

# The Coordinated School Health Program: Implementation in a Rural Elementary School District

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## Abstract

Child health is a complex issue that requires a comprehensive approach to address the many factors that influence it and are influenced by it. In light of the complexity of children's health, the Coordinated School Health Program (CSHP) was developed as a framework for a systems approach to planning and implementing school-based children's health programs. CSHP implementation focuses on building healthy school environments that foster healthy lifestyles. This paper describes the process of implementing CSHP in a rural, elementary school district in Southern Illinois. Each of the eight components of CSHP is identified, followed by a discussion of its application in the school district. A District Wellness Committee and School Health Teams were formed, teachers were provided new health education curriculum and received training in integrating the new curriculum into their practice, and a District Wellness Policy was developed and approved by the School Board. Numerous other initiatives were implemented and are described in the paper. Finally, a discussion of lessons learned in the process is offered to assist others who may wish to implement CSHP.

## Introduction

Child health is a complex issue that requires a comprehensive approach to address the many factors that influence it and are influenced by it. In light of the complexity of children's health, the Coordinated School Health Program (CSHP) was developed as a framework for a systems approach to planning and implementing school-based children's health programs (Allensworth & Kolbe, 1987). CSHP implementation focuses on building healthy school environments that foster healthy lifestyles (Lohrmann, 2009). Eight components are

included in the model: health education, physical education, health services, nutrition services, counseling, psychological and social services, staff health promotion, family and community involvement, and healthy environments. When fully implemented, CSHP includes coordination of health programs and services across the entire eight component framework (Lohrmann, 2009). Furthermore, CSHP consolidates health education and community resources to address health needs of children, families, and school staff. The CSHP model is widely used across the United States and has been shown to contribute to positive changes in health behaviors (Allensworth & Kolbe, 1987; Parcel, Perry, & Taylor, 1990). The purpose of this paper is to describe the process and application of CSHP in a large elementary school district in Southern Illinois. The needs assessment and description of the project related to each component will be discussed, followed by a brief section on lessons learned in the process.

## The needs assessment

The elementary school district has four school sites and includes pre-Kindergarten through eighth grade. Located in rural Southern Illinois, the district is unique in the region because it comprises a highly diverse school population; at the same time many of the families fall within the lowest socioeconomic status. According to Johnson and Strange (2007), rural education presents unique challenges in terms of student achievement due to socioeconomic challenges with higher proportions of students eligible for free and reduced lunch and higher rates of adult unemployment, compared to urban schools. Approximately 74% of students in the Southern Illinois school district are eligible for free and reduced lunch. At the same time, rural schools are challenged by greater student diversity compared to some urban schools, also presenting a challenge to student achievement. The authors state that rural schools tend to have "few resources and poor outcomes" compared to schools in more urban areas (Johnson & Strange, 2007, p.6). Jones, Brener & McManus (2003) reported that, when compared to urban schools, rural schools have fewer health promotion programs and facilities in place, creating an even greater need for a Coordinated School Health Programs in rural school districts.

In 2008, a District Wellness Committee was formed that included teachers, staff and administrators from the school district as well as community members and health education faculty from a large Midwest university in the region. The purpose of the District Wellness Committee preliminary meetings was to conduct a needs assessment of the school district to identify strengths and weaknesses related to children's health programs. Through that process, it was concluded that the physical environment in the schools was supportive of children's health but that all of the remaining seven components needed

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additional attention and resources. This discovery led to the decision to apply for grant funding from the U.S. Department of Education; fortunately the school district was awarded the funding and was then empowered to make significant progress in further efforts to create and sustain a health and wellness mindset throughout the school district and community.

### **Description of the grant**

In 2010, the school district was awarded the Carol M. White Physical Education Program (PEP) grant. This grant provides resources and infrastructure to enable schools and community agencies to focus on programs and services to enhance children's health. While the title implies the grant is solely for physical education, it encompasses all eight of the CSHP components and, having received the funding, the District Wellness Committee proceeded to develop implementation strategies across all eight components. Following is a description of some of the initiatives the school district successfully implemented over three years. Each CSHP component is identified accompanied by a brief description of the component followed by descriptions of some of the related initiatives.

### **Implementation of Eight CSHP Components**

**Health Education.** According to the CDC, "Comprehensive school health education includes courses of study (curricula) for students ...that address a variety of topics such as alcohol and other drug use and abuse, healthy eating/nutrition, mental and emotional health, personal health and wellness, physical activity..." (<http://www.cdc.gov/healthyyouth/cshp/components.htm>). To address this component of CSHP, the HealthSmart Curriculum (ETR Associates) was purchased for each grade level (Kindergarten through 8th grades) and classroom teacher (n=44) in the school district. The new curriculum, which cost approximately \$16,000 (about \$2,000 per grade level), was selected by the teachers and administrators in the school district due to its comprehensive, skills-based approach. Prior to the purchase of the new curriculum, there was little or no dedicated health curriculum in place and teachers used either their science materials or were responsible for locating health information to share with their students. Trainings were conducted by expert faculty from the University for each grade level, introducing teachers to the materials and the content. Additionally, during the trainings teachers were asked to reflect on areas in which to integrate the health curriculum material into their current practice; for example, how concepts related to the importance of adequate hydration might be incorporated into an existing science unit on body systems. Summary sheets were created from notes gathered during integration training that included the health curriculum topics and specific areas for classroom integration. This strategy was implemented to reduce anxiety and resistance to implementing the new curriculum among those teachers who might have felt unprepared to teach health content in the classroom.

**Physical Education.** "Physical education is a school-based instructional opportunity for students to gain the necessary skills and knowledge for lifelong participation in physical activity." (<http://www.cdc.gov/healthyyouth/cshp/>

components.htm). In efforts to support existing physical education programs and curricula in the school district, several initiatives were put in place. Students were provided enhanced access to multiple opportunities for physical activity. The Physical Education teachers and administrators in the school district were given a great deal of autonomy in selecting equipment to enhance the physical education program. After researching various options, climbing walls were selected and purchased for each of the four buildings in the school district. These were selected because they provide opportunities for nearly all children to participate and they are non-competitive (Haug, Torsheim & Samdal, 2008). Another major purchase was "Exergames", which incorporates computer gaming with physical activity. The decision to purchase Exergames was based on current research indicating that children are more inclined to participate in the games compared to other, more competitive activities. Furthermore, computer gaming promotes socializing and increases physical activity (Hansen & Sanders, 2011). The combined cost for the climbing walls and the Exergames for each of the four school buildings was approximately \$113,000.

Physical education teachers received funds to attend several professional development trainings and workshops designed to introduce them to cutting-edge practices in physical education and to provide opportunities for them to share with and learn from teachers across the country. Moreover, the teachers were encouraged to examine their teaching methods and content and compare those with the state teaching standards to identify areas to be strengthened in order to meet the standards.

Finally, the existing District Wellness Policy was revised to reflect more stringent expectations with regard to the quantity and quality of physical education. The newly adopted policy now states that students will "...participate in fitness assessments that measure their individualized success in achieving milestones for cardiovascular fitness, muscular endurance and flexibility." This was included in order to increase the use of individualized fitness plans on an ongoing basis. Moreover, the policy directs that students will "engage in activity that is moderate to vigorous during 50% of PE class time" and that this will be periodically evaluated using the SOFIT observational movement analysis system.

**Health Services.** "These services are designed to ensure access or referral to primary health care services or both, foster appropriate use of primary health care services..." (<http://www.cdc.gov/healthyyouth/cshp/components.htm>). Prior to the beginning of the school year, immunizations and check-ups were provided in one of the school buildings in conjunction with school registration. These services were provided in partnership with a community health center and the county department of public health. There were nominal charges to parents for the immunizations and check-ups; this strategy made it much more convenient for working parents to accompany their children to both register and obtain the required immunizations at the same time. It also provided a contact between health care providers and families in the community. Because the services were provided by community partners and health-care providers, there were no costs charged to the grant budget.

**Nutrition Services.** "Schools should provide access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students..." (<http://www.cdc.gov/healthyyouth/cshp/components.htm>). Trainings for

food service personnel in the school district were conducted by a registered dietician on how to prepare healthful yet tasty foods children would eat. Food service personnel attended the trainings after the regular school day and were compensated \$25.00 per hour for their time. Trainings focused on raising awareness regarding appropriate portion sizes and incorporating fruits and vegetables.

Nutrition lessons were developed by graduate students in Dietetics from the partner university and were delivered to students, educating them about the importance of a healthy diet. Lessons were interactive and designed to engage students in the process of determining the differences between “healthful” and “less healthful” food choices. There was no cost associated with this initiative as it represented an alliance between the University and the school district.

A social marketing campaign was additionally developed by a Dietetics graduate student as a research project in which photos were taken and posters made of students, teachers and administrators eating healthy foods and drinking water rather than soft drinks. The posters also displayed catchy health slogans to serve as cues to healthy action (e.g. “Fruits and veggies help you grow and give you energy. Eat 5 per day!”). Evaluation of the social marketing campaign is planned later in the 2013-2014 school year to determine whether it influenced students to adopt healthier behaviors.

**Counseling, Psychological and Social Services.** “These services are provided to improve students’ mental, emotional, and social health and include individual and group assessments, interventions, and referrals.” (<http://www.cdc.gov/healthyyouth/cshp/components.htm>). A School Improvement (SIP) Day entitled “The Whole Child: Physical and Emotional Wellness” was planned and implemented for the purpose of professional development to the teachers, staff and administrators throughout the school district. The key objectives of the SIP Day were: (1) Provide information to all staff on the status of the grant projects, (2) Provide training on integrating physical and emotional health into personal and professional practice, and (3) Engage in activities to develop strategies geared toward ‘whole child wellness’. During the SIP day, multiple workshops were held that comprised all aspects of children’s health including the importance of physical activity throughout the school day, 40 Developmental Assets (<http://www.search-institute.org/research/developmental-assets>), and the effects of domestic violence on children. Each session was designed to address factors that may affect children’s ability to learn. Approximately 120 teachers and staff were in attendance and evaluation was conducted via surveys completed by every attendee. Results of the evaluation indicated that 94% of the participants reported they “acquired the intended skills and knowledge” for the workshops, and fully 100% indicated that the “workshop objectives were successfully accomplished.”

**Staff Health Promotion.** “Schools can provide opportunities for school staff members to improve their health status through activities such as health assessments, health education, and health-related fitness activities.” (<http://www.cdc.gov/healthyyouth/cshp/components.htm>). A second SIP day was implemented focused on staff wellness. Sessions for this SIP day included stress management, circuit training, eating organic foods, and effective methods of weight control. Approximately 150 school staff attended the SIP day and the evaluations of the day were very positive, with nearly unanimous

agreement that the event was “conducive to learning” and that it “provided information that was personally and professionally relevant.” Qualitative feedback included statements such as, “...really liked being healthy—should do this more often” and “I learned about lots of ways to eat healthy and lower stress. This workshop day made me more aware.”

An additional initiative resulted from a request by teachers in one school building for yoga and Zumba classes after school. Two days per week, instructors came to the school at the end of the school day and teachers from the entire district attended the classes. On average, approximately ten individuals regularly attended the classes. Although there was no formal evaluation conducted of this initiative, anecdotal evidence indicated the response to the classes was largely positive.

**Family and Community Involvement.** “An integrated school, parent, and community approach can enhance the health and well-being of students. School health advisory councils, coalitions, and broadly based constituencies for school health can build support for school health program efforts.” (<http://www.cdc.gov/healthyyouth/cshp/components.htm>). Two events were offered in efforts to engage parents and families in adopting healthy habits. The first was a community health fair at which agencies and vendors from around the region showcased their services. The health fair was used to increase awareness of the district’s move toward a health and wellness mindset by presenting a variety of health information, health screenings, and nutritional and movement activities. This event was attended by approximately 270 people. A survey instrument was developed to evaluate the event. Of the total attending the health fair, 55 (18.5%) completed and returned surveys. While this represents a low response rate, 18% of respondents indicated they learned about “healthy eating choices” and “how to lead a healthy lifestyle”. Twenty percent reported they planned to “eat more fruits and vegetables” and 17% indicated they planned on “getting more exercise”. When asked to rate their overall experience, 93% rated it “good” to “excellent.”

The second event was a series of meal-planning workshops at which a registered dietician provided programs and information about how to shop for and prepare nutritious, affordable meals. The workshop series was attended by teachers, administrators and community members and families but the overall attendance was low with only 15 attending all of the six weekly sessions. This low attendance was likely a result of inadequate marketing regarding the workshops. Furthermore, the sessions were held at 6:00 in the evening and many families were unable to attend at that time.

**Healthy Environment.** “A healthy and safe school environment includes the physical and aesthetic surroundings and the psychosocial climate and culture of the school.” (<http://www.cdc.gov/healthyyouth/cshp/components.htm>). School health teams were created at each of the four school buildings. Health teams were charged with identifying areas within their schools that warranted improvement in terms of creating a healthy environment for all. Additionally, the District Wellness Committee was responsible for revising the District Wellness Policy, expanding it to encompass all areas of the CSHP in addition to setting expectations for physical education and activity as mentioned above. The policy was voted on and approved by the school board and is now the official policy in the district.

Three hundred and fifty Isokinetic ball chairs were purchased for the classrooms so that children could alternate during the school day between sitting on the balls and their normal chairs. Research has demonstrated that sitting on the balls for some portion of the day increases children's attention and improves academic performance (Fedeaw & Erwin, 2011). Currently, approximately 60% of the classrooms use the Isokinetic balls on a regular basis. The total cost for the balls was \$9,000.00. To address sun-safety, sunscreen dispensers were purchased and placed near the exit doors of buildings so that students could apply it prior to going outside for recess. Concurrently, students were educated about the value of sun protection to avoid skin cancer.

**Lessons Learned.** The needs assessment and subsequent implementation of the CSHP occurred over more than three years. Rolling out the initiatives in stages was an important factor in the overall success of the program because it enabled participation by people throughout the school district as well as the surrounding community. This approach also made it possible to be flexible in terms of programs and services offered, depending on the needs identified by those in the district, thus creating a health and wellness mindset in the process.

As is always the case in health promotion programs, there were several lessons learned in implementing the CSHP that others may find useful: (1) Obtain administrator and teacher buy-in, (2) identify the true leaders, (3) stay focused on the desired outcome, and (4) plan for sustainability from the very beginning. Each of these is described in greater depth below.

**Obtain administrator and teacher buy-in.** First, it is absolutely imperative to have administrator and teacher buy-in from the very beginning to ensure diffusion (O'Brien, Draper, & Murphy, 2008; Rogers, 2003; Turnbull, 2002). Everyone in the school district: teachers, staff, and students and families, looks to administrators for leadership regarding the values and culture of the district (Chemers, 1987). Without administrators' authentic support, the CSHP cannot be fully or successfully implemented. Efforts by administrators should be positive and made to encourage teachers to take ownership of any new initiative in a school (Sahin, 2011; Singer, 2005). Teachers who are excited about making their schools and students healthier are the best advertisement for the positive impact of the changes being made. The initiatives described above were all implemented and diffused with a team of devoted individuals in each school building starting with administrator and teacher buy-in.

**Identify the true leaders.** Similar to the above statement, it is expected that leaders (not just administrators but those in the trenches) will step forward who believe in and are committed to CSHP implementation; be sure to focus efforts on supporting these leaders (Singer, 2005). Leaders can be anyone within the school social system and include principals, classroom teachers, physical education teachers, or cafeteria supervisors (O'Brien et al., 2008). Others will eventually come along, while others may never truly get involved or support implementation efforts. It is important to note that as long as there are strong, effective and committed leaders, the CSHP can thrive. The total number of leaders is not as important as having leaders who identify with the initiatives. Leadership gaps lead to the likelihood of failure.

**Stay focused on the desired outcome.** Sometimes when attempting to implement a new program or approach in a school

district it can be difficult to see program progress because of resistance and challenges along the way. The details of how to implement CSHP will sometimes be a matter of discussion and compromise, but all those involved should have a common goal of and commitment to children's health and learning.

**Plan for sustainability from the very beginning.** In the project described above, numerous initiatives were implemented with long-term sustainability in mind. For example, the climbing walls and Exergames were chosen for present and future generation of students and will be in place in the school buildings for many years to come, and will serve as reminders of the importance of physical activity for all. Additionally, the HealthSmart Curriculum will support the efforts of current and future teachers to include health education in their classrooms. Finally, the partnerships established between the school district, the university, and community agencies will help to sustain the culture shift toward healthier lifestyles.

## Conclusion

From the experience of developing the CSHP in the school district described above, it is clear that the CSHP model makes a difference when each of the eight components is effectively addressed. It is possible to create a culture in a school district that communicates and supports health for all, and the strategies described in this paper may have potential for implementation in other settings. While the specific implementation of CSHP will be unique depending on the needs of a given school district, the Coordinated School Health Program is an invaluable framework for creating and sustaining healthy schools and most importantly, healthy children.

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