

Pilot-Testing an Intervention to Enhance Wellness Policy Implementation in Schools: *Wellness Champions for Change*

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ABSTRACT

Objective: To develop and pilot-test *Wellness Champions for Change* (WCC) to enhance local wellness policy (LWP) implementation by forming wellness teams.

Design: Randomized, controlled school-level pilot study.

Setting: Five Maryland school districts.

Participants: A total of 63 elementary, middle, or high schools.

Intervention(s): Developed from stakeholder interviews, focus groups, and existing programs. Schools were randomized within district to (1) WCC training (6-hour, single-day teacher training), (2) WCC training plus technical assistance (TA), or (3) delayed training (control).

Main Outcome Measure(s): Online teacher/administrator survey pre-post (spring, 1 year apart) that examined the direct effect of the intervention on active wellness team formation (postintervention, 8-item sum score) and LWP implementation (29 items, not implemented to fully implemented)/indirect effect of intervention on LWP implementation via active wellness team formation.

Analysis: Adjusted linear or logistic regression and mediation modeling.

Results: Postintervention, WCC plus TA and WCC had more active wellness teams (vs control, $\beta = 1.49$, $P = .02$ and $\beta = 1.42$, $P = .03$, respectively). No direct effect of intervention on LWP implementation was found. Formation of active wellness teams mediated the association between both WCC plus TA and WCC and LWP implementation (WCC plus TA confidence interval [CI], 1.22–16.25; WCC CI, 10.98–15.61 [CI was significant without 0]).

Conclusions and Implications: The WCC intervention approaches indirectly affected LWP implementation through the formation of active wellness teams. These results support building and school-level wellness teams.

Key Words: pediatric obesity, policy, school, wellness programs (*J Nutr Educ Behav.* 2018;50:765–775.)

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INTRODUCTION

Childhood obesity is a significant public health problem in the US; approximately 17.5% of children (aged 6–11 years) and 20.5% of adolescents (aged 12–19) were classified as obese from 2011 to 2014.¹ Children who are overweight or obese are likely to develop into obese adults and have major health complications such as type 2 diabetes, hypertension, sleep

apnea, stroke, cardiovascular diseases, and cancer.^{2–4}

Children and adolescents consume about a third of total daily calories at school and spend more time in school than any other place besides home; thus, schools are logical targets for pediatric obesity prevention.⁵ Furthermore, obesity-related behaviors, including diet/physical activity (PA), are highly influenced by peers, teachers, and the social and physical

environment at school.^{5,6} Thus, school-wide obesity prevention strategies are needed to address these influences.

Federal legislation addressed childhood obesity through a focus on schools. In 2004, the Child Nutrition Reauthorization Act mandated all school districts participating in the US Department of Agriculture (USDA) *National School Lunch and/or Breakfast Program* to create a local wellness policy (LWP), a written document intended to guide school efforts to establish nutrition/PA standards.⁷ The 2010 Healthy Hunger-Free Kids Act (HHFKA) added provisions to emphasize implementation, evaluation, and reporting of LWPs in schools.⁸ In 2016, the HHFKA LWP implementation final rule required the establishment of wellness policy leadership (district or school level), public participation,

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and public reporting of school-level LWP implementation.⁹ Although researchers extensively examined the existence and strength of district-level LWPs,^{10–13} factors associated with school-level LWP implementation (ie, accountability, resources, support) are under-studied. The few studies that assessed these factors report mixed findings partly owing to a lack of consideration of school-specific culture, barriers, and resource needs.^{14,15}

Recent evidence suggested that forming and providing tailored training to stakeholder teams (ie, wellness teams) can address these considerations, thus enhancing implementation of LWPs and accelerating changes to the school environment that promote obesity prevention.^{16–18} In addition, a recent study demonstrated that among schools with wellness teams, those with active wellness teams that met best practices (met ≥ 4 times/y; set goals for healthy eating and PA; had representation from key school staff, parents, and students; and had mechanisms to inform the public) were more likely to implement wellness policies and practices.¹⁹ There is a need to investigate this relationship further as well as to understand strategies better, such as tailored training, that can support the formation of active, sustainable wellness teams in schools.

The purpose of this study was to develop and pilot-test an intervention to enhance LWP implementation in schools. The intervention, *Wellness Champions for Change* (WCC), was a randomized, controlled pilot study aiming to promote LWP implementation by training teachers to become wellness champions and lead school-based wellness teams. The WCC training was based in Social Cognitive Theory (specifically, observational learning, self-efficacy, and reciprocal determinism)²⁰ and Social Ecological Theory (focusing on social networks and organizational factors).²¹ The added impact of providing technical assistance (TA) to wellness teams in the form of support for setting and meeting goals throughout the school year was also examined. This article describes the intervention development process and examines the impact of the

intervention on planned school-level outcomes: (1) wellness team formation, specifically the formation of active wellness teams (meeting wellness team best practices¹⁹), and (2) LWP implementation (endorsing implementation of wellness policy best practices¹⁶). The mediating role of forming active wellness teams (school survey: 8-item active wellness team sum score) in the relation between the interventions and greater LWP implementation (school survey: 29-item LWP implementation scale) is also examined.

METHODS

Institutional Review Board

The study team represented a partnership among 2 state universities, the state department of education, state and local health departments, and participating school districts. Methods consisted of formative research that informed the intervention development and pilot study procedures. The institutional review boards at University of Maryland School of Medicine and University of Maryland College Park approved these methods separately. Formative study participants provided informed consent for participation. Pilot study participants were asked about school policies and practices, did not report on personal opinions, and did not provide personal information beyond their roles in the school (ie, administrator, teacher). Therefore, the pilot study was deemed exempt by the institutional review board and written informed consent was not required.

Formative Research and Intervention Development

The researchers conducted formative research to inform the WCC training curriculum. The formative research plan included qualitative method triangulation in which individual in-depth interviews with school wellness stakeholders ($n=6$) and a teacher/administrator focus group ($n=8$ participants) were combined to generate complementary views of a phenomenon.²² A standardized protocol and detailed scripts were developed. Using the protocol,

the focus group meeting and in-depth interviews were conducted by 3 trained extension field educators with substantial interview experience.

Because the WCC training was to be developed based on Social Cognitive Theory²⁰ and Social Ecological Theory,²¹ interview guides were developed with probes to collect key constructs of these theories. For example, organizational factors were explored by asking, *What have you found to be key factors influencing successful wellness policy implementation in schools? Were there any specific partnerships?* Moreover, to apply the concept of observational learning to the WCC curriculum, proxy questions were probed, such as *What makes some school wellness champions more effective than others in leading a wellness team?* All interviews were audio-recorded with participants' permission and transcribed verbatim. Using inductive content analysis,²³ an open-coding, grouping, categorization, and abstraction procedure was followed.

Formative research findings indicated the importance of (1) forming a wellness team; (2) having buy-in and support from key stakeholders including teachers, principals, parents, and district administrators; (3) offering resources (eg, a list of healthy snacks or sample letters sent to parents); (4) building partnerships (eg, partnering with parent-teacher and community groups to provide additional resources, creating school-level clubs for students, such as a running club); (5) overcoming possible barriers (eg, finding co-champions, using peer sharing, ensuring district support); (6) setting clear, attainable, and simple goals with an evaluation and monitoring plan; and (7) providing an avenue to share information among schools and wellness teams.

From these findings and an extensive literature review, a single-day training was developed for wellness team leaders based in both Social Cognitive Theory and Social Ecological Theory. Specifically, for Social Cognitive Theory, reciprocal determinism was a major thread throughout the training, homing in on the relation between building teachers'

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