COLORADO HEALTHY SCHOOLS
SMART SOURCE

GENERAL HEALTH POLICIES AND PRACTICES
NUTRITION
HEALTH SERVICES
PHYSICAL EDUCATION/PHYSICAL ACTIVITY
HEALTH EDUCATION
COUNSELING, PSYCHOLOGICAL AND SOCIAL SERVICES
HEALTHY AND SAFE SCHOOL ENVIRONMENT
FAMILY, COMMUNITY AND STUDENT INVOLVEMENT
STAFF HEALTH PROMOTION

EXECUTIVE SUMMARY

RESULTS FROM THE FIRST PILOT 2014-2015

OCTOBER 2015

Colorado Healthy Schools Smart Source assesses school health policies and practices in order to provide objective, feasible, and specific data back to schools.

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INTRODUCTION

About Smart Source

Colorado Healthy Schools Smart Source (Smart Source) is a tool that measures school health policies and practices in Colorado. The purpose of Smart Source is to streamline multiple tools that have previously existed in the state in order to reduce the burden on schools, improve the quality of school-level health policy and practice data, and increase the number of schools assessing their health policies and practices. Smart Source is funded by Kaiser Permanente and is a partnership between The Colorado Education Initiative (CEI), the Colorado Department of Education (CDE), and the Colorado Department of Public Health and Environment (CDPHE).

Tool Development

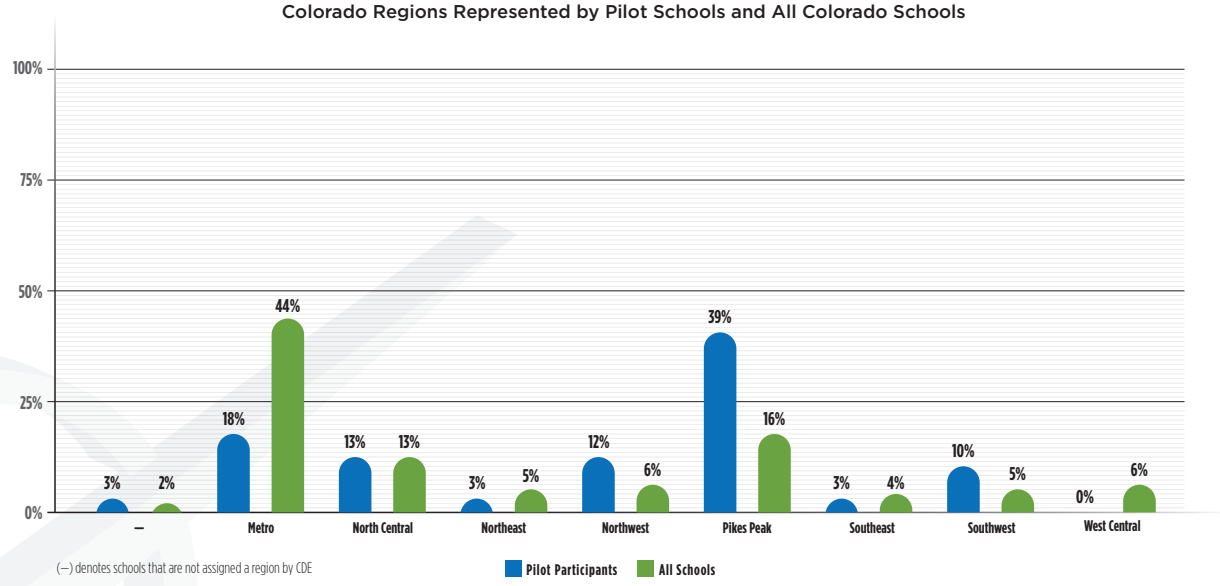
The Smart Source tool piloted during the 2014-2015 school year was developed over a one-year period with input from numerous stakeholders throughout the state, including school and district representatives, funders, research and evaluation experts, state agency representatives, and other content experts. Throughout the tool development process, items were assessed and refined for objectivity, specificity, and feasibility. Items on the Smart Source tool span nine content areas: general health policies and practices; nutrition; physical education/ physical activity; health education; health services; counseling, psychological, and social services; healthy and safe school environment; family, community, and student involvement; and staff health promotion.

First Pilot Overview (2014-2015)

The first Smart Source pilot was administered between October 2014 and January 2015 with 77 total participating schools from rural, urban, and suburban communities across the state, including 40 elementary schools, 32 secondary schools, and 5 schools that have both elementary and secondary grades. Although the pilot included only schools that volunteered to participate, CEI targeted recruitment based on the region, setting (e.g., urban, rural), size, and free and reduced-price lunch (FRL) eligibility percentage to yield participation from schools that generally represent the variety of schools throughout Colorado.

Overall, the proportions of each school level represented in this Smart Source pilot matched those throughout the state. Additionally, the mean school size (462 students) and percentage of FRL eligibility (43 percent) among participating schools were similar to the statewide means (484 students and 45 percent, respectively).[1] Finally, as shown in **Figure 1**, Smart Source pilot schools represented all but one region in the state.[2]

Figure 1
Colorado Regions Represented by Pilot Schools and All Colorado Schools



1 These state means were calculated using 2014 CDE data.
2 These regions reflect those used by CDE. To learn more about these regions, visit CDE's website at https://www.cde.state.co.us/cdeedserv/rgmapage.

Summary of Results

Overall, Colorado schools that participated in the first Smart Source pilot have policies and practices that support and improve the health of students, particularly in the areas of nutrition; physical education/physical activity; and family, community, and student involvement. A majority of schools responded that they have a wellness team, and the pilot results indicate that the majority of these wellness teams are actively engaged in schools' health efforts. Schools also reported implementing practices that promote healthy eating and ensure quality physical education (PE). Additionally, most schools responded that they have numerous strategies to help create a healthy and safe school environment and promote staff wellness.

The Smart Source pilot results also indicate that there are some areas where school health efforts are underemphasized. For instance, only a small percentage of elementary and secondary schools reported using a universal screening process to identify students' social, emotional, and behavioral health needs (4 and 14 percent, respectively). Fewer schools have practices in place to ensure quality health education compared to their practices for PE. Finally, while schools reported engaging students in a variety of school health components, most only collect suggestions from students rather than providing them opportunities to help make decisions or develop policies.

Interpretation of Results

Prepared by CEI and Slope Research, this executive summary presents aggregate results for a selection of Smart Source items within each of the content areas for all elementary and secondary schools that participated in the first pilot. Because some substantial differences exist between how elementary and secondary schools implement health policies and practices, the responses of elementary and secondary schools are displayed separately throughout this report.[3] Additionally, multiple items from the Smart Source tool are not highlighted in the summary due to space limitations and, in only a few instances, concerns about the validity of the responses.[4] Finally, although the Smart Source tool addresses all components of school health, Smart Source is meant to measure the key factors that schools should prioritize, so the tool and its results are not meant to be an exhaustive list of all health policies and practices. Additionally, content areas may not be comprehensive due to other tools or efforts already collecting relevant data in that area.[5]

RESULTS

General Health Policies and Practices

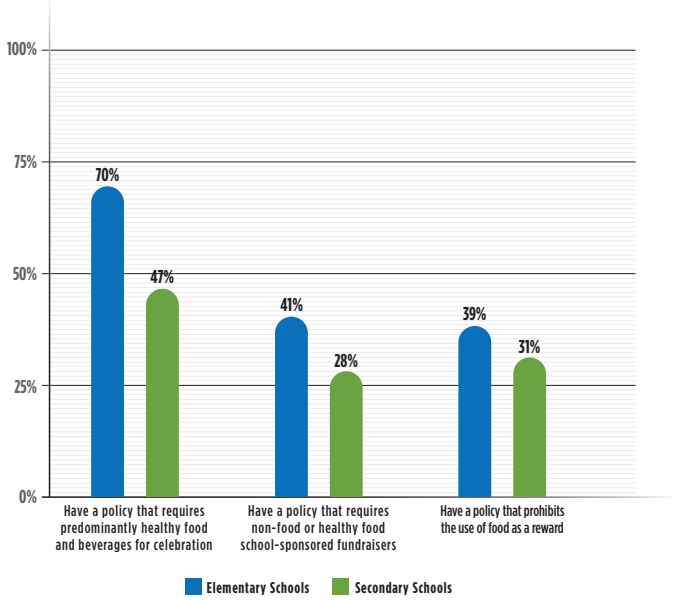
To address health and wellness, schools should implement foundational policies and practices, such as having a wellness team, to support their efforts. Over 80 percent of schools that participated in the pilot have wellness teams. Of those with wellness teams, nearly all reported that those teams communicate the importance of school health efforts to school stakeholders and seek funding and community partnerships to support school health efforts, while over two-thirds of schools' teams review relevant data to identify student health needs, evaluate strengths and gaps of their school's health efforts, and review health-related curricula or instructional materials. Additionally, nearly 90 percent of schools reported having a school or district wellness policy in place, and slightly more than half responded that they include a health and wellness goal in their Unified Improvement Plan.

3 The five schools with both elementary and secondary grades are included in the aggregate results for both elementary and secondary participants.
4 For example, Smart Source items related to PE minutes were designed to allow for a calculation that took into account differences in how PE is offered at different schools, but the number of PE minutes calculated for Smart Source pilot schools varied substantially between elementary and secondary schools, possibly indicating inaccurate data. Refinements for these types of items will be explored before the next pilot.
5 For example, items about the school meal program (beyond the number of minutes provided) were not included in the Smart Source tool, as this information is already collected at the district level via mandated federal and state processes.

Nutrition

Schools should consider what types of foods and beverages are available to students and review the policies in place that address when and how students have access to them. Of the schools that provide food and beverages for purchase by students, sugar-sweetened beverages and diet soda are the two least common items made available. Additionally, secondary schools reported providing at least five more minutes for breakfast (25 minutes vs. 20 minutes) and lunch (20 minutes vs. 15 minutes) compared to elementary schools. However, as shown in **Figure 2**, elementary schools are more likely to have nutrition-related policies in place.

Figure 2
Food-Related Policies



Health Services

Health service providers in schools should assess student health needs, manage chronic health issues, and provide in-school healthcare services as well as referrals to services outside of school as needed. As evident in **Figures 3 and 4** below, a roughly similar percentage of elementary and secondary schools provide screenings and referrals for hearing, vision, and oral health, but the figures do not show the variation in response options for screenings. Interestingly, a much higher percentage of elementary schools screen for these health conditions in all grades every year (75 percent for hearing and vision; 27 percent for oral health) compared to secondary schools (26 percent for hearing and vision; 14 percent for oral health).

Figure 3
Hearing, Vision, and Oral Health Screenings

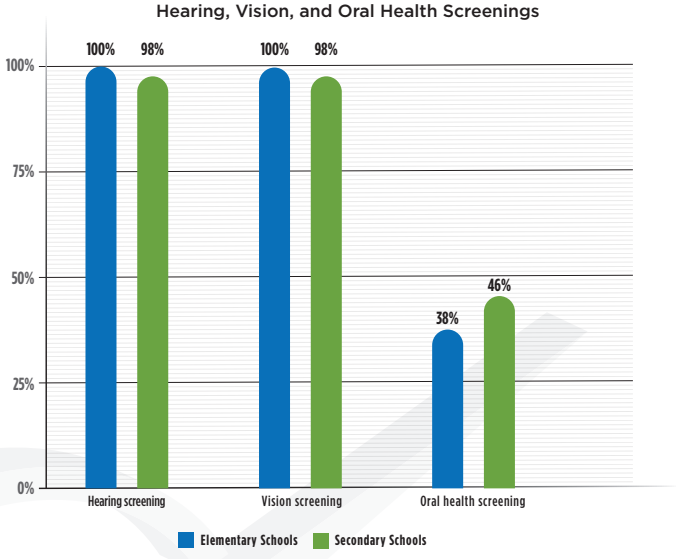
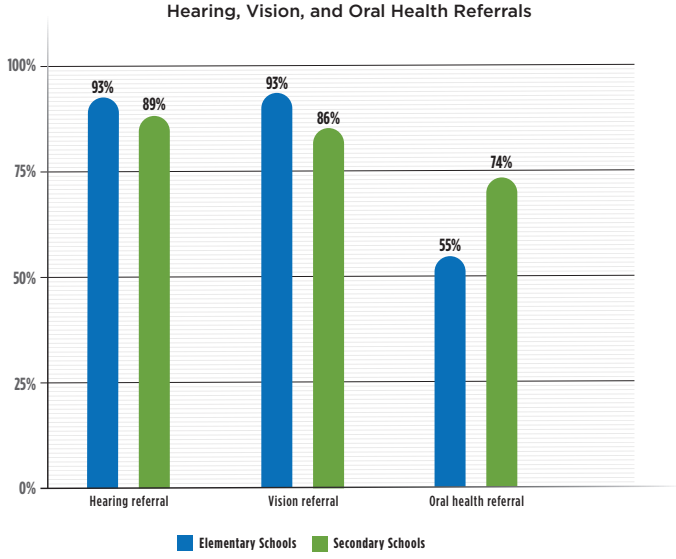


Figure 4
Hearing, Vision, and Oral Health Referrals



Physical Education/Physical Activity

Schools should address Comprehensive School Physical Activity, which includes physical education (PE) instruction as the foundation and incorporates physical activity opportunities before, during, and after school. A majority of both elementary and secondary schools provide physical activity opportunities outside of PE, including through intramural or recreational sports and physical activity clubs. Additionally, both elementary and secondary schools reported offering an average of five physical activity breaks in the classroom during the day. Finally, **Figures 5 and 6** below show that students are engaged in moderate-to-vigorous physical activity during most of PE class time and that a majority of PE teachers have undergraduate training in PE, are licensed with an endorsement in PE, and receive ongoing professional development related to PE (at least annually).

Figure 5
Percentage of PE Time Students Engage in Moderate-to-Vigorous Physical Activity

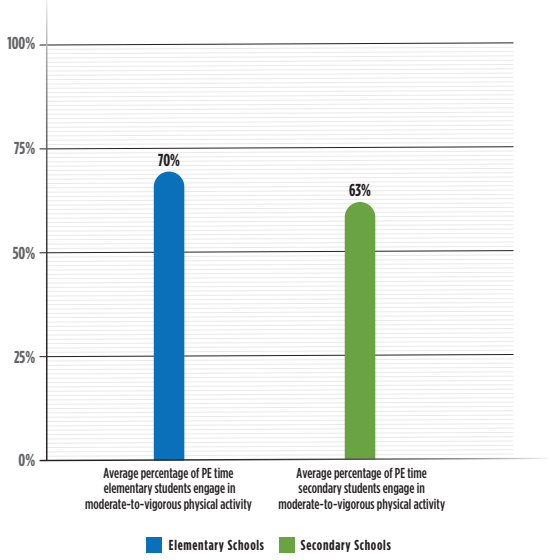
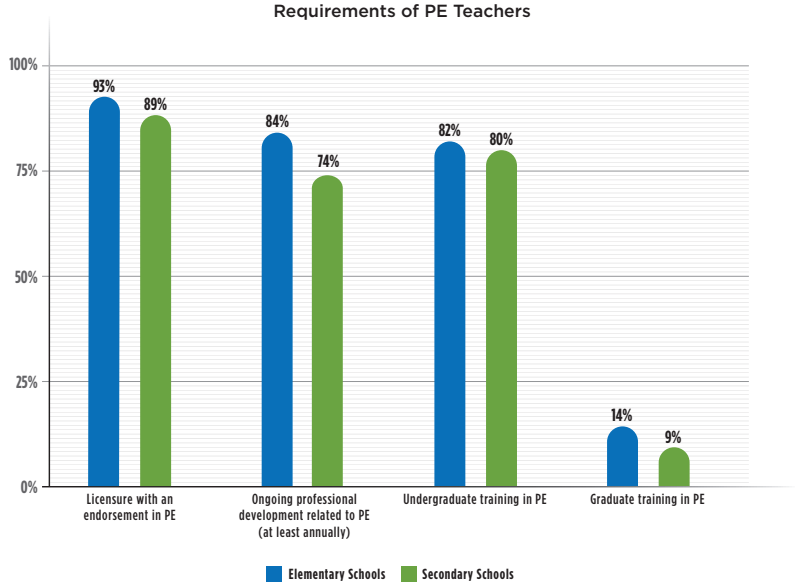


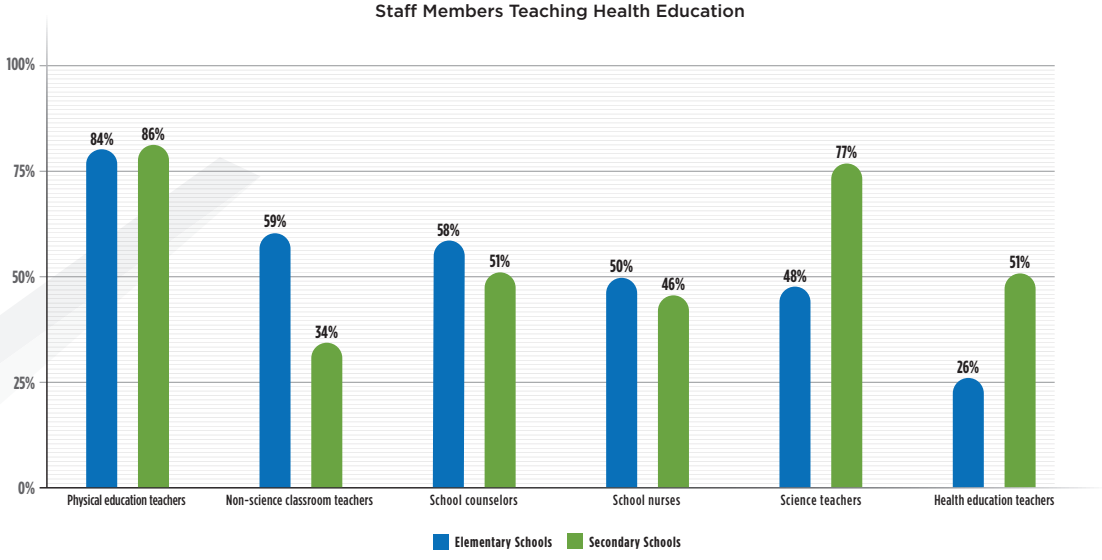
Figure 6
Requirements of PE Teachers



Health Education

Instruction related to health education should be offered to students, so they can access valid information about their health, make healthy decisions, and analyze what influences health and wellness. Both elementary and secondary schools reported including a variety of topics in their school's health education, but slightly fewer elementary schools responded that they use unit lesson plans, measurable objectives, curriculum aligned to the Comprehensive Health and PE standards, and summative assessments compared to secondary schools. As shown in **Figure 7**, PE teachers are the most likely to teach health education in their schools.

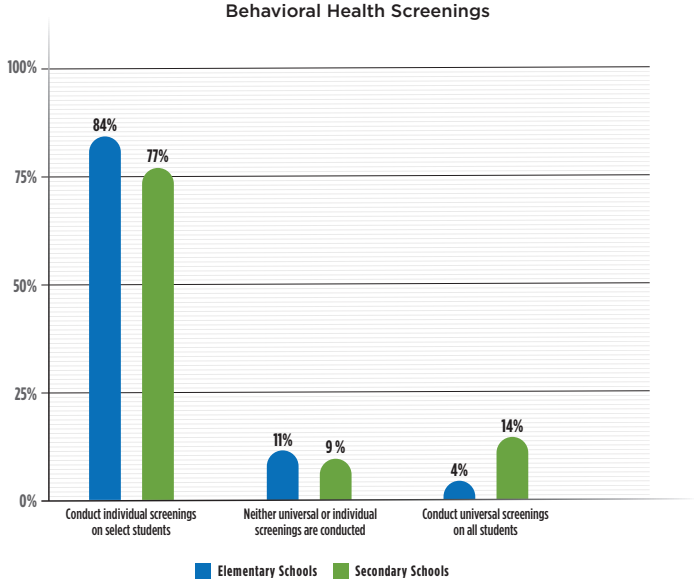
Figure 7
Staff Members Teaching Health Education



Counseling, Psychological, and Social Services

School counseling, psychological, and social services are supports provided to students that help address social, emotional, behavioral, and mental health needs. Schools should work to identify these needs in students and offer in-school services or referrals for students identified with needs. A much higher percentage of secondary schools provide services around gender identity and sexual orientation, sexual assault and dating violence, eating disorders, and substance abuse compared to elementary schools. Additionally, over 90 percent of schools reported training counselors, administrators, and health professionals to identify mental/behavioral health needs, with fewer schools reporting training teachers and coaches. Finally, as shown in **Figure 8**, only a small percentage of schools reported using a universal screening process to identify students' social, emotional, and behavioral health needs (4 and 14 percent, respectively).

Figure 8
Behavioral Health Screenings



Healthy and Safe School Environment

Schools should address the safety and accessibility of the physical environment of the school, how the climate of the school impacts students and staff, and how prepared they are to address emergency situations. Although limited differences exist between elementary and secondary schools related to policies or practices to prevent bullying (see **Figures 9 and 10**), elementary schools were less likely to report holding schoolwide activities that give students opportunities to learn about diverse cultures, having student-led clubs dedicated to creating a welcoming environment regardless of sexual orientation or gender identity, engaging students in service learning, using instructional materials that reflect the diversity of their student body, or providing information about warning signs to parents/guardians and students.

Figure 9
Practices to Prevent Bullying

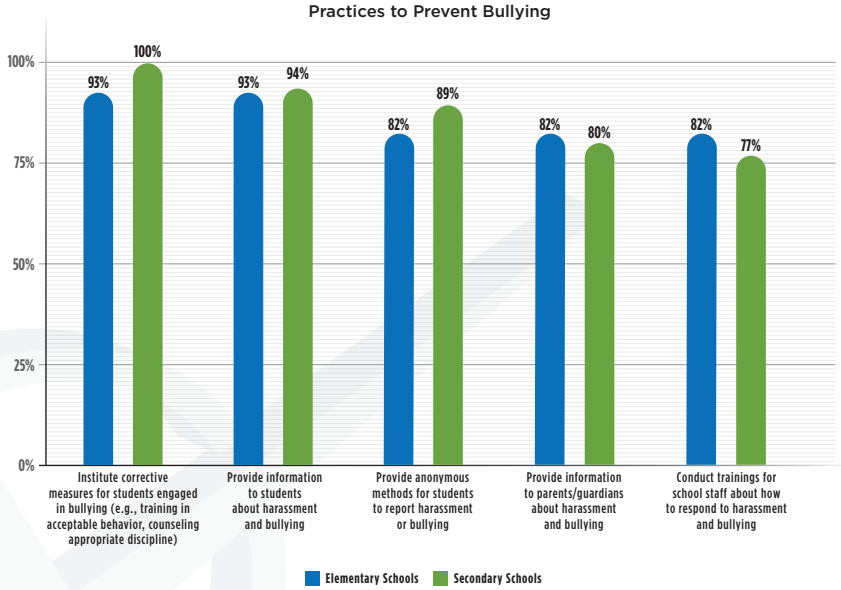
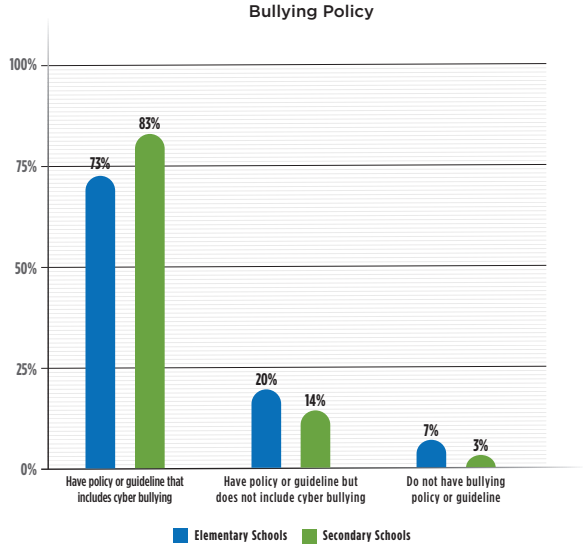


Figure 10
Bullying Policy



Family, Community, and Student Involvement

Establishing community partnerships and engaging families and students in school health are central to increasing the availability, strength, and longevity of school health and wellness efforts. Elementary schools were slightly more likely to report providing community access to both indoor and outdoor facilities compared to secondary schools. As evident in **Figure 11**, elementary schools are also slightly more likely to engage parents and families in school health programs. Finally, schools reported engaging students most often in school climate and culture compared to other school health components.

Figure 11
Family Engagement Strategies

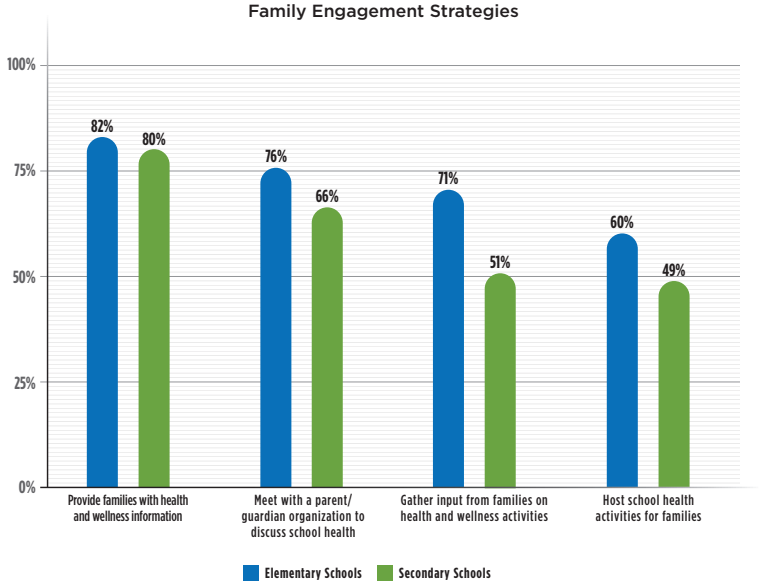
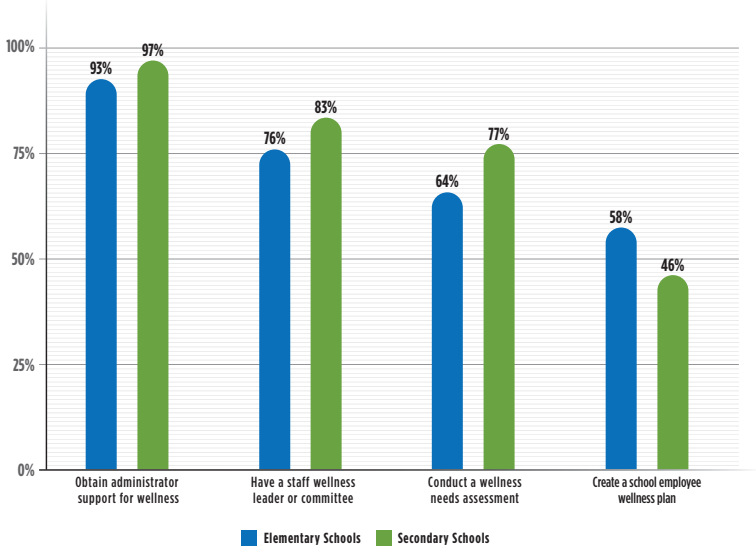


Figure 12
Staff Wellness Activities



Staff Health Promotion

Schools should offer health screenings for staff, identify a staff person to lead and coordinate staff wellness offerings, and refer staff to services and support as needed. Promoting staff health not only has benefits for staff members but also students within the school. Over three-fourths of schools reported providing physical activity opportunities, first aid/CPR training, stress management activities, and annual flu shots for their staff. Additionally, as highlighted in **Figure 12**, schools are less likely to create, schools are less likely to create a school employee wellness plan compared to other practices that promote staff wellness such as obtaining administrator support for staff wellness, having a staff wellness leader or committee, and conducting a staff wellness needs assessment.

NEXT STEPS

About the Second Pilot (2015-2016)

CEI is analyzing Smart Source survey questions and utilizing regional trainings and follow-up interviews with participants to collect feedback on the tool. This information is informing refinements and the overall administration process prior to the second pilot starting in October 2015.

For this second pilot, CEI hopes to increase participation to approximately 350 schools, and plans to target more schools that include both elementary and secondary grades — and will prioritize recruitment in the Denver Metro area and Northeast, Southeast, and West Central regions.

About CEI

The Colorado Education Initiative is an independent nonprofit working in partnership with the Colorado Department of Education, educators, schools, districts, and other public education stakeholders to unlock the unique potential of every student by incubating innovation, shining a spotlight on success, and investing in sustainable change that improves outcomes for all students. CEI envisions that every student in Colorado is prepared and unafraid to succeed in school, work, and life, and ready to take on the challenges of today, tomorrow, and beyond.

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