Continuing Education Contact Hour Opportunity

Success Stories: Communicating the School Health Message

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Abstract

Background: Thirteen school district teams from Michigan and Indiana participated in the Michiana Coordinated School Health Leadership Institute with the intent of Coordinated School Health Program (CSHP) implementation. The study purpose was to analyze the utilization of success stories for documenting CSHP achievements. Methods: Throughout the three-year Institute, teams were introduced to the process of sharing success stories with school and community stakeholders and provided a common format for crafting stories. To conceptualize stories, data were analyzed via content analysis. Results: Success stories primarily focused on four CSHP components: physical education and activity, food and nutrition services, family and community involvement, and staff wellness. "Success" was typically defined through four avenues: receipt of grants and financial support, high participation rates, requests for follow-up events, and community support. Discussion: Stories are an effective strategy for communicating school health messages and successes. They provide advantages for both authors and audience members. For authors, composing a story may be a less intimidating process that does not require an extensive skill set. For audience members, the structure provides a memorable story line. This study helps substantiate the use of success stories as a practical tool for articulating and disseminating the importance of CSHP. Key words: coordinated school health programs, teams, success stories, physical activity, nutrition services, staff wellness.

Background

A multitude of chronic health problems experienced by adults result from unhealthy behaviors adopted in childhood and adolescence (Alter & Lohrmann, 2005). To illustrate, nearly one third of deaths from coronary heart disease, type II diabetes, and breast and colon cancers could be prevented with proper nutrition and physical activity (Michigan Department of Education, 2011; World Health Organization [WHO], 2012). Similar results could be generated by eliminating cigarette smoking and abuse of alcohol and other drugs; reducing intentional and unintentional injury; and adopting behaviors that prevent the spread of human immunodeficiency virus (HIV) and sexually transmitted infections (STIs) as well as unintended pregnancies. Hence, the Centers for Disease Control and Prevention (CDC) recommend adoption of healthy behaviors in childhood to prevent chronic disease in adulthood. Ultimately, this is the goal of coordinated school health programs (CSHP) (Marx & Wooley, 1998; Alter & Lohrmann, 2005).

CSHP focuses on creating a health-promoting culture inside and outside the school to encourage, support, and reinforce students' healthy decisions and set the stage for a healthy adult lifestyle (Lohrmann, 2009). The approach of CSHP involves coordination of health programs and services across eight critical, interrelated components (Table 1) (Lohrmann, 2010). CSHP cannot reach this potential unless fully implemented, evaluated, and sustained over an extended period of time (Lohrmann, 2009; Barnes, Torrens, George, McCormack-Brown, 2007; Lohrmann, 2010; Dewitt, Lohrmann, O'Neill, & Clark, 2011).

Michiana

The American Cancer Society (ACS) has supported dissemination of CSHP through leadership training intended to build local school districts' capacities to sustain a health-promoting school culture. In 2003, the first Michiana Coordinated School Health Leadership Institute (Michiana I) was initiated by the ACS, in collaboration with state education and health agencies, to address the increasing rates of childhood obesity and high levels of tobacco use among teens (ACS, 2011; Michigan Department of Education, 2011). Michiana's purposes were 1) to arm participants with the leadership skills needed to foster systemic change and 2) to promote establishment of the essential CSHP organizational structures required for sustainability (ACS, 2011). Teams from eighteen school districts in Michigan and Indiana were provided the training, technical assistance, and financial support needed to implement CSHP and proved to be effective in increasing physical activity programs, health education offerings, healthy meal options, student healthcare, and grant funding (ACS, 2011; Dewitt, Lohrmann, O'Neill, & Clark, 2011).

Subsequently, Michiana II (2008-2013) was launched in April 2008 with "teams" from fourteen additional Michigan and Indiana school districts. It consisted of six, 2-3 day semi-annual sessions held over the first three years, after which teams continued on independently for a minimum of two additional years (ACS, 2011; Michigan Department of Education, 2011). Teams' responsibilities included: providing

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Table 1

Eight Components of Coordinated School Health Programs (Lohrmann, 2010)

Components	Components Described within the Context of a Health Promoting School Culture
1. Health Education	"The school culture strongly supports and reinforces the health literacy knowledge, attitudes, behaviors, and skills students learn through a high-quality curriculum" (p. 105).
2. Physical Education	"The school culture strongly supports and reinforces the lifelong fitness knowledge, attitudes, physcial activity behaviors, and skills students learn through a high-quality curriculum" (p. 109).
3. Health Services	"The school culture ensures student access to primary prevention, intervention, and treatment of disease and medical disorders" (p. 119).
4. Food and Nutrition	"The school culture supports, promotes, and reinforces healthy eating patterns and food safety for students and staff" (p. 114).
5. Counseling, Psychological, and Social Services	"The school culture ensures student access to primary prevention, intervention, and treatment of mental health and substance abuse problems" (p. 124).
6. Healthy School Environment: School Facilities and Transportation plus Social and Emotional Climate	"The school culture ensures that buildings, grounds, and vehicles are secure and meet all established safety and environmental standards (p. 101) ……. and is conducive to making students, families, and staff members feel safe, secure, accepted, and valued" (p. 91).
7. Health Promotion for Staff	"The school culture ensures high-level job performance and healthy role models for students by supporting and facilitating physical and mental health and well-being of all employees" (p. 129).
8. Family and Community Involvement	"The school culture encourages, supports, and facilitates involvement of parents or guardians and the broader community in health programming" (p. 97).

leadership for the implementation of CSHP, advocating for school health, utilizing assessment and evaluation strategies to identify and track program status, and advancing the institutionalization of CSHP (ACS, 2011). Specifically related to assessment and evaluation strategies, several tools were developed for teams to assess short- and long-term outcomes for building a CSHP infrastructure. Participants recognized the importance of documenting programmatic outcomes; however, a majority of the teams did not use the process evaluation tools provided to them because they felt that the tools required too much time and did not fully comprehend how doing so would contribute to effective CSHP implementation (Barnes, Lohrmann, Day, Shipley, & O'Neill, in press). In an effort to simplify Michiana II evaluation activities, Institute leaders asked teams to periodically prepare "success stories" that described their activities and accomplishments (Michigan Department of Education, 2011).

Stories

The human mind is exquisitely tuned to understand and remember stories (Willingham, 2009). Although no sound consensus exists regarding what constitutes a story, most sources point to four general characteristics, referred to as the four C's: causality, conflict, complications, and character (Table 2) (Willingham, 2009). These characteristics combine to provide the reader with an interesting story line that is easy to comprehend and to remember; stories have been consistently rated as more interesting than other formats even when the same information is discussed. Nevertheless, stories need to be concise because stories that present too much information are rated as less interesting (Willingham, 2009). CDC's Division of Adolescent and School Health (CDC-DASH) has recognized the important utility of stories for documenting and disseminating CSHP successes, because school and community stakeholders are more likely to resonate with evidence that is presented in a story format (CDC, 2012).

Success Stories

CDC-DASH has encouraged school health practitioners to compose success stories, defined as a narrative, usually between one and two pages, highlighting the achievements and progress of a program or activity (CDC, 2011). Such stories can document program improvement and demonstrate the value of program activities. Other benefits of developing and sharing

successes include: demonstrating responsible use of resources, sharing "best practices" with similar programs, and attracting new partners for collaboration (CDC, 2012). When presented effectively, success stories can be a useful tool for educating key stakeholders about the outcomes of CSHP (CDC, 2011). At the end of Michiana II, teams were tasked with providing Institute leaders with at least three final success stories.

Accordingly, the purpose of this research was to analyze teams' CSHP success stories from the Michiana II Institute in order to answer these research questions:

1) What was the primary foci or topic of submitted success stories?
2) How did teams determine what constituted as a success?
3) What short-term, programmatic outcomes resulted from the successes reported in teams' stories?

This study was intended to investigate the use of success stories as a practical tool for articulating the importance of CSHP and contributing to conditions that assure its sustainability.

Methods

Subjects

Eleven of the fourteen teams (6 from Michigan; 5 from Indiana) attended the final Michiana II Institute in April 2011. Teams had 3-7 members most commonly comprised of health and physical education teachers, food services directors, and school nurses. Other positions represented included: superintendent, school counselor, parent, community stakeholder, school principal and assistant principal, social worker, and school board member. Professional experience among team members ranged from 3-46 years ($\bar{x}$=19.25 years). Indiana teams represented approximately 63,291 students in 139 schools while Michigan teams represented approximately 29,343 students in 63 schools (Michigan Department of Education, 2011).

Success Stories Format

The format was adapted from CDC-DASH as an effective strategy for describing CSHP partners and stakeholders as well as for cataloging and reporting programmatic outcomes and outputs (CDC, 2011). Teams were provided with criteria for assisting with the preparation of success stories. Like CDC-DASH, the Institute leaders recommended incorporating the following sections: title, problem overview, program/activity description, program/activity outcome, and any additional information (CDC, 2007). Teams were instructed to craft titles that summarized the overall message, used an action verb, and captured the reader's attention. The overview was expected to describe the situation and why it was important, use data to frame the situation, and specify the target population. The program/activity description was to identify who was involved, describe how the program/activity was implemented, identify the target audience, and describe how the program/activity was evaluated. Finally, the program/activity outcome was expected to include the short-term and intermediate outcomes, provide a conclusion, and demonstrate the program's overall impact (CDC, 2007). This study received exempted approval from the Indiana University's Institutional Review Board.

Procedure

Teams were provided with the format and introduced to the process of sharing success stories throughout the three-year Institute. As "homework" to be completed during the six months between Institute sessions, teams were encouraged to record and compile success stories. At the final Institute session, teams' success stories were uploaded onto an external hard drive, reviewed by Institute leaders for completion and, thereafter, turned over to a team of evaluators for analysis.

Data Analysis

In order to conceptualize teams' success stories, authors developed a matrix with three major areas. The first area explored how the success stories related to the eight components of coordinated school health, the second area deciphered how teams defined the meaning of a success, and the third area assessed the short-term, programmatic outcomes that resulted from teams' reported successes. Using the constant comparative method, (Zhang & Wildemuth, 2009; Glaser & Strauss, 1967) researchers reviewed stories independently, segmented data into pieces (open-coding), and then placed pieces into categories. Through memo writing**,** themes emerged and provided a glimpse into teams' development, evaluation, and implementation of CSHP (Van Manen, 1990). To ensure inter-rater reliability, commonalities and unique patterns in teams' responses were discussed between two authors with a concordance of 80% (Patton, 2002). If discrepancies were noted, reviewers revisited the stories in order to generate a solidified decision (Shipley, Lohrmann, Barnes, & O'Neill, in

Table 2

The Four "C's" of Stories (Willingham, 2009)

Characteristic	Description
1. Causality	The events in the story are related to one another
2. Conflict	A goal that the main character is unable to reach
3. Complications	Sub-problems that arise from the main goal
4. Character	Stories are built around strong and interesting individuals and/or groups

press). The few discrepancies between reviewers' judgments were fully reconciled through close adherence to this protocol (Patton, 2002).

Results

Teams' success stories related primarily to four CSHP components: physical education and activity, food and nutrition services, family and community involvement, and staff wellness. Other represented components included: health services; health education; counseling, psychological, and social services; and healthy school environment. Each component will be discussed in turn.

Physical Activity

The majority of teams (n=11) reported at least one success story relating to physical education and/or activity. Three teams added walking trails (asphalt and grass paths) around school playground areas to motivate students to walk during recess time. Teams found that the trails served as a rather inexpensive tool for increasing students' physical activity levels. One team's story noted, "The trails provided an incentive for students to be active during recess rather than just standing around." Two other teams introduced exercise balls into the classroom setting to replace traditional desk chairs. The story of another team contended, "The early indicators were positive as teachers and aides reported fewer disruptions in class and more focused learners." Another two teams adopted the "Safe Routes to School" initiative to encourage students to walk or ride a bike to school in order to decrease transportation costs and increase physical activity levels (National Center for Safe Routes to School, 2012). Elementary students residing within one mile from school and secondary students residing within 1.5 miles are encouraged to participate in "active transportation" (i.e. walking or biking) (National Center for Safe Routes to School, 2012). Lastly, one team raised nearly $13,000 to purchase new playground equipment and rubber padding. The money was also utilized to purchase "activity carts" with sporting equipment, jump ropes, and chalk for students to use during recess. The team reported a dramatic increase in student engagement in play and a significant decrease in student altercations during recess. Other success stories involving physical education and/or activity included: 5k walks/runs, ACS- sponsored "Relay for Life" events, and student/staff walking programs. Still another team reported in its story, "The events provided an opportunity for students, teachers, administrators, and community members to participate in physical activity together."

Nutrition

The majority of teams (n=8) also included at least one success story relating to food and nutrition services. One team sought to introduce new entrees to students with less processed foods and improved nutritional content. This team successfully applied for and received nearly $135,500 in funding from a private source to revamp school menus, build school gardens, provide fresh fruits and vegetables to students, and purchase new milk coolers. The team reported providing healthier meal options for students and staff, increasing awareness of the importance of fruits and vegetables, and planting two new school gardens. Additionally, the team's story emphasized that, "Milk consumption has increased 20% district-wide."

Another team received a $40,000 grant to improve nutrition within the school district. The district completely overhauled the types of food consumed in the cafeterias, classrooms, concession stands, and fundraising events. Breakfast and lunch items now include reduced fat, reduced sugar, and reduced sodium foods. Fruits and vegetables are offered daily and whole grain is used for all buns, breads, and pizza crusts. In their story, the districts' food service director concluded that, "They have received very little resistance because monetary sales have not been negatively affected during the transition."

A different team accomplished several nutrition-related goals. The food service director aimed to: provide healthier options, increase lunch time periods, and increase the number of students buying school breakfasts and lunches. The team was able to introduce new lunch choices at the elementary level, change the serving lines to accommodate more students, send home monthly nutrition newsletters, and gather student and parent input regarding food options. This team reported that, "There has been an increase in the number of students eating school breakfasts and lunches and a reduction in the number of complaints regarding lunch time periods."

Lastly, several teams reported success stories relating to "taste testing" events to introduce students to fresh fruits and vegetables. A typical team's story offered that, "The events increased access to fresh fruits and vegetables, particularly for students with low socioeconomic status." Students practiced health skills by making healthy choices and provided positive comments about the samplings. Overall, teams reported a variety of noteworthy successes in the area of food and nutrition services.

Family and Community Involvement

Teams' (n=5) success stories also included family and community involvement. Three teams held health fairs to allow families the opportunity to experience local nutrition, physical activity, and health resources. Yet another story stated, "The council sought to bring the community closer by planning a health fair involving all the districts' schools grades K-12." This team collaborated with local vendors to provide resources, screenings, samples, and give-a-ways.

With the loss of leadership and the Healthy School Coordinator position, another team reported feeling unsure of its future. Therefore, this team elected to conduct a survey to gain an understanding of parents' attitudes, knowledge, and support for healthy school initiatives. Findings were utilized to inform administrators and school board members about the extensive parental support for school health initiatives (i.e. additional physical activity, vending machine policies, busing/transportation policies, etc.) and resulted in positive changes to district policies and practices, including the wellness policy. The team summarized, "The survey findings demonstrated the overwhelming support for school health among parents and community members." Lastly, one team partnered with community agencies providing medical, behavioral, nutrition, exercise, community education and support to create a pediatric weight management program. The program is a free, family-focused, community approach for decreasing obesity and encouraging healthy lifestyles for children and their families.

Staff Wellness

Three teams provided success stories relating to staff wellness. One team described offering free exercise classes and physical activity programs, providing basic health screenings, and free consultations with health and wellness coaches. A second team described a "staff gym" containing cardiovascular equipment for staff to utilize during non-school hours. The team obtained an $8,000 grant to purchase the equipment and is collaborating with the district's science department in a sustainability project that converts the human-produced kinetic energy into direct current energy to provide power for the devices. The "Calories to Kilowatts" leader happily noted in their story, "[faculty member's name] Wednesday workout alone would have produced 1.0239 kilowatts of energy when converted." A third team offered staff the opportunity to obtain CPR certification free of charge at the local hospital. The event was well-received and over 35 teachers, aides, bus drivers, and other employees attended the training. This team described the reaction as, "The participants were grateful for the opportunity to learn the life-saving skills." Other teams briefly mentioned increasing staff wellness by including: discounts at local YMCAs or fitness facilities, reduced membership fees for weight management programs, and walking clubs before or after school.

Healthy School Environment

Other components of CSHP were highlighted in teams' success stories. One team accomplished the planning of, funding for, and realization of a school-based health center (SBHC). The team received a $50,000 state grant and financial support from the local hospital to provide health services to individuals ranging in age from 10-21 years old. The team positively reported, "The SBHC is on track to exceed annual, unduplicated visits required for state grant funding at a mere five months into its second year." This same team applied for and received a nearly $400,000 grant to integrate mental health services into the school district. The team partnered with mental health agencies to develop surveys, staff training, district policies, and official protocols. Together, a collaborative agreement was developed along with a referral policy, a crisis response manual, and staff/parent trainings.

Social and emotional climate was emphasized in two teams' success stories. Both teams developed a "youth advisory council" to inform local agency, government, organizational, and school decision makers. Student members helped identify and raise awareness of physical and mental health issues. The topics of bullying and suicide prevention were the focus of educational campaigns both teams developed based on youth input. One team's goal was for, "The campaigns to encourage school administrators to reexamine issues of bullying within their schools."

Lastly, two teams highlighted improvements related to their school districts' wellness policies. One team met with administrators, local partners, community members, and teachers throughout the school year to review, revise, and discuss the wellness policy. By agreeing to meet on a regular basis, the group successfully developed a plan for continued work on health initiatives. This team stipulated, "The group plans to take on some of the concerns that have been discussed within the group such as using food as a reward, the amount of time for lunch and recess, and education related to healthy school parties." The other team obtained a grant to identify areas of strength and weakness for policy and environmental change.

Teams typically defined a success through four avenues: receipt of grants and financial support, high attendance and participation rates, requests for follow-up events, and compliments or community support. During the final Institute, nine teams reported successfully applying for and receiving funding ranging from $500 to $400,000 with grant monies delegated to implementing tobacco-free campuses, upgrading nutrition standards, improving playground equipment, and adopting the safe routes to school program. Lastly, many teams noted strong community support regarding school health initiatives and programming events. A parent attending a health fair event is reported as commenting, "The event was a great way to teach her child about physical activity and to receive hands-on experience." Teams reported record attendance rates, support from parents and community members, and requests for future events. One team highlighted, "We had a great turnout from families. According to administrators, it was the largest turnout for a health fair in the township's history."

Additionally, success stories revealed little about perceived academic and health outcomes. Several teams generally attributed students' improved learning and productivity to increased physical activity levels. For example, teachers reported more focused and engaged learners after traditional student chairs were replaced by exercise balls in the classroom.

Discussion

This study sought to substantiate the use of success stories as a practical tool for articulating the importance of CSHP and contributing to conditions that assure sustainability. The theme of obesity prevention consistently emerged with the majority of stories focusing on physical education and activity and nutrition. Teams found several creative measures for increasing physical activity within the school; walking trails and programs served as effective, low-cost strategies for promoting physical activity for students and staff alike. Teams also included more nutritious and appealing foods within school cafeterias, vending machines, birthday parties, and fundraising events. Ultimately, district teams' efforts to implement effective CSHP policies and programs were aligned with ACS' original goal for Michiana of reducing cancer deaths through proper nutrition, physical activity, and weight control (ACS, 2011).

Teams described memorable storylines through the inclusion of the four "C" characteristics (Willingham, 2009). For "causality," the stories linked program initiatives and educational events to today's most prominent health issues including obesity and bullying. The storylines also included "conflicts" involved in achieving program goals and objectives, primarily the struggle to overcome resistance to changing existing practices that encouraged unhealthy behaviors or failed to promote healthy behaviors. "Complications" are sub-problems that arise from the main goal. Teams faced a variety of challenges, including limited time, funding, and resources, when developing programs. Lastly, the storylines

included strong and compelling "characters" including students, teachers, administrators, community members, and other key stakeholders. Together, these four characteristics combined to create captivating storylines that both engaged and informed readers (Willingham, 2009).

When communicating with others, Michiana teams adhered to a defined story structure that is known to provide several advantages (Willingham, 2009). First, their stories were easy to understand because the characters and events they wrote about were casually connected. Second, teams' stories were interesting because they were neither too difficult nor too easy to follow. Institute leaders recommended that success stories be presented in a concise format (i.e. one to two pages), advice that teams followed in order to retain reader interest. Lastly, these stories were memorable because readers were engaged throughout the entire storyline (Willingham, 2009), a property that helps to maintain the interest of policy makers and other stakeholders who make decisions. For, the more informed and convinced they are about its goals, activities, and successes, the more likely they will be to support and defend CSHP (CDC, 2011).

Throughout teams' success stories, the importance of applying for and receiving funding was evident. With as little as $500, teams were able to accomplish many CSHP objectives. Obtaining these types of resources, no matter how small, seemed to increase the likelihood of achieving overall success. Therefore, CSHP practitioners are encouraged to expand available resources with the assistance of grant monies, in-kind donations, and fundraising events.

Based on feedback from Michiana I, Michiana II placed a greater emphasis on promoting data-driven decision making (Dewitt, Lohrmann, O'Neill, & Clark, 2011). Teams were encouraged to use appropriate data to organize, enhance, or defend CSHP. However, many teams still utilized process or informal evaluations rather than outcome or data-driven evaluations to determine what constitutes "success." Immediate results, in the form of participation rates, attendance, and community support, appeared to be favored as "evidence of success" rather than official data that measured changes in health programming and outcomes (Dewitt, Lohrmann, O'Neill, & Clark, 2011). This practice could possibly prove practical in some situations where data might not absolutely be necessary to justify the need for school health initiatives. For example, the need for obesity prevention may be obvious just by walking through school cafeterias and playgrounds. Because resources are often limited, schools should consider using existing data sources (i.e. childhood obesity statistics) to validate the need for addressing the most pervasive health issue. Despite this perceived shortcoming, school health teams should continue to collect and compile data needed to gain support, plan wanted health programs, inform advocacy initiatives, and sustain CSHP. Perhaps even more importantly, data are often required by grant funders.

Limitations

Results may possibly be biased due to the self-reported nature of the data collection procedures. The Institute leaders provided teams with the background and organizational outline for creating success stories; however, teams alone were responsible for composing the final success stories. Also, the format for this study was specifically prepared based on the Institute learning objectives and activities conducted during the Institute or as homework completed by teams between Institute sessions, and thus, may have limited teams' options for what stories to include (Dewitt, Lohrmann, O'Neill, & Clark, 2011). Despite these limitations, this study has practical importance relating to the utilization of success stories for documenting CSHP achievements.

Conclusion

Conducting meaningful field-based evaluations with little or no external support can present a daunting challenge. Because they effectively communicate school health messages and successes, teams are encouraged to adopt easier-to-use approaches, such as success stories and CSHP portfolios, that can be accomplished as part of their every day routine work (Barnes, Torrens, George, & McCormack-Brown, 2007). Stories provide many advantages for both authors and audience members (Willingham, 2009). For the authors, composing a story may be a less intimidating process because it is time-efficient and effective in conveying their message, but does not require an extensive skill set, prior research experience, or additional resources. For the audience, the structure can provide an interesting, engaging, and memorable story line. Furthermore, the texts of well-constructed success stories can be mined by evaluators for information they can use to gauge the extent to which programmatic objectives were attained.

References

Alter, R.J. & Lohrmann, D.K. (2005). Building support for coordinated school health programs. *The Health Educator,* 37(1), 3-7.

American Cancer Society. (2011). *Michiana coordinated school health leadership institute.* Retrieved June 1, 2011, from http://www.cancer.org/InYourArea/GreatLakes/ProgramsandServices/michiana-coordinated-school-health-leadership-institute

Barnes, P., Lohrmann, D.K., Day, K., Shipley, M., & O'Neill, J. (2012). *Examining indicators of partnership success among Michiana coordinated school health teams.* Manuscript submitted for publication.

Barnes, S., Torrens, A., George, V., & McCormack-Brown, K. (2007). The use of portfolios in coordinated school health programs: Benefits and challenges to implementation. *Journal of School Health*, 77, 171-179.

Centers for Disease Control and Prevention. (2012). *How to develop a success story.* Retrieved December 5, 2011, from http://www.cdc.gov/healthyyouth/stories/pdf/howto_create_success_story.pdf

Centers for Disease Control and Prevention. (2007). *Success stories template.* Retrieved September 17, 2012, from http://www.cdc.gov/dash/reporting_guidance/docs_pdfs/success_story_template.pdf

Centers for Disease Control and Prevention. (2011). *Coordinated school health.* Retrieved September 17, 2012, from http://www.cdc.gov/healthyyouth/cshp/

DeWitt, N., Lohrmann, D.K., O'Neill, J., & Clark, J. (2011). A qualitative analysis of success stories from Michiana coordinated school health leadership participants. *Journal of School Health,* 81, 727-732.

Glaser, B.G., & Strauss, A.L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Piscataway, NJ: Aldine Transaction.

Lohrmann, D.K. (2009). A complementary ecological model of the coordinated school health program. *Journal of School Health,* 80, 1-9.

Lohrmann, D.K. (2010). *Creating a healthy school: Using the healthy school report card* (2nd ed.). Alexandria, VA: Association for Supervision and Curriculum Development.

Marx E., & Wooley S.F. (1998). *Health is academic: A guide to coordinated school health programs.* New York, NY: Teachers College Press.

Michigan Department of Education. (2011). *Michiana coordinated school health leadership institute: An introduction.* Retrieved December 5, 2011, from http://www.michigan.gov/documents/mde/Michiana-Intro_323973_7.pdf

Michigan Department of Education. (2011). *Michiana.* Retrieved December 5, 2011, from http://www.michigan.gov/mde/0,4615,7-140-43092_48774---,00.html

National Center for Safe Routes to School. (2012). *Safe routes to school.* Retrieved January 9, 2012, from http://www.saferoutesinfo.org/

Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications

Shipley, M., Lohrmann, D.K., Barnes, P., & O'Neill, J. (in press). Advantages of coordinated school health portfolios: Documenting and showcasing achievements. *Journal of School Health.*

Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy* (2nd ed.). Albany, NY: State University of New York Press.

Willingham, D. (2009). *Why don't students like school?* San Francisco: Jossey-Bass.

World Health Organization. (2012). *Chronic diseases and health promotion.* Retrieved September 17, 2012, from http://www.who.int/chp/media/news/releases/2011_2_physicalactivity/en/index.html

Zhang, Y., & Wildemuth, B. M. (2009). Qualitative analysis of content. In B. Wildemuth (Ed.), *Applications of social research methods to questions in information and library science* (pp.308-319). Westport, CT: Libraries Unlimited.

This article may provide one Continuing Education Contact Hour Opportunity for CHES (Approval Pending)

Instructions and self-study questions may be found on page 35

Editor's Notes

As I assume the editorial role for *The Health Educator*, I want to thank the Eta Sigma Gamma Board of Directors for allowing me this honor and opportunity to serve as Editor. On behalf of the Board of Directors, I would like to extend our sincere appreciation and thank-you for a job well done. Your expertise and professionalism as Editorial Associates has continued to enhance *The Health Educator* and you have proven to be a valued resource to the authors and editorial associates alike. Thank you, Dr. Ogletree, for making this transition between editors a pleasant and painless process.

As we come to closure on this issue of *The Health Educator*, I would like to thank the following editorial associates who are completing their three year terms of service: Jodi Brookins-Fisher, Amar Kanekar, James Leone, Susan McCarthy, Michele Pettit, and Regina Galer-Unti. Each of you has provided invaluable guidance to the authors of manuscripts. Publishing *The Health Educator* is truly a collaborative effort and I truly thank you for your expertise, timeliness and professionalism.

I also would like to welcome and thank our new editorial assistant, Ms. Nickie Lay; a graduate student in Exercise Science at Cleveland State University. She will continue to be a great asset to *The Health Educator* and brings a wealth of organizational skills and good humor to these efforts. In this issue we offer two articles available for CECH for the CHES/MCHES credentials. Please note that these articles will be available to you throughout the 2013 year and are brought to you without additional costs. We would like to thank Dr. Regina Galer-Unti for her help in overseeing this opportunity through *The Health Educator*. Our goal is to have 1-2 articles in both the Fall and Spring issues of *The Health Educator* that are designated CECH opportunities.

In this Fall 2012 issue, the articles are varied in content and purpose --from a teaching technique to examples of health education practice and descriptions of research. This issue definitely has something for Gammans of all backgrounds.

We also honor and applaud all the recipients of Eta Sigma Gamman awards given at the Fall meeting in San Antonio. Please refer to the ESG website http://www.etasigmagamma.org/healtheducator to learn more about these Gammans and their successes.

Continuing Education Contact Hour Self-Study

Success Stories: Communicating the School Health Message

Active members of Eta Sigma Gamma may receive one (Category 1) continuing education contact hour for CHES and MCHES. Complete the self-study questions below by circling the correct answer and completing your contact information. A score of 80% is passing. Send a copy of this page to: Susan Koper, Eta Sigma Gamma, 2000 University Avenue, CL 325, Muncie IN 47306; or FAX this page to 765-285-3210. This CECH opportunity is available from February 22, 2013 through December 31 2013. (Approval Pending)

1. Which of the following was **NOT** a primary focus of CSHP components?
   a. Family and community involvement
   b. Programmatic funding
   c. Physical education and activity
   d. Food and nutrition services

2. Why didn't the majority of Michiana II teams use the provided evaluation tools to assess short- and long- term outcomes?
   a. They believed the tools required too much time
   b. They did not receive the evaluation tools
   c. They believed the tools were not reliable
   d. There were no outcomes to assess with the tools

3. Which of the following does **NOT** represent one of the four C's?
   a. Causality
   b. Conflict
   c. Complications
   d. Compromise

4. What method was used by researchers to review stories independently and segment data into categorized pieces?
   a. Lead scoring
   b. Constant comparative method
   c. Concepts method
   d. Closed-coding

5. Which of the following activities was **NOT** added to team schools to increase physical activity?
   a. Walking trails
   b. Exercise balls in the classroom
   c. "Safe Routes to Schools"
   d. An increase of 10 minutes in recess time

6. Which of the following was **NOT** done to help improve nutritional concepts at the team's schools?
   a. Building school gardens
   b. Taste testing fruits and vegetables
   c. Decreasing the number of students buying breakfast
   d. Increasing lunch time periods

7. In this study, offering free exercise classes, discounts at local YMCA's, and free CPR certification classes at a local hospital were all part of what CSHP component?
   a. Staff wellness
   b. Family and community involvement
   c. Physical education and activity
   d. Food and nutrition services

8. What was one 'complication' teams faced when developing programs?
   a. Limited time
   b. Limited knowledge of CSHP
   c. Not having enough participants
   d. Program Format

9. What resource seemed to increase the likelihood of achieving overall success with many CSHP objectives?
   a. Exercise tips
   b. Funding
   c. Nutritional handouts
   d. Health education speakers

10. What was one limitation of this research study?
   a. There was not enough data collected
   b. The majority of teams didn't include success stories about family and community involvement
   c. Self-report bias
   d. Some of the success stories did not follow the correct format

Name: _____

Address: _____

E-mail: _____

CHES/MCHES #: _____ *Remember to keep a copy for your records.*