week.”

Another specific program participants thought School B needed was a summer program. Both the School Nurse and Physical Education Teacher stated they needed a summer program to keep students engaged and motivated. The School

Nurse stated, “Students have nothing to do over the summer in terms of PA [physical activity]. Parents are worried students will sit around watching TV or playing video games and gain a lot of weight. The parents can’t afford camp, so it would be great if the school offered a PA program.” The Physical Education/Health Teacher stated, “We need a summer program; students are sad to go when school lets out; need a way for students to move.” The Education Director thought there needed to be a preschool health program to start building healthy habits early. The Education Director wanted to start at the preschool level showing students and parents healthy activities: “Most students have a sibling at the school, so we already know who’s coming in.” HSP didn’t have robust resources for supporting a pre-K program, only elementary school and high school. The Physical Education Teacher thought there should be more programs targeted to teacher wellness. Although employee wellness is a School Health Environment Assessment area, most content on the site and resources are targeted to student health. In the Physical Education/Health Teacher’s opinion some teachers were healthier than others. A program targeted to teachers would help to improve their health behaviors.

- 3) **Increase Access to Healthy Foods**—HSP doesn’t provide content or tools to help a school like School B, which had families that were struggling to put food on the table, to address these issues. The Family Coordinator stated that School B needed to offer more food through the Food Pantry Program: “Most of the time what the main food bank sends is not enough.” Related to this statement, the 3rd

Grade Teacher stated, “If there were a way to subsidize healthy eating so there was another option beyond Food Town [a local store], this would help.”

4) **More Tailored Content Incorporating Language, Culture, Social Context—**

HSP is a templated program that does not take school culture or language into account. Nearly all of the content on the HSP website is in English, with only a handful of documents in Spanish. These appear to be translations from English, and do not take into account Hispanic culture. The 3rd Grade Teacher stated,

Health programs need to be tailored to individual school needs and the community. It would make it better if the program were tailored to the community. If you tell this community to eat healthy and exercise more generally without tailoring it to their culture it’s not going to work because they are immigrants. They’re used to eating their foods. They’re scared to go the park.

The 3rd Grade Teacher thought a needs assessment with parents, teachers, and administrators would be helpful to inform the program design. There needed to be more cultural relevance in health programming and health communication, which HSP currently does not have. The Education Director stated,

Health messages need to come from someone who looks like them, speaks the language, understands who they are, who can say this is the healthy way to live, this is the way that we can still be who we are and do it the healthy way. Health message content needs to be culturally relevant and delivered in the school population’s native language. Spanish is the norm.

Food Staffer/Parent 2 stated, “Culture is very important in terms of the foods people eat and the content of the activities people do at the school. How food tastes, how it’s made, it connects people to where they come from.”

5) **Need a Mental Health Component and Focus on Behavior—**HSP does not address mental health or the cognitive components of health coaching that underlie health behavior change. The Dean of Students thought bringing in

different professionals to talk about mindfulness and how to decompress the mind so that students weren't feeding the body junk because their minds were too busy would be helpful: "Mental health is balance. Stress management supports eating healthy and engaging in exercise." Similarly, the School Social Worker said her "dream would be to have a mental health clinic that was available to all of our students and their families." She thought being able to provide family therapy and individual therapy would be a "game changer." She saw mental health and easy access to therapy to be the foundational element to healthy eating and exercise:

A lot of parents are committed to getting their students the therapy they need. School access would be so incredibly helpful. Access is key. Parents are super committed to making sure their students get the right support. A lot of our parents bust their butts to get to services and I'm just amazed by that. Their students have every single specialist that they need, and they don't speak English, you know, like, how do they do that? If we could have a mental health clinic on site, if parents could easily get therapy for their students at the school and didn't have to worry about appointments or bilingual therapists, (which is always tough or a waiting list or the limited resources available) that would be very helpful.

The Dean of Students also thought practical healthy lifestyle skill-building would be helpful:

Skills supporting a healthy lifestyle would be helpful. Time management skills, financial management skills, organizational skills are really important. Field trips to grocery stores or going to the bodega to learn how to eat healthy on a budget would be very helpful. How to cook a chicken for five—our parents are good at that because they don't come from wealthy backgrounds; part of survival coming from low economic situation.

Implementation Support

Participants offered the following thoughts regarding improving HSP implementation:

School B's Participant Recommendations for Improving HSP Implementation

<u>Recommendation</u>	<u>Participant Comments</u>
Need Outside Resources to Facilitate Program Implementation	The Education Director stated, “It would be helpful to have someone come in from the outside (outside company or person) to spend time at the school, get to know their culture, operations, and priorities and help them to set realistic goals.” Then help School B transition to managing on their own.
Capacity Building—Financial and Human	If an outsource is used it needs to help School B to build its capacity so the program can continue and be sustainable. According to the Education Director “The other issue is that initiatives start but then the grant runs out and then they stop. And if the school doesn’t have the capacity to take it on, then that’s the end of the program.”
Consistency and a Dedicated Leader	Need a dedicated person to lead health within School B vs. health being divvied up across multiple people who have competing responsibilities in the school.

<u>Recommendation</u>	<u>Participant Comments</u>
Better Communication of Wellness Benefits to Staff	<p>Teachers could be even better educated about HSP and the benefits of eating healthy and engaging in PA. HSP and health and wellness needs to be incorporated into teacher professional development. More opportunities to show staff games and activities they can do with students.</p>
Technology as an Implementation Tool	<p>Participants felt that mobile apps, particularly those optimized for phones, could be used to better engage parents. Content would need to be in Spanish and culturally relevant. Social media could also be better used to better connect parents to each other and the school. Technology was viewed as being helpful but as complement to health activities held at the school, not in place of .</p>

1) Need Outside Resources to Facilitate Program Implementation—The

Education Director stated, “It would be helpful to have someone come in from the

outside (outside company or person) to spend time at the school, get to know their culture, operations, and priorities and help them to set realistic goals.” The school needed someone to “hold their hand, help them to set realistic goals, and then transition.” This led to the next point that a health program needed to be sustainable.

- 2) **Capacity Building**—If an outside resource was used it would need to help School B to build its capacity so the program could continue and be sustainable.

According to the Education Director, “The other issue is that initiatives start but then the grant runs out and then they stop. And if the school doesn’t have the capacity to take it on, then that’s the end of the program. So it needs to be something that is continuing and sustainable.”

- 3) **Consistency and a Dedicated Leader**—The School Nurse stated there needed to be more consistency of programming:

Being able to offer programs more consistently throughout the year and having a person who’s in charge is important; right now, like everybody’s doing a little bit here and there, but there isn’t like a person where health and wellness is their focus, where their sole function is managing health and wellness in the school.

- 4) **Better Communication of Wellness Benefits to Staff**—The Physical

Education/Health Teacher thought teachers could be even better educated about HSP and the benefits of eating healthy and engaging in physical activity. The Physical Education/Health Teacher stated,

We need to incorporate more health and wellness into professional development. More opportunities to show staff games and activities they can do with students. Program components need to target teachers. Teachers need more time. They are overextended. If teachers had more free time during the day. Currently teachers are so overscheduled, with every single minute of the day accounted for with prep.

- 5) **Technology as An Implementation Tool**—HSP has digital tools for teachers and administrators to use in school to track program implementation and to provide health contents for use in school. However, there is no digital application for parents to access with health content. The Dean of Students stated online tools may be a solution for engaging parents: “They may not have internet at home, but all of the parents have phones. They also know every free Wi-Fi place in town. Having online videos and health information available via mobile would be the best.” The 3rd Grade Teacher stated online videos teaching people how to cook and exercise, that were fun, could complement the activities happening in the school. Online programs should be apps optimized for phone; “parents have a phone before they have a computer.” Both the Education Director and the Family Coordinator thought a wellness app might be helpful, but only as a complement or supplement to school-based activities, and content needed to be culturally relevant and in Spanish. The Family Coordinator stated,

Health and fitness through online/app would be helpful but not much. Still need activities at the school. Parents have their phones, but they don’t really access their phones that often. The school always communicates to parents via robocalls or text blast messages. Not many times they check their cell phones. Don’t think it would help a lot. They love social interaction, so if you give them classes, if we can provide classes for them, they will come. Online classes, I don’t think so. Or online resources, it’s rare. Probably not the Hispanic parents. Probably the other parents. The African American parents or the other parents in the community. But I don’t see them accessing their phones just to check on the latest media or the class. I don’t see them doing that. It might work if you have apps to complement/supplement activities at the school.

Similarly, Business Administrator/Parent 1 thought online tools targeted to parents may help wellness implementation but only if the parents are introduced to it and the tools are culturally relevant and complementary to school activities:

Basically, all the parents have phones. At home they may not have internet or cable. Some of their families rent rooms in a house. Fitness videos and tools online/app may be helpful and interesting to parents, but people have to be introduced to something new by someone they know and trust; it has to be something they can do together with other people in the community. More personal. Let's try this together. Otherwise it's intimidating, especially when many parents don't speak English.

Food Staffer/Parent 2 thought that technology could be used for better health communication and connecting people to each other, the school, and wellness. He stated,

Social media can also be useful. Parents are always on it. Same with text messaging. The school sends out text messages when the school is closed due to bad weather. They could also send out a text message about health and wellness events that are happening at the school and in the community. Things that will connect people and bring them together. In addition to text messaging it would be helpful for parents to have a tech app that has online fitness videos, nutrition, updates on health events in the community in addition to coming to the school for events. People nowadays don't sit down in the computer and kind of research. Everything is through their phone.

The School Social Worker thought technology could also potentially be incorporated to help parents, families, and students to be healthier. Tech-based videos (e.g., in an app) with culturally relevant and sensitive content might be helpful. The School Social Worker stated, "almost everyone has a smartphone at this point," which was different from when she first started at School B. She stated, "Smartphones and technology are everywhere, our families." The Physical Education/Teacher made a similar comment: "An online component for parents designed for phones would be helpful; most don't have computers, but they have phones. It would need to be culturally relevant and in Spanish."

CONCLUDING THOUGHTS

School B had adapted and partially implemented some elements of HSP. The need to adapt and only partially implement HSP can be attributed to several factors: 1) Some components of HSP fundamentally did not work for School B as a small independent charter school. HSP seemed to be optimized for larger traditional public schools; 2) School B was under-resourced and did not have a dedicated person who could help with program implementation. Staff wore multiple hats within the organization. Health was “divvied up” across multiple people; 3) The cultural context of School B, with a large Hispanic, undocumented immigrant population had required that HSP be tailored to fit School B’s population. Ethnic culture and cultural sensitivity were cited as being important in wellness program design. However, HSP was not perceived as including culturally relevant content and information. It was described as more “generic.”

Within school walls, School B was successful at implementing policies supporting nutrition and integration of physical activity. However, due to a number of social, environmental, and economic issues, HSP and healthy behaviors were not being supported as well as intended outside of school at home.

HSP was also perceived as not tailored to School B’s unique needs, both in terms of the school’s culture and its size/organizational structure. Program content needed to resonate with this largely Hispanic immigrant population and needed to fit the organizational structure of School B as an independent charter school. HSP was perceived as being targeted to large traditional public schools situated in more “idyllic” conditions vs. the reality of School B’s context. School B needed more and different resources. According to stakeholders, the school wanted to offer more classes targeted to

students, parents, both students and parents, and the larger community. School B was overwhelmingly cited across interviews as a “safe place” where parents and students felt comfortable coming. The student body experienced several social and economic stressors, including the threat of deportation. For families, the school served as a beacon. “Schools are not just schools; they are community centers,” and they needed more resources to better serve the community. To help push wellness initiatives forward at School B, participants stated they needed a dedicated person to oversee health. This person (or entity) could come from outside but this person or entity first must understand the needs and priorities of School B and lead wellness in that context.

Based on review of the various data sources, it is possible to conclude that promoting a healthy lifestyle was a core part of School B’s culture. The overall educational philosophy of School B focused on the whole child—not only their academic performance but their overall well-being. Although only some interviewees were aware of the specific Healthy Schools Program, all interviewees were aware of the school’s policies around nutrition and that School B had a health initiative. Awareness and the enforcement of the school’s nutrition policies positively impacted HSP implementation and supported health promotion more generally. In terms of demographics, the mostly Hispanic immigrant population permeated every aspect of the school, including not only the school’s area of focus academically (dual-language) but also implementation of HSP and health and wellness more broadly. The demographic change in the broader community since the school had opened approximately 20 years before had had an effect on School B’s charter agreement, performance as measured by NJDOE Performance Framework, instructional context and innovation, and teacher staffing and retention.

Immigration status and culture impacted HSP implementation. A factor that impacted HSP implementation and wellness overall was the largely ESL, undocumented immigrant population. HSP would need to be modified to better fit the needs of this population. Specifically, there is no cultural component to HSP.

Being an independent charter school had both positives and negatives that impacted HSP implementation. Positives included the school's ability to be flexible in the types of programs they offered. Another positive was that being independent and small allowed the teachers and administrators to really get to know their students and families. A con was that there were limited financial and people resources. It was very common for one person to wear multiple hats in the school. Participants stated they needed more funding, so School B could provide more programs at the school, the anchor of their world, for parents and families. School B's teachers and administrators wanted to offer more healthy programs to the school community and broader community, but they stated they needed more resources—financial and human.

Finally, consistent across all interviews was that parents were considered critical in helping students to be healthier and there needed to be more programs and resources targeted to parents and improving parent health educations. A key element missing in HSP that could help with implementation of the program at School B was programming targeted specifically to parents. Reaching and engaging parents was cited as the critical missing element. According to participants, School B did a great job monitoring student health behavior while students were at school, but School B could do a better job engaging parents in health so that the wellness efforts in school would be supported at home. For purposes of better engaging parents, it was suggested by stakeholders that

technology could be used in more helpful ways. For example, having culturally relevant content (videos, social media), featuring people who looked like School B's population, in Spanish, was thought to be helpful, but it would have to be a complement to activities at the school and not in place of them. This content could be delivered via an app because all of the parents had smartphones, even if they didn't have internet at home.

Overall, School B's perception of HSP was positive. According to the Dean of Students and Education Director, HSP worked for them the way they used it. However, data from stakeholders suggests that to better support and advance School B's wellness efforts, with parents as the critical area of focus, School B needs a different or an additional program with different and additional resources.

APPENDIX 4-3

Case Report—School C

SCHOOL INTRODUCTION

School C was located in a New Jersey City with a population of approximately 250,000 people in which 17% lived below the poverty line. It was created as an independent charter school approximately seven years ago. School C had been a type of private school. That school closed and the new charter school reopened. It served approximately 380 students in Grades K-8. In terms of demographics, School C served a low-income, predominantly African American population (89%); 9% of the students were Hispanic. According to school administrators, 87% of students qualified for free and reduced lunch. The student teacher ratio was 17:1, above the state average of 12:1.

Interviews

Interviews were conducted with a variety of HSP stakeholders.

Participant	# of Years at School C	Overall Role	HSP Role
Director of Development	7 years; since it opened	Responsible for securing grants and funding, program development, and public relations.	Part of the original team that signed up for HSP. Actively managed HSP. Went to in-person HSP training sessions with the traditional public school over a 4-year period.
Food Service Staffer	7 years; since it opened	Served the kids breakfast and lunch.	Worked with the vendor who supplied the food served. Followed the USDA guidelines.
Physical Education/Health Teacher	6 years; first year teaching health	Taught all physical education classes; also the lunch and recess coordinator.	Responsible for physical education. Supposed to track height/weight measurements, but not tracking. Led other PA initiatives.
Science Teacher	4 years	Responsible for crafting hands-on science	Revised his curriculum to include health; explained the

Participant	# of Years at School C	Overall Role	HSP Role
		activities for 4th through 8th grades.	connection between what kids eat and obesity from a science perspective.
4 th Grade Teacher	5 years	Taught multiple sections 4th grade.	Member of the initial team focused on sustainability, which included green initiatives and HSP. Teachers' garden administrator. She trained on a sustainability curriculum, of which health and wellness was a part.
Principal	3 years	The instructional leader of the school. Focused on instruction, testing, enrichment programs for the students.	Knew of a health initiative but not directly involved.
CEO	Started the school	Did the business plan along with the school business administrator. The CEO submitted the educational part, curriculum, and instruction, assessment; oversees school operations.	Oversaw with Business Administrator hiring of food vendor; worked with him on implementing health education program.
School Nurse	3 years	Conducted all screenings, which included height, weight, vision, hearing, blood pressure, screening for scoliosis; responsible for immunizations.	Communicated with parents if a child's weight was 50th percentile; sent referrals home if blood pressure is high; provided information/contacts to the Physical Education/Health Teachers for the Health Fair.

Documents—The school charter, school mission, student handbook, School Wellness Policy, meal menus, and HSP online school dashboard were reviewed.

- ***School Charter and School Mission***—Academics and educational excellence were the foci of School C's written mission statement and

charter agreement. The School C mission also focused on character education, which spoke to developing overall positive characteristics of the School C student.

- ***Student Handbook***—The student handbook had comprehensive information about School C’s operations, but the School Wellness Policy was not included.
- ***School Wellness Policy***—School C had a written School Wellness Policy that outlined very specific standards for student nutrition, physical activity, and enforcement. These standards were based on HSP and government recommendations. The School Wellness Policy called for students to receive 60 minutes of physical activity daily and 60 to 89 minutes of physical education weekly. This was not occurring. The School Wellness Policy also called for regular meetings of the School Wellness Council and tracking and reporting of enforcement of the policy. The School Wellness Council did not meet formally as a cohesive body, but met informally in separate smaller groups.

School Health Environment Observations—Common areas including the gym and open spaces where physical activity took place were observed. Health messages and images promoting healthy eating and engaging in physical activity were posted in hallways and outside classrooms on every floor. Nutrition messages were posted in the cafeteria. Photos were taken of these messages. School C also had a gym and a playground.

LEVEL OF IMPLEMENTATION AS MEASURED BY THE HSP 6 STEPS

The six steps involved in HSP implementation are: 1) Formation of a School Wellness Council; 2) Completion of the HSP School Health Environment Assessment; 3) Local Prioritization and Action Planning; 4) Technical Resource Development; 5) Take Action; and 6) Monitoring and Evaluation of Progress. In terms of level of implementation as defined in this study (i.e., number of HSP implementation steps taken by a school, with six being the maximum), School C had taken some action in the implementation steps, but not all. School C had partially completed Steps 1, 2, 3, 4 and 5, and done none of Step 6.

<u>Steps</u>	<u>School C's Actions</u>
Step 1: School Wellness Council Formation	Formed; Not Active
Step 2: School Health Environment Assessment	Online Health Assessment: Partially completed Meeting USDA/HSP nutrition requirements Not meeting state/HSP physical activity requirements; not meeting for Grades K-5 (96%); not meeting for Grades 6-8 (64%)
Step 3: Local Prioritization/Action Planning	Informal Planning School Wellness Policy: Created; conditionally enforced
Step 4: Technical Resource Development (HSP Training/Technical Support)	Trained with school district and HSP relationship manager
Step 5: Take Action	Partial Implementation
Step 6: Monitoring	No monitoring

School C's Implementation of the HSP 6 Steps to Making School Environments Healthier

Step 1 FORMATION OF A SCHOOL WELLNESS COUNCIL

School C had formed a School Wellness Council, but it was not active. The CEO, Principal, Science Teacher, School Nurse, Physical Education Teacher, Food Service Coordinator, and Director of Development were all members on paper.

Step 2 COMPLETION OF THE HSP SCHOOL HEALTH ENVIRONMENT ASSESSMENT

Regarding Step 2, School C had completed School Health Environment Assessments in the eight online content areas: 1) School Health and Safety and Environmental Policies; 2) Health Education; 3) Physical Education; 4) Nutrition Sciences; 5) Health Services; 6) Counseling, Psychological, and Social Services; 7) Health Promotion for Staff; and 8) Family and Community Involvement. Based on the assessments, School C had created action items in School Health and Safety and Environmental policies, of which 33% had been completed; 50% of the action items in Physical Education and Other Physical Activity Programs had been completed; 90% of the action items in Nutrition Services had been completed; 10% of the action items in Health Promotion for Staff had been completed; and 100% of the action items in Family and Community Environment had been completed. No action items in Health Services or Counseling, Psychological, and Social Services had been created. School C's dashboard had not been updated since May 2016. However, consistent with interview data that revealed School C had been focused on nutrition and community involvement, School C was eligible for Gold HSP recognition in Community Involvement and Silver HSP recognition in Nutrition Services.

Assessment Area 1—School Health and Safety and Environmental Policies

The Director of Development stated there were no vending machines. This was consistent with school environment observations. The Director of Development and Food Staffer stated only watered and low-fat milk were offered to students. This was consistent with school environment observation and menu review.

Assessment Area 2—Health Education

School C had taken the online assessment and created an action plan. The Physical Education Teacher was also supposed to be teaching health education, but currently was not. Health education was not offered at School C at the time of this dissertation study.

Assessment Area 3—Physical Education and Other Physical Activity

The HSP/New Jersey state recommendation for physical activity is 150 minutes per week for elementary (K-5) grades and 225 minutes per week for middle school (6-8) grades. School C students were receiving 45 minutes of physical education per week and 20 minutes of recess per day, for a total of 145 minutes of physical activity per week, approximately 96% and 64%, respectively, of the recommended amounts of physical activity for elementary and middle school.

Assessment Area 4—Nutrition Services

School C was meeting the HSP/USDA guidelines school nutrition. School meals, breakfast and lunch, were provided via an outside food vendor. The School C Food Staffer then warmed up and served the food. The Food Staffer stated,

Yes. We follow the guidelines of the breakfast and lunch programs. With the right amount of meats and breads. There's no white bread. Comes in a package meal. But the food is fresh I can say that. But nine times out of 10 the vegetable is frozen because it comes in a package meal. Lean protein. A lot of that comes too. The Food Vendor really follows those to a T.

In terms of menu selection, the outside company set the menu, but the Food Staffer had input on the menus. The Food Staffer stated,

Yeah. If there's something that I really see that they don't like or they put on the menu, sometimes they put brunch for lunch. My kids don't like that. So I put, no, please serve me something else and they do accommodate and change the menu that way. But 90% of the time they make the menu.

Assessment Area 5—Health Services

The School Nurse provided general health support services to School C's student population. Her services included completing all screenings and tracking immunizations.

The School Nurse also provided health information and education to parents.

Assessment Area 6—Counseling, Psychological, and Social Services

Interview data revealed that School C offered psychological and social services to students with needs. Evaluation and intervention services were provided by the Child Study Team, whose responsibility focused on identifying students who may be in need of an Individualized Education Program (IEP). The team consisted of a school psychologist, a learning disabilities teacher, and a school social worker.

Assessment Area 7—Health Promotion for Staff

School C offered fitness classes to the staff, but they were intermittent. There was no consistent health promotion plan in place for School C staff.

Assessment Area 8—Family and Community Involvement

School C offered health events open to School C's families and the community throughout the school year, such as the Health Fair.

Step 3 LOCAL PRIORITIZATION AND ACTION PLANNING

School C did not formally do Step 3, but was informally doing some action planning by garnering resources around wellness initiatives, as needed. There were several health

initiatives in the school such as the community garden, the Health Fair, and sustainability, which included promoting healthy eating and engaging in physical activity via HSP implementation. School C had no overall, formal wellness plan. School C had a School Wellness Policy but knowledge of it was not consistent, and the policy was not consistently enforced.

Step 4 TECHNICAL RESOURCE DEVELOPMENT

School C used to use the HSP dashboard and access HSP implementation tools online. School C also trained with an HSP relationship manager with the traditional public school district. However use of the dashboard and stopped May 2016, which also coincided with the grant ending that funded HSP training.

Step 5 TAKE ACTION

School C was implementing the USDA/HSP guidelines for student nutrition. However the School Wellness Policy regarding acceptable healthy snacks and foods in the school was not being adhered to by parents, and not being enforced by teachers and the administration.

Step 6 MONITORING AND EVALUATION

Overall, School C was not monitoring HSP implementation progress or evaluating outcomes in a rigorous or systematic way. School C was not directly measuring and tracking changes in parent and student health behaviors to assess the effectiveness of HSP on the school health environment or health outcomes.

FACTORS IMPACTING HSP IMPLEMENTATION

There were many factors unearthed in this study that explain why HSP implementation had occurred in the manner it had in School C. These factors included School C's charter school context (e.g., social, environmental, demographic, organizational, economic factors) that had become barriers or facilitators to HSP implementation. Of these the largest factors were: 1) School leadership not fully supporting the School Wellness Policy that is based on HSP best practices; 2) Parents not adhering to the School Wellness Policy or supporting HSP principles at home; 3) Lack of funding; and 4) Lack of people—both number of people and people with health education expertise.

HSP is designed to help schools to implement policies and practices to make their school environments healthier, with the outcome of having students engage in healthier behaviors. In addition to helping school environments to be healthier and influencing student behaviors in school, a goal of HSP is to have these healthy behaviors continued and supported when students go home. School C had been somewhat successful at implementing wellness policies, practices, and initiatives that supported student health and created a healthier school environment within school walls. However, there were in-school factors and out-of-school factors that impeded this implementation in school, as well as out-of-school factors that served as barriers to students continuing healthy behaviors beyond school walls. Overall, there were many external social and environmental factors that served as barriers and facilitators to HSP implementation both within School C, and outside of the school when students went home.

IMPLEMENTATION BARRIERS AND FACILITATORS—SCHOOL C

<u>In-School</u>		<u>Out-of-School</u>
Barriers	Facilitators	Barriers
No Kitchen Infrastructure: Food not cooked on premises, only heated up, students were not smelling the food and getting excited to eat it; seen as a barrier to students eating the food	USDA Guidelines: Knowledgeable Food Vendor— School Food Vendor knowledgeable on the HSP/USDA guidelines; followed them to the letter	Parents: <ul style="list-style-type: none"> • Parent Education—not knowing what healthy eating is; not understanding the relationship between obesity and health problems; obesity-related diseases were too long-term and nebulous • Parent work schedule—not home to oversee student eating; not able to attend health events at school • Parent Engagement—was mixed around School C activities in general and low around student health
Students: <ul style="list-style-type: none"> • Not like the taste • Resistance to trying new foods • Lack of Exposure 	School Leadership: Belief in Positive Relationship Between Student Health and Academics— School leadership believed there was a relationship between student health and better academic performance Teachers: Passionate Staff— Core group of teachers and staff who believed in the	Social and Environmental Issues: <ul style="list-style-type: none"> • Lack of Transportation—Some families did not have cars, making it difficult to get to a grocery store selling healthy food • Cost of Food—healthy food more expensive than junk food • Environment Infrastructure— Corner stores selling junk food prevalent and easily accessible to students and parent • Safety—unsafe neighborhoods served as a barrier to students playing outside

Barriers	Facilitators		Barriers
	mission of healthy students and were committed to supporting student healthy eating and physical activity.		
<p>School Context: Lack of Leadership Support— Change in leadership shifted focus away from HSP implementation; prior principal signed School C up for HSP; had a strong commitment to student health. New principal wanted to focus on new initiatives. Although both the CEO and Principal thought health was important, support and enforcement of wellness policies was not occurring consistently throughout the organization; staff felt health was not supported from the top consistently and unconditionally</p> <p>Academic Performance— School C was on academic probation for 3 years; was off probation at the time of this dissertation study. Although test scores had improved, school leadership's priority was further score improvement</p> <p>Academics is the Priority—to the detriment of HSP support</p>	<p>School Context: Multi-Pronged Approach to Supporting Students and Families— School C offered multiple support services to students and parents, including Parent University, to support overall student and family well-being</p> <p>Schools Are More Than Schools— School leadership believed schools needed to take leadership role in communities, serve the community fully, and fill in the gaps where other</p>		

Barriers	Facilitators	Barriers
<ul style="list-style-type: none"> • Teacher Turnover—disrupted HSP information exchange • Teacher Enforcement Inconsistent *Teacher awareness of HSP was mixed *Teachers not consistently enforcing HSP due to confrontational parents; policy enforcement not mandated from the top • Lack of Funding—Lack of overall funding impacted HSP implementation • Lack of People— *Needed more people to oversee physical education and physical activity *Needed a health educator to teach health education to the students and help with educating the parents and staff *Needed a project manager to oversee all health initiatives • School Age/Charter Renewal—School C a young school, 7 years old; still a school in transition. School C was going to go through the 	<p>organizations are failing to service social needs affecting parents and students</p> <p>Sustainability—School C had an overall focus on sustainability which included green initiatives; health and HSP.</p>	

Barriers	Facilitators		Barriers
charter renewal process the next year			
	Kitchen Staff: Encouraged students to eat healthier		
	Obesity Prevention: School C teachers/administrators/ parents believed obesity prevention was a role the school should take		
	More Flexibility/Less Bureaucracy: Teachers felt empowered in their classrooms for initiatives they would like to take for general education Easier to get things done More staff input		

IN-SCHOOL IMPLEMENTATION BARRIERS AND FACILITATORS

IN-SCHOOL HSP BARRIERSS

Charter School Context Factors Impacting Implementation

Below are factors about School C's context that served as barriers to HSP implementation.

School C's Evolution—School C was a charter school conversion from a private school.

In that process, School C did not have the benefit of a planning year but had to keep its doors open to continue to serve the students and families of the community. The CEO stated there was a big cultural shift of going from a private school to a public school.

The CEO spent a lot of time setting up new infrastructure and resources. The CEO stated,

Most charters have a planning year, so they spend a year getting their systems in place, making sure they're rounding out their staff properly. Most charters open up K-1, 2, or K-1, they don't include 3rd grade those first couple of years because that's when you start having those standardized tests with charters that measure those schools or measures as to their academic success. So schools have to make sure that they have a solid infrastructure in place. We didn't have the luxury to do that, and primarily in part because we didn't want to not be there for the kids who had been in the prior school.

The Principal also stated School C went through a significant transformation:

School C was as a school when I came in, in need of transformation. So a transformation project usually takes, on the average, three to five years. This is my third year as a principal here along with the assistant principal. Macro level. Instruction, there weren't any viable instructional systems or the way they operate. Everyone operated in their own classroom in a closed-door system. The culture and climate were acidic, divisive. The management, there were changes happening there as well. When I say management, meaning the people who handle the business side of the organization.

School C was on probation by the state at the time, according to the Principal. In his first year they got off probation. From the Principal's perspective, he needed to put foundational elements in place. The Principal stated,

So first and foremost, I was getting some type of foundational instructional systems, routines, and procedures. We're a stand-alone charter school. Sometimes, the vernacular has used mom-and-pop. I'm not a fan of that terminology because, for me, it conjures up a perception that we're like a grocery store. Like we're just kind of winging it. So I want to get away from that. So systematizing operational procedures and memorializing some things, so that everyone's on the same page from the custodian to what's happening in the classroom. Everyone can verbalize what's going on. We're kind of making a vision plan, so people can run with it. That's number one. Number two, leading whole child development. Not only for students and academic student growth, but also the family at large. We have over 85% students who are free and reduced lunch.

The Challenge of Meeting a New Standard—The CEO stated that School C did not change into a completely different school, but related to School C changing from being a (private) school to a public school, the CEO stated that meeting the new public school testing standard was a challenge. The CEO stated,

We didn't go from selling apples to selling oranges. I think the other challenge was a level of rigor that was expected in the charter school. So, for example, standardized tests that students they took as a [private] school weren't as rigorous at the time as the [public school] test. So they went from a standardized test to a standardized test that was much more rigorous and foreign.

The CEO also stated that for a number of political reasons, charter schools were held to a higher standard; they were expected to exceed the performance of their traditional public school counterparts, and the framework by which they were evaluated, according to the CEO, was very stringent. The CEO stated that School C was expected to perform "measurably better" than their traditional public school counterparts, which School C was not doing due to the fact that 80% of the students had come from the private school and were not used

to taking the traditional public school test. School C went on probation the year after they opened and stayed on probation for three years. The Science Lab

Teacher stated,

As a charter school, standards for student development and student progress are higher than your public school. So we're judged at a higher standard than the local public schools, so it's not just enough for us to perform on par with them. We have to exceed them, in order to justify us continuing being a charter school, and that is a difficult thing to do. The teachers here are incredible. I've been in education for 12 years. I've never seen such sustained dedication. Some days I'll come in. When you work, some days you come in and you're like, "Oh my god, how am I going to get through the day?" I watch these guys, and I'm humbled.

The 4th Grade Teacher stated, "We have to prove ourselves. That it's a necessity to have charter schools. That was the whole spin-off of public to charter. Public wasn't doing well. Charter comes along. We got to step the game up in order to substantiate us being here."

Charter School Age/Renewal Status—School C was still relatively young as a charter school, at just 7 years old. They were up for charter renewal 4 years ago and will go through charter renewal again next year. The Food Staffer was also aware they had been on academic probation. The Physical Education/Health Teacher knew where School C was in their renewal cycle: "We got renewed for the first five, we were on probation, it was touch and go. But we got fully renewed off probation. But now we're coming up on renewal again. I think we got two years, they're going to come soon, looking again."

School Leadership

- ***Change in School Leadership***—A change in school leadership made health less of a priority, which served as a challenge to HSP implementation. The 4th Grade Teacher stated the previous principal was less tolerant of junk food and unhealthy snacks in the school. She stated,

If you make a statement that it's not allowed, and it'll be taken away from the kid and given to them at the end of the day. You can't take it and throw it in the garbage. But I've heard from other schools when we went to this meeting, a whole group of us were there from different counties, and cities, and everything. And they said the same thing. Once they mandate that it can't be brought into the school, they could take it away. Not throw it away, but take it away. So parents sign off, and they agree to this. And everybody wants their child to be healthy. You may have some parents that say you have no right to say John or Sarah can't have certain things. But when everybody else is doing it, John and Sarah are not going to want to be different.

School C did not mandate that no junk food was allowed in School C. The mandate started under previous school leadership and then stopped under current school leadership. According to the 4th Grade Teacher this was due to the focus being on education.

- ***Lack of School Leadership Support***—The Food Staffer stated,

We try to not let the junk food in, and to me that comes from the higher-ups. That comes from the principal to say in the beginning of the year. We try to have parent participation and say no junk food, but it still comes in. We try to enforce it, but we have to focus on not letting the junk food in.

The Food Staffer stated that the Wellness Policy regarding providing students with healthy foods, and the need for parents to support the policy by only sending healthy foods with the kids, were not discussed at the beginning of the year in orientation. The Food Staffer stated the focus was on academics. She stated,

More or less have the kids be on time. Have them dress properly. Do homework. More focused on schooling than the rest. I guess with us being a new school you have to have those PARCC tests up. So I don't know whether right now in the beginning they see that's more important to get it up, so we do stay open.

The Physical Education/Health Teacher stated, "We were on probation, new leadership, focus is academics." Getting off probation, according to the Physical Education/Health Teacher, was "interconnected" with the new principal arriving. There

was a refocusing of efforts under the new leadership. The Physical Education/Health Teacher stated,

Unfortunately, the old leadership—what happened was they had program overload. They wanted this place to be so great, but we started 17 different programs and none of them stuck. So I think when new administration came, they really wanted to focus in on a few to make sure that they were successful first before moving on other things. The new administration's goal is they bring you in and they want you to keep the school open. Everybody wants the school to be open first and foremost. And again, that is not based on how many hours of physical education they're getting, it's based on their test scores. I think the problem is that it's definitely academic focused; our health and wellness is definitely on the secondary.

The Food Staffer stated she thought there was a Wellness Policy about junk food. She stated,

But it's not enforced. I work with the nurse a lot where we put the letters together and said what a healthy snack should be if you're sending your kid in with snacks. Alternatives than sending the peanut butter sandwiches in. We've tried different things. The administration needs to say to the parents, "This is the policy. This is how the school is going to be run, and we will not allow this." Because I feel like we're the low men on the totem pole. We try to do our best. And if we throw that bag of chips or that bottle of soda away, and the parent is coming to argue with us and the administration don't stand by you, and goes with the parent, then it's like fighting for what? So I really think it has to come from up top.

Organizational Structure—The CEO stated the focus of the Principal was purely on academics. The CEO stated,

We want the principal to really be able to solely focus on being a principal. We don't want the principal to have to worry about whether this building's getting renovated or not and overseeing it. We'll have a principal whose sole focus is on the academic side. And then the CEO/lead person would be able to focus on all of the other things.

School C's Priorities—The Food Staffer stated,

The priority is getting those test scores up. The education. That ice cream truck is out there. And it's started back up again. If you're here around 3:30, 4 o'clock you'll see it. It's how do you get that man not to park there? The focus is academics, less about health. Some of it may be related to where the school is in

terms of being a relatively young school. I guess just getting off of probation. This sense of needing to get the school more on stable footing academically. It's frustrating. Sometimes I think maybe I don't do enough, but sometimes I feel just like getting the workshop lady to come in and try and get the parents in. Sometimes I think I go above and beyond and then there's nothing to show for it. So do I just give up or do I keep fighting? And maybe I just have to keep fighting and get more of the parents involved.

The School Nurse stated academics were the priority. She stated,

Academics, of course, is a priority in the school, yeah, but they know how important health is now. They know that we need to have someone in the classroom teaching our students about health. We had our meetings. We talk about it. It's just getting that steady person to come in. I mean, once we do that, I think our school's going to benefit so much more, than having me bouncing around. We're all working together, but I think we need a steady person to come in on a day-by-day basis.

Need More Resources—People, Time, Infrastructure

- ***Need More People; Staff Wearing Multiple Hats***—The Science Lab Teacher

stated,

It almost feels like I have three jobs, because not only do I do my regular teaching, I supervise the green team. When all of this started, I was elected the supervisor so I'm essentially in charge of that. I'm in charge of the garden project. But once we grow the produce and process it, then it becomes the domain of our cafeteria people who are all so wonderful and are integral to all of this, because they're the ones who prepare the food. It would be a lot easier for me to be at another school where I don't have all of these extracurricular responsibilities, but I enjoy it and the kids are great, and you know, it's great.

- ***Need a Person with Health Education Expertise***—The CEO, Principal, and School Nurse all stated there needed to be a health educator on staff to help with health education of students and parents.
- ***Need a Project Manager/Leader of Health***—The CEO and the Principal both stated there needed to be a project manager or leader of health in the school to tie School C's health initiatives together, oversee execution, and move them forward.

- ***Inconsistent Health Initiatives Due to Lack of People and Funding***—School C had had many health initiatives over the years that were compatible and complementary to HSP. According to the Physical Education/Health Teacher, School C had implemented programs such as Build Our Kids' Success (BOKS), and Fitnessgram, funded by Presidential Fitness, but these all ended due to grant funding ending or lack of people to run the program. The Physical Education/Health Teacher also stated School C was not tracking BMI due to both the Physical Education/Health Teacher and School Nurse being swamped, and they had to coordinate to do it. The Physical Education/Health Teacher stated, I go in there, and there is no less than three, four kids a day. So it's hard for her to get the information, because I need her to do height and weight for me. So I can teach them how to do their own BMI. I can't, unfortunately, with the time that I have them.

Technical Assistance—The School Nurse stated she had not received any training from HSP. Having training from an HSP person would be helpful. The School Nurse stated, “Absolutely. I would love to have someone to sit down. I mean, I try my best to do the best that I can with my own knowledge.”

Need More Time—The CEO stated,

If we could just stop the train for a month, right, and just say, okay. We don't have to do anything but worry about planning out what we're discussing, ideas will emerge. I mean that's why corporations have corporate retreats.

No Kitchen Infrastructure—School C didn't cook on the premises. School C received packaged food which was provided by an outside organization. According to the Food Staffer, School C didn't have a kitchen, which made food preparation a challenge. The Food Staffer stated that not being able to cook food on premises negatively impacted students' ability to like the food. She stated,

I think when you smell something, your stomach gets hungry, you want to eat. I think here, it's sad to say, you see them take the food, and today is chicken patties and toss the bread and the vegetables. So to me they're not getting quality food and to me I think they're still hungry. I wish we can cook on premise because cooking on premise you get fresh food here. Right now we get packaged lunch. Yeah, it's rented meals is what they call it. Today they're having chicken patties with corn or carrots today.

Teacher Factors Impacting Implementation

Turnover—Regarding turnover, the CEO stated,

I think it's been mixed. We've had turnover. Clearly we've had turnover. And we've had turnover in areas where people where I might have looked to say, this is the person who's going to be able to move that forward. We haven't had what I would say excessive turnover to the point where it would raise a red flag.

The CEO further stated turnover had had an impact on the school's wellness initiatives. The CEO stated,

Every project, every program has to be led. You have to have a team in place. You need consistency. And that's very difficult, just in reality, like our sustainability program. It's not where it really should be. Even our garden. If you go outside right now, I'm not happy about that. I mean where's the garden? There's no garden. And part of the problem is when you have staff that leave. We had a teacher who was very active working in the garden last year. She left. Fortunately, she just came back, and she's excited and wants to get involved with that.

Wellness Policy Enforcement—The Food Staffer stated, “You got certain teachers that don't want the conflict with the parents and will let the student eat the junk food. Others will take the food away.”

The Physical Education/Health Teacher stated,

So I mean, in my opinion, we have a lot of initiatives, but we're doing a really good job of the food part. The food part, we were really better than I've seen everywhere else. In other schools, kids would just go up and get four cookies for lunch. But here, they really, really tried and it was working, it still is working, the lunches. The lunches they provide were good. I think we've fallen off with trying to really push parents not sending kids in with bags from the store with chips and soda or whatever because at one point we were outright banning them.

Student Factors Impacting Implementation

Students Sometimes Resist Healthy Foods—The Food Staffer stated,

They'll eat it if it's something that they like. Today they will eat the mashed potatoes and the chicken. Will they eat that bread? No. So there's certain things. Sometimes the office ladies will come downstairs and they say, "They're throwing their vegetable away." I say, "I know they're throwing them away." Go to the next school, I would tell my daughter, who was at [another school]. I say, "Do the kids eat their lunch there?" She says, "Mom, they eat what they want. They throw everything away. The vegetables, they don't eat." So I don't know if it's the inner city kids again with a lot of parents being on food stamps. Do they get those fresh fruits and vegetables at home?

The Food Staffer questioned whether students were exposed to fruits and vegetables at home and thought they were not used to these foods and therefore did not like them.

The Food Staffer stated that consistent exposure was key. The Food Staffer stated,

Like, with my granddaughter, my daughter said, "Ma, I can't get her to eat broccoli." I would tell her put it on her plate every day. Eventually she's going to eat that broccoli. She's five. What does she love today? Broccoli. But if you don't keep pushing it and introducing it they're never going to eat it.

As an example, the Food Staffer stated students had resisted eating whole wheat bread because they were used to eating white bread.

Consistent with comments the Food Staffer made, the School Nurse stated,

Our children give us resistance also sometimes. But I think they're getting better when it comes to that. We're trying to implement everything the way we're supposed to. Sometimes kids, you have a few that want to give you resistance one out of one days. But I think that it just takes time to sit down with them and explain to the children and the families, "Okay, what we're trying to accomplish, the importance of what we're trying to accomplish. We're looking out for the well-being of your children." What we're doing is also educating the families and our staff too.

PHYSICAL ACTIVITY

Lack of Time, Space, Personnel are Cited as Barriers to Physical Activity

Implementation—School C was not meeting the HSP/New Jersey state guidelines for physical activity. Study participants cited lack of time and space, and need for more people as reasons. These factors were connected to other school priorities taking precedence over the Physical Education/Health Teacher's time. The Physical Education/Health Teacher stated,

The students are not getting enough physical activity. It's not enough. It's definitely not enough. I've been talking recently with the Director of Development about how many hours we should have and how many hours we don't have. She asked me what I would need to get us up to snuff, so to speak, and I basically told her, a 2 million dollar extra gym and two more full-time health/physical education teachers because I am only one human being and I'm the only person here who does it. So it's just not feasible, and especially because we have a very rigid schedule. We're under the state limit. We're doing 100% better on the food part but we need more people and more space for the physical activity part. From a scheduling perspective, our schedule is very rigid. When the new administration came, our big push was to have collaboration and coordination among the levels of teachers. So they wanted all of Grades K through 2 to have prep at the same time so that they can meet as a group and discuss who's on what reading level. And they really wanted that coordination, even every day. So in doing that, we had very limited space to put specials, like PE, in.

The Physical Education/Health Teacher further stated,

Implementing the food part is easier because it doesn't take away from anyone. Physical activity is low if it is a priority. I don't want to assume what people are thinking, but I'm going to say that it is low. And that is just a sign of education in the year 2018. Test scores. We can't have physical activity if we're not open. We can't have a healthy school program if we're not open. So our goal, due to our low test scores, was academics and raising the test scores. So I feel like the health and wellness plan got pushed to the back burner. The food part does not take away from anything. So it doesn't pull resources from anywhere, it doesn't pull time, everyone has to eat, but physical activity does. We need more personnel.

IN-SCHOOL IMPLEMENTATION FACILITATORS

Charter School Context

Benefits of Being an Independent Charter School

More Freedom, Less Bureaucracy—The 4th Grade Teacher stated there was more freedom to implement academics and health and wellness initiatives. The 4th Grade Teacher stated, “We have to go through the Principal and CEO, yay and nay. That’s it. We don’t have to go to a whole lot of people because we’re not that big conglomerate from the public school system. So it’s an easier process.”

The Physical Education/Health Teacher stated,

Less bureaucracy; more autonomy. If we need something we can get it. You don’t have to wait until it’s time to order at this month of the year and send in your order. Public schools have a process, and they only buy it from the one or two companies that they have the contract with.

More Innovation—The Science Lab Teacher stated that School C tried to be innovative in their curriculum. He stated,

We try to be innovative. I mean, I do backflips every two weeks trying to figure out new approaches to old material, and I know I’m not alone. In fact, I would say that I have it easier than most, because I’m a science teacher. It’s easy to be creative when you’re dealing with science, because there’s so many ways you can approach it. Not so much with say, math, which is very cut and dried. It’s much tougher to come up with new approaches to teach math than science. We still have to stick to state standards, but I’ve been in public schools, and I have to say that I think I’m afforded a little bit more latitude here than I was at the other schools.

More Input—The Physical Education/Health Teacher stated,

I think the best thing about it is that I feel like I have more input and more of a stake in it. I feel like, when you’re working in a huge school district, it has a thousand-plus kids in the high school. You’re just another cog in the wheel. But here, especially with our current administration, I feel like my input is valued and wanted, not just to make me feel like I’m being valued, but because I’m actually valued. Administration is very open to suggestion. Everybody is on the same page. We all want what’s best for the kids, ultimately. So I think that, if

somebody comes with something new, as long as they can prove it and we can get money for it.

School C's Unique Context

School Mission/Vision—The 4th Grade Teacher thought sustainability, of which health and wellness is a part, was consistent with School C's mission and vision. She stated, "The school wants it to be that way." The School Nurse thought health and wellness was consistent with the school's mission and charter. She stated, "Absolutely. If you don't have a healthy child, then the child's not going to function and excel academically."

The Physical Education/Health Teacher stated, "I'm pretty sure there's something in there about health but I know that the main thing is we're an academic charter school. That's what we're promoting. That's what it is."

Strong Sense of Responsibility to the Community—The CEO stated,

We are a neighborhood charter school. We're a community school. We're here, you've heard me use this word before, we're here, in effect, to be an oasis in this community. This option is a much better alternative for them than the neighborhood schools that they would otherwise have to attend if this school didn't exist.

Holistic Approach to Supporting Students and Their Families—The CEO stated,

There are other things that we need to be looking at. There are other things that we need to bring to the table to help these kids and their families be successful. We had a financial literacy program. We've built [category pillars] to success, health and wellness being one, mentoring, Parent University.... You have to bring all of these components to the table, in a structured way, to support the core mission. That's the undergirding. That's the infrastructure that I'm talking about beyond the bricks and mortar.

Parent University—The CEO stated,

You go into a home where the parents are underemployed, and you go into a home and maybe they're unemployed. Or because they're not earning a real, legitimate wage, I mean advocates or organizers call it a living wage or whatever.

And they're working two or three jobs, they don't have the time to read to their kid. They're underemployed, you're not going to find a technology in the home.

School C partnered with a large internet provider to give parents access to the internet. The CEO stated,

The larger vision for Parent University is to help strengthen the environment that envelops the parent. So what is it that the parent needs? So if you have a parent who is not technologically savvy, how can they sit down and help their student, their child when the student comes home with a computer and has to work on the computer. So you want to strengthen the skills. It's skill-building. So you want to strengthen the parent's strength as well. Another element of Parent University that we'll, at some point, activate is financial literacy. Parent University is about trying to equip the parent. Maybe at some point, I would love to sponsor some kind of training program here for parents to be prepared for the 21st-century economy, right, and maybe do some skill-building.

Senior Leadership Saw a Relationship Between Healthy Eating and Academic

Performance—The Principal stated,

Every morning as you saw when you came in, students come with the black bags from the local bodegas that's full of sugar, salt, etc. So there's an ebb and flow to their energy levels. The sugar takes them here and then they bottom out, and then it goes up again after lunch, and then it comes down. And it is a direct correlation to the behaviors that we see. We want to spend less time on behaviors, more time on incorporating healthy attitudes, healthy habits, mind, and body so that it goes hand in hand with making sure the students are able to focus on academic rigor. We have Fresh Fruits and Vegetable Initiative. We have a garden. We've harvested some of our own crop. Fresh vegetables. We have a very good cafeteria management team who make sure that the snacks that are given on a daily basis are healthy whether it's fruit or whether it's vegetables. So it's good to see the clear plastic wrapper replace the black bag, that are full of all of the dead foods.

Although this was what the Principal stated, in practice, other study participants stated that operationally School C leadership was not supporting wellness initiatives.

Obesity Was Viewed a Problem in School C and One the School Should Address—

Participants felt obesity was a problem in School C and one the school should take an active role in preventing. The Food Staffer thought overweight and obesity was

an issue in the school, with about 15% to 25% of the students being overweight and obese. She deferred to the School Nurse for her assessment. The 4th Grade Teacher stated,

We have a lot of kids that are overweight. I walk up the stairs three or four times with them, taking them up and down. Sometimes, I have to stand at the top of the staircase and wait for them. Because they're huffing and puffing, and can't get up the stairs. And I'm used to going up the stairs, because I used to own the house down the block, where it took me 34 stairs to get up to my bedroom. So it wasn't a big deal for me. But these are kids that are 9 and 10 years old, and having a hard time. Even when you see them running around in the school yard, they're struggling. So something needs to be done.

The Physical Education/Health Teacher stated obesity was a problem at School C. The Physical Education/Health Teacher stated,

Yes. 100%. And even students who aren't obese, they have a very low tolerance for cardiovascular activities. Anything that involves a ton of running. I don't know if that's the area. I don't know what it is. But definitely, it's a problem.

Other Complementary Wellness Initiatives to HSP were Being Implemented

- ***Integrated Sustainability Program with Health as a Core Component***—School C had a focus on sustainability as an overarching school goal. Sustainability included sustainability green initiatives with the environment and initiatives with health. Health and wellness were viewed by the CEO, the Director of Development, the 4th Grade Teacher, and the Science Lab Teacher as being a key part of School C's overall sustainability initiative. In the wellness component, the 4th Grade Teacher viewed HSP as part of School C's overall sustainability program. The 4th Grade Teacher stated that she and a core group of teachers, some of whom were no longer at the school, were responsible for developing a sustainability curriculum that included HSP components focused on improving school nutrition and increasing physical activity. This curriculum was

to be integrated into the overall School C curriculum. The 4th Grade Teacher stated that School C had started to implement the curriculum but with the change in school leadership, implementation stopped.

- ***BOKS***—School C had a before-school physical activity program, Build Our Kids Success (BOKS), sponsored by Reebok. It was led by the Physical Education/Health Teacher and then a parent volunteer. The parent volunteer stopped leading the program when her child left the school. Without someone to lead the program, the program ended.
- ***School Health Fair***—The School Nurse and the Food Staffer worked together to produce health fairs. The School Nurse stated, “I think we had 19 or 20 different organizations that came in and helped us out with this health fair. It was pouring out there. And can you believe I don’t know how many parents came with their kids? It was unbelievable.”
- ***Fruit and Vegetable Program***—The Fresh Fruit and Vegetable Program was a state-run and -funded program that was separate from HSP. The program provided fresh fruits and vegetables to School C daily. This program was complementary to HSP in helping students to eat more fresh fruits and vegetables. The Food Staffer stated that schools qualified if they had a high percentage of students in the free and reduced lunch cost program. It was totally separate from the USDA/HSP guidelines but compatible and complementary. The Food Staffer stated,

They are totally separate because the breakfast and lunch have their own set of rules that have to be met, which we meet, and the fresh fruit and vegetable is also just an initiative to get them to eat healthier things, fresh fruit and vegetables. To have them eat the broccoli or the cauliflower we

send up upstairs. Again the peppers were really good. Just for them to have that. The fresh fruit and vegetable are given to them at a different time. So it's not included in their meal.

Training and Technical Assistance—School C Received In-Person HSP Training

Trained with HSP Staff with the Local Traditional Public School—The Food Staffer stated she had attended a training three years ago. This was with the district. The Food Staffer stated,

It was just a workshop, a seminar for healthy eating. To try to get yourself from gold, silver, bronze medals to be a healthier school. It was about the healthy eating, the bread, the nutrition factors. It was how to become a sustainable school, how to grow your own garden. It covered a lot. But then that stopped. It was helpful. It was helpful and to me I find it more helpful when you do cooking on site.

The Director of Development also trained with traditional public school and the HSP relationship manager. She found the training to be “Excellent. Really helpful, but then the grant ran out and it ended.”

OUT-OF-SCHOOL IMPLEMENTATION BARRIERS AND FACILITATORS

OUT-OF-SCHOOL HSP BARRIERS

Parents

Parents Did Not Adhere to School C's Nutrition Policies—The 4th Grade Teacher stated,

We can't stop the parents from purchasing the things. Because a lot of the kids come in the morning, and I start arguing with them because they have sodas and potato chips. And they sneak and eat them. But I wouldn't allow them to eat them before breakfast. That's something you can eat as a snack at lunchtime. But it's not a sustainable snack. It's not something that's going to take you through the day. It's junk food. It's going nowhere in your body. And if you educate the kids and they know the knowledge of what they're eating, then they can educate their parents.

The Principal stated about 70% of the parents adhered to the School Wellness Policy.

The Principal offered this explanation for non-adherence to the School Wellness Policy:

We get the information out and through the school nurse. Where we have to be more consistent at is making sure that the message is consistent. It's more if today's my birthday and the parents come in with the traditional cake, the balloons, etc. So what we have done is say, "Okay, you got it. You spent your money. We're not going to take it." We'd be creating a storm that we really would prefer not to deal with.

Lack of Parent Education—The 4th Grade Teacher thought students could educate their parents. The 4th Grade Teacher stated,

I feel that if the kids are educated, they can in turn educate their parents. But also we should have classes separate to let the parents know we're no longer accepting these foods in here. Once parents as well as children are educated on the benefits of being sustainable and putting nourishment into their bodies, over the long term, this is going to be a benefit both ways. Because if you start healthy at a young age, you carry that into old age.

The 4th Grade Teacher stated parents didn't understand the cause and effect of not eating healthy:

Are they taking it seriously? They have to. I mean, that's just total ignorance. Or like my mama said, "If you don't know, you just don't know. Because you're not educated." But are you taking the time to see that your child is overweight, and her face is lying on her chest? I have kids in my class that are like that. They're happy as can be, but they're like a walking time bomb as far as time is concerned. Because at some point, it's going to affect them: cholesterol, high blood pressure, and early death too. Because they're already big. Some of my kids are bigger than I am, and they're only 10 years old. And that's bad. That's really bad. But they're happy little kids now.

The 4th Grade Teacher stated unless the situation was a crisis, parents would not engage.

Parent Engagement—The Physical Education/Health Teacher stated parent support of health had tapered off. The Physical Education/Health Teacher stated,

I'm going to say that it's slid off. We've lost a couple of parents who were kind of like our champions. We still have people. So I think that hurt us a little bit. We don't have a PTO or a PTA as far as I know. If we do it doesn't have much of a presence in the school. So I mean, I would say that's definitely like a strike

against us. But as far as the healthy foods go, we have parents and community members working in the garden for our sustainability. The more people we have, the easier it is to implement HSP but we don't. At this point, we're definitely lacking.

The Food Staffer stated, "Turnout at the open house is better; about 50% of parents because they are already at the school, but if it's separate nutrition seminar it will be two parents who show up." The School Nurse stated, "I think we could work harder at that, to be honest with you. I think we need to involve our parents. Because it stems from home." According to the Food Staffer, getting parents to attend workshops on nutrition was a challenge. The Food Staffer stated,

That's a challenge. We would try to do workshops and then two parents would show up. On nutrition. To me it's not enough parent involvement. So I would have you come in and sit there and think we're going to get at least 50 parents to come in and when you are there, and you only have two. How do you get the parents to get more involved? Sometimes I think maybe it should be a requirement that the parents do whether it's on nutrition, education, fitness. To me maybe if we made it a requirement that you do three seminars throughout the year just for your child.

Regarding the School Wellness Policy, the Physical Education/Health Teacher stated,

I don't think that it outright bans junk food, but I think that it strongly advises against it because I do believe that when we banned junk food there was some parental pushback. People just, I don't know, they didn't want to eat here. And you tell the kid, if that's all they have, you're like, "Oh, you can't have this," "My mother said I could have it." I mean, at that point what do you do? You can't take the food away from the kid. It's the only food that they have. So it's a very sensitive issue...you want parents to get on board and it's not easy, but I think that's why we went with a little bit less of a harsh move. But it shows, in terms of how many students are bringing in stuff that they shouldn't.

Parents Can Be Confrontational—The Food Staffer stated,

How do I go and tell the kids, especially when these parents are so confrontational? So I've seen a parent screaming at a teacher because the kid wanted to stop and tie his shoe and the teacher said move to the side because somebody is going to knock you over or fall while you just stop. They fight over penny-ante stuff. So how do I take that bag of chips and say you can't have it?

For what we can introduce to the kids we are trying to follow that it's just getting the kids on board with their parents to say this is what it is. I mean they do get more healthy eating here. They do get more of the healthy eating here than at home and like I keep saying to myself it starts at home.

Parent Work Schedules/Parents Not at Home to Supervise Student Eating—The

School Nurse stated,

A lot of the parents work nights. And the kids are there and whoever [is] there supervising them are much younger. I'm saying teenagers. What parents say to me about eating healthy eating is, "I can't afford it and I'm not home. Once they're at home by themselves I'm not supervising them so they're eating this and that." So that becomes an issue.

Culture—The School Nurse stated how parents were raised impacted their perspective on health and healthy eating of their children. The School Nurse stated,

I have some parents say, "Well, this is my child. This is the way I was raised. Eating this and that. So and this is what I do, from my childhood. I'm not going to stop." So all I could do is educate them. I'm not here to battle with parents. You just educate them and bring awareness.

Home Life and Parent Health Affect Student Health—The CEO stated there were a number of social and environmental factors impeding implementation, starting with parents being unhealthy at home. The CEO stated,

There are multiple, multiple impediments to how well kids perform in school. And not being healthy, and not just themselves, either. When I think of our health and wellness initiative, it's the students and then by extension their parents, and then by extension the community at large. So if you're a child, and you're living in a home where your parents were dealing with health issues, that impacts you. You may have to do more at home than maybe a child who's living in a house that they're not faced with that. If your mother or your father has to go for dialysis, for example, what does that do to that family? How does that impact their child psychologically just having to see that? If the parents are not home eating healthy, then the kids aren't going to be eating healthy. And then the kids come to school, and if they're hungry or if they're not well-nourished, they're not going to perform well.

Social and Environmental Factors

Across interviews, there were many social and environmental issues that negatively impacted parents and students eating healthy:

Schools Are Dealing with Social and Environmental Weaknesses that Affect Both

Health and Academics—The CEO stated there were social and environmental factors that were affecting the health, well-being and academic performance of students and their families of School C. The CEO stated,

Even though I said these communities are different, there are some commonalities. It's unfortunate that we're at this place where the school, in effect, has to become this entity to address all of these societal weaknesses, because if all of your other institutions are not, I jump around here, but it's economics, it's housing, it's education, these are weaknesses. These are societal weaknesses. They're not being addressed in a manner that they need to be. And so when there is a weakness, or when there is a gap, when there's a hole, something has to plug it. It doesn't mean that that's the right tool. It doesn't mean that that's the right or the thing that should be happening. Schools shouldn't necessarily have to play this role, but we're playing this role because there's an absence and lack of a structure in place, to help mitigate the fact that we're dealing with all these issues.

The CEO further discussed violence in the community. The CEO stated,

Look, I'll take you downstairs right now. We go into the kitchen, I'll show you the closet. Up above there's a bullet hole. Over the weekend, one day there was a shootout across the street. Thank God it didn't happen one day when we were all here. Bullet came through the kitchen window and it embedded itself in one of our doors. Now we shouldn't have to deal with that, right? So as a school now, what do we do? So maybe a mentoring program, or we need to bring the parents in. Nothing's perfect. I get that. I'm what I call an idealistic realist. I understand it won't be perfect. But all I'm saying is the school has to become that kind of a place where you're dealing with all of these tangential issues, all these externalities.

Cost of Food—The Science Lab Teacher thought cost was a barrier to healthy eating. The Science Lab Teacher stated,

Lower quality foods tend to be sold in urban areas. That's a fact, it's not debatable. Eating habits at home, by and large are, I'm sorry to say, quite poor. And there's nothing the child can do about that. That's not the child's responsibility, that's the responsibility of the adult. Cost is also a factor. The reason why a lower quality of food is sold in urban areas is because good food, organic food, is pricey. I ought to know, because I live in the suburbs. I buy organic food, and I can see the price differential.

The Food Staffer stated, "They're living off food stamps. It's hard for them to see what they buy. I go to BJ's and it's the first of the month and you see their carts filled with fast food. The Hot Pockets and the quick lunches. Those Lunchables." The Food Staffer, Director of Development, and School Nurse all tried to do what they could in terms of exposure and making sure the students were eating healthy, but they all stated there was not continuity when the students went home. School C could not control what students were eating at home. There were factors like money and food stamps that were beyond their control. Parents not being able to afford healthier foods negatively impacted student exposure to healthy foods, which impacted student eating behavior in school. The Food Staffer stated,

Yes, food stamps that they don't have enough to go out and buy this stuff. And at home they only buy the white bread. So when they see the hamburger on a whole wheat bread they look at the bread and say what is this? You don't have white bread? No, I can't give you white bread. This is healthier for you to eat it.

The Corner Store was a Barrier to Healthy Eating—The Principal stated,

So within our community, a lot of the fresh fruits and vegetables have been replaced by local bodegas that support an on-the-move, on-the-go, packaged lifestyle, whether that's breakfast, lunch, and/or dinner. A lot of foods that you see in these markets are primarily processed packaged goods. So you can get in there grab it and go. A lot of my parents, because I'm out in the community, I see them either eating breakfast in a car.

The Science Lab Teacher also stated students were getting junk food from the corner stores: “Well, there are corner stores around here where they get the junk food. We do have school policies. We don’t give out junk food.” The Food Staffer also stated that a barrier to implementation was the students having easy access to junk food at the corner store. She stated these foods were competition to the healthy foods offered at the school. The Food Staffer stated,

It’s that junk food that they’re buying at the corner store and bringing here and eating. And maybe, again, if it came from the enforcement of even though you bought in the store you’re not eating it in the building. There’s also an ice cream truck that parks outside every day. They still go to the corner store. The ice cream truck is still outside.

Safety—The Principal stated, “We are in the most violent section of our city. Literally, there was just a murder down the street in the park yesterday as I was leaving. So we’re in a traumatized neighborhood.”

Lack of Transportation—The Principal stated,

A lot of our families do not have access to transportation to get to the Whole Foods, the ShopRites, etc. So we’ve brought ShopRite in, where I think it was last year or the year before last, we brought the nutritionist from ShopRite to talk to our parents, doing one of our parent nights, and talk about the different advantages of shopping at stores where you can buy fresh fruits and vegetables. So that’s what we deal with.

IMPROVING HSP IMPLEMENTATION—RECOMMENDATIONS

School C participants had the following thoughts about how to improve HSP implementation.

- **Make Parent Participation Mandatory**—The 4th Grade Teacher stated additional funds would help with parents,

But getting them to come. We have the kids, so to speak, captive. They’re already here. Who’s going to want to do that on a regular basis to be

educated? That's the problem. It's just like open school night. We're here from 1:00 to 8:00. We don't get all of the parents.

- **More Money and Resources**—If School C had more money and resources, the 4th Grade Teacher stated,

Educate and exercise. Those are the two main things. If they have the knowledge of what would happen to them as far as their physical being, and incorporate that with exercise, longevity is key.

- **Need More People**—A person dedicated to overall health initiatives and a dedicated health teacher.

- ***Need a Health Educator***—The CEO, Principal, School Nurse, Director of Development, and School Staffer all felt School C needed a health educator. The Food Service Staffer stated,

We need a new person who can help change behavior of the parents. Someone to help guide me. Years ago it wasn't so much focused on salt. Now they're trying to get salt out of the diet totally which is fantastic but years ago you didn't have to worry about that. Now, where they are focused on the healthier living it comes—to me it starts at home.

- ***Need a Health Project Manager***—The CEO and Principal felt there needed to be someone to manage health initiatives in School C.
- ***Need More People Generally***—The Physical Education/Health Teacher stated they needed more people. It would have been really helpful to have someone dedicated to health. The Physical Education/Health Teacher stated,

I feel like if we had a concentrated health teacher that would help. We don't have one. I am a teacher of health but that's not what I'm doing. Somebody said, "Can you do this?" And I said, "I can but unless you can make a clone of me, I don't have the time in the day to do it.

The Principal stated,

I need the project manager to take these ideas that have already been established, this particular aspect had been established before I got here, and then let's project manage. What does it look like in the beginning? Where do I want to go? And how do we identify stages and metrics as we have with the healthy school index along the way to make that come 100% to life.

- ***Lack of Health Education Expertise***—The School Nurse thought health was a priority for school leadership, but the school needed a dedicated resource who had expertise in health. The School Nurse stated,

We need a health educator. I am a teacher of health also. The thing is I can't put myself in the classroom on a daily basis because of what happens here. I have mini ER here. So I really feel that we need to get a teacher of health to come in and teach our kids more. We could use more people. And the more knowledgeable and the more people that are more knowledgeable in health, the better we do as a school.
- ***Use of Video and Technology and Video***—The Principal stated that use of

online health video and tools would be helpful for supporting HSP implementation for parents and students. The Principal stated,

Some online resources and tools that they can have as a reference library on our website to promote our being a healthy school would be great. Given what I call the lunch box or the packaged to-go lifestyle that most families lead here, including our staff, yes, it would be nice to have yoga here at the end of the day and tools online.

The CEO stated it would be helpful to offer health and wellness content that parents could access through Parent University, but it would also be important to have events at the school. The CEO stated,

Some of it I think would be programmatic, like come to the gym on Tuesdays and Thursdays. Some of it might be giving them access to content, directing them to the websites where they can get information. Maybe building out a portal on our website specifically to provide them with e-content that we think that might be beneficial to them around health and wellness, or around finances, or around legal strategies if they have to deal with issues around legal issues, political. Let them know that there are events going on.

The 4th Grade Teacher thought produced videos featuring people from School C's neighborhood talking about health and wellness, talking about their personal health experiences, how they got healthy and what being healthy meant to them, would be helpful in engaging parents to live healthier. The 4th Grade Teacher stated,

Because I know you. As long as the people know the people, they have the connection. So everybody in this neighborhood is connected through some means. This one's cousin, uncle, brother, something. They're all related. That sounds very good. But just having a general doctor, not as much impact.

The School Nurse stated online health content for parents that parents could access through their phones or the school portal, Class Dojo, could be helpful.

- ***Engaging Key Stakeholders and Partnerships***—Leveraging other resources in the community could help with HSP implementation. The CEO stated,

Sometimes you have to think more broadly about your approach and your strategy. The reflex answer is always, give me more money, right, and then I can go buy the resource that I need. It's not always just that. Sometimes it's taking a step back and saying, well, maybe we can accomplish what we want to accomplish via collaboration.

An idea the CEO discussed was having a consortium of independent charter schools that were engaged in wellness initiatives to share resources (financial and people), programs, and services.

- ***Increasing Parent Engagement and Volunteers***—The Physical

Education/Health Teacher stated,

If we had the parents we can bring back those morning programs and make them bigger. It doesn't matter where the people are coming from. We can train them. We can get it. You don't need 17 gym teachers. I can, or two, or three people can oversee the mass of people and help out. You need people that are willing to work.

More Programs

- ***Programs Targeted to Parents***—The Food Staffer thought if there were a way to track whether or not a parent had read a flyer, that might be helpful. Integration of health content into the existing school portal, Class Dojo, might work to improve parent education and engagement.

The Food Staffer stated,

The school does its part but to get those parents involved. The parents need to say they [the kids] get a healthy breakfast, they get a healthy lunch, they get a healthy snack. Let me try to continue this at home and to get them involved and participating. Yes, because the parents put the food in front of the children. It's not the children that are going to the grocery store buying it is the way I see it. It's the parents that are bringing it home to saying, okay, this is what you get to eat. So to me, if you don't change the parents....you must change the parents.

The Food Staffer thought it would be helpful to have more events targeted to parents at school. The School Nurse echoed similar thoughts. The School Nurse stated,

Open up more programs for our parents. Where we could involve our parents on nutrition and health. I think we need more education when it comes to our parents; more courses or workshops on education for our staff and our parents. I think we need to try to organize more workshops. We need more programs involve our parents. And that's something that we're also working on.

- ***Wellness Programs for Teachers***—The Principal stated they needed programs targeted to teachers as well.

CONCLUDING THOUGHTS

The biggest factors impacting HSP implementation in School C were 1) School leadership not fully supporting HSP; 2) The School Wellness Policy not being widely disseminated; 3) Mixed teacher awareness of HSP and inconsistent policy enforcement; 4) Lack of parent engagement and education; 5) Ease of access to junk foods via corner stores; and 6) Lack of funding for HSP training and wellness initiatives implementation.

School C felt that HSP training was excellent, when they had it. The grant ending, compounded with a change in School C's leadership focus to academics to the detriment of HSP and health implementation, served to thwart the momentum School C had in making their school environment healthier.

For HSP program designers the recommendations were:

1) Provide School Administrators with More Information on the Correlation

Between Academic Performance and Health—School C had health advocates on its staff. Providing them with more information about the correlation between health and academics may help to better focus the school leadership on health.

2) Provide School a Health Consultant—School C needs a person to project manage health initiatives in the school.

3) Provide a Health Educator—In addition to needing a project manager, School C also needs someone who is qualified in health education to help School C's staff as they helped to educate students and parents on proper nutrition and how to engage in physical activity, as well as teach a health education class to students.

- 4) **More Content Targeted to Parents**—All study participants felt that lack of parent education was a barrier to program implementation. There need to be more programs and content targeted parent education
- 5) **More Focus on Understanding the Social and Environmental Context of School**—School C had many social challenges that affected HSP implementation, both in School C and out of School C when students went home to their communities. An issue cited was the easy access to cheap junk foods sold via ubiquitous corner stores. HSP administrators could work with school leadership, city, and state to discuss policies and economic subsidies to help place healthy foods in these corner stores. School C's cultural context should also be taken into consideration when designing content and programs. Culture should also be taken into account in programs designed for parents.
- 6) **More Resources to Support School C as a Social Service to the Community**—Health promotion and HSP implementation were very intertwined with School C's social environment. HSP administrators should look at advocacy to provide funding for social services to be at School C that support health and HSP implementation—e.g., mental health and behavioral support, or social services support.
- 7) **Use of Technology**—Use of apps and culturally relevant video were suggested, as was to increase access to health content and improve HSP implementation. This content could be disseminated via mobile apps for phone, as well as possibly integrated into School C's existing platforms, such as Class Dojo.

APPENDIX 4-4

Case Report—School D

SCHOOL INTRODUCTION

School D was located in a New Jersey City with a population greater than 250,000 people in which 17% lived below the poverty line. It was founded 5 years ago as an independent charter school. It served approximately 400 students in Grades K-6. The school was planning to expand to K-8 the following school year. School D served an Asian (44%), Hispanic (38%), African American (12%), and White (5%) low-to-middle income population in which 46% of the school population qualified for free and reduced lunch. The student teacher ratio was 21:1 as compared to the state average of 12:1.

Interviews — Interviews were conducted with seven key HSP stakeholders (3rd Grade Teacher, Food Service Staffer, two Physical Education/Health Teachers, the Principal, the CEO, and the School Nurse). School D was a young charter school in the absolute but also relative to the other charter schools included in this study. As a result, a common theme that emerged across interviews was that participants wore multiple hats and their responsibilities changed depending on where their help was needed.

Participant	# of Years at School B	Overall Role	HSP Role
3rd Grade Teacher	5 years; since it opened This was her first job	Teacher 3rd grade; coordinator of the entrepreneurship program in which students learn real-life business skills by operating a business; this is integrated into the core curriculum	Enforced the School Wellness Policy as a teacher regarding healthy snacks and lunches
Food Service Staffer	1 year	Served the kids breakfast and lunch	Made sure students ate healthy e.g. low-fat milk, vegetables; an outside vendor

Participant	# of Years at School B	Overall Role	HSP Role
			cooks and delivers the food
Physical Education/Health Teacher 1	3 years; first year teaching health	Health was previously taught by the classroom teachers Teaches K-2 grades	Responsible for the physical education/physical activity and health education components of HSP; coordinates health events with Physical Education/Health Teacher 2
Physical Education/Health Teacher 2	First full year at the school	To alleviate some of the work for Physical Education/Health Teacher 1 and to make room for the new health program, this second teacher was hired. Taught 3rd-6th grades Both teachers certified K-8 and K-12 to be health teachers. School D had heavier enrollment K-2 so Physical Education/Health Teacher 2 took these grades and the Physical Education/Health Teacher took the grades 3-6 for the gym classes	Responsible for the physical education/physical activity and health education components of HSP; coordinated health events with Physical Education/Health Teacher 1
Principal	Second year in the building; first year as full-time principal	Last year hired one year prior to the start of this study to be an instructional coach/vice-principal; worked as CEO right hand instruction and school operations; had multiple roles in the organization	Oversaw with CEO hiring of food vendor; worked with CEO on implementing health education program
CEO	Started 2013/2014 academic school year; brought on 2012 to start the school	Did the business plan along with the school business administrator. The CEO submitted the educational part, curriculum, and instruction, assessment; oversees school operations	Oversaw with Principal hiring of food vendor; worked with on implementing health education program

Participant	# of Years at School B	Overall Role	HSP Role
School Nurse	3 years	Completed all screenings, which include height, weight, vision, hearing, blood pressure, screening for scoliosis, was responsible for immunizations	Communicated with parents if a child's weight is 50th percentile; sent referrals home and if blood pressure is high; provided information/contacts to the Physical Education/Health Teachers for the health fair.

Documents—The school mission, charter agreement, and vision reflected a commitment to the children's overall well-being and a commitment to instilling civic duty in students. These documents were aligned with the components of HSP. Additionally, school menus showed several healthy options—vegetables, lean proteins, whole grains, fruit—were served. This was consistent with interview data. The HSP online school dashboard was also reviewed.

School Health Environment Observations—Common areas including the gym and open spaces were observed. In terms of health messages, School D had health messages posted in the school gym. School D did not have a playground. Because School D's cafeteria was a rented, shared space, School D could not put any messages or posters up in the cafeteria. Photos were taken.

LEVEL OF IMPLEMENTATION AS MEASURED BY THE HSP 6 STEPS

Levels of implementation in this study were measured by the six steps involved in HSP implementation: 1) Formation of a School Wellness Council; 2) Completion of the HSP

School Health Environment Assessment; 3) Local Prioritization and Action Planning; 4) Technical Resource Development; 5) Take Action; and 6) Monitoring and Evaluation of Progress. School D had taken some of these steps, but not all, resulting in an adaptation of HSP and partial program implementation.

LEVEL OF IMPLEMENTATION—SCHOOL D

<u>Steps</u>	<u>School D's actions</u>
Step 1: School Wellness Council Formation	Formed; Not Active
Step 2: School Health Environment Assessment	Online Health Assessment: Partially completed Meeting USDA/HSP nutrition requirements Exceeding state/HSP physical activity requirements for Grades K-5 (143%); not meeting for Grades 6 and 7 (75%)
Step 3: Local Prioritization/Action Planning	Informal Planning School Wellness Policy: Created; conditionally enforced
Step 4: Technical Resource Development (HSP Training/Technical Support)	No Training
Step 5: Take Action	Partial Implementation
Step 6: Monitoring	No Monitoring

Step 1 FORMATION OF A SCHOOL WELLNESS COUNCIL

According to the CEO, School D had a School Wellness Council on paper, but it did not function as an official, governing health body. The CEO stated, “So we have one officially, on paper, but we don’t meet formally with meeting notes etc. But we do have our administration, the gym teachers that we touch in base with. We have that.”

Although School D’s wellness indicatives were not formally led by the governing body of the School Wellness Council, resources were being leveraged to lead health initiatives in the school. Physical Education/Health Teacher 1 was not aware that the school had a Wellness Council. Physical Education/Health Teacher 1 stated, “If it would be anyone it would be us because the fact that we had to do the brochures, beginning of the year, to educate parents on snacks, I guess that would be, in a sense, our responsibility, but it’s not set in stone that we’re in a committee, necessarily.”

Physical Education/Health Teacher 1 echoed thoughts similar to the CEO’s:

So to answer your question before when you said, “Is the policy in a group?” No, but I feel like the same people are communicating. So, I guess, maybe that is the group, maybe we think we’re a part of it, but it’s not written in stone, but there’s always communication about health.

Step 2 COMPLETION OF THE HSP SCHOOL HEALTH ENVIRONMENT ASSESSMENT

Regarding Step 2, School D had completed none of the School Health Environment Assessment of assessment content areas online: 1) School Health and Safety and Environmental Policies; 2) Health Education; 3) Physical Education; 4) Nutrition Sciences; 5) Health Services; 6) Counseling, Psychological, and Social Services; 7) Health Promotion for Staff; 8) Family and Community Involvement.

However, interviews uncovered some steps School D had taken in each of the content areas. In particular, School D was meeting the USDA/HSP nutrition guidelines.

Assessment Area 1—School Health and Safety and Environmental Policies

The CEO and Principal stated there were no vending machines. Only watered was offered. This was consistent with school environment observations.

Assessment Area 2—Health Education

At the time of this study, School D had just started implementing, in the past year, a separate formal health education class, taught by Physical Education/Health Teacher 1. Physical Education/Health Teacher 1 stated, “Previously, it was the classroom teachers teaching health here. They would just sort of incorporate stuff that are in the books that they could partake in, and then I took over the role so they could focus more on their academic stuff and I could do more of what I do.”

Assessment Area 3—Physical Education and Other Physical Activity

The CEO stated students got two 45-minute gym sessions per week and recess every day for 25 minutes. Other physical activity included brain breaks. Physical Education/Health Teacher 1 stated,

I did a presentation last year for this school on brain breaks. So we all signed up for a professional development in our schools. You had your own in-house, professional development, and I did a brain break one and/or meditation-type presentation, and it went over so well that [the CEO] said they wanted me to, eventually, do it for the whole school because something like that, everyone needed to do. So teachers have said to me, “Can you send me the link of activities or brain breaks.” And I basically printed out the whole presentation to each teacher, so they have the ability to utilize brain breaks in the classroom.

Assessment Area 4—Nutrition Services

School D had taken steps to provide nutritious foods their kids would eat. According to the Principal,

Before I came in we used one particular lunch company. The kids really didn't like the food as much. We ended up, then, looking for another vendor. Found another vendor, we tried them out last year and the kids, they loved the food. So now, it's like, they're looking forward to many of the dishes that are now being provided that are, literally, made and then brought over. With good choices. I think they're good, healthier choices. And they have vegetarian options and non-vegetarian options.

The CEO agreed, "They love lunch." Under the new food vendor, the CEO stated,

Food is homemade and served buffet style. Food is made two blocks away and then delivered. They have a full kitchen. There's a whole salad section of it that they can have salad, they can have apples, bananas, oranges. We always have apples, bananas, and oranges so we always keep a basket around.

Assessment Area 5—Health Services

The School Nurse provided general health support services to School D's student population. Her responsibilities included completing all screenings, which included height, weight, vision, hearing, blood pressure, and screening for scoliosis. The School Nurse also was responsible for immunizations. In terms of weight, I compared the results of one particular student to a grid. If a student was over the 50th percentile, the School Nurse would send a referral home.

Assessment Area 6—Counseling, Psychological, and Social Services

School D offered behavioral, psychological, and social services to students with needs. Evaluation and intervention services are provided by the Child Study Team, whose responsibility focused on identifying students who might be in need of an Individualized Education Program (IEP). The team consisted of a school psychologist, a learning disabilities teacher, and a school social worker.

Assessment Area 7—Health Promotion for Staff

School D offered Zumba classes to the teachers and parents, but this program had lasted only a few months. Interest in the program waned. No other health programs or activities targeted to teachers were identified through interviews.

Assessment Area 8—Family and Community Involvement

School D offered an annual Health Fair in which parents and members of the community were invited to the school to participate in various wellness opportunities.

Step 3 LOCAL PRIORITIZATION AND ACTION PLANNING

School D did not formally do Step 3 but had done some action planning informally by garnering resources around wellness initiatives, as needed. According to Physical

Education/Health Teacher 1:

For those two events, I send out parent volunteer sheets that would go to each classroom teacher. So I'll have, even though that it's a school-wide event for the kids, each classroom teacher will designate a parent that would come in, or two parents that could sign up and help out with just the walking around and interacting with the event. So then that'll be the first initiative thing, and then I'll basically have an in-depth itinerary of what the schedule looks like, what's going to be a part of, who's going to be part of it, what we're learning. And the same thing with field day, it's from the morning to afternoon exactly what you're doing and why we're doing it. And since it's been implemented for the years that I've been here, I send an email out, "The health and wellness is coming up, end of this month. So let's get ready."

The Physical Education/Health Teachers took the lead on health and wellness initiatives in the school. School D held a number of health-oriented events throughout the year:

Field Day—was a track and fitness activities event that the Physical Education/Health Teacher 1 ran.

Health and Wellness Fair—Physical Education/Health Teacher 2 ran the Health and Wellness fair. They had speakers come in and talk. According to Physical Education/Health Teacher 2,

The idea of it is to have parents come home with knowledge of workouts that they can do at home. So I'm going to set up a circuit. So invite the kids to come in. I'm going to bring a Zumba instructor, and as an icebreaker, get them dancing, moving around. And then kind of go through a circuit with simple workouts that they can do at home every single day. It doesn't take much time or much room. And then we'll end with maybe yoga or meditation, just something to tie it all in. But that's the good thing, too, about a charter school, we can kind of go outside those boxes, but still be in the realm of like the Healthy Schools Program in our own way because we're not tied down by maybe some of the limitations.

The Principal stated, "The Health Fair is a really big deal just because I know that they bring a lot of local vendors, and local community members that own businesses or have advice to give to the kids. Or they have activities."

Physical Education/Health Teacher 1 stated that the Health and Wellness fair was School D's biggest health event. It covered all aspects of health: mental health, physical health, social health. He stated, "We have speakers that come in and talk about hygiene, that talk about mental health, city workers, officials. We had an NFL athlete that came in last year, we had a karate instructor. So we do a physical aspect as well as a mental aspect, and kind of tie it all together."

Family Fitness on Saturday—Physical Education/Health Teacher 2 coordinated Zumba on Saturdays: "We're doing family fitness on Saturday. I have a Zumba instructor come in, stuff like that, where we have families participate."

School Wellness Policy—School D also had a School Wellness Policy that had been written by an outside company.

Step 4 TECHNICAL RESOURCE DEVELOPMENT

According to the CEO, School D was not actively using HSP online tools, e.g., the portal or the dashboard. As an independent charter school, School D was assigned an HSP relationship to lead in-person training sessions.

Step 5 TAKE ACTION

School D was implementing the USDA/HSP guidelines for student nutrition, and leading wellness initiatives as previously discussed. School D was meeting 143% of the New Jersey state/HSP requirements for physical activity for Grades K-5 and 75% of the New Jersey state/HSP requirements for Grades 6 and 7.

Step 6 MONITORING AND EVALUATION

School D was not tracking or evaluating HSP implementation in a rigorous or systematic way. In terms of school meals, the Principal stated, “They’ll let us know from time to time if the kids really enjoyed one particular meal. Then maybe we need to order more because it looks like that we are almost ran short. Or when they’re just letting us know all the kids really loved this one.” The CEO stated, “We’ve never debriefed with them [the food staff] and said, ‘How many kids ate lunch today?’ Or, ‘What are you finding?’ That might be something we should do.”

FACTORS IMPACTING HSP IMPLEMENTATION

There were many factors unearthed in this study that explain why HSP implementation occurred in the manner it had in School D. These factors included School D’s charter school context (e.g., social, environmental, demographic, organizational, economic factors) that had become barriers or facilitators to HSP implementation. HSP is designed to help schools to implement policies and practices to

make their school environments healthier, with the outcome of having students engage in healthier behaviors. In addition to helping school environments to be healthier and influencing student behaviors in school, a goal of HSP is to have these healthy behaviors continued and supported when students go home. There were a number of in-school factors that facilitated HSP implementation, as well as factors that impeded implementation within school walls. There were also many social and environmental factors that served as barriers and facilitators to HSP implementation both within School D, and outside of the school.

BARRIERS AND FACILITATORS TO HSP IMPLEMENTATION—SCHOOL D

<u>In-School</u>		<u>Out-of-School</u>
Barriers	Facilitators	Barriers
Physical Education/Physical Activity: <ul style="list-style-type: none"> No playground or outdoor space for recess was a barrier School D did not have gym but an area designated for space that the school was outgrowing 	USDA Guidelines: <ul style="list-style-type: none"> Good School/Vendor relationship 	Parents: <ul style="list-style-type: none"> Parent Education—not knowing what healthy eating was; not understanding the relationship between obesity and health problems; obesity-related diseases are too long-term and nebulous Parents’ Reactions to School Wellness Policy Not the Same—reactions to School D’s policy to have healthier snacks in schools differed by culture and ethnicity Parent work schedule not home to oversee student eating; not able to attend health events at school Parent Engagement—mixed engagement around School D activities in general and low around student health; engagement also differed by culture and ethnicity
Students: <ul style="list-style-type: none"> Not like the taste Resistance to trying new foods Lack of Exposure 	School Leadership: <ul style="list-style-type: none"> School leadership committed to health as a school priority. The CEO and principal saw the correlation between student eating healthy and behavior. In addition to helping students to learn better school leadership was genuinely concerned 	Social and Environmental Issues: <ul style="list-style-type: none"> Lack of Transportation—Some families did not have cars, making it difficult to get to a grocery store with healthy food Cost of Food—healthy food more expensive than junk food Environment Infrastructure—Corner stores selling junk prevalent and easily accessible to students and parent Safety—unsafe neighborhoods served as a barrier to students playing outside

Barriers	Facilitators		Barriers
	with overall student wellness beyond academics		
School Context: <ul style="list-style-type: none"> • Teacher Enforcement Inconsistent *Teacher awareness of HSP was mixed *Teachers not consistently enforcing HSP due to confrontational parents; policy enforcement not mandated from the top • Lack of Funding— Lack of overall funding impacts HSP implementation • Lack of People— *Needed a project manager to oversee all health initiatives • Lack of Support— Needed someone to help with HSP training and implementation 	Teachers: <ul style="list-style-type: none"> • In general teachers modeled healthy behaviors by eating healthy in front of students • Teachers also generally supported the Wellness Policy regarding foods. When they saw students eating non-healthy foods, they encouraged students to make healthier choices in the future • Teachers also integrated physical activity into the classroom Kitchen Staff: <ul style="list-style-type: none"> • Encouraged students to eat healthier School Context: <ul style="list-style-type: none"> • Mission—HSP consistent with School D's mission and charter • Schools Are More Than Just Schools— 		

Barriers	Facilitators	Barriers
<ul style="list-style-type: none"> • Teacher Turnover—disrupted HSP information exchange • Combating Misconceptions about Charter Schools—School leadership spent a lot of time dealing in meetings dealing with an “us vs. them” mentality with the traditional public school districts. This took school resources • Autonomy is a Double-Edged sword—on one hand School D enjoyed more flexibility in the management of the school, curriculum, and what they prioritized as key school initiatives. However, they had less funding, less people, and have to do more with less. • Pressure to Outperform Traditional Public 	<p>School leadership believed School D exists to serve the community, not just the student, but the student’s family and the broader community; there was an overall commitment to develop students into productive civic leaders in their community, of which good student health is a core element. The administration would like to have school ultimately be a wellness center for students, their families, and the community</p> <ul style="list-style-type: none"> • Obesity Prevention—School D teachers/administrators/parents believed obesity prevention was a role the school should take • More Flexibility/Less Bureaucracy—Teachers felt empowered in their 	

Barriers	Facilitators	Barriers
<p>Schools—School D felt they must prove their existence by outperforming traditional public schools on test scores and academics</p> <ul style="list-style-type: none"> • School Age Charter Renewal—School D was young, 5 years old; still a school in transition. School went through the charter renewal process the previous year; this took up a lot of time and resources 	<p>classrooms and for initiatives they would like to take for general education and health promotion</p> <p>*Easier to get things done; More staff input</p> <p>*More opportunities to innovate in terms of overall curriculum and with health</p>	

IN-SCHOOL IMPLEMENTATION BARRIERS AND FACILITATORS

IN-SCHOOL HSP BARRIERS

School Priorities—From the administrators’ perspective, they stated they had a lot of priorities that pulled on their time. The CEO stated, “Competing priorities is a big challenge.” School D’s priorities intersected with some of the challenges of being an independent charter school and also the fact that School D was only 5 years old.

According to the CEO,

The list is making sure that the teachers are staffed. Making sure classroom instruction is up to the rigor that it needs to be, making sure that they are preparing them for the test, making sure any special ed or ESL students are getting all the services that they need. Potentially identifying special ed or ESL students. Making sure that they have the testing in place, meeting with the parents, and the psychologists, and the counselors to make sure that plan is in place. Making sure grades are done in an ethical manner. Reviewing lesson plans, providing feedback. Because you have to do everything you can to support teachers before you terminate them. You have to have everything documented. Every conversation. . You have to have every conversation documented with a staff member. And then, you make sure the kids are good.

The Principal and CEO also stated they had to contend with social and family issues a student was going through outside of school that impacted that student’s behavior and well-being within the school. Making sure the students were okay emotionally and behaviorally was on the list of school administrator’s priorities. The CEO stated,

We have kids that come out with different issues every day. We have two boys who witnessed their mom being murdered by their father, last year. So it’s checking in on those kids, “Are you okay? How was your weekend? Do you need to talk? I’m here if you need to talk.” And sometimes they just need a hug. But you got to be there and give them the hug that they need because they’ve suffered this tremendous loss. You got to touch base with the teacher to make sure she’s doing everything that she can for those children. But also, that she’s not triggering by asking a question, such as, “How was your weekend? What did you do with your family?” Because the word family triggers something in a child. And that’s maybe until 11 o’clock.

The CEO also outlined other priorities that she had to manage:

You got to monitor recess. You got to figure out who is out and get the coverage for them. You got to be the nurse, if the nurse is out. You got to answer the phones if no one is there. Parents are calling with issues, you got to meet with parents. You got to meet with the vendors. You got to plan for next year. You got to meet with teachers if they have an issue, “I feel I was treated in this way.” Then you got to document. You got to let your attorney know what’s going on. You got to make sure you’re following the law.

Changing Responsibilities and Long Hours—Physical Education/Health Teacher 2

cited the hours as being a challenge, as they were long and could vary. “Yeah. I would say that if anything, it may be the time that’s needed from us. It can vary.” Staff roles would change. According to Physical Education/Health Teacher 2,

We’re utilized where needed. I would say that that role can change. I know at one time during the year, I would be doing the bus duty outside in the morning, and then after school, we do bus duty every day—or handing out the breakfast—and that can change kind of on a week-by-week basis, depending on who’s available, roles change for various reasons. So yeah, we definitely have to put on different hats. I mean, we definitely have to be ready to help.

Teacher Turnover—Teacher turnover at the school had been high, according to the teachers, CEO, and Principal. However, the amount of turnover was consistent with other charter schools and with where School D was in its development. In terms of teacher turnover, Physical Education/Health Teacher 1 felt that turnover was common for a lot of schools, especially charter schools. Physical Education/Health Teacher 1 stated,

I would say it’s the same, probably for a lot of schools. I think teachers come and go, so I can’t really say that it’s higher or lower than other schools, but the schools that I’ve been a part of, there’s always someone coming and there’s always someone leaving. But I think that’s just a part of hiring a younger staff and developing and growing and moving on. That’s basically how it is in charter schools from my perspective.

Physical Education/Health Teacher 1 had seen an impact of teacher turnover on his class. From his perspective, high teacher turnover could negatively affect what he was

doing in his class with respect to physical education and health education, impacting implementation of HSP.

He stated,

The only thing from this job and my previous job that as a special teacher—and I say special, meaning physical education, health, art, music—the only thing I feel like that changes is that if there is a turnover rate that you're going to have a new teacher and a new way of them running their class and you getting to adjust to how they are and their teaching ability because whatever they do in the classroom could affect my classroom.

Similarly, the CEO also stated teacher turnover impacted training and educational continuity. The CEO attributed the difference in pay at charter schools vs. traditional public schools as a factor. She stated that teacher turnover made it difficult to have continuity in institutional knowledge and teaching. The CEO stated,

For some teachers, it is kind of like, okay, well, I'm going to go where I'm going to get paid. So it makes it equally challenging because every year, with the exception of last year, we've had transitions and turnovers in teachers. And so it's hard to build the continuity of learning in upper grade levels because the kids get attached to the teacher, and there's a relationship, I want to learn from you, I want to make you proud. But then I'm leaving to go to the public school, there's a new teacher that we have to train. So then there has to be extensive training because we've been here for five years so we have certain programs and processes in play that they have to learn all over again.

The Principal agreed,

The training is, the expectation is higher here, so not just for students but also for teachers. So they're expected to do more. And unfortunately, with the salary situation, I feel like we are guilty of overtraining our teachers to the point then, when they do decide to leave us, they see the expectation varies depending on where they go. And also, just like what we do. We do so much more than a lot of the other public school entities do.

The CEO and Principal stated their teachers were poached; less funding led to lower salaries, which led to teacher turnover. Overall, teacher turnover created discontinuity in educational programs and processes, including implementing HSP.

Another issue that led to teacher turnover was the longer days charter schools have. School D had recently shortened its school day, but it was still longer than a traditional public school day. According to the CEO, “That’s part of the requirements that you have to have, like an extended school year and an extended school. It’s part of the charter requirements. Because we have to show that we’re doing something different.”

The CEO stated, “We have to do a lot more with a lot less.”

Need Outside Help/Dedicated Health Personnel—School D and the administrators were already doing a lot of things that actually were very consistent with HSP. But School D needed help in tying them all together. Whether it was a person (or people) from HSP or not, School D needed an additional resource to help focus their wellness efforts and create a cohesive plan. The CEO stated, “That would be awesome. That would be such a big help. Because then, at least we will have the plan, and then we just have to implement. Instead of us trying to figure it all out.”

Role of Technical Assistance—According to the CEO and Principal, School D received no technical assistance or support from HSP staff. However, they had endeavored to train their staff on areas that supported student well-being. The school administrators would find it helpful to receive outside help from HSP. They were not aware of the online tools HSP provided through its website but thought having a relationship manager would be helpful given the administrators had so much on their plates.

Charter School Context Factors Impacting Implementation

Needing to Outperform Traditional Public Schools—According to the CEO, charter schools are held to a higher standard than traditional public schools. The CEO stated,

We have New Jersey learning targets. We have to participate in PARCC, which basically assesses how the students have mastered those standards. Now, those

were to change, I think, in 2017. They were released a little bit earlier. So we completely changed our curriculum, the minute they were released. Some school districts, the state gave you up to a year to change it. So we were a little bit ahead of the game. Those standards have really impacted, they really dictate, what we do in the classroom. But yes, the test is intense. The standards are intense. Everything we do on a daily basis surrounds we have to pass that test. Not only do we have to pass it, but we have to exceed the expectations and score better than the traditional public because when we score better than them, it substantiates, “Okay. This is why we need this charter school.”

According to Physical Education/Health Teacher 1, “Differentiating the school from the neighborhood TPS was also important.” Physical Education/Health Teacher 1 stated,

We want to give the reason to differentiate from the public school down the street, and if the reason’s going to be higher test scores or just better presentation or better equipment, whatever that would be, I think that they’re going to push for that and try to keep that standard. So if there’s a new teacher in that position or a veteran, they’re still going to be held to the same standard of growth, and your students need to get from point A to point B, and this is what we expect.

Limited Funding and Resources—The CEO went on to say limited resources were also a challenge while trying to meet this higher standard. The CEO stated,

In the public school district we are held to a high standard, but we are given minimal resources to do so. So whereas, part of the funding for public schools, they get to put towards facilities, we get no support from the public school district with facilities. Most of our budget is for the facility and we have to start teachers’ salaries, or staff members’, at extremely low in comparison to the public school. Public schools, they start at \$50K, \$52K a year. It’s maybe \$40K or \$41K here so it’s about a \$10,000 difference.

Autonomy is a Double-Edged Sword—The Principal stated,

The autonomy we have is a double-edged sword. So it’s great because we have a lot of say in that we can do but we have a lot on our plate, as well. So we don’t have a large team of people to have all these different positions like in a public district would have because a lot of the decisions, like involving facilities, and all these things, we have to make.

According to the CEO, School D used an outside company to write their policies. This company wrote the policies, based on the New Jersey statute, for most public schools.

The Principal stated,

We have an advantage here because I think we are very involved with the kids, with the families. They know us. And if they want to speak to us, they reach out to us. And it's more like, it's not rejecting kids of the baggage but understanding, respecting the baggage, and making sure that we're there to just provide help with them.

According to the Principal and CEO, a drawback of autonomy was that School D was understaffed, but a positive of autonomy was that it provided flexibility and the opportunity to be more connected to students. But being understaffed pulled on the attention of School D's staff, making it difficult to dedicate more time to HSP implementation.

Student Factors—A barrier to HSP implementation in the school was student behaviors.

Students sometimes didn't like the healthier options. According to the School Nurse,

We have a share table and whatever the student doesn't want, they are to put the item that they don't want on the share table. So instead of them throwing it into the garbage. When it's salad day, when they used to have the pre-packed salads, the table will be full of salads. There will be packed salads and you have to open it like this. It will be full, the share table, of salads. Kids won't eat it because it doesn't taste good.

Both the CEO and Principal agreed students needed more education and exposure to different foods to change their eating habits and tastes.

In-School Implementation Barriers—Physical Activity

No Playground—There were many barriers to implementing HSP in terms of nutrition and physical activity. Regarding physical activity, both the CEO and the Principal thought that lack of space for a playground was the biggest challenge. The CEO stated,

I think, for us, our biggest challenge is that we have no outdoor play area for them to be physically active. And being inside for such a long amount of time, it does something to you mentally. That's a big challenge that we have just because of our location. We've been looking for different spaces. We can't afford any because the rent is ridiculous.

IN-SCHOOL HSP FACILITATORS

School Mission—According to the CEO, School D wanted to support overall student wellness. The CEO stated,

I think, in general, speaking of health and wellness, it's like mind, body, soul, and spirit, for us. It's the whole child, overall. It's not just what you do here, it's what you do when you leave here, when you go home, when you're out in the community. It's teaching them to make good choices, not just with food, but starting with food.

Charter School Age and Renewal Cycle—School D was a relatively young school, having been founded 5 years before. In that time the school had gone through a number of staff changes. The school had received its renewal for another 5 years the previous year. According to the CEO, the charter renewal process that School D went through was very rigorous. The CEO stated,

It was so intense. It's like re-opening the school all over again because you have to give the state everything that they ask for, you could possibly think of, they're like, "We want to see this. We want to see that. We want to see your curriculum. Do you have teachers in play?" So going through a renewal was a little less stressful but it was stressful. We had to analyze our data, and explain gaps in our data if there were any. But, thankfully, we've outperformed the local schools in the district and the state level, academically, so we've established ourselves as academically sound. So because of that, what we did do is we applied for the expansion. And we got that K to 8.

At the time of this study, School D had another 4 years until they had to do the whole process again. The Principal stated, "And now we're growing. And since we went through that renewal, then we decided, well, let's expand now. Let's do this. So, this is going to be fun to do, too. Middle school is always fun." The CEO and Principal stated they were still figuring out where they were going to put the additional grades.

School Leadership—School leadership was very supportive of wellness events and actively participates. Physical Education/Health Teacher 1 stated,

School leadership is absolutely supportive. These are the events that they let us kind of take the lead on and create what—using our knowledge that we’d add over the years and kind of creating our own event and, obviously, periodically checking in with them and giving them the update on who’s coming and what the event’s going to look like and the dates. So it’s something that is definitely an ongoing communication throughout the year.

Both the CEO and Principal believed there was a correlation between the overall health of a child and academic performance. In terms of policy enforcement, the Principal stated they tried to enforce the school’s nutrition policies. The Principal stated,

So we have in our policy that the sugary snacks and the sugary foods are not allowed, because we do have kids that bring snacks throughout the day to eat because it seems like most classes have a snack time or a break. But it’s making sure we enforce the fact that we want them to make better choices when it comes to the snacks that they’re bringing and involve their parents in that decision making.

The CEO stated she consistently sent memos out to parents regarding healthier eating options: “I mean, it seems like we’re always sending the memo of what you can and can’t bring to school. But we had one kid who was just eating powdered donuts every day for breakfast, like a pack of them. Parents need to be on board.”

Both the CEO and the Principal stated exposure was key to helping kids to eat better.

More Input—According to Physical Education/Health Teacher 1, one benefit of being an independent charter school was more opportunity:

Well, I would say as a first-year gym teacher, being in a charter school, as far as the amount of creative freedom over an event and just what I’m able to put together, I get more of an opportunity, I think, in that aspect to, let’s say, reach out to vendors on my own. The administration will say, “I think this is a great idea. Send your proposal.” And they definitely roll with you. So it feels good from that aspect.

Innovation, Flexibility, and Autonomy—Physical Education/Health Teacher 2 felt that innovation was part of School D’s educational philosophy and approach. Innovation, flexibility, and autonomy were also mentioned by the CEO and Principal of School D as

benefits of being a charter school. In terms of having flexibility with the curriculum, the CEO stated,

It's different because I report to the board of trustees, so the process is quicker. If there's something that [the Principal] has in a program, he's like, "Can we purchase this?" If I check, and we have the funds, I'll present it to the board, the program, we will have it within the next week.

Teacher Factors—An HSP implementation facilitator in general was that teachers were working with the Physical Education/Health Teachers to integrate physical activity into the classroom. Physical Education/Health Teacher 1 stated,

It's important that teachers disseminate health information in their classrooms and also incorporate movement in the classroom, which for the most part they are doing. I think that just kind of being on the same page. We did that early on in the year with the snacks. If we're sending out some type of brochure that says, "We want children to bring the snacks in," obviously, they're [the teachers are] the ones that are sending it out and communicating with the parents about the snacks. We're not going to talk to every single parent about why there's backlash or something. Us, as physical education, health teachers, we're making sure that there is some type of movement and activity in the classroom, combined with the academic aspect.

With regard to the healthy snacks policy that had implemented the previous year, some parents were still sending their kids in with unhealthy snacks. According to the 3rd Grade Teacher,

There were one or two kids that will still bring in chips. And I'm not going to deprive a child of their snack time. Absolutely not. "You eat it. You eat it. That's fine. Okay, if you can make a healthier choice tomorrow, let's try that."

Regarding the school policy on celebrations, the 3rd Grade Teacher stated,

I think it's okay that the kids have occasional treats like on birthday parties, a cake, or cupcakes, pizza, whatever it is. If parents are bringing in items, we'll say, "Please keep it as healthy as possible. Refrain from bringing cupcakes with excessive frosting. It needs to be store bought. Nut free." And things like that. When we have parties, we always try to give a list of things that the can bring in. String cheese, yogurt, pretzels. Things that are healthier, but still fun for kids to eat. So we really try to monitor that, as well. Nobody wants to celebrate their birthday party with no cakes.

According to the CEO, the Physical Education/Health Teachers were also instrumental in continuing to educate students to make healthier eating choices. Consistent with statements from the Physical Education/Health Teachers, the Principal stated,

The gym teachers, both, have been helpful. And in the beginning of the year, sending out actual posters and things that they've made that offer different nutritional snacks they can have that are better for the children. That they constantly reinforce and let the children know, "This is what you should be eating." The general education teachers are generally on board but when parents push back sometimes they may not force the issue as there are other priorities or things the teacher may need the parent to focus on.

The School Nurse stated that teachers were on board with supporting HSP and getting kids to eat healthy. When teachers saw a kid eating unhealthy they didn't just take the unhealthy food away. The School Nurse stated, "We don't just take away and leave the kid empty-handed. We always try to replace it. We discourage the junk food. If we see them with junk food, we say something about it. We don't ignore it."

OUT-OF-SCHOOL IMPLEMENTATION BARRIERS AND FACILITATORS

OUT-OF-SCHOOL HSP BARRIERS

Parent Factors

Parent Education—Parents needed to be better educated on what foods are healthy. All study participants stated that parent support of the healthy snack and lunch policy had been mixed. This negatively impacted HSP implementation at home and in school. According to the CEO and the Principal, when they had tried to implement the no-birthday-cakes policy the previous year, they got pushback from parents. The CEO stated,

When we did try it, we got so much backlash from parents. Like, “What do you mean I can’t bring cupcakes? It’s my child’s birthday. We want to do this.” So we’ve tried to do things where you can bring the cupcakes, but we have to see what is in it. It can’t be homemade because we don’t know what you’re putting in there. We have to see the ingredient list. It has to be prepackaged. And we only give it out at the end of the day. Birthday celebrations are limited to the end of the week on a Friday. For a half hour. And we ask them to bring activities. And we’ll tell them, “You can bring fruits, you can bring a fruit goody bag. You can bring a goody bag with toys, or a book, a free book or something.”

Overall, the CEO and Principal felt that parents were still not totally on board with the health and wellness goals of School D. According to the CEO, “it’s about 50/50” with parents being on board with the school’s nutrition policies. The Principal agreed. He stated,

There’s still some pushback. Especially, when we enforce the snack situation. Every time I send the memo, I get another email, like, “I don’t understand.” And it’s always reemphasizing to them, showing our kids how to make better choices. So it is 50/50 where some parents who are like, “Yes. Thank God.” And other parents are more like, “I think that we should give them more choice.” And I’m like, “But you’re setting your child up to these behaviors when they’re sugared up.

According to the CEO, parent support of healthy eating seemed to be tied to economics. The CEO stated, “We’ve noticed is the parents who can afford the whole foods, the fruits, and all of that, they’ll send that. The parents who can’t will just go to the corner store.”

The CEO stated parents needed to be better educated in order to get them more on board with School D’s nutrition policies. The CEO stated,

I think to get them on board we probably should because we haven’t been doing enough; we usually do parent academy sessions. And some parents are just ill-informed as to what, how food triggers certain things in your child throughout the day. But I think we probably should do that. This is what you can give your child. But I do think, there’s an element there that we need to teach them.

Physical Education/Health Teacher 2 also stated School D had to educate the parents. Physical Education/Health Teacher 2 stated,

We had to fight back at first where there were some questions, but after they educated them after a few weeks, that seemed to go away. But there were definitely parents calling and concerned, their child's coming home upset over being told, "This snack's not okay." And it's their favorite snack. There was some pushback on that, but they definitely are being pretty stringent as far as the snacks that are brought in and the education with the parents as to why it's not a healthy snack, why there's better options out there, or we think it's important for them to utilize the more healthy options.

In terms of better educating parents, participants stated there was a general lack of understanding of the cause-effect relationship of poor eating today and poor health tomorrow; the long-term effects of not eating healthy or obesity were too nebulous to parents. If it was not an acute health problem, parents didn't view it as a real health issue. The School Nurse stated,

When I have called them to discuss nutrition or their student is hungry, did not eat any breakfast, I usually get a voicemail. I tell them to call me back. I leave a voice message to call me back. And they don't like to be bothered if it's not an emergency because they're busy working. So it's like I start my point across but, for some reason, they don't have the time to complete discussing the subject. Until they expect to see an emergency like a fever. Then they'll take the kid to the doctor. They have to see something that will really persuade them. I think it doesn't become real until they hear it from their doctor or from a health care professional.

Parent Work Schedule and Lack of Time—According to both the CEO and Principal, some parents were working multiple jobs, and this inhibited them from monitoring what kids were eating, or parents got the cheap, easy, junk food option. Some parents didn't work but were still sending their kids to school with junk food. The CEO stated, "Some of them don't work. They're here all the time, they don't work. We had one parent that the child never ate the school lunch. So every day, mom and dad were bringing McDonald's, Burger King, pizza. Something fast food."

The School Nurse noticed that a lot of students were not getting breakfast at home because the parents said they had no time. The School Nurse stated,

I'm also seeing kids that come to the school, the parents are in a rush-rush, some of them, they don't eat breakfast. They're not eating a healthy breakfast, just whatever they could throw in their mouths so that they won't be starving and concentrate in school. We do serve breakfast here in the school but some of them come late because of the rush-rush, traffic-traffic. And there's usually more than one sibling at home. The parent, before going to work, they will have to do three or four stops dropping off all their siblings to school. And there's no time.

Social and Environmental Factors

Across interviews, there were many social and environmental issues that negatively impacted parents and kids eating healthy:

- ***Ethnic Culture***—School D was very mixed ethnically. The school population was a combination of mostly Asian, Hispanic, and African-American students.

According to Physical Education/Health Teacher 2 there had been some pushback from parents who would justify unhealthy eating. Some of it was due to how they ate and also the convenience issue, as previously cited. Conversely, School D had a large Asian population who were predominantly vegan or vegetarian and ate healthy. According to participants, health habits seemed to differ by culture.

Physical Education/Health Teacher 2 stated, “In terms of the snacks the Asian population brings in, their foods are fresher but are more restricted but also tighter on what they're going to accept as a healthy meal.”

According to the School Nurse, there was a large Indian population. The School Nurse felt culture played a role in in diet, and that the Indian kids seemed to be better fed than their African American or Hispanic counterparts. The School Nurse stated,

Well, even though the Indian community, they bring their own lunch, I don't ever see them complaining that they're starving. They don't come to me because of being hungry versus Hispanics. They come to me feeling hungry. African Americans feeling hungry—that's what I've seen.

According to the Principal, culture played a role in the kids eating healthier. The Principal stated,

Because we have quite a few are families, we notice, in the Hispanic population, African American population, will bring in a lot of the sugary foods or the corner store sandwiches. Or something that is homemade but it's not necessarily healthy.

The CEO stated, "I think, too, the East Indian parents will always bring their child's food. They will always send their children to school with food. If not, they will come by and bring it. And nine times out of 10, those children have a vegan lunch."

- ***Lack of Transportation***—The parents of School D students also did not have access to cars, and this affected parents' ability to have access to healthy foods.
- ***Cost of Food***—Cost also played a role in impeding HSP implementation.

According to the School Nurse,

I had one student talk to me about money. He said that they didn't have a car and he wanted to eat more salads. But because the salads were cheaper in Walmart versus other supermarkets. And that they didn't have a car and that it was hard for them to get to Walmart, where the grains and foods are cheaper, versus the local bodegas, and he was just hoping to go to Walmart. So instead of eating the local food because he really wanted to eat healthy food.

- ***Environmental Factors***
 - ***Lack of Access to Healthy Foods***—Physical Education/Health Teacher 1 also stated that **convenience** played a role in what parents were feeding their children. From an environmental standpoint the corner stores were

used because they were what was easily accessible in the neighborhood.

Physical Education/ Health Teacher 2 stated,

When I started going over nutrition and health, I wanted to show a video on why nutrition's important, especially in the inner city. And one of the things that I see is for lunch and snacks, a lot of parents, they do what is convenient. There are corner stores. There are no ShopRites. There are no Whole Foods that they have access to. So when they're walking here, and a lot of kids walk with their parents, they walk to the corner store and it's almost like, "I'm giving you a treat here. Have a treat for today for school." And I think it was a 1st-grader during recess, I saw he had a Honeybun. I looked at the label, and it was 400 calories, it was 50 grams of carbs and 40 grams of sugar, and that was his lunch or snack. And I think that's the battle that we have to fight is that we can educate, but there are three or four corner stores, basically, surrounding the schools. So, unfortunately, that's the kind of battle that we have to fight against obesity and education and educating not only the students but the parents as well.

- ***Lack of Safety***—According to Physical Education/Health Teacher 2, students did not go to parks "because of safety."
- ***Multiple Child Household***—Another issue the School Nurse cited was growing families, with multiple children in the household, which created hardship for the parents, who could barely make ends meet. Parents also had less time to cook healthy meals for their kids.

IMPROVING HSP—RECOMMENDATIONS

Target Parents

Compulsory Participation with Consequences—This would address the parent involvement issue. According to the School Nurse, getting parents involved would be more stick than carrot. The School Nurse stated HSP would be more effective and it would help with implementation if there were something that increased parent engagement through mandatory activities. The School Nurse stressed these activities would need to be trackable in terms of parent completion. The School Nurse stated,

Restricting some things from parents. For example, to have the parent become more engaged. Let me give you an example. You must to come such meeting, even if it's in the evening. You must sign this that you understood. It could be an online video, answer the questions. You must, or else restrict something from them. Or else, for example, restrict something from the parent. I don't know what would be a good idea, but give a consequence. "If you don't watch this online video, if you don't answer these questions," showing some kind of engagement from the parent, or participation, then there's going to be a consequence.

Nutritionist—According to the School Nurse it would be helpful to have a nutritionist on staff. The School Nurse stated a nutritionist was needed to help with parent education. She also thought HSP needed to incorporate a mental piece run by a psychologist and focusing on building willpower and self-control.

More Programs Targeted to Parents—The CEO stated, "I would, first, have those monthly parent academy sessions where they really understand how health and wellness affect their child's long-term development." The Principal stated he would also like to have more choice for fitness classes and offer them consistently. The Principal and CEO both stated that if School D had the money, they would hire a fitness person and offer a weekly health and wellness activity that they could do after school.

More Wellness Activities for Parents and Kids—School D wanted to do more health initiatives but did not have the resources to do so. The CEO stated,

Each month we would like to teach parents a physical activity class. We have Zumba on Saturdays, which is really good. They love that. But again, turnout is low. If we had the capacity to do more stuff like that, we would. But by 4 o'clock, 5 o'clock at the end of the day, we're exhausted. And somebody has to be here to supervise.

Need a Dedicated Person—It would be helpful if, similar to a traditional public school, an HSP relationship manager were assigned to School D. The CEO stated,

That would be great. A person would be helpful. Just someone to check in, like, "Hey, make sure you do this." Or "Make sure you're following this." Or, "Look at this." Or, "Here's a great resource." That would be so helpful.

The Principal agreed, “That would be super useful.”

Use of Technology—Both the CEO and Principal felt an online app with health tips and content that was culturally relevant, in native languages such as Spanish, would be helpful in supporting School D’s wellness goals. “That would be awesome,” the Principal said. The CEO stated they had had an app the previous year. The CEO stated, “We had an app last year. Just for the school. Like notifications and things like that. Links to the website. Eight hundred parents subscribed.” The Principal stated, “It would have been cool to have a connection with a health/wellness thing with that. That would be kind of cool. They’ll download that. They can browse when they want. They would do that.” The School Nurse also thought an app for phones with culturally relevant content would be helpful in terms of targeting messages to different populations and targeting completion. According to the School Nurse, being able to educate by ethnicity would be helpful. She stated,

“For example, for Hispanics, there’s a high incidence of diabetes. And I mean just by a person being Hispanic, they’re already a high risk of becoming diabetic. Yeah. So that’s already statistical information to provide them, the Hispanics. There is obesity, a high increase of obesity. Therefore, eliminating starches and eliminating content in high glucose should be eliminated and encourage more grains because of the high statistical incidence in, for example, Hispanics developing diabetes. African American, there’s a high incidence of high blood pressure and cardiovascular disease.”

Need Behavioral Health Component—According to the CEO, School D wanted to support overall student wellness. The CEO stated,

I think, in general, speaking of health and wellness, it’s like mind, body, soul, and spirit, for us. It’s the whole child, overall. It’s not just what you do here, it’s what you do when you leave here, when you go home, when you’re out in the community. It’s teaching them to make good choices, not just with food, but starting with food. Teaching them if there is a situation, they have to try to learn coping mechanisms. And trying to train them how to diffuse a situation, how to

control your emotions. So we're also looking into, for next year, bringing in that whole social-emotional growth aspect of health and wellness. We have a couple of teachers that we sent to training this year so they can get their certificate on it so that they can come back and train the other teachers.

The Big Idea: Create a Wellness Center at the School—The CEO stated,

If we had lots of money, I would even do a health and wellness center as part of the school. Psychological, mental health. When you're trying to have a conversation with someone, depending on that person's state of mind, or what they dealt with that day, or what personal issues they have going on in their life, your reaction, their reaction is going to be different. We need to teach kids coping mechanisms because they don't have that. But we're so busy focused on these standards that we have to teach, that we just don't have the time to prioritize that. So I think that would be. And then, getting them the help they need. And following up. Like checkpoints because it's ongoing, because, are you ever fully recovered from whatever situation? It's ongoing, dealing with traumatic issues. It would be helpful to have those issues addressed here vs. outsourcing. Instead of having the parent, like having to call the insurance company to get the referral to go to the psychologist, or the nutritionist, they would be here. They would do it. It'd be easy and convenient. If we work around their schedule, that would be great.

CONCLUDING THOUGHTS

Findings show School D was implementing elements of HSP but only parts of the program. Factors that were facilitating HSP implementation were: 1) The school leadership was dedicated to helping the students to eat healthier and engage in physical activity; 2) Teachers were also generally supportive, but for the new teachers it took time to get fully on board; teacher turnover was an issue; and 3) HSP was aligned with School D's mission and charter in terms of helping students to become productive, contributing members of society, in which good health plays a critical role. Reasons why School D had only implemented part of HSP were related to School D's age. The school was only 5 years old, and although it had made many advances in those 5 years, the school was still largely in startup mode. The school Principal and CEO both had a breadth and depth of priorities on their to-do lists. Teachers did multiple jobs with their duties changing,

“pitching in” as needed. School D had only the past year implemented a separate, standalone health class. The meals program had been recently changed to a new vendor, who offered foods meeting USDA/HSP guidelines that also tasted better. School D was under-resourced and ideally would have a person dedicated to health to help with HSP implementation and health initiatives more broadly.

In terms of technical assistance, School D received none. Additionally, staff were overwhelmed with the day-to-day operations and were largely unaware of the online resources available on the HSP website.

In terms of other barriers to HSP implementation, needing parents to be more on board and supportive was cited across interviews. Participants felt more needed to be done to improve parent education around healthy eating and increasing physical activity. Additionally, time management and organizational skills that would support a healthy lifestyle were also cited as content to include in HSP. According to study participants, parents pushed back on the school’s healthy snack policy due to lack of understanding of what a healthy snack was. Some parents cited cost as an issue, with junk foods being cheaper to provide. Tied to time management, it was also quicker and easier to provide these junk foods to the kids. Culture also played a role in parent reactions to the school policy regarding nutrition.

In terms of adaptation, with the resources it had, School D was implementing a number of programs aligned with HSP to support healthy eating and to increase physical activity. The school was doing this informally, without the structure of a formal School Wellness Council.

For HSP program designers the recommendations are:

- 1) **Provide School D with an HSP Relationship Manager**—School D needs an HSP relationship manager to help with HSP implementation.
- 2) **More Content Targeted to Parents**—All study participants felt that lack of parent education was a barrier to program implementation. There needed to be more programs and content targeted parent education. Within this content, differentiation based culture should be taken into account because all parents, and their reactions to the School Wellness Policy, are not the same.
- 3) **More Programs Targeted to Parents and Students**—Parents and students being able to do health activities together at School D would be helpful in implementation. This would increase parent engagement and improve parent education as well as give parents and students time to bond over wellness activities. This would in turn help support HSP implementation beyond school walls, outside of School D.
- 4) **More Focus on Understanding the Social and Environmental Context of School**—School D had many social challenges that affected HSP implementation, both in School D and out of School D when students went home to their communities. An issue cited was the easy access to cheap junk foods sold via ubiquitous corner stores. HSP administrators could work with school leadership, city, and state to discuss policies and economic subsidies to help place healthy foods in these corner stores. School D's cultural context should also be taken into consideration when designing content and programs. Culture should also be taken into account in programs designed for parents.

5) **More Resources to Support School D as a Social Service to the Community—**

Health promotion and HSP implementation were very intertwined with School D's social environment. HSP administrators should look at advocacy to provide funding for social services to be at School D that would support health and HSP implementation— e.g., mental health and behavioral support, or social services support.

6) **Use of Technology—**Use of apps and culturally relevant video were suggested as ways to increase access to health content and improve HSP implementation. This content could be disseminated via mobile apps for phones as well as possibly integrated into School D's existing platforms, such as Class Dojo.

In summary, for School D to improve HSP implementation, they need more support—both financial resources and people resources. Being a young, understaffed school, teachers and administrators were already acting at capacity, so School D needs a person, whether hired from the outside as an organization or consultant or hired on the staff, to facilitate program implementation. The CEO stated, “We want to do more, and we’ve done a lot, we just have so much on our plate.”

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