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Stakeholder Perspectives: Implementation of Local School Wellness Policies in the Kent Intermediate School District

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STAKEHOLDER PERSPECTIVES: IMPLEMENTATION OF LOCAL SCHOOL WELLNESS
POLICIES IN THE KENT INTERMEDIATE SCHOOL DISTRICT

by

Adrienne A. Wallace

A dissertation submitted to the Graduate College
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
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December, 2018

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A project of this size and significance is not completed by *just* a single researcher, it takes a village. I'm thankful to the following people that compose my village: my dissertation committee, for saying "yes" and ushering me into this new title of scholar; Derek DeVries, my love and number one fan who never doubted I could conquer a Ph.D. and for many years took a back seat to my journey; Donijo Robbins (& Lucy & Keith), for the unconditional support, snacks, mentoring, answering my dumb questions via text or to my face like a saint, re-teaching me research methods for graduate students, and for consuming every bad draft before there was a "good" draft; Jen, Andrea, Caryn, & Lesley, who scheduled our friendships around my Ph.D. work for years; Bode, who let me walk away gracefully even though it could have hurt her business in doing so; Tiffany, for having more confidence in me, than I have in me; Emma, for lapping me, but pretending still that I'm more accomplished; Nanda (& Alma, our cohort baby), for perspective on the journey of a Ph.D. student; my parents Pat & Liz, who have no idea what it is that I am doing, but are excited anyway; my brother Aaron, who thinks higher education is a scam but paid for the last of my grad school credits as a gift to me; my thoughtful colleagues at Grand Valley State University (GVSU) (especially Melba Vélez Ortiz & "Professor Chad", Robin Spring, Frank Blossom, Tim Penning, Jon Hodge, & Dean Antzcak) for not rushing me, trusting in me and my journey, and for letting me do award-winning work with my own students while just being a mediocre Ph.D. student myself; the Kent ISD school district employees for returning a stranger's survey instrument; my rescue dogs Rosie & Watson, for providing needed distraction whenever it was required; my students at GVSU who were always cheering me on this; and finally, coffee, well because, coffee is the real hero here.

Adrienne A. Wallace

STAKEHOLDER PERSPECTIVES: IMPLEMENTATION OF LOCAL SCHOOL WELLNESS POLICIES IN THE KENT INTERMEDIATE SCHOOL DISTRICT

Adrienne A. Wallace, Ph.D.

Western Michigan University, 2018

The purpose of this study was to explore attitudes and perception of stakeholders (teachers, principals, nutrition service directors, nutrition service supervisors, school nurses, nutrition specialists and administrators) toward the implementation of the local school wellness policy in public schools within Kent County, Michigan. The subjects of interest were stakeholders from more than 300 schools and 20 public school districts within the Kent Intermediate School District. Subjects responded to a survey assessing their perspectives regarding the implementation of the local school wellness policy pursuant to the Healthy Hunger-Free Kids Act of 2010 an Obama-era policy, the results were then examined using ANOVA and theoretical foundations of Policy Implementation Framework (PIF), Advocacy Coalition Framework (ACF), and Multiple Streams Model (MSM). In this study, the author identifies the perceptions of stakeholders to bring about a more effective understanding of the consequences of an unfunded mandate that fuels local school wellness policy in Kent County. This study fills a gap in nutrition policy literature at the local/district level and demonstrates that there is a perception that school employees/staff responsibilities were negatively impacted by the HHFKA and that local school wellness policy lacked proper implementation due mostly to lack of training for stakeholders.

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CHAPTER I

INTRODUCTION

Over the past three decades, childhood obesity rates in America have quadrupled. Today, nearly one in three children in America are overweight or obese (Centers for Disease Control [CDC], 2017). Combined overweight and obesity rates for youth ages 10 to 17 ranged from 19.2% in Utah to 37.7 % in Tennessee, according to the most recent state-by-state data from the 2016 National Survey of Children's Health (NSCH, 2017). Nationally, 31.2 % of youth in this age range are overweight or obese. Seven of the 10 states with the highest rates are in the South. The 10 states with the lowest rates are either in the West or Northeast (State of Obesity, 2017).

While the national childhood obesity rate has leveled off, and rates have even declined in some places and among some groups, troubling racial and ethnic disparities persist among communities of color. Black and Latino youths have substantially higher rates of overweight and obesity than do their White peers. This is true among younger children, older adolescents, and both boys and girls where nearly 40% of the children are overweight or obese. If a solution isn't discovered one third of all children born in 2000 or later will suffer from diabetes at some point in their lives (Schwimmer, Burwinkle & Varni, 2013; State of Obesity, 2015; Hedley, 2004; Let's Move!, 2012); many others will face chronic obesity-related health problems like heart disease, high blood pressure, cancer, and asthma (American Heart Association (AHA), 2015).

Most of these problems include factors such as intake of high calorie, high processed foods, lack of physical activity, unhealthy food choices, or a combination of all of these (CDC, 2015; CDC, 2010; Munoz, Krebs-Smith, Ballard-Barbash & Cleveland, 1997; Hastert, Babey,

Diamant, & Brown, 2005). As 95% of children between Kindergarten and 12th grade (K-12) are enrolled in schools (National Center for Education Statistics, 2005) and over 31 million children receive meals through the school lunch program, with most if not all of their meals received through national school nutrition programs (Let's Move), schools play a tremendous role with healthy eating and physical activities education taking part in American. Promotion of these positive behaviors can occur with well-designed and implemented programs through schools; hence, nutrition and physical activity programs should be a key goal in every school district policy (Center for Disease Control and Prevention [CDC], 1996, 1997a; Gortmaker et al., 1999, and Robinson, 1999).

The Pew Charitable Trusts surveyed 489 school nutrition managers nationwide and found that six in 10 still face obstacles related to the updated federal requirements (2016). This study will explore the perceptions and attitudes of key stakeholders (principals, nutrition service directors, nutrition service staff, school nurses, and nutrition specialists) implementation of the local school wellness policy (LSWD) in public schools in Kent County, Michigan toward the Healthy, Hunger-Free Kids Act of 2010 (HHFKA) (P.L. 111–296) a federal statute signed into law by President Barack Obama on December 13, 2010. This statute was part of the reauthorization of funding for Child Nutrition and WIC Reauthorization Act of 2004 (CNRA) signed into law by President George W. Bush on June 30, 2004. “This legislation authorizes funding and sets policy for USDA’s core child nutrition programs: the National School Lunch Program, the School Breakfast Program, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), the Summer Food Service Program, and the Child and Adult Care Food Program,” (USDA, para 1). The bill that reauthorizes these programs is often referred to by shorthand as the child nutrition reauthorization bill.

This particular bill reauthorized child nutrition programs for five years and includes \$4.5 billion in new funding for these programs over 10 years. Many of the programs featured in the Act do not have a specific expiration date, but Congress is periodically required to review and reauthorize funding, generally every five years. This reauthorization presents an important opportunity to strengthen programs to address more effectively the needs of our nation's children and young adults" (Let's Move, para 2). As a result of The Child Nutrition and WIC Reauthorization Act of 2004 and most recently the Healthy Hunger-Free Kids Act of 2010, all districts that participate in the federal Child Nutrition Programs must adopt, implement, and report on the state of their local school wellness policies (LSWP).

Local school wellness policies have the ability to impact the health of students and the school environment in a manner targeted best toward the district from which they originate as the intent of the policy is that they are developed within the community served by stakeholders, shareholders and community partners. The HHFKA was written to include provisionary action in order to increase the involvement of stakeholders' involvement implementing, monitoring, and reporting about their local school wellness policies. It was the intent that "policies can also encourage district staff members, a key stakeholder group, to model healthy behaviors as a part of daily life;" (CDC, 2014, p. 3) however, research done by the CDC as late as school year 2011-2012, shows that this "intent has fallen on deaf ears as few districts required stakeholder involvement within wellness policies" (CDC, 2014, p. 2).

"Each local educational agency that participates in the National School Lunch Program or other federal Child Nutrition programs is required by federal law to establish a local school wellness policy for all schools under its jurisdiction" (USDA, 2017, para 1). While both Bush and Obama bills were intended to affect physical education, food service in schools, and K-12

nutrition programming, the guidelines were written in broad terms with a “hands off” approach in order for local districts to have freedom to interpret, develop, and implement this law as they saw fit. In addition to being a mandate that lacks policing, this autonomy may have made it tougher for local districts to correctly implement these guidelines in a timely or effective fashion. In recognizing the lack of monitoring, evaluation, and reporting from the implementation of the 2004 Act, the HHFKA included provisions that required school districts periodically measure and report on policy implementation and progress. Despite these provisions in the mandate, few districts in the US met even the most basic reporting measure of “making the policy publicly accessible such as on the district web site” (CDC, 2014, p. 3).

Local wellness policies are an important tool for parents, local educational agencies (LEAs), and school districts in promoting student wellness, preventing and reducing childhood obesity, and providing assurance that school meal nutrition guidelines meet the minimum federal school meal standards (USDA, 2017). In December of 2016, the Child Nutrition Reauthorization (CNR) which is the every-five-year Congressional review and reauthorization of all programs, including the school lunch program was halted in Congressional session by Senate Agriculture Committee Chairman Pat Roberts (R-Kansas). The implications of policy reform and child nutrition programs under a new administration have only increased the relevancy and timing of this policy and this study.

Policy researchers have often used frameworks to deepen understanding of different methods of policy analysis as matched to tools in governance contexts (Howlett, Ramesh & Perl, 2009). Richardson et al., 1982; Van Waarden, 1995; Howlett, 2000 encourage the use of alternate or complementary techniques such as frequent use of public consultation or stakeholder participation, or simply the view of an entrenched preference for the specific use of this type of

policy instrument as proposed in this study. Policy analysis uses rational policy analysis as an approach to evaluating new and proposing alternatives to existing policy. By collecting stakeholder data, this study aims to identify and analyze the attitudes and perceptions of policy implementation in order to bring about a more effective understanding of the mandate and stakeholders that fuel local school wellness policy implementation in Kent County. This information will allow for critique, evaluation, and potential improvement of implementation of an important policy that has an impact on nearly every single school-aged boy and girl in the United States.

This study was created to explore the perceptions and attitudes of key stakeholders (principals, nutrition service directors, nutrition service staff, school nurses, and nutrition specialists) on implementation of the local school wellness policy (LSWP) in public schools in Kent County, Michigan toward the Healthy, Hunger-Free Kids Act of 2010 (HHFKA) (Pub.L. 111–296) a federal statute signed into law by President Barack Obama on December 13, 2010.

Problem Statement

Drafting and implementing Local School Wellness Policy (LSWP), a requirement of the Healthy, Hunger-Free Kids Act of 2010 (HHFKA), is a complicated process, involving many people, and may or may not be implemented as the law intends.

Background (Definition of Major Concepts, History)

The nutritional health of American children has changed during this century, improving dramatically in some ways, but not in others. In the early 1900s, the principal health problems among children were infectious diseases made worse by diets limited in calories and nutrients. As the economy improved, and as more was learned about nutritional needs, manufacturers

fortified foods with key nutrients, the government started school feeding programs, and the results were a decline in nutrient deficiency conditions. That severe undernutrition has virtually disappeared among American children can be counted as one of the great public health achievements of the twentieth century (Tran, 2013).

For the great majority of American children, the problem of not having enough food has been solved. Whether children are eating the “right food,” is another matter. Obesity rates are rising rapidly among children and adolescents, especially those who are African-American or Hispanic (DHHS, 2012). Over the past 15 years, there has been significant progress to prevent obesity and stabilize obesity rates, especially among children. Strong state policies play a key role in improving access to healthy food and increasing physical activity which are essential for promoting a healthy weight (State of Obesity, 2016).

The most important nutritional problem among children today is obesity — a consequence of eating too much food, rather than too little (Nestle, 2009). This seems counterintuitive in a nutrition study; however nutrition, the process of providing or obtaining the food necessary for health and growth, can be categorized in terms of “right foods” (aka functional foods) which the USDA defines as ‘are designed to have physiological benefits and/or reduce the risk of chronic disease beyond basic nutritional functions, and may be similar in appearance to conventional food and consumed as part of a regular diet’ (USDA, 2010) and “wrong foods” or those foods with excessive amounts of added sugar, solid fats, and sodium (USDA, 2010).

The health consequences also are rising: high levels of serum cholesterol, blood pressure, and "adult-onset" diabetes. This increase has occurred in response to complex societal,

economic, demographic, and environmental changes that have reduced physical activity and promoted greater intake of foods high in calories but not necessarily high in nutrients (Nestle, 2009). It is easier and more effective to prevent overweight and obesity during early childhood than to reverse trends later in life. Early childhood education (ECE) settings can encourage a healthy diet, physical activity, limits on screen time and other best practices to help young children adopt healthy habits early in life (State of Obesity, 2017).

“Schools have direct contact with more than 95% of our nation’s young people aged 5-17 years, for about six hours per day and up to 13 critical years of their social, psychological, physical, and intellectual development. Schools play an important role in promoting the health and safety of children and adolescents by helping them to establish lifelong health patterns” (CDC, 2017, para 1). Additionally, the Center for Disease Control says

Healthy students are better learners, and academic achievement bears a lifetime of benefits for health. Schools are an ideal setting to teach and provide students with opportunities to improve their dietary and physical activity behaviors and manage their chronic health conditions (asthma, diabetes, epilepsy, food allergies, and poor oral health). When policies and practices are put in place to support healthy school environments, healthy students can grow to be healthy and successful adults. (para 2)

In 1946, President Harry S. Truman signed into law the National School Lunch Program (NSLP) or the Richard B. Russell National School Lunch Act (79 P.L. 396, 60 Stat. 230) (Appendix A), which was the first federal government wellness policy to come into effect in a powerful response to harsh claims that American men were not fit to serve in World War II due to health problems related to diet. The program was created

as a measure of national security, to safeguard the health and well-being of the Nation's children and to encourage the domestic consumption of nutritious agricultural commodities and other food, by assisting the States, through grants-in-aid and other in providing an adequate supply of foods and other facilities for the establishment, maintenance, operation, and expansion of nonprofit school lunch programs. (79 P.L. 396, 60 Stat. 230 Sec. 2)

This Act was amended many times eventually involving public, private, and residential daycare institutions the ability to engage in the National School Lunch Program in an effort to broaden the reach and become more inclusive of children at other levels of education and socioeconomic status. In 1996, The Child Nutrition and WIC Reauthorization Act (CNRA) was revised to strengthen and expand food service programs to even more children in America. This introduced additional research that had made an impact on the National School Lunch Program thereby assisting states in safeguarding the health and well-being of the “nation's children,” encouraging domestic product consumption, and increasing the availability of grants-in-aid and other supplemental programming (USDA, 2017).

The provision of a “local school wellness policy” was included in the Child Nutrition and WIC Reauthorization Act of 2004 (Appendix B). This Act required that every local educational agency (LEA) that participated in the nutrition program author a local wellness policy. This coupled with the original Childhood Obesity Prevention Act in 2004 (Rep. Castle, in H.R. 2227) required that a local wellness policy be created and implemented at a local level through a committee of concerned parents, teachers, administrators, school board members, etc. The exact nature of content is not dictated to districts but rather mentions that it “encourages nutrition education while emphasizing the importance of physical activity” (USDA, 2006, n.p.).

Full responsibility for creation and implementation was left at the discretion of the LEAs thus likely varying from district to district with guidance given to include the following components as a result of the Child Nutrition and WIC Reauthorization Act:

1) appropriate goals for nutrition education, physical activity, and other school-based activities designed to promote student wellness; 2) nutrition guidelines for all foods available during the school day, with the objectives of promoting student health and reducing childhood obesity; 3) assurance that guidelines for reimbursable school meals shall not be less restrictive than regulations and guidance issued by the Secretary of Agriculture; and 4) a plan for measuring implementation of the school wellness policy, including designation of at least one person to maintain responsibility for the program operation. (2004)

Additionally, the Act requires involvement of a variety of actors to comprise an advisory committee including parents, students, community members, and school staffers responsible for monitoring the progress of the LSWP creation and implementation.

Then, in a USDA memo dated July 8, 2011, Section 204 of the Healthy, Hunger-Free Kids Act of 2010 (the Act), Public Law 111-296 (Appendix C), added Section 9A to the Richard B. Russell National School Lunch Act (NSLA) (42 U.S.C. 1758b), Local School Wellness Policy implementation. The provisions set forth in Section 204 expand upon the previous local wellness policy requirement from the Child Nutrition and Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Reauthorization Act of 2004 (Public Law 108-265). The USDA summarized the action as such:

Local wellness policies are an important tool for parents, LEAs and school districts to promote student wellness, prevent and reduce childhood obesity, and provide assurance that school meal nutrition guidelines meet the minimum Federal school meal standards. While many LEAs included plans for implementation in their written wellness policies as required by the Child Nutrition and WIC Reauthorization Act of 2004, they were not required to report on policy compliance and implementation; as a result, implementation and evaluation efforts were not monitored or conducted regularly. Section 204 of the Act strengthens wellness policies by emphasizing ongoing implementation and assessment. This provision also supports a robust process at the community level, including the expansion of the team of collaborators participating in the wellness policy development to include more members from the community. This approach is intended to foster broad-based community support for the development and implementation of effective wellness policies. (2011)

As a result of this, the Act requires that implementation, periodic assessment, and public updates be maintained to assure compliance with the local school wellness policy and insure progress toward attaining the goals set forth by the local education agency (LEA) in the designation of one or more official to police for compliance. The USDA instructions on this matter were namely “LEAs should be working toward developing a reasonable method to implement this requirement” (USDA, 2010, p. 3).

The HHFKA legislation expanded upon the 2004 legislation to focus on implementation, evaluation, and reporting of local school wellness policies. Local school wellness policies are only effective, if they are implemented (Gaines, Lonis-Shumante, & Gropper, 2011; Lanier,

Wagstaff, DeMill, Friedrichs, & Metos, 2012; Schwartz, et al., 2015). A Connecticut study (Schwartz, et, al., 2012) took this one step further, it supports

the importance of writing clear, strong policies and suggests that policy strength makes a difference in likelihood of implementation and improvement of practices. These conclusions support efforts on the part of state government and nongovernment organizations to continue to monitor the strength of the written policies, provide feedback to districts on how to strengthen their language, and continued evaluation of the implementation of the policies into practices at the school level. (p. 267)

As you can see the literature in this area evolving, more recent literature studies “effectiveness” and shows that bigger does not equal better. “The comprehensiveness and strength of school wellness policies varies by district size” (Meendering, et al., 2016). Their research, performed in a “rural Midwest state” showed that smaller districts write policies that are more comprehensive to governmental standards and use more definitive language than larger districts (p. 655).

Taking policy from theory to practice is a complex process particularly when considering all the moving parts associated with the HHFKA. A 1977 work by Greenburg, Miller, Mohr, and Vladeck states that research involving policy making, implementation and innovation involve: 1) a series of decisions that occur over a period of time without beginning or end points, 2) outcomes whose implications are far too complex for single factor theories, 3) a large number of participants, 4) situations that are “special.” Therefore, implementation is a tough subject to take under study consideration. In order to prep for policy outcomes “the most important evaluative criterion is whether or not the projected outcome will solve the policy problem to an acceptable

degree” (Bardach, 2012, p 32). As a result, theory of policy cycle introduced by Howlett and Ramesh (2009) can aid in the timeline from creation to evaluation of policy by studying the stages of: agenda setting, policy formulation, decision-making, policy implementation, policy evaluation.

This study, focused on the implementation stage of the policy cycle as a guiding framework for examination into LSWP, answering research questions, and providing insight into the evaluation of HHFKA as studies are just now becoming available as to its efficacy. Part of this study demonstrates the complexity of federal policy making as implemented at the school district level.

Significance of the Study

Obesity (Body Mass Index of 30+) in the United States is serious, common, and costly to the American taxpayer and employers, more than one-third (35%) of US adults have obesity. Obesity impacts some groups more than other groups; non-Hispanic blacks have the highest rate of obesity (48%) followed closely by Hispanics (43%). It is highest in middle-aged adults (40-59 years old) (CDC, 2017). The estimated annual medical cost of obesity in the U.S. is \$147-210 billion dollars; medical costs associated for people who suffer from obesity are \$1,429.00 higher than those of a normal weight (CDC, 2016; The State of Obesity, 2017). Per capita healthcare costs for severely or morbidly obese adults (BMI >40) are 81 % higher than for healthy weight adults. In 2000, around \$11 billion was spent on medical expenditures for morbidly obese U.S. adults. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer (CDC, 2016).

Michigan has the 10th highest adult obesity rate in the nation, according to The State of Obesity: Better Policies for a Healthier America released September 2017 through the Robert

Wood Johnson Foundation. Michigan's adult obesity rate is currently 32.5 %, up from 22.1 % in 2000 and from 13.2 % in 1990.

According to the most recent data (2017), adult obesity rates now exceed 35 % in five states, 30 % in 25 states and are above 25 % in 46 states. West Virginia has the highest adult obesity rate at 37.7 % and Colorado has the lowest at 22.3 %. U.S. adult obesity rates decreased in one state, Kansas, between 2015 and 2016 and increased in Colorado, Minnesota, Washington, and West Virginia while remaining relatively stable in the remaining states. “This marks the first time in the past decade that any states have experienced decreases — aside from a decline in Washington, D.C. in 2010” (2016, para 1)

In Kent County specifically, the obesity rate is 38.1% for females and 35.7% for males (Institute for Health Metrics and Evaluation, 2016). A report released by the Centers for Disease Control and Prevention (CDC) in August 2013 showed that 18 states, including Michigan, and one U.S. territory experienced a decline in obesity rates among 2- to 4-year-olds from low-income families between 2008 and 2011. Over that period of time from 2011 to 2015, Michigan's rate of obese 2- to 4- year olds fell from 13.9% to 13.2%, a statistically significant decrease according to the CDC analysis (State of Obesity, 2016).

Obesity prevalence in 2016 according to the self-reporting CDC Behavioral Risk Factor Surveillance System (BRFSS) data shows that no state in the U.S. had a prevalence of obesity less than 22.3%; 14 states (Alabama, Nebraska, West Virginia, Mississippi, Michigan, Indiana, Oklahoma, Arkansas, Texas, Louisiana, South Carolina, Kentucky, Tennessee and the Virgin Islands) had an obesity prevalence of 32.1-37.7%; the South had the highest prevalence of obesity (31.2%), followed by the Midwest (30.7%) (CDC, 2016).

While schools by themselves are not able to solve this problem, they do play an important role in dealing with childhood obesity which is worth noting, as the HHFKA places additional responsibility on the school district(s) to promote health and reduce obesity in school-aged children through broad procedures and lack of standards which may result in ineffective local school wellness policies that do not provide a significant reduction in disease or increase in health for young U.S. citizens.

As the obesity epidemic continues in the United States public policy task forces and legislation abounds from federal levels to local levels and even at the school level. Attempting to address disease through policy has proved to be challenging with the factors which impede legislation. Masse, Naiman and Naylor (2013) concluded in a qualitative study that mandated policies are in fact “an essential step in improving physical activity and healthy eating; however, policy makers need to: monitor whether schools are able to implement the guidelines, support schools struggling with implementation, and document the impact of the guidelines on students’ behaviors” (p. 11).

In states like California, schools are making “significant progress toward the implementation of state nutrition standards” (Samuels, et al., 2009, p. S43) but find that the complex interpretation required in order to meet the current standards is a large barrier to the implementation of nutrient-based food standards. Samuels, et al., concluded from their California study that “additional support is needed from federal, state, and local jurisdictions to provide schools with the resources to implement and monitor new food and beverage policies” (p. S44).

Following the initial mandate and policy implementation, “over time, the intent of the original policy runs the risk of being watered down if not analyzed in its original and complete context” (Harriger, et al., 2014, p. 283) this leaves ill-defined constructs which could mean

different things to different people as they are exposed to the mandate as implemented by various stakeholders.

A 2011 comprehensive review of literature performed by Metos and Murtaugh examined the gap between policy makers and the educational community to determine if policy language created by bureaucrats translates to school practices and subsequently improvement in student eating habits, activity, and body mass index (BMI) of children and adolescents. Their summary concluded that while almost all articles demonstrated policy compliance with policy development and initial implementation, there was a tendency for school districts to shower more attention on the cafeteria environment itself and less on the provisions in the WIC Reauthorization of 2004 and HHFKA 2010 for physical activity or health education. There is a very strong translation issue however, and that is creation of policy in some studies they examined was used interchangeably with implementation. So, this barrier is significant to reviewing literature of all types.

Secondly, a barrier to literature in existence is the lack of any real or measured penalties for non-compliance. No accountability in an unfunded mandate does not exactly improve required actions in states or districts with few resources. A Pennsylvania study (2008) suggests the naming of a school district representative who has had adequate time and training should be made available to manage implementation and evaluation of the LSP. As this is often above and beyond current duties of staff or faculty, it is difficult to require or compel staff into compliance (Probart, McDonnell, Weirich, & Schilling, 2008; Probart, et al., 2010).

A corroborating study done in 2016 by Hager, Rubio, Eidel et al., further suggests the formation of a school-level school health council (SHC) and to establish a formal position that is compensated fairly for SHC chairperson who they deemed acts as the “wellness champion”

within the school. The chairperson would then be responsible for the wellness committee's goals, action plan, and reporting. This would then also track compliance within the law through implementation reporting guidelines.

Similarly, finding a combination of qualified staff and invested community members to achieve sustaining measures for wellness policies was examined in a 2008 study which concluded there is "considerable need for supporting schools in their implementation and evaluation of LWP" (Moag-Stahlberg, Howley, & Luscri, 2008, p. 567) and that "schools will need outside assistance to meet each of the mandates provided by the federal mandate" (p. 567) by way of community support and representation on the wellness committee, national direction to school health educators, school nurses, administrators and other stakeholders within the community at large.

Purpose Statement

A sad truth in development practice is that the pilot programs are implemented poorly and some of them are scaled up even before they are evaluated for impact on the targeted population. This is partially because the capacity for program evaluation is weak, or missing. (Babu, Gajanan, & Sanyal, 2014, p. 477)

This paper seeks to illuminate the complexity of federal policy making and implementation, in general as it impacts this type of policy at the school district level; hence, the study, will focus on the implementation stage of the policy cycle as a guiding framework for examination into LSWP; with intent to provide insight into three frameworks that could illustrate policy change, creation, and implementation for more robust implementation in schools due to "better" policy making.

The purpose of this study was to examine attitudes and perceptions of stakeholders in Kent County public school districts toward the implementation of the Healthy Hunger-Free Kids Act. This study also examined whether there is a perception that responsibilities for staff and faculty were impacted as a result of the LWSP. This study also sheds light on whether the staff feels like this policy, as implemented is making a difference in the health of students.

The information collected through this county-wide study proves valuable for future nutrition or health policy creation, implementation and evaluation. The results also demonstrate where bottlenecks in policy understanding and implementation lie within this ISD which could lend insight to other district implementation in the state of Michigan or nation-wide.

Future study could attempt to broaden the data collection over multiple districts in the state of Michigan or the United States to make recommendations for policy implementation at the states level or comparisons between districts or counties regarding implementation. The wider aim is to examine and encourage analysis, or to think about the relationship between different perspectives on policy theory and analysis for nutrition, or what is largely now called, food politics. Drawing on policy theories and concepts with this particular topic frames the important issue of health and policy, therefore fleshing out potential solutions to future policy making and implementation.

Framework/Theoretical Perspectives

Theory is critical lens in which to provide context to facts and observations of study, moreover, a sense of relevance, and a place in history in order to determine importance of the research. Application or observance of framework/theory ensures data collected are not overlooked or incorrectly perceived. Therefore, this research will ensure data is collected and analyzed through a strong theoretical approach in public policy analysis.

Taking policy from theory to practice is a complex process particularly when considering all the moving parts associated with the HHFKA. Theoretical approaches used in implementation science have three overarching aims: describing and/or guiding the process of translating research into practice (process models); understanding and/or explaining what influences implementation outcomes (determinant frameworks, classic theories, implementation theories); and evaluating implementation (evaluation frameworks) (Nilsen, 2015). This study examined public policy/administration theories/frameworks regarding policy implementation of a federal mandate.

This study collected, examined and evaluated the literature present in relationship to key public policy/analysis models: Policy Implementation Framework, Multiple Streams Model (MSM), and Advocacy Coalition Framework (ACF); to potentially illuminate the policy formulation/formation and operation; show / make recommendations for policy implementation analysis, policy improvements and criticisms; and lastly, examined gaps in current literature and makes recommendations for future study as a result of analysis of stakeholder perceptions, attitudes, and further evaluation. These frameworks help consider the relationship between public policy formation and implementation.

Poor theoretical underpinning makes it difficult to understand and explain how and why implementation succeeds or fails, thus restraining opportunities to identify factors that predict the likelihood of implementation success and develop better strategies to achieve more successful future implementation (Nilsen, 2015). Examined in this paper are three models/frameworks of implementation theory, their attributes are summarized in Figure 1 and will be further examined

(Appendix G) in Chapter II, the literature review.

Model/ Framework	Attributes/ Relationship to Study/ Implementation
Implementation Process Theory Author(s): Van Meter and Van Horn Year: 1975	Six Variables Link Policy to Performance A) Policy standards and objectives. B) Policy resources. C) Inter-organizational communication and enforcement activities. D) Characteristics of implementing agencies. E) Economic, social, and political conditions. F) Disposition of the implementers.
Multiple-Streams Model Author(s): Kingdon Year: 1984	Impacts all levels of local implementation: Decision making under extreme conditions. Participation is fluid: • Problem stream • Policy window • Policy stream • Policy entrepreneur • Problem stream Considered an evolutionary-type model/ theory but is a flexible model and malleable metaphor. Many problems to solve, polices vie for attention; "messy" problems/ solutions are non-linear. Tough for problems to gain the support they require for success. No ordered stages impacts implementation. Draws on "Garbage Can Model" which is flexible and adaptable.
Advocacy Coalition Framework Author(s): Sabtier and Jenkins-Smith Year: 1988	Encompasses learning which follows implementation Aims to explain complicated policy environments An "ambitious" framework attempting to provide overview of the entire policy process, all steps. Key Terms: Beliefs Advocacy Coalition Policy Learning Subsystems Policy Sovereign Policy Change Enlightenment

Figure 1. Frameworks and models to be used in examination of implementation with expressed relationship to this study

Theoretical Perspective - Policy Implementation Framework

Van Meter and VanHorn used six variables that shaped the relationship between policy and performing in their 1975 model. The variables are: 1) Policy standards/objectives; 2). Policy

resources; 3) Inter-organizational communication and enforcement; 4) Economic, social and political conditions present; 5) the disposition of the policy implementers (1975).

This framework is what would be considered an ideal representation of a policy implementation environment. From this simplified framework it is easy to understand that implementation is a process that can be wrought with failure and misunderstanding, and that the environment of the system engages at all levels of the policy system Sharkansky and Van Meter (1975).

The disconnect between authorship of public policy and implementation of the same policy is tricky. In the literature, this is an elusive topic for a number of reasons. Eaton Baier, March and Saetren (1986) outline in their article *Implementation and Ambiguity* how volatile the relationship is between policy makers and policy implementers:

Studies of implementation have established two conspicuous things: First, policies can make a difference. Bureaucracies often respond to policy changes by changing administrative actions. Second, policy as implemented often seems different from policy as adopted. Organizational actions are not completely predictable from policy directives. Efforts to tighten the connection between policy and administration have, for the most part, emphasized ways of augmenting the competence and reliability of bureaucracies, of making them more faithful executors of policy directives. Alternatively, they look for ways of making policy makers more sophisticated about bureaucratic limitations. Such recommendations, however, assume that policies either are clear or can be made so arbitrarily. By describing discrepancies between adopted policies and implemented policies as problems of implementation, students of policy making obscure the extent to

which ambiguity is important to policy making and encourage misunderstanding of the processes of policy formation and administration. (p. 197)

It is simpler to manage implementation in cases where the government authority promoting a policy is the one to also implement it (Salamon, 2002); however, then implementation often falls to other actors. The more numerous these are, the more complicated implementation can be, because it is necessary to negotiate these actors' involvement and to ensure that they respect their commitment to act in pursuit of the desired objective. In such situations, it is necessary to ask whether those spearheading the public policy can rely on an appropriate system of incentives, training, and sanctions to guide the activities of the other actors involved in implementation (Sabatier & Mazmanian, 1980).

Theoretical Perspective - Model -Multiple Streams Framework/Model (MSM)

In the Multiple Streams Framework/Model (MSM), the policy stream represents the ideas to which Kingdon (2001) referred (i.e., the policy alternatives and possible solutions to a problem). The political stream represents or addresses the overall mood, ideology, or attitudes of policymakers and the public. The problem stream discusses the issues that may require [governmental] action. These streams flow independently until a [policy] window or otherwise referred to as simply, window of opportunity (Kingdon, 1995) presents. Such “windows” open when changes occur in the problem or political streams, perhaps because of new or additional/updated indicators, focusing current events which are watched closely publicly, or distinct changes in political parties or ideology present. Proposals from the policy stream that encompasses feasibility, possible acceptance, and affordability then emerge through the policy

window with the help of a policy entrepreneur. Such a person will invest his or her own resources to advocate a particular policy leading to its adoption (Zahariadis, 2007).

Theoretical Perspective - Model - Advocacy Coalition Framework (ACF)

Questions in policy involving learning, belief, policy change, and the role of scientific and technical information in policymaking “operate in complex, interdependent political environments where hundreds of participants interact in the context of nested institutional arrangements, uneven power relations, and uncertain scientific and technical information about problems and alternatives” (Weible, Sabatier, and McQueen, 2009, p. 121). The results are a complexity that requires a matter of simplification in order to enact any real change or policy implementation. A particular policy framework that was specifically developed to conquer such variables is the Advocacy Coalition Framework (ACF). ACF was developed by Paul Sabatier and Hank Jenkins-Smith in 1988 in a response to what they saw as limitations in policy process literature.

Use of the data in this study examined under the aforementioned lenses allowed for a more thorough look at implementation of nutrition policy when not implemented by the policy maker, as is the case with schools throughout the United States of American with regard to the Healthy, Hunger-Free Kids Act legislation. Alternatively, this data will help shed a light on potential shortcomings researchers Salamon (2002), Bardach (2012), Howlett and Ramesh (2009) have outline in framework scholarship, and allows for potential alterations to either future policy crafting or future policy implementation which may or may not alter the success of the policy.

Research Questions

The following research questions guided this study:

RQ1: What is the level of key school district stakeholder familiarity in regard to local school wellness policy?

RQ2: What is the perception of key school district stakeholders in regard to the failure or success of local school wellness policy implementation?

RQ3: What is the perception of key school district stakeholders with regard to the impact of local school wellness policy?

RQ4: What is the perception of key school district stakeholders with regard to the level of support available to implement and/or sustain the local school wellness policy?

RQ5: What, if any, disconnect exists between policy creation and implementation? If disconnect exists, what characteristics should be considered by future policy makers for implementation at the local level?

RQ6: How do policy implementation models make for a more comprehensive policy as analyzed?

Scope

This study was limited to perceptions of stakeholders (principals, nutrition service staff and directors, school nurses, and teachers) from all K-12 public school districts in Kent County. Over twenty districts were examined with over 125,000 students enrolled, of which 46.8% of students receive free and reduced lunch (Kids Count, 2016), a program of the HHFKA.

The stakeholders identified are important as they are potential and ideal members of local wellness committees as stipulated by the HHFKA. The population included 300 schools within 20 public districts within the boundary of the Kent Intermediate School District.

Methods Overview

A survey (Appendix F) was used to collect data to inform perspectives of the local school district community consisting of teachers, nutrition faculty and staff, food service officials, school nurses, principals and administrators. This sample survey method was used in basic and applied research with the outcome of qualitative and quantitative data analyzed appropriately (Creswell, 2014). ANOVA was run to determine if differences occurred that were significant to report based on responses within the stakeholder groups. Once it was determined that differences existed with the means, post hoc tests and multiple comparison were conducted to determine which differ. The Bonferroni Correction was used to test possible contrasts in full as it is a conservative measure of significance.

Data Collection

A survey was administered containing 25 questions to collect data pertinent to the research questions. The questions were made available through a common online collection method (Survey Monkey). The survey data was then downloaded for accurate collection and analysis statistically using SPSS version 22.

Limitations

This study was not administered to constituent groups of students, school board members, superintendents, assistant superintendents, members of the public, or parents. The focus on this

study was on the nutrition component only; physical activity might be considered for further consideration as well as the study of snacks and food served at extracurricular events including sports and vending machines available to the student population. This study was limited to the comments, beliefs and assumptions of directors of nutrition services, nutrition specialists, school nurses, school teachers, principals, and nutrition supervisors who are employees of the school districts located within the Kent Intermediate School District.

Significance of the Study

Obesity in the United States is serious, common, and costly to the American taxpayer and employers, more than one-third (36.5%) of US adults have obesity. Obesity impacts some groups more than other groups; non-Hispanic blacks have the highest rate of obesity (48%) followed closely by Hispanics (43%). It is highest in middle-aged adults (40-59 years old) (CDC, 2016). The 2008 estimated annual medical cost of obesity in the U.S. was \$147 billion dollars; medical costs associated for people who suffer from obesity are \$1,429.00 higher than those of a normal weight (CDC, 2016). Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer (CDC, 2016).

Michigan has the 10th highest adult obesity rate in the nation, according to *The State of Obesity: Better Policies for a Healthier America* released September 2017 through the Robert Wood Johnson Foundation. “Michigan's adult obesity rate is currently 31.2 %, up from 22.1 % in 2000 and from 13.2 % in 1990. According to the most recent data, adult obesity rates now exceed 35 % in four states, 30 % in 25 states and are above 20 % in all states. Louisiana has the highest adult obesity rate at 36.2 % and Colorado has the lowest at 20.2 %. U.S. adult obesity rates decreased in four states (Minnesota, Montana, New York and Ohio), increased in two

(Kansas and Kentucky) and remained stable in the rest, between 2014 and 2015. This marks the first time in the past decade that any states have experienced decreases — aside from a decline in Washington, D.C. in 2010 (2016, para 1).

In Kent County specifically, the rate is 38.1% for females and 35.7% for males (Institute for Health Metrics and Evaluation, 2016). A report released by the Centers for Disease Control and Prevention (CDC) in August, 2013 showed that 18 states, including Michigan, and one U.S. territory experienced a decline in obesity rates among 2- to 4-year-olds from low-income families between 2008 and 2011. Over that period of time from 2011 to 2015, Michigan's rate of obese 2- to 4- year olds fell from 13.9% to 13.2%, a statistically significant decrease according to the CDC analysis (State of Obesity, 2016).

Obesity prevalence in 2015 according to the self-reporting CDC Behavioral Risk Factor Surveillance System data shows that no state in the U.S. had a prevalence of obesity less than 20%; four states (Alabama, Louisiana, Mississippi, and West Virginia) had an obesity prevalence of 35% or greater; the South had the highest prevalence of obesity (31.2%), followed by the Midwest (30.7%) (CDC, 2016).

While schools by themselves are not able to solve this problem, they do play an important role in dealing with childhood obesity (CDC, 2016) which is worth noting, as the HHFKA places additional responsibility on the school district(s) to promote health and reduce obesity in school-aged children through broad procedures and lack of standards which may result in ineffective local school wellness policies that do not provide a significant reduction in disease or increase in health for young U.S. citizens.

The information collected through this study is valuable for future health policy creation, implementation, and evaluation. The results demonstrate where bottlenecks in policy understanding and implementation lie within this district. Future study could attempt to broaden the data collection over multiple districts in the state of Michigan to make recommendations for policy implementation at the state level. Chapter II, provides a deeper understanding of the literature around policy implementation, health policy history, state of Michigan health policy research, and models of implementation considered for this study. Subsequently, an examination of the methods used for this study can be found in Chapter III, with results of data collected in Chapter IV, and finally, a discussion in Chapter V that communicates findings, limitations of this research, and future study.

CHAPTER II

LITERATURE REVIEW

Since the mid 1940's, laws and policies that mandate the nutritional standards of food service in public schools have varied greatly. These laws range in content and context from establishing the minimum/maximum nutritional values of items sold, to portion control of the items sold, to mandatory content/ingredient listing of items sold. In addition to policies set forth by government, states and therefore their school districts have always been able to create and uphold more strict rules or laws regarding nutritional requirements. Some states maintain the minimum federal standards while others maintain higher standards for student care (CDC, 2012).

Public policy can be a powerful and important tool that can be used to correct citizen malaligned choices with what is in their best interest. Policies that have public health at the heart of their objectives like seatbelt use, water quality, immunization, health insurance mandates, and taxes levied on destructive products like cigarettes and alcohol have been wildly effective in improving overall public health (Elder et al., 2010; White, Koplan & Orenstein, 1985; Callinan, Clarke, Doherty, & Kelleher, 2010; Beck & Shults, 2009). While government has a pivotal role in addressing the obesity epidemic, it is important that citizen rights are respected. Public health then will be protected most effectively by the implementation of well-developed law and policies that do not seek to restrict the limit of consumer freedom (Roberto et al., 2014).

Historically speaking, childhood nutrition policies have been bipartisan in nature and infrequent in the discussion of public health; however, as childhood obesity rates in America have quadrupled over the past three decades with youth obesity totally over double digits in every state (NSCH, 2017) focus in recent years has included school-nutrition based initiatives as a potential deterrent to obesity-related illness and disease. This chapter reviews United State

nutrition policy history through present day studies related to health issues and local school wellness policy as dictated by federal nutrition policy mandates, starting with Figure 2, a historical timeline of nutritional policy in the United States

History of Nutrition Policy in the United States

United States Childhood Nutrition Initiatives Historical Timeline		
Sporadic Food Services	1853	Children's Aid Society of New York
"Penny Lunch Program"	1894	Starr Center Association in Philly
Hot Lunches to High Schools	1908	Boston School Committee
From Charity to School Programming	1909	William Penn High School for Girls
Experimental Elementary and Milk Program	1910	Home Economics Classes
Department of HS Lunches Established (Philly)	1912	Boston School Committee
Commodity Donation Program Agricultural Act (PL 320)	1935-36	
Public Law 129 to amend the Agricultural Act of 1935	1943	
Amendment Agricultural Act (Expanded to Childcare Facilities)	1944	
Richard B. Russell National School Lunch Act (79 P.L. 396, 60 Stat. 230)	1945	
Agricultural Act of 1949	1949	
Amendment to Agricultural Act of 1949 (Help Indian Affairs)	1949	
The Special Milk Program	1954	
Amendment to NSLA (Redistribution of Funds)	1962	
National School Lunch Week Established	1962	
Food & Agriculture Act of 1965 (Commodity Credit Program for Dairy)	1965	
Child Nutrition Act (US Fed Law)	1966	
School Breakfast Pilot Program	1966-1968	
Amendment to NSLA (Dietary Restrictions)	1968	
School Breakfast Program Expanded	1971	
School Breakfast Program Revised	1973	
School Breakfast Program Received Funding	1975	
William F. Goodling Child Nutrition Reauthorization Act of 1998 (P.L. 105-336)	1998	
Child Nutrition and WIC Reauthorization Act of 2004 (Sec. 204 PL108-265)	2004	
Healthy, Hunger-Free Kids Act of 2010 (PL 111-296)	2010	

Figure 2. Historical timeline for United States nutrition initiatives from 1853 to current

Richard B. Russell National School Lunch Act Public Law 79 P.L. 396, 60 Stat. 230

The United States government has recognized the importance of children's health and nutrition. President Harry Truman signed into law the Richard B. Russell National School Lunch act in 1946. In it, it states:

It is hereby declared to be the policy of Congress, as a measure of national security, to safeguard the health and well-being of the Nation's children and to encourage the domestic consumption of nutritious agricultural commodities and other food, by assisting the States, through grants-in-aid and other means, in providing an adequate supply of foods and other facilities for the establishment, maintenance, operation and expansion of nonprofit school lunch programs. (p. 3)

This act essentially created the National School Lunch Program (NSLP), which is a federally-run meal program in most United States public schools. It was put into effect in order to improve the health of underserved children by offering at least one meal, at school for a free or reduced price pending certain rules, regulations, and an application for service delivery. The program was established as a way to prop up food prices by absorbing farm surpluses, while at the same time providing food to school age children (USDA, nd). Historically, this was the first step in creating a country of healthy youth through mandate.

This program did not appear magically but rather evolved from a roughly 100 year history of testing and development which can be traced back to 1853 when the Children's Aid Society of New York opened an industrial school free feeding at noon; 1933's Civil Work Administration and Federal Emergency Relief Administration's takeover of school-meal programming during the Great Depression; and finally this act in 1946 after realization a few years earlier that 18-year olds trying to enlist in the armed forces during World War II suffered from malnourishment and were rejected from enlistment efforts. It was then amended five times

adding pilot breakfast programming and the “Special Milk Program and centralized efforts around 1965-1966 (USDA, 2016).

Child Nutrition Act of 1966 (CNA)

Later, in 1966, the United States Congress passed into law the Child Nutrition Act of 1966 which gave authority to create regulation concerning nutrition to the Secretary of Agriculture. The purpose for which was:

In recognition of the demonstrated relationship between food and good nutrition and the capacity of children to develop and learn, based on the years of cumulative successful experience under the national school lunch program with its significant contributions in the field of applied nutrition research, it is hereby declared to be the policy of Congress that these efforts shall be extended, expanded, and strengthened under the authority of the Secretary of Agriculture as a measure to safeguard the health and well-being of the Nation’s children, and to encourage the domestic consumption of agricultural and other foods, by assisting States, through grants-in-aid and other means, to meet more effectively the nutritional needs of our children. (p. 2)

In addition, the Child Nutrition Act of 1966 established the Special Milk Program for high schools with the intent of children consuming more milk. It also established the School Breakfast Program giving the Secretary of Agriculture access to funds that would make breakfast accessible in public schools to underserved students that met certain financial requirements. These breakfasts ensured that all students had the opportunity to obtain the nutrients their bodies needed to establish healthy weight management and also, for proper brain development which in order to promote learning ability through consumption of healthy foods (USDA, 2010).

Child Nutrition and WIC Reauthorization Act of 2004 (CNRA) (Sec. 204 PL108-265)

The Child Nutrition and WIC Reauthorization Act of 2004 amended the Richard B. Russell National School Lunch Act and the Child Nutrition Act of 1946 to provide school-aged children with better access to food, nutrition, and physical education standards to simplify the program offerings and increase the outcomes of child nutrition programming in the United States. This law requires that local education agencies develop policy that addresses the growing problem of childhood obesity (Dietz, Benken & Hunter, 2009).

Requirements of the policy include: nutritional educational goals, physical activity goals, nutrition standards for all foods available at school, goals for other school-based activities designed to promote student wellness, a plan for measuring implementation of the local wellness policy and involvement of others (students, community members, parent orgs, etc.) (Dietz, Benken & Hunter, 2009). These local policies were intended to be collaborative in nature and written in plain language so as to be unambiguous. This was the first time that the local wellness policy was introduced to educational systems, it would be further elaborated on in subsequent guidelines.

Healthy, Hunger-Free Kids Act of 2010 (HHFKA) Pub. L. No. 111-296, 124 Stat. 3183

Fast forward to the Healthy Hunger-Free Kids Act of 2010, the first nutrition act reform for school-aged children in over three decades. Proposed by the Food and Nutrition Service of the United States Department of Agriculture and signed into federal law by President Barack Obama in December of 2010 (HHKFA, 2010) it amended the 1966 Child Nutrition Act in adopting standards that would take update nutrition standards to current dietary guidelines for America. While President Barack Obama signed the bill into law on December 13, 2010, The Healthy, Hunger-Free Kids Act took effect in 2014. The final rule requires local educational

agencies to revise their local school wellness policies (which were supposed to have been created via the 2004 ruling) and be in full compliance by June 30, 2017.

This law added new provisions for local school wellness policies related to implementation, evaluation, and publicly reporting on progress of local school wellness policies established as part of the 2004 ruling, with implementation in school year of 2006-2007.

Through this act, the Secretary of Agriculture was to consider any reputable scientific recommendation for the improvement of nutrition standards of the foods served in public schools. These changes were intended to improve and increase consumption of an adequate amount of nutritionally dense foods during the school day which aimed to create an environment in which to learn healthy eating habits (USDA, 2010). The changes included:

New nutrition standards

Gives USDA the authority to set new standards for food sold in lunches during the regular day, including vending machines.

- Authorizes additional funds for the new standards for federally-subsidized school lunches.
- Provides resources for schools and communities to utilize local farms and gardens to provide fresh produce.
- Provides resources to increase nutritional quality of food provided by USDA
- Sets minimum standards for school wellness policies
- Limits milk served to nonfat flavored milk or 1 % white milk
- Reduced portion sizes in meals

Increases access

Increased the number of eligible children for school meal programs by 115,000

- Uses census data to determine student need in high-poverty areas, rather than relying on paper applications.
- Authorizes USDA to provide meals in more after-school programs in "high-risk" areas
- Increases access to drinking water in schools

Program monitoring

- Requires school districts to be audited every 3 years to see if they have met nutrition standards
- Requires easier access for students and parents about nutritional facts of meals
- Improves recall procedures for school food
- Provides training for school lunch providers

Regarding evaluation and maintenance of this policy, the policy is specific:

All LEAs must assess their wellness policy at least once every three years on the extent to which schools are in compliance with the district policy, the extent to which the local wellness policy compares to model local school wellness policies, and the progress made in attaining the goals of the local wellness policy. LEAs must make this assessment available to the public. (USDA, 2010, para 16)

See Table 1 for additional compliance changes from the 2004 mandate to the 2010 mandate:

Local School Wellness Policy Comparison Chart between 2004 and 2010 Mandates (USDA, 2010).

**Local School Wellness Policies (LWP):
Comparison Chart of 2004 vs. 2010 Requirements**

	Old Requirements Child Nutrition WIC Reauthorization Act, 2004	New Requirements Healthy, Hunger-Free Kids Act of 2010
Overview	Directs local educational agencies (LEAs) to have in place a LWP for each school under its jurisdiction.	Strengthens LWPs and adds rules for public input, transparency, and implementation.
Elements of the Local School Wellness Policy	LWP to include, at a minimum, goals for nutrition education, physical activity, and other school-based activities to promote student wellness, as well as nutrition guidelines for all foods available on school campus.	In addition to the 2004 requirements, the LWP is also to include goals for <u>nutrition promotion</u> .
Stakeholder Involvement	LEAs are required to involve parents, students, and representatives of the school food authority, the school board, school administrators and the public in the development of LWP.	In addition to the 2004 requirements, LEAs are now required to permit <u>teachers of physical education</u> and <u>school health professionals</u> to participate in the development of LWP.
Stakeholder Participation	The stakeholders named above are required to participate in the development of the LWP.	In addition to the 2004 requirements, LEAs are now required to permit <u>all stakeholders named above and in 2004</u> to participate in the <u>implementation and periodic review and update</u> of LWP.
Local Discretion	LEAs can determine the specific policies appropriate for the schools under their jurisdiction, provided that those policies include all required elements specified in the Act.	Same as 2004 requirement.
Public Notification	None.	LEAs are required to inform and update the public (including parents, students, and others in the community) about the content and implementation of the LWP.
Measuring Implementation	LEAs are required to establish a plan for measuring implementation of the LWP.	LEAs are required to measure periodically and make available to the public an assessment on the implementation of LWP, including the extent to which schools are in compliance with LWP, the extent to which the LWP compares to model LWP, and to describe the progress made in attaining goals of LWP.
Local Designation	LEAs are required to establish a plan for measuring implementation of the LWP, including designation of one or more persons within the LEA or at each school, as appropriate, charged with operational responsibility for ensuring that the school meets the LWP.	LEAs are required to <u>designate one or more LEA officials or school officials</u> , as appropriate, to ensure that each school complies with the LWP.

09/20/2011. Drafted by US Department of Agriculture's Food and Nutrition Service (USDA FNS); US Department of Education (ED); and US Department of Health and Human Services, Centers for Disease Control and Prevention (CDC).

Food Politics in the United States

“Several loosely related approaches in political science had previously noted that, although policy making often proceeds smoothly with marginal, or incremental accommodations, it also is regularly torn by lurches and significant departure from the incremental past (True,

Jones and Baumgartner, 2007, p. 156). This shift — from too little to too much food — has created a dilemma for the USDA and other agencies in federal and local governments. Since its inception, the USDA has had two missions: to promote American agricultural products and to advise the public about how best to use those products (Baumgartner & Jones, 1993). The school lunch program derived precisely from the congruence of the two missions. The government could use up surplus food commodities by passing them along to low-income children. As long as dietary advice was to eat more, the advice caused no conflict.

Once the problems shifted to chronic diseases, however, the congruence ended. Eat less means eating less of fat, saturated fat, cholesterol, sugar, and salt, which in turn means eating less of the principal food sources of those nutrients — meat, dairy, fried foods, soft drinks, and potato chips. USDA was then faced with the problem of continuing to promote use of such foods while asking the public to eat less of them — a dilemma that continues to the present day.

For the federal government to suggest that anyone eat less of any food does not bode well in our commercialized political camp. It is assumed that a mere mention of “less” might hurt sales. Please recall the great broccoli debacle of George HW Bush’s presidency where he declared “I do not like broccoli. I’m President of the United States, and I’m not going to eat anymore broccoli,” (Dowd, 1990, para 3) which sent the United Fresh Produce Association into a tizzy of epic proportions over the possibility of lack of endorsement from the president. This matters, because we vastly overproduce food in this country something that seems only to be known to analysts in the Economic Research Service via the USDA (Philipson, et al., 2004). The average per capita supply of calories available from food produced in the U. S. — plus imports, less exports — is 3,900 per day for every man, woman, and child, more than twice what is needed on average. These are food availability figures and they cover food wasted, fed to pets,

and fats used for frying, but they have gone up by 600 calories since 1970 and are more than sufficient to account for rising rates of obesity among adults and children (Nestle, 2009 and Schwartz, et al., 2015).

Moreover, overproduction makes for a highly competitive food supply. People can only eat so much. So to sell more, as the graphic above (Wilson & Roberts, 2012) shows, companies and lobbyist groups, must get us to eat their foods, not those of a competitor, or to in general eat more, thereby encouraging us to become obese (Nestle, 2009).

School food issues are at the center of issues related to equality in our society. Americans live in a pluralistic society. For democracy to work, the interests of constituencies must be appropriately balanced. School food as a current issue is in a state of conflict regarding the balance between corporate interests and those of advocates for children's health.

School Nutrition Environment, Policy, and Obesity

Obesity has critical consequences on the health and longevity of our nation's health and economy. Its link to dozens of chronic diseases costs taxpayers in the United States over 190 billion dollars annually (Meyerhoefer & Cawley, 2012) with businesses suffering from obesity-related job expenses due to absenteeism estimated at 4.3 billion dollars annually (Cawley, 2012). Public approaches to public health are considered an important factor in reduction of obesity numbers. Schools in particular are identified as a setting key to changing the future of United States obesity health woes as children spend more time in schools than in any other single environment away from home (Story, Nannery & Schwartz, 2009). Stakeholders - whether they represent school personnel, students or parents, health professionals, academia, non-governmental organizations, the private sector, industry, media or marketing interests - may have

important information about an issue, affected by a policy decision or be in a position to affect (Canadian Public Health Association, 2010, p. S20).

More than 95 % of American youth aged five to seventeen are enrolled in school (Story, Nanney & Schwartz, 2009). It stands to reason that the environments by which children are exposed daily can rank high in influence of the health of their diets. The school food environment, programming, and policies are uniquely positioned to facilitate and reinforce healthful eating behaviors (CDC, 2011). A literature review performed in 2010 reinforces this idea emphasising that “school personnel, such as administrators, teachers, coordinators, and food service staff, have unique roles in the context of school-based health promotion initiatives” (Canadian Public Health Association, 2010, p.S21).

More and more attention has been paid worldwide to issues of school nutrition and rising obesity rates in children particularly in the United States where poor dietary behaviors during the school day occur sometimes due to lack of compliance with standards for lunch program nutrition (Nelson et al., 2007) and also, relatively easy access to foods lacking nutritional complexity (French et al., 2003; Neumark-Sztainer et al., 2005). The later of these foods are known as “competitive foods” as they relate to school nutritional policy and local school wellness policy. These foods are those which are high in added sugar, fat, calories, and sodium, frequently over-processed and sold in snack lines, vending machines and at extracurricular activities (Fried and Simon, 2007). There are two main avenues or programs by which schools can take make an active impact influencing the diets of their students the aforementioned “competitive foods” and those foods provided through federally sponsored meal programs like the National School Lunch Program.

Early studies done regarding school-aged children obesity issued tended to focus on familial, genetic or individual interventions required to impact change (Summerbell et al., 2005; Hawkes, 2007; Knai et al., 2006; Peterson & Fox, 2007) with very little done to review the policy or behavior impacting children at the very place where they are the majority of their waking time, the school environment. More recently, policy change in schools are among the most popular in addressing childhood obesity (Gostin, 2007; Swinburn, et. al., 2004).

Changes to school food environments and policy practices that lead to improved dietary and nutrition behavior are a powerful strategy to reverse the childhood obesity epidemic in the United States (Briefel, Crepinsek, Cabili, Wilson & Gleason, 2009). Schools are often promoted by policy making bodies as a logical setting for correctives changes and tackling obesity. A literature review performed by Jaime & Lock (2009) focused on reviewing the effectiveness of school food and nutrition policies in improving school food environments, dietary intake and decrease in obesity in school- aged students concluded that “some school policies have been effective in improving the food environment and dietary intake in schools but there is little evaluation on their impact on BMI” (p. 52). The review also found evidence for nutrition guideline impacts showing “positive changes in decreasing total and saturated fat and increasing fruit and vegetable availability in school food provision and improving students dietary intake” (p. 51).

School-based programs steeped in local wellness policy initiatives in a meta-analysis done by Gonzalez-Suarez, Worley, Grimmer-Somers, and Dones in 2009 showed that “there was convincing evidence that school-based interventions are effective, at least in short-term, in reducing the prevalence of childhood obesity. Longer-running programs were more effective than shorter programs” (p. 426). Results from another study by Coffield et al., (2011) corroborate

that wellness policies can significantly reduce the risk of adolescent obesity. They go on to mention that policy makers “should remain focused on school-based wellness programs, while providing latitude in the specific types of policy components districts enact to ensure that the school environment is tailored to the characteristics of their respective populations” (p. 369) or that a policy that is more a reflection of the observations and needs of an individual school would be more successful than a policy template from the federal government.

Policy makers proposed a single strategy that addresses the growing problem of obesity in children integrating local school wellness efforts, knowledge, skills and attitudes that promote healthier lifestyles chosen by students creating CRNA and HHFKA that seize this opportunity, this comes with significant obstacles however, bill requirements, wellness overhauls, resource reapplication, community engagement, staffing resources, major and minor changes to nutrition programs in schools and physical education requirements and lifestyle change of families and community members (Lefebvre, 2006). To do this, the USDA identified eight key steps to developing and implementing a LWP in any school district in the US. Those points were (Team Nutrition, nd):

- Initial Homework (Audit)
- Identify a Policy Development Team
- Assess the District’s Needs
- Draft a Policy
- Build Awareness and Support
- Adopt the Policy
- Implement the Policy
- Maintain, Measure and Evaluate the Effort

As the impact of local school wellness policy is tied to development and implementation of said policy, Story et al., (2009) point out there are pros and cons to the flexibility of federal law as it applies to local school wellness policies. On one hand, local policy development (as opposed to state or federal) allows for the opportunity for stakeholder involvement thus gaining “buy in” of people like parents, students, community members, teachers, food service, leadership, board members and the like; on the other hand, the lack of rigor and ease of template adoption for minimal standards has led to very weak and ineffective policies (Story, Nanney & Schwartz, 2009).

Development, Implementation and Impact of Nutrition Policies

There are tools available to examine policy strength and comprehensiveness (Falbe, et al., 2011; Schwartz, et al., 2009; Alaimo et al., 2015), effectiveness (Nachtigal, 2016; Alaimo et al., 2015) and even a USDA template which schools could fill in the blanks to create a LSWP that was in compliance with the law there is little literature that discusses reporting, monitoring or “policing” of LSWPs (Metos & Murtaugh, 2011; Samuels, Bullock, Woodward-Lozez, Clark, Kao, Craypo, Barry, & Crawford, 2009; Schwartz, Henderson, Falbe, et al., 2012; Metos & Murtaugh 2011; Harriger, Lu, Kyer, Pruitt, & Goodson, 2014; Harger, Rubio, Eidel, Penniston, Lopes, Saksvig, Fox, & Black, 2016) other than to say it’s “poor;” or perception of stakeholders in the process of implementing a LSWP; however, a growing body of literature of evaluative studies post implementation exists (Gregson, Foerster, Orr, Jones, Benedict, Clarke, Hersey, Lewis & Zotz, 2001; Alaimo et al., 2015; Gaines, Lonis-Shumate, & Gropper, 2011; Taylor, McKenna & Butler, 2010; Hirschman & Chriqui, 2012; Brissette, Wales, & O’Connell, 2013).

And finally, assessments comparing measured strength of LWP versus perceived implementation success find mixed results in implementation perception success (Kubik, Wall,

Shen, et al., 2010; Agron, Berends, Ellis & Gonzalez, 2010; Schwartz, Henderson, Falbe et al., 2012; Wall, Litchfield, Carriquiry, et al., 2012; Snelling, Belson, Watts, Malloy, VanDyke, George & Katz, 2017).

A review done by Phulkerd et al., (2016), “identified 52 relevant studies across different policy areas, levels, and settings, including 49 tools/methods used for assessing the implementation of government policies to create healthy food environments. The quality of these tools/methods varied widely, with only three tools/methods rated as high quality according to the detailed assessment criteria” (p. 11). Findings of this study are instrumental in the quest for informing policy implementation and accountability mechanisms over time for obesity and diet-related issues. While new tools for evaluation are novel, the concept of as Phulkerd et al., (2016) describes as “harmonization” of the use of these high-quality tools and methods which will allow for comparison of implementation across differing settings and over time whereas the environment as it is now with numerous tools of varying specificity and impact, makes it nearly impossible to benchmark and compare across schools, districts or communities at large.

State of Michigan Nutrition Policy Implementation

In October of 2007, as part of a project funded in part with federal funds from the USDA Food and Nutrition Services, the Michigan Department of Education studied the status of local school wellness policy adoption and implement across local education agencies. In their research, “Local Wellness Policy Implementation Grant Data Report,” they found that a total of 1,022 Michigan local educational agencies (LEAs) were participating in the National School Lunch Program as authorized by the Richard B. Russell National School Lunch Act or the Child Nutrition Act of 1946 and therefore, as a result of the 2004 WIC Reauthorization Act and the Health Hunger-Free Kids act of 2010 were required to develop, adopt and implement a local

school wellness policy (LSWP). The results of their assessment included the following (MDE, 2007):

- 85% of LEAs had a LSWP or was in process of creating one
- Only 150 LEAs were without LSWP (8 public school districts, 27 public school academies, 74 private school districts and 41 residential care institutions)
- Public school districts were “more aware” of LSWP, the federal law, and its requirements
- Most private school districts and residential child care institution believed that they were outside of the mandate
- Of those with LSWP, 58% have a method to measure implementation
- Of those with LSWP, 23% indicated they were experiencing 0 barriers related to implementation
- However, when barriers were identified to them, 37% indicated, lack of funding to implement as a problem
- 86% reported that it was too early to know if there were changes associated with implementation

Even more troublesome, a Michigan study found little association between wellness policies and school-reported nutrition practices (Alaimo, Oleksyk, Golzynski, Drzal, Lucarelli, Reznar, Wen, & Yoder, 2015). Fox (2010) suggests that research regarding the rigor of such policies should be examined with a common set of tools as well as addition examination of implementation styles and impact observed for a more comprehensive policy review.

Studies have attempted to determine the degree of implementation of written wellness policy success in the state of Michigan with mixed findings. Lucarelli, et al.,’s (2015) study “examined cross-sectional associations between written policies and matching school-reported

policies and practices and found little concordance between the two” (p. 200). The study concludes that there is clearly room for improvement in the quality of policies and the translation of policies into health-promoting school practices. The Healthy, Hunger-Free Kids Act of 2010 provides an opportunity to address some of these shortcomings. The proposed rule accompanying this Act calls for increased school leadership, public participation, transparency, and evaluation of implementation of wellness policy initiatives. In essence, the wellness policy mandate was intended to stimulate a collaborative method in which a diverse team of stakeholders jointly determined which approaches complement their school’s unique circumstances to promote health. The widespread adoption of template policies in this study indicates that schools are not using this approach. (p. 199-200).

While slightly different in topic, a similar study on implementation of policy in schools, found extreme variations in concordance between fundraising policies and practices in schools, ranging from 15% to 68% (Kubik, Lytle, Farbakhsh, Moe, & Samuelson, 2009). Additionally, several studies have found that wellness policy quality was associated with implementation. In Connecticut, wellness policy strength scores combined with a program that financially rewarded schools for implementing nutrition standards were associated with lower availability of unhealthy foods outside of school meals (Friedman, 2009). Another found that higher wellness policy scores were associated with the healthfulness of foods and beverages in competitive food venues (Hood, Colabianchi, Terry-McElrath, O’Malley, & Johnston, 2013); however, both wellness policy provisions and availability of food and beverage items were self-reported by school personnel in this study not observed in nature (Hood et al., 2013). Yet again, a study found that written wellness policy quality was associated with administrator-reported implementation limitations one year later (Schwartz et al., 2012).

In contrast, one study found little change in physical activity provisions or school nutrition environments after wellness policy adoption (Belansky et al., 2009; Belansky et al., 2010). Another study found that wellness policy strength scores did not predict perceived implementation of nutrition standards in meals or competitive foods (Wall, Litchfield, Carriquiry, McDonnell, & Woodward-Lopez, 2012). With some wellness policies lacking a timeline for implementation or details regarding evaluation, it is not surprising that implementation has lagged (Action for Healthy Kids, 2007; Gaines, Lonis-Shumate, & Gropper, 2011; Moag-Stahlberg et al., 2008).

Why Policy Implementation Fails

As the obesity epidemic continues in the United States public policy task forces and legislation abounds from federal levels to local levels and even at the school level. Attempting to address disease through policy has proved to be challenging with the factors which impede legislation. Masse, Naiman and Naylor (2013) concluded in a qualitative study that mandated policies are in fact “an essential step in improving physical activity and healthy eating; however, policy makers need to :monitor whether schools are able to implement the guidelines, support schools struggling with implementation, and document the impact of the guidelines on students’ behaviors” (p. 11). They suggest the framework Diffusion of Innovations in order to plan for meaningful interventions as changing the school environment is not a process that can be a passive one, it must be deliberate. Their findings support what many other studies have noted and that boundaries to implementation are varied and complicated.

In states like California, schools are making “significant progress toward the implementation of state nutrition standards” (Samuels, et al., 2009, p. S43) but find that the complex interpretation required in order to meet the current standards is a large barrier to the

implementation of nutrient-based food standards. Samuels, et al., concluded from their California study that “additional support is needed from federal, state, and local jurisdictions to provide schools with the resources to implement and monitor new food and beverage policies” (p. S44).

Following the initial mandate and policy implementation, “over time, the intent of the original policy runs the risk of being watered down if not analyzed in its original and complete context” (Harriger, et al., 2014, p. 283) this leaves ill-defined constructs which could mean different things to different people as they are exposed to the mandate as implemented by various stakeholders.

A 2011 comprehensive review of literature performed by Metos and Murtaugh examined the gap between policy makers and the educational community to determine if policy language created by bureaucrats translates to school practices and subsequently improvement in student eating habits, activity, and body mass index (BMI) of children and adolescents. Their summary concluded that while almost all articles demonstrated policy compliance with policy development and initial implementation, there was a tendency for school districts to shower more attention on the cafeteria environment itself and less on the provisions in the WIC Reauthorization of 2004 and HHFKA 2010 for physical activity or health education. There is a very strong translation issue however, and that is creation of policy in some studies they examined was used interchangeably with implementation. So this barrier is significant to reviewing literature of all types.

Secondly, a barrier to literature in existence is the lack of any real or measured penalties for non-compliance. No accountability in an unfunded mandate does not exactly improve required actions in states or districts with few resources. A Pennsylvania study (2008 & 2010) suggests the naming of a school district representative who has had adequate time and training

should be made available to manage implementation and evaluation of the LSP. As this is often above and beyond current duties of staff or faculty, it is difficult to require or compel staff into compliance (Probart, McDonnell, Weirich, & Schilling, 2008; Probart, et al., 2010).

A corroborating study done in 2016 by Hager, Rubio, Eidel et al, further suggests the formation of a school-level school health council (SHC) and to establish a formal position that is compensated fairly for SHC chairperson who they deemed acts as the “wellness champion” within the school. The chairperson would then be responsible for the wellness committee’s goals, action plan, and reporting. This would then also track compliance within the law through implementation reporting guidelines.

Similarly, finding a combination of qualified staff and invested community members to achieve sustaining measures for wellness policies was examined in a 2008 study which concluded there is “considerable need for supporting schools in their implementation and evaluation of LWP” (Moag-Stahlberg, Howley, Luscri, 2008, p. 567) and that “schools will need outside assistance to meet each of the mandates provided by the federal mandate” (p. 567). As part of the monitoring process called “administrative review” where analysts will review the LSWP and associated documents, there are many areas wherein the school could face “corrective action” yet, none of these warrant incentivizing measures or restrictions and equal a “slap on the wrist” when it comes to monitoring implementation. The monitoring process is specific, yet lacks enforcement (Appendix H).

The Paradox of Policy Analysis and Policy Making

“We invest tremendous resources in policy analysis, yet common wisdom, political science theory, and years of empirical research suggest that analysis is not used by policymakers to make better policy” (Shulock 1999, p. 226). Equally disappointing is that legislators use

insider (read: lobbyists) information instead of outside expertise and have little use for information “that relates to their probable outcomes in society. Legislators are rewarded for their positions, not for the policy outcomes that result from their positions” (Shulock, 1999, p. 227 discussing Ferejohn, 1986; Mayhew, 1974; Shepsle, 1986; Shepsle & Weingast, 1987). Whiteman (1995) as mentioned in Shulock (1999) also found that “the more salient an issue is to constituents, the less analytical information is used” (p. 227).

Meltsner (1976) articulated in his classic work *Policy Analysts in the Bureaucracy* that while the practice and use of policy analysis has expanded it has “been influenced by a set of recurring problems, problems of the policy process that involve both analysts and their clients. These problems are identified as “sins.” Sinful policy analysis is channeled, distant, late, superficial, topical, capricious, and apolitical” (Epilogue, ii). While analysts and policy makers are part of our everyday political system, there is much suspicion about government, advising, policy making, and process. Sometimes to the point of stymying progress in relatively straightforward matters like health for example. Policy making is increasingly partisan in nature and used as a weapon in the current climate of American democracy. Under a climate of suspicion, policy analysts and policymakers separate themselves from the broader context in which they are working and fail to recognize that they are essentially advisors between practice and application (Meltsner, 1976). As a result, there are tons of errors in making policy decisions and negative conditions are either created or maintained.

One of Meltsner’s “sins,” “too far away” sets the stage for the application of the theoretical models and frameworks forthcoming. The principle of “too far away” is that distant advice is based on ignorance or not grounded in reality (Meltsner, 1986); meaning that the analyst is far away from the audience and immediate reality of the situation at hand, so that the

solutions that are created are not tangible or specific enough to provide a meaningful or powerful to the problem. That the advice “cooked up in Washington does not square with the reality” (p. 375) of in our case Kent County, Michigan. This is not just a sin of geography or even proxemics but rather of absence from the day-to-day inner workings of the policy situation or field. This “sin” is one of the original issues with policy making, the difference between policy as written and perception of policy implementation is of great value to this study.

Stewart et al., 2014 concludes in a study of food policy collaboration measures that “nutrition policy has been largely unsuccessful [in influencing consumer behavior] in part because recommendations focus on isolated nutrients and specific food-health relationship, but largely ignore the social/cultural aspects of eating, regulatory environment and prescribed food standards that guide food selection and availability” (p. S72). He recommends a more “synergistic approach” to nutrition policy with greater collaboration and the development of common goals (Stewart et al., 2014).

Cairney (2015) suggests that academics or policy analysts enjoy the distance to “develop a breadth of knowledge and produce generalisable conclusions across government [areas]” (p. 1) with the major barrier to implementation as prescribed being the level of understanding between the academic and practitioner divorcing policy analyst and maker from the “real world” (2013). While it is difficult to demonstrate a causal link this does not stop researchers from trying (Cairney, 2015). “Studies of implementation are based on the simple point that decisions made by policy makers may not be carried out successfully” (p. 5) instead we are able to demonstrate an “implementation gap” which represents the intent or expectations of the policymaker and the actual policy outcome (Hill & Hupe, 2014; deLeon, 1999; deLeon & deLeon 2002; Hogwood & Gunn, 1984; Cairney, 2015). Shulock (1999) concludes that “even with these limitations [of the

process], policy analysis can have a major impact on policy. Ideas, aided by institutions and embraced by citizens, can reshape the policy landscape. Policy analysis can supply ideas” (p. 241).

Theoretical Models/Frameworks

Policy Implementation Framework

Van Meter and VanHorn (Figure 3) used six variables that shaped the relationship between policy and performing in their 1975 model. The variables are: 1) Policy standards/objectives; 2). Policy resources; 3) Inter-organizational communication and enforcement; 4) Economic, social and political conditions present; 5) the disposition of the policy implementers (1975).

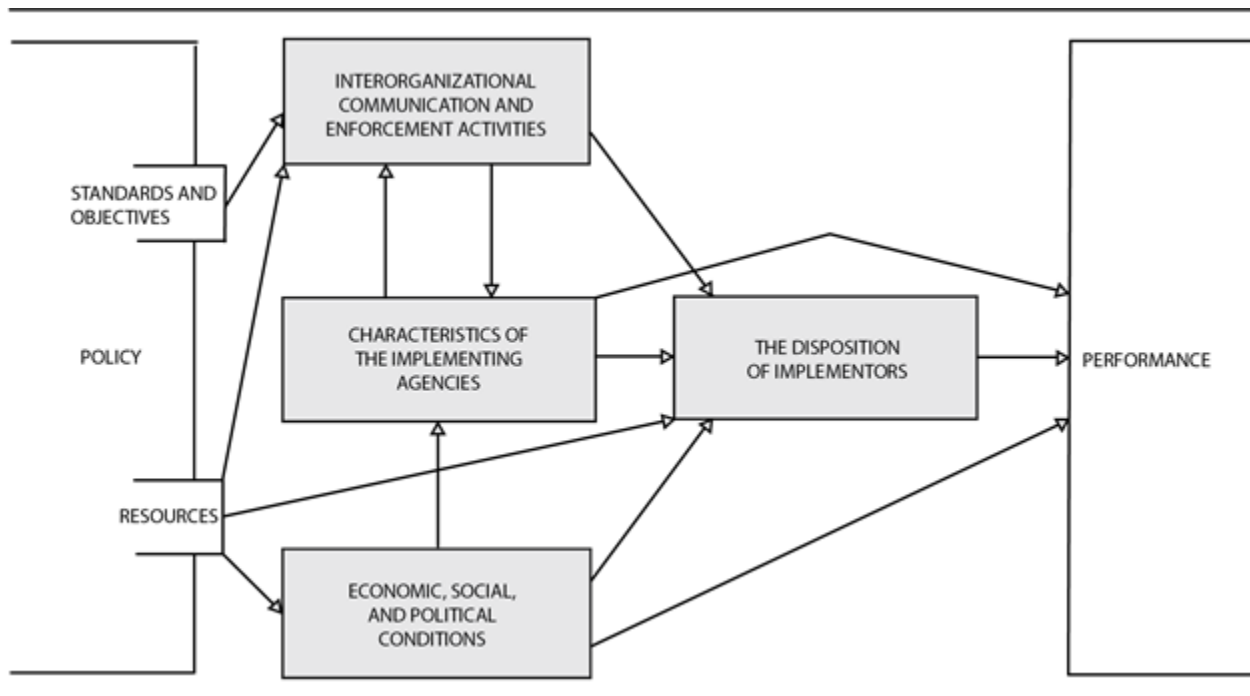


Figure 3. The policy implementation system/framework adapted from Sharkansky and Van Meter (1975).

This framework is what would be considered an ideal representation of a policy implementation environment. From this simplified framework it is easy to see that implementation is a process that can be wrought with failure and misunderstanding and that the environment (Figure 4) of the system engages at all levels of the policy system Sharkansky and Van Meter (1975).

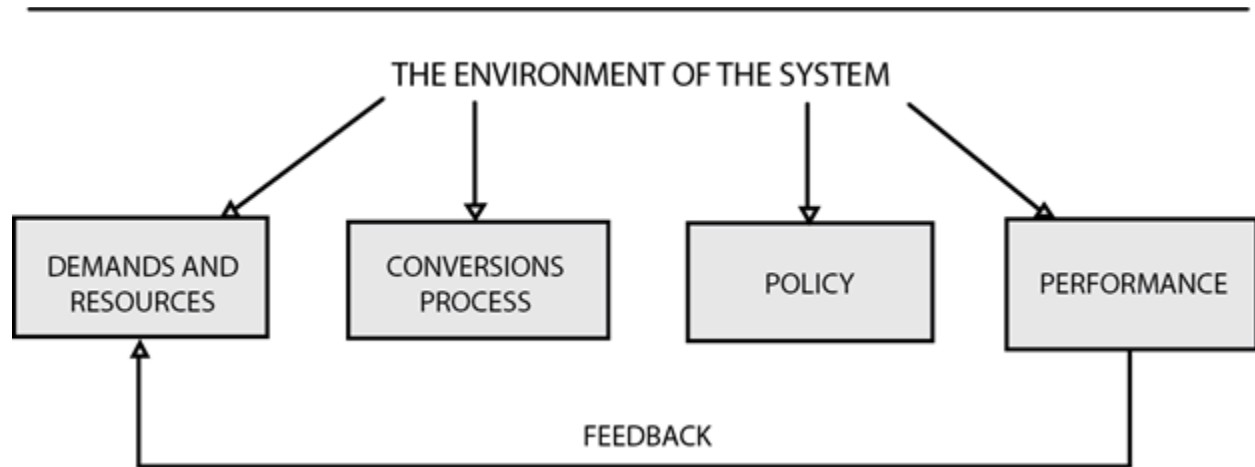


Figure 4. The policy delivery system environment adapted from Sharkansky and Van Meter (1975).

The disconnect between authorship of public policy and implementation of the same policy is tricky. In the literature, this is an elusive topic for a number of reasons. Baier, March and Saetren (1986) outline in their article *Implementation and Ambiguity* how volatile the relationship is between policy makers and policy implementers:

Studies of implementation have established two conspicuous things: First, policies can make a difference. Bureaucracies often respond to policy changes by changing administrative actions. Second, policy as implemented often seems different from policy as adopted. Organizational actions are not completely predictable from policy directives. Efforts to tighten the connection between policy and administration have, for the most part, emphasized ways of augmenting the competence and reliability of bureaucracies, of making them more faithful

executors of policy directives. Alternatively, they look for ways of making policy makers more sophisticated about bureaucratic limitations. Such recommendations, however, assume that policies either are clear or can be made so arbitrarily. By describing discrepancies between adopted policies and implemented policies as problems of implementation, students of policy making obscure the extent to which ambiguity is important to policy making and encourage misunderstanding of the processes of policy formation and administration. (p. 197)

A 1977 work by Greenburg, Miller, Mohr, and Vladeck states that research involving policy making, implementation and innovation involve: 1) a series of decisions that occur over a period of time without beginning or end points, 2) outcomes whose implications are far too complex for single factor theories, 3) a large number of participants, 4) situations that are “special.” Therefore, implementation is a tough subject to take under study consideration. In order to prepare for policy outcomes “the most important evaluative criterion is whether or not the projected outcome will solve the policy problem to an acceptable degree” (Bardach, 2012, p 32). As a result, theory of policy cycle introduced by Howlett and Ramesh (2009) can aid in the timeline from creation to evaluation of policy by studying the stages of: agenda setting, policy formation, decision-making, policy implementation, policy evaluation.

At the center of the Assessment’s adaptation process cycle in Figure 5, according to Bierbaum et al., (2014), is stakeholder engagement. They state:

Participatory approaches support the integration of stakeholder perspectives and context-specific information into decision-making. This approach can include having community members and governing institutions work collectively to define the problem and design adaptation strategies that are robust while being sensitive to stakeholder values. (p. 28)

Adaptation Process

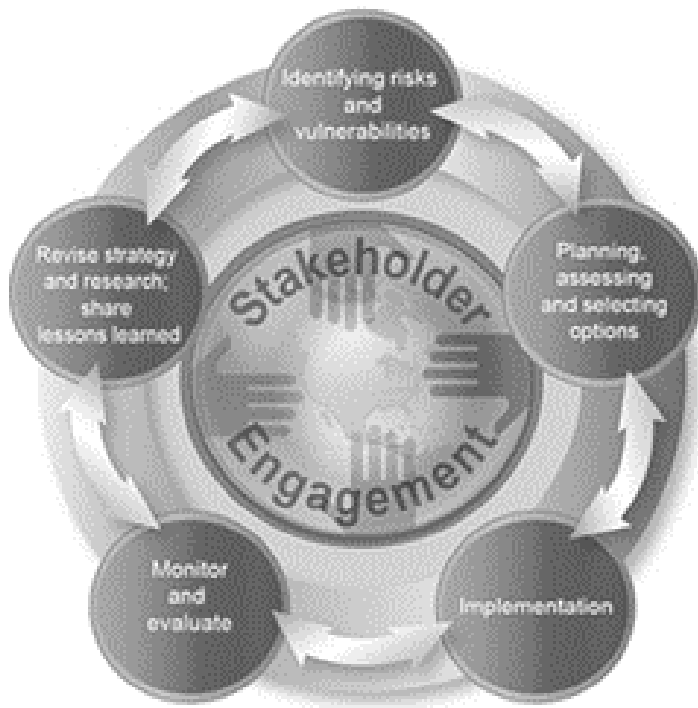


Figure 5. The policy cycle with stakeholder engagement added (Bierbaum, et al., 2014).

It is simpler to manage implementation in cases where the government authority promoting a policy is the one to also implement it (Salamon, 2002). However, implementation often falls to other actors. The more numerous these are, the more complicated implementation can be, because it is necessary to negotiate these actors' involvement and to ensure that they respect their commitment to act in pursuit of the desired objective. In such situations, it is necessary to ask whether those spearheading the public policy can rely on an appropriate system of incentives, training, and sanctions to guide the activities of the other actors involved in implementation (Sabatier & Mazmanian, 1980). Use of the data in this study examined under this lens will allow for a more thorough look at implementation of nutrition policy when not implemented by the policy maker as is the case with schools throughout the United States of American in regard to the Healthy, Hunger-Free Kids Act legislation. Alternatively, this data will

help shed a light on potential shortcomings researchers Salamon (2002), Bardach (2012), Howlett, Ramesh and Perl (2009) have outline in framework scholarship and allow for potential alterations to either future policy crafting or future policy implementation which may or may not alter the success of the policy.

Multiple Streams Model/Framework

The rate among overweight children in the United States has more than quadrupled in the last three decades. Survey data from the National Health and Nutrition Examination Survey (2003 through 2006) estimated that 32% of children and adolescents had a body mass index (BMI) for age at or above the 85th percentile (Ogden, et al., 2008). Overweight status as a child is more than likely to continue into adulthood and increases the likelihood for a multitude of diseases in childhood and adulthood (Whitaker, et al., 1997; Edgeland, et al., 2004). Adolescents with very high BMI have also been shown to have adult mortality rates up to 40% higher than those observed in adolescents with medium BMI (Edgeland, et al., 2004).

Hence, from the president down, obesity interventions and prevention have, consequently, become a major priority for policymakers, health care professionals, economists, and the general public. Prior to 2003, several states and the federal government had enacted limited legislation aimed at reducing and preventing childhood obesity (Graaf, et al., 2012); however it was put on the national agenda for reform when President Obama appointed the Task Force on Childhood Obesity really that efforts were ramped across the scale from household to White House. For the first time in over 30 years, reforms would be made to federal core child nutrition programs. With this large of a lens, including various levels of government and as this issue seems to be broad enough, the Multiple Streams Framework could be applied in a

discussion of how policies are made by governments under strains of capacity and ambiguity (Zahariadis, 2003).

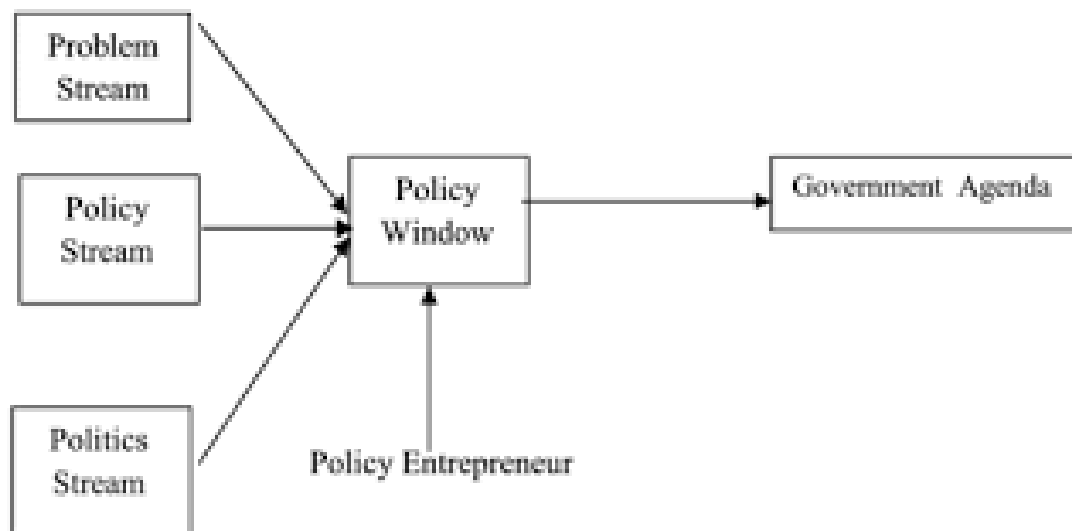


Figure 6. 1995 Multiple streams framework/model

Policy Stream

Several events have drawn attention to overweight and obesity as public health problems. In 1998, the National Heart, Lung, and Blood Institute in cooperation with the National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health released the Clinical Guidelines on the Identification, Evaluation, and Treatment of Obesity in Adults: Evidence Report. This report was the result of a thorough scientific review of the evidence related to the risks and treatment of overweight and obesity, and it provided evidence-based treatment guidelines for health care providers. In early 2000, the release of Healthy People 2010 identified overweight and obesity as major public health problems and set national objectives for reduction in their prevalence.

The National Nutrition Summit in May 2000 illuminated the impact of dietary and physical activity habits on achieving a healthy body weight and began a national dialogue on

strategies for the prevention of overweight and obesity. Finally, a Surgeon General's Listening Session, held in late 2000, and a related public comment period, generated many useful ideas for prevention and treatment strategies and helped forge and reinforce an important coalition of stakeholders. Participants in these events considered many prevention and treatment strategies, including such national priorities as ensuring daily physical education in schools, increasing research on the behavioral and environmental causes of obesity, and promoting breastfeeding. Finally in 2001, David Satcher, M.D., Ph.D., Surgeon General of the United States, issued a plea to action. The report, entitled "The Surgeon General's Call to Action to Prevent and Decrease Overweight and Obesity," outlined strategies that communities can use in helping to address the problems (Thompson, 2001). Those options included requiring physical education at all school grades, providing more healthy food options on school campuses, and providing safe and accessible recreational facilities for residents of all ages.

"Overweight and obesity are among the most pressing new health challenges we face today," HHS Secretary Tommy G. Thompson (2001) said. "Our modern environment has allowed these conditions to increase at alarming rates and become a growing health problem for our nation. By confronting these conditions, we have tremendous opportunities to prevent the unnecessary disease and disability they portend for our future." "Overweight and obesity may soon cause as much preventable disease and death as cigarette smoking," People tend to think of overweight and obesity as strictly a personal matter, but there is much that communities can and should do to address these problems (Thompson, 2001).

Approximately 300,000 U.S. deaths a year currently are associated with obesity and overweight (compared to more than 400,000 deaths a year associated with cigarette smoking). Over the course of ten years, the political climate aligned finally with direct correlations to an

economic toll on American businesses for attention due to the direct and indirect costs attributed to overweight and obesity which amounted to \$117 billion in the year 2000; the environment was ripe for change (CDC, 2012).

Political Stream

Childhood obesity and nutrition has been on the radar for many years. The political battles over what children eat and drink are crucial to the nation's health. Tripling the rate in childhood obesity in the last three decades pretty much insures that diabetes, heart disease and other illness in decades to come. America is one of the fattest nations on Earth, and the Institute of Medicine (IOM), the health group of the National Academy of Sciences, in a 2006 report requested by Congress, said junk food marketing contributes to an epidemic of childhood obesity that continues to rise.

This report builds on the IOM's 2005 report, *Preventing Childhood Obesity: Health in the Balance* (Koplan, 2005), which was a congressionally mandated study that provided a guide outlining deliberate actions for many stakeholders—including government, industry, media, communities, schools, and families—in an attempt to rally said groups and respond to the growing obesity epidemic in children and youth.

The follow up reports to be released by the IOM would contain entirely more urgent language in 2010 and 2012 the titles to these volumes respectively were: *Accelerating Progress in Obesity Prevention* and *Speeding Progress against Obesity Crisis*. Reports issued on this topic by the IOM could be sourced back to 1997 as researchers began formal notification of pending health woes as a result of nutrition, weight, and disease in youth and adults. This news was punctuated and brought from the researchers to the streets with numerous documentaries in the last 20 years; however, it hit a critical mass in 2011-2012 via mainstream media ironically with

HBO's Emmy-winning production and free live streaming events on YouTube via a project called *Weight of the Nation: America's Obesity Crisis* a collaborative between IOM, Centers for Disease Control (CDC), National Institutes of Health (NIH), a private insurance company (Kaiser Permanente) and a private foundation (Michael & Susan Dell Foundation). "It will take many individuals and organizations at all levels, public and private, to tackle the obesity crisis, one of the most serious threats to our nation's health," said IOM President Harvey V. Fineberg (Koplan, 2005). This collaborative alone essentially leapfrogs over government control by enlisting private-public-government partnership to inform and educate stakeholders on the now termed "obesity epidemic."

Problem Stream

In 1990, among states participating in the Behavioral Risk Factor Surveillance System, ten states had a prevalence of obesity less than 10% and no state had prevalence equal to or greater than 15%. By 2000, no state had a prevalence of obesity less than 10%, 23 states had prevalence between 20–24%, and no state had prevalence equal to or greater than 25%. In 2010, no state had a prevalence of obesity less than 20%. Thirty-six states had a prevalence equal to or greater than 25%; 12 of these states (Alabama, Arkansas, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Oklahoma, South Carolina, Tennessee, Texas, and West Virginia) had a prevalence equal to or greater than 30% (Center for Disease Control, 2006, 2008, and 2010; Mokdad, A. et al., 1999, 2001, and 2003).

Policy Window and Policy Entrepreneur

As a result of these changes in the political and problem streams, a temporary policy window opened, providing the opportunity for comprehensive policy changes to combat childhood obesity. As the "Let's Move!" Campaign and Healthy, Hunger-Free Kids Act were the

last pieces of the window of opportunity opening in regard to obesity as an identified national topic of interest, a direct result of First Lady Michelle Obama's political action platform, we will for purposes of this paper consider her as the policy entrepreneur as she has more perceived power in this scenario as a result of her status. Secondary and tertiary entrepreneurs are present, multiple and overlapping surrounding this topic ranging from public, to elected officials, policymakers, private and public citizens as well as lobbyists. Kingdon (1995) asserted that although generation of policy alternatives may be incremental, as was the case for the Healthy, Hunger-Free Kids Act, agenda change is nonincremental and occurs when a combination of the three streams opens a policy window as illustrated above.

The Multiple Streams Framework incorporates the important and frequently frustrating role of luck, or chance, in the process (Zahariadis, 2007). Policy windows are short, include random players, and are almost always unpredictable in nature. Recognition of professionals in understanding the policy environment, previous research, actors, and prior policy is critical in engaging with the appropriate moment of time when the three streams converge and the opportunity window opens in order to act swiftly (Zahariadis, 2007). Kingdon's Multiple Streams Framework continues to be a useful model for understanding many cases of health/wellness policy reform, particularly comprehensive change such as Healthy, Hunger-Free Kids Act of 2010 to be examined as it really represents a model for a concept whose time has come as primarily this model focuses on the crisis itself, not on the rest of the policy cycle.

Advocacy Coalition Framework (ACF)

The first limitation was their interpretation of the stages heuristic as an inadequate causal theory of the policy process (Sabatier and Jenkins-Smith, 1993). The second was in response to top-down and bottom-up approaches to implementation research and need for system-based

theories in policymaking (Sabatier, 1987). The last was the lack of theory and research on the role of scientific and technical information in the policy process (Jenkins-Smith, 1990; Sabatier, 1988). ACF was created as a system-based model that allows for both top-down and bottom-up approaches to studies but puts technical info, science in key place in its goals (Sabatier, 2007a).

Sabatier's (1988) original version of ACF focused on two paths to change (Figure 7). The first path is external subsystem events defined as policy core attribute shifts. The second path: policy-oriented learning defined as intended paths that result from experience or new information that are relevant to policy objectives (Sabatier and Jenkins-Smith, 1999). In 2007, two additional paths were added in a revision by Sabatier and Weible to include the third path of internal subsystem events occurring to highlight failures in current practices and the final path considering alternative dispute resolution or agreements involving two or more coalitions.

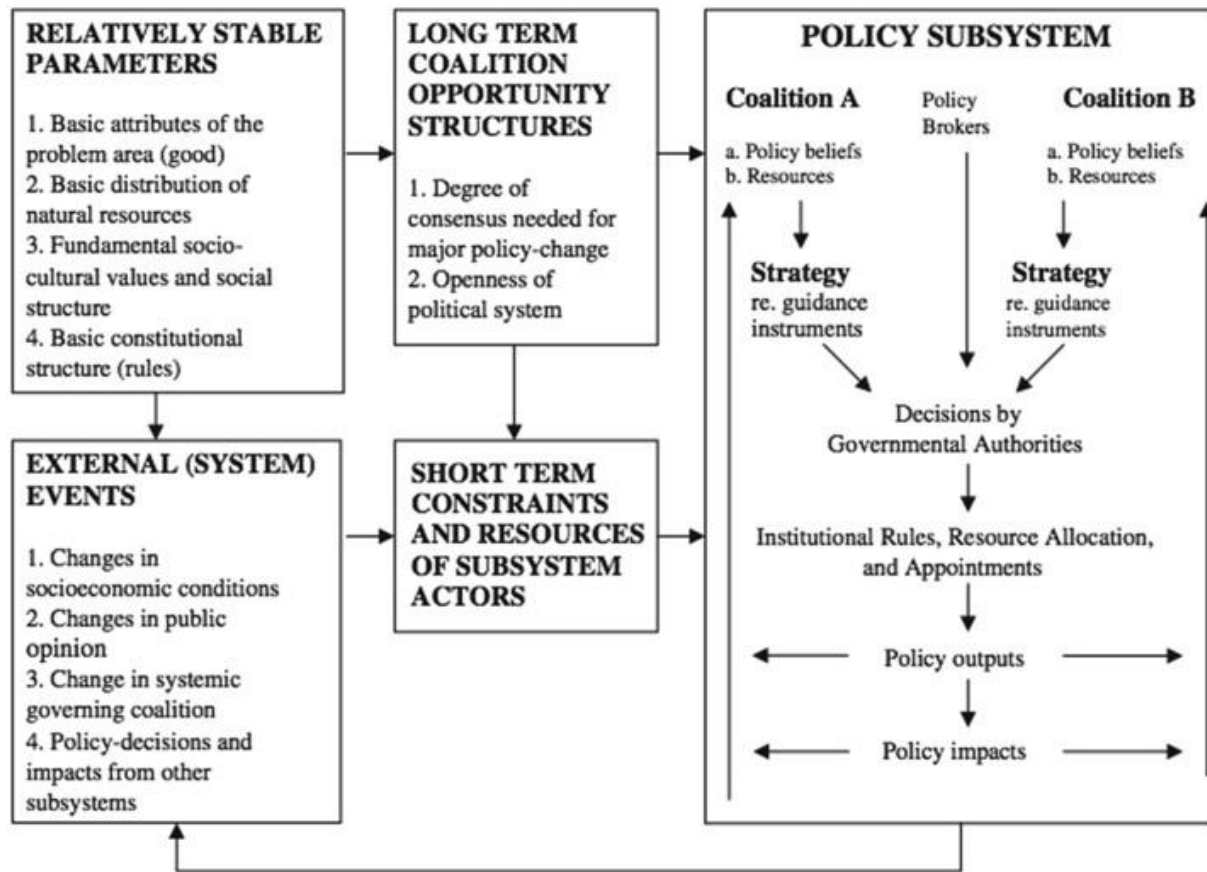


Figure 7. Sabatier 1998 advocacy coalition framework

Within the ACF framework policy formation and change is a function of competing advocacy coalitions within a policy subsystem. A policy subsystem consists of “actors from public and private organizations who are actively concerned with a policy problem” (Sabatier, 1988, p. 131). The actors within a policy subsystem are grouped into a number of advocacy coalitions that consist of individuals who share a particular belief system for example, a set of basic values, causal assumptions, and problem perceptions and who show a coordinated and deliberate degree of activity over time (Sabatier, 1988). Advocacy coalitions attempt to realize a set of shared policy beliefs 'by influencing the behavior of multiple government situations over

time' (Sabatier and Jenkins-Smith, 1993a, p. 212) it considers a set of corresponding beliefs to be the most significant factor bringing and holding coalitions together.

While the overarching model of ACF considers policy change as the result of the learning process among and across coalitions, it stops there. ACF focuses exclusively on the structure of the advocacy coalitions without accounting for how actors within certain policy belief systems develop, maintain, or make lasting action within the coalitions. Advocacy Coalition Framework has been known to be used to map structures of learning and knowledge while evolving or being accompanied by other models, theories, or frameworks to describe policymaking as a holistic process. The ACF predicts that stakeholder beliefs and behavior are embedded within informal networks and that policymaking is structured, in part, by the networks among important policy participants. Likewise the framework assumes that policy participants strive to translate components of their belief systems into actual policy before their opponents can do the same.

In order to have any prospect of success, they must seek allies, share resources, and develop complementary strategies (Sabatier, 2007b). Although some applications of the ACF merely identify the competing sides of a political debate, the purpose of the ACF is much broader: to explain belief change and policy change over long periods. Sabatier and Weible (2007) reinforce the four paths to major policy change within the ACF:

(1) policy-oriented learning: “relatively enduring alterations of thought or behavioral intentions that result from experience and/or new information and that are concerned with the attainment or revision of policy objectives” (Sabatier and Jenkins-Smith, 1999, p. 123). Sabatier believes that changes in deep and policy core beliefs are resistant to new information but over

time, change can evolve with appropriate resources, information, and time (Sabatier and Jenkins-Smith, 1993b).

(2) external shocks: significant perturbations include changes in socioeconomic conditions, regime change, outputs from other subsystems, or disaster (Sabatier, 2007). These shifts agendas, focus, attract or detract attention which can flip the majority and minority actors or coalitions within the policy system affecting change.

(3) internal shocks: Sabatier and Weible (2007) describe these as changes within the policy subsystem and can lead to major policy change. Internal shocks confirm policy core beliefs in the minority advocacy and increase doubt within the dominant coalition. These shocks directly question policy core belief of the dominant policy coalition.

(4) negotiated agreements: In collaboration with the literature on alternative dispute resolution (ADR) (Carpenter and Kennedy, 1988) involving perceptual filters and distrust in creating conflict that reverberates through a policy system, agreements are negotiated fairly using certain “prescriptions” (Sabatier and Weible, 2007) to arrive at a solution for policy control or change.

Literature Review Summary and How this Study Expands the Literature

The information collected through this literature review begins with historical precedent for food and nutrition policy in the United States of America from a nation of children not consuming enough calories interfering with physical and brain development to fighting disease in placing limits on foods while increasing physical activity to curb diseases like diabetes and obesity in school-aged children. It shows that while health conditions central to nutritional impact have been for the most part gone without government policing for about thirty years prior

to the HHFKA of 2010, that the impact of a health policy to aid in constituent health is 1) not simple to write and 2) does not ensure favorable outcomes.

In examining food policy at the federal level and then moving down to the state level, the impact of policy implementation can be better studied. This countywide study proves valuable for future nutrition or health policy creation, implementation and evaluation as expands the literature to include a local or district level look at implementation of federal nutrition policy through the eyes of those trusted with implementation of the federal policy, district stakeholders.

The literature review goes on to talk about two common conundrums related to the policy process 1) why policy implementation fails, and 2) the paradox present between policy maker and policy implementer; this better shapes the discussion and study results. Finally, the literature review tackled the theoretical nature of the implementation process and introduced three popular implementation models for examining the results of this stakeholder study.

In total, this literature review shows that policy implementation stakeholders have a wider aim to examine and encourage analysis, or to think about the relationship between different perspectives on policy theory and analysis for nutrition, or what is largely now called, food politics. Drawing on policy theories and concepts with this particular topic frames the important issue of health and policy, therefore fleshing out potential solutions to future policy making and implementation.

The literature review in Chapter II, upcoming results in Chapter IV and discussion in Chapter V of this manuscript act to demonstrate where bottlenecks in policy understanding and implementation lie within this regional educational organization which could lend insight to other district implementation in the state of Michigan or nationwide.

CHAPTER III

METHODS

The literature review presented in Chapter II, offers extensive background from federal nutrition policy history to implementation challenges that organizations face with regard to federal mandates. It is clear that research exists at the federal and state levels, but is lacking at the local or district level. This study addresses the gap in the literature by recognizing a need for local or district level implementation assessment data. Ultimately, this research seeks to identify bottlenecks in the implementation process so as to create “better” policy initiatives moving forward; but to do so, first the challenges must be identified through stakeholder research. Therefore, this study was designed to record stakeholder perspectives of implementation of federal food policy at the local level in the Kent Intermediate School District.

A research plan demonstrates how one will study a research question. It indicates what will be tested, what analysis units will be applied, how observations will be handled, what information will be collected, and how the data will be examined (Johnson, Reynolds, & Mycoff, 2016). The design of this study was of cross-sectional design employing a survey to a large number of people in an effort to establish or search for some type of relationship. The focus of this study was to review and evaluate the stakeholder perspectives of implementation of local school wellness policies in the Kent Intermediate School District. The researcher did this via a survey instrument. Then, these results were collected, analyzed, and applied.

The relationships of these results were examined through the lens of three key public policy analysis models: Policy Implementation Framework, Multiple Streams Model (MSM), and Advocacy Coalition Framework (ACF); to shed light on how the model explains policy

formulation and operation; show / make recommendations for policy analysis “best fit”; and lastly, to show gaps in current literature and make recommendations for future study.

Problem Statement

Drafting and implementing Local School Wellness Policy (LSWP), a requirement of the Healthy, Hunger-Free Kids Act of 2010 (HHFKA), is a complicated process, involving many people, and may or may not be implemented as the law intends.

Purpose of the Study

The purpose of this study was to examine attitudes and perceptions of stakeholders in Kent County school districts toward the implementation of federally mandated policy. This study also examined whether there is a perception that responsibilities for staff and faculty were impacted as a result of the LWSP. The information collected helps shed light on evaluation measures and efficacy of LWSP on the district school children.

Research Approach/Design

In order to measure attitudes, Likert-type scale was used to evaluate cognitive and affective components of attitudes in relationship to the HHFKA. Likert-type or frequency scales use fixed choice response formats and are designed to measure attitudes or opinions (Bowling, 1997). These ordinal scales measure levels of agreement/disagreement. A copy of the survey is located in the Appendix E for review. Below, please find an inventory of research questions, survey questions, and intent of data collection for each research question.

Responses intended on gaining knowledge regarding R1: What is the level of key school district stakeholder familiarity in regard to local school wellness policy?

- I am familiar with the Healthy Hunger-Free Kids Act of 2010.
- I am familiar with Local School Wellness Policy requirements as a result of the Child Nutrition & WIC Reauthorization Act of 2004.
- I am familiar with the wellness policy of my school district (Local School Wellness Policy or LSWP)
- Participation in Local School Wellness Policy activities is a requirement under federal law.

Responses intended on gaining knowledge regarding R2: What is the perception of key school district stakeholders in regard to the failure or success of local school wellness policy implementation?

- The Local School Wellness Policy is fully implemented in my school district.
- Enforcing the Local School Wellness Policy should be a priority.
- Based on my knowledge, the Local School Wellness Team assessed the needs of the students prior to developing the wellness policy.
- The Local School Wellness Policy has had no impact on stakeholders responsibilities (stakeholders: principals/assistant principals, teachers, nutrition specialist/dietitian, director of child nutrition)
- Based on my knowledge of the Local School Wellness Policy, I believe it is being appropriately applied in my school district.
- I have been thoroughly trained to properly implement the Local School Wellness Policy.

Responses intended on gaining knowledge regarding R3: What is the perception of key school district stakeholders with regard to the impact of local school wellness policy?

- There should be a designated person to monitor the Local School Wellness Policy.

- The Local School Wellness Policy will make a positive impact on the students and the US obesity epidemic.
- Local School Wellness Policy can be sustained in schools with interaction from all stakeholders.
- The school district should involve students in developing the Local School Wellness Policy.
- The requirement to implement Local School Wellness Policy is too broad.

Responses intended on gaining knowledge regarding R4: What is the perception of key school district stakeholders with regard to the level of support available to implement and/or sustain the local school wellness policy?

- The United States Department of Agriculture (USDA) provided unlimited guidance and assistance in the development and implementation of the Local School Wellness Policy.
- Our district has enough financial resources to properly implement the Local School Wellness Policy.
- Based on my knowledge, tremendous efforts were taken to create a sound Local School Wellness Policy.
- Based on my knowledge, tremendous efforts were taken to implement a sound Local School Wellness Policy.
- Based on my knowledge, tremendous efforts were/are taken to sustain a sound Local School Wellness Policy.
- Our district struggles to properly implement the Local School Wellness Policy.
- Our district has enough staff to properly implement the Local School Wellness Policy.
- Our district has enough money properly implement the Local School Wellness Policy.

- Our district has enough time properly implement the Local School Wellness Policy.
- Our district has active community involvement in order to properly implement the Local School Wellness Policy.

R5: What, if any, disconnect exists between policy creation and implementation?

If disconnect exists, what characteristics should be considered by future policy makers for implementation at the local level?

R6: How do policy implementation models make for a more comprehensive policy as analyzed?

For research question 5 an open-ended response box was summarized, analyzed and sorted into themes for answering this question; for question 6, the models of Policy Implementation, Multiple Streams Model and Advocacy Coalition Framework (all implementation models) were examined with regard to the HHFKA in order to demonstrate how better policy can / should be created via analysis of this data and policy through three models. Through assessing the policy via three common implementation models, insight was attained which could lead to better policy making and/or viable implementation based on the answers demonstrated by the Kent ISD population surveyed.

Population, Sample, Site (Unit of Analysis)

Kent ISD is a regional educational service agency devoted to achievement for all students. It provides instructional and administrative services to more than 300 schools, 20 public districts, three non-public districts, and many public school academies and non-public schools within their boundaries. It serves the broader community by helping schools prepare nearly 120,000 students for school and life success. The organization helps districts devote more dollars directly to the classroom by providing essential services, collaborative initiatives, and valuable learning for the region's students and teachers.

Population

The population in this study included all K-12 school districts in the Kent ISD. From the 300+ schools in the Kent ISD within the 20 districts representatives were polled for stakeholder perspectives within the districts. As this entire population of stakeholders is available via email, all principals, vice principals, directors/supervisors/managers of nutrition or food services, nutrition or food service specialists/dietitians, and school nurses/health professionals were delivered a survey for consideration.

Inclusionary Criteria

The data collection was limited to perceptions of stakeholders (principals, nutrition service staff and directors, school nurses, and teachers) from all K-12 public school districts in Kent County as identified in the stakeholder analysis (Appendix G). Over twenty districts were examined with over 125,000 students enrolled, of which 47.3% of students receive free and reduced lunch (Kids Count, 2015), a program of the HHFKA.

Exclusionary Criteria

People that were excluded from this field of study were: students, community members, parents, superintendents, assistant superintendents. Instead the study focused on the perspectives of the employed individuals who would make for sound implementation stakeholders per the mandate language.

Explanation of Criteria

This group selected represents “ideal candidates” for stakeholders as recommended by the local school wellness provision of the CNRA and HHFKA. The stakeholders as identified are important as they are potential and ideal members of local wellness committees and essential to

policy implementation as stipulated by the HHFKA. The population included 300 schools within 20 public districts within the boundary of the Kent Intermediate School District. This information was assessed in collaboration with the ISD website and staff yet was not a sponsored activity in any way by the ISD. In any case, this information is both public and fully accessible online.

Recruitment

All participants were paid staff within the Kent ISD. While this was not a project in collaboration with the Kent ISD, upon contact, Dr. Cheryl Blair, Director of Comprehensive School Health Education Services for Kent, Ionia and Montcalm Counties confirmed that the ISD was not opposed to this project taking place and is interested in the results upon completion. All listed stakeholders from the ISD public districts were sent an electronic survey and a note to participate via an email request from researcher (Appendix G).

Description of Sample

The population sample for this study included census from Kent County ISD stakeholders in the following roles: Director/Supervisor of Nutrition or Food Service, Nutrition or Food Service Specialist or Dietitian, School Nurse (included Occupational Therapist, Speech Pathologists and Psychologists), Teacher or Educator (included Parapro designation), and Administrator (directors, principals, secretaries, etc.). Of the 6,779 survey questionnaires sent directly to the survey population, 1,424 emails were returned as “undeliverable,” leaving 5,355 or 79% of surveys delivered to inboxes without incident.

Informed Consent Process

Consent was obtained by an introductory email (Appendix E) sent with a survey link reviewing the purpose of the study and time expectations as well as the researcher's contact information to answer any questions that were to arise. As the survey is confidential and contains no personal information that could lead to individual identification, there was no further consent necessary.

Michigan has 687,937 students or 46.1% of the student population that qualify for federal program free and reduced lunches. In Kent County the average follows the statewide number reporting 47% (49,292 students) of students that qualify for free and reduced lunches. Students from families with incomes below 185 % of the poverty level are eligible for free or reduced prices in the federal School Lunch Program. Students from families reporting income between 130 and 185 % of the federal poverty line are eligible for reduced priced meals, while children from families with incomes below 130 % of poverty are eligible for a fully subsidized or "free" meal.

Kent Intermediate School District (ISD) is an educational agency dedicated to the region of west Michigan known as Kent County. The ISD provides "instructional and administrative services to more than 300 schools, 20 public districts, three non-public districts, and many public school academies and non-public schools within our boundaries. [They] serve the broader community by helping our schools prepare nearly 120,000 students for school and life success" (About Us, para 1). The ISD assists classroom success by providing initiatives for collaboration, learning opportunities for the region's students and teachers and essential services. The ISD leads learning and teaching for the region.

Research Questions

Six research questions were developed to guide this study:

R1: What is the level of key school district stakeholder familiarity in regard to local school wellness policy?

R2: What is the perception of key school district stakeholders in regard to the failure or success of local school wellness policy implementation?

R3: What is the perception of key school district stakeholders with regard to the impact of local school wellness policy?

R4: What is the perception of key school district stakeholders with regard to the level of support available to implement and/or sustain the local school wellness policy?

R5: What, if any, disconnect exists between policy creation and implementation?

If disconnect exists, what characteristics should be considered by future policy makers for implementation at the local level?

R6: How do policy implementation models make for a more comprehensive policy as analyzed?

For research question 5 an open-ended response box was summarized, analyzed and sorted into themes for answering this question; for question 6, the models of Policy Implementation, Multiple Streams Model and Advocacy Coalition Framework (all implementation models) were examined with regard to the HHFKA in order to demonstrate how better policy can / should be created via analysis of this data and policy through three models. Through assessing the policy via three common implementation models, insight was attained which could lead to better policy making and/or viable implementation based on the answers demonstrated by the Kent ISD population surveyed.

Instrument

Creswell (2014) notes that “a survey design provides a quantitative or numeric description of trends, attitudes, or opinions of a population by studying a sample of that population; from sample results, the researcher generalizes or draws inferences to the population” (p. 155-156). In order to collect data for this study, a survey was administered with questions designed pertinent to addressing the research questions. Due to the time and cost constraints of this study, as it is unfunded, and because of the availability of the survey sample and their extensive use of email for inter-organizational communication, the instrument was made available through online collection method called Survey Monkey (Nesbary, 2000; Sue & Ritter, 2012). The survey data was then downloaded for accurate collection and analysis statistically using SPSS version 22 and SAS.

In order to determine and analyze the power, networking and political will of the actors involved in implementation, a stakeholder map was created. This is useful in identifying the promoters, detractors of political influence in policy and can isolate the actors involved in the implementation process (Majchrzak & Markus, 2014; Reed, et. al, 2009; Brugha & Varvasovsky, 2000). This item is located in the Appendix for consideration (Appendix H).

The survey (Appendix F) was used to collect data to inform perspectives of the local school district community with respect to implementation-based stakeholders (Appendix H). It is a survey method that is basic and applied research with the outcome of qualitative and quantitative data analyzed appropriately (Creswell, 2014). Survey research provides a quantitative or numeric description of trends, attitudes, or opinions of a population by studying a sample of that population. This research is cross-sectional using a questionnaire for data collection with the intent of generalizing from a sample of stakeholders in Kent County.

A polling instrument was created in order to obtain information on attitudes and

perceptions of stakeholders identified as instrumental in the implementation of local school wellness policies. This survey collected K-12 district enrollment information and disregarded demographic data as not germane to the central research questions. Polling, or survey research “is an indispensable tool in social and political research” (Johnson, Reynolds, & Mycoff, 2016, p. 195), in this case it seemed logical to ask the stakeholders themselves regarding their perceptions involving implementation of the HHFKA at their particular institution. Information regarding perception in the workplace, is more likely be reported in a factual manner in this anonymous environment; likewise, instead of manipulating an independent variable, this design asked if our sample has been exposed to a factor or factors and then initiates responses based on his/her own experience or behavior (Johnson, Reynolds & Mycoff, 2016).

The survey itself provided closed-ended questions to the respondents with a list of response from which to choose. Nominal measures were exhaustive and mutually exclusive, containing all the possibilities for the measure in question with every respondent fitting into one and only one category for one part of the survey with the other part of the survey featuring ordinal categories asking respondents to categorize their specific viewpoint in relationship to a variety of statements where one would strongly disagree to strongly agree to the statements provided. Each question had five possible answers for which to quantify the respondent feelings/attitudes/beliefs toward each question. These questions deployed a Likert-type scale for the purpose of coding such that the data could be analyzed by computer in a statistical program for ease of study (Johnson, Reynolds & Mycoff, 2016). In the final section, one open-ended comments area for respondents was made available, to include any information that would be advantageous to the researcher.

Data Collection Procedures

This survey was delivered at a low overall cost to the researcher via email through Survey Monkey software with short to medium questions and medium overall number of questions. A list of specific stakeholder email addresses was obtained through each individual school district website and was mined with the sole purpose of collecting data for this study.

The following research questions with corresponding survey questions, guided the author in constructing the instrument:

R1: What is the level of key school district stakeholder familiarity in regard to local school wellness policy?

Responses intended on gaining knowledge regarding R1:

- I am familiar with the Healthy Hunger-Free Kids Act of 2010.
- I am familiar with Local School Wellness Policy requirements as a result of the Child Nutrition & WIC Reauthorization Act of 2004.
- I am familiar with the wellness policy of my school district (Local School Wellness Policy or LSWP)
- Participation in Local School Wellness Policy activities is a requirement under federal law.

R2: What is the perception of key school district stakeholders in regard to the failure or success of local school wellness policy implementation?

Responses intended on gaining knowledge regarding R2:

- The Local School Wellness Policy is fully implemented in my school district.
- Enforcing the Local School Wellness Policy should be a priority.
- Based on my knowledge, the Local School Wellness Team assessed the needs of the students prior to developing the wellness policy.

- The Local School Wellness Policy has had no impact on stakeholders responsibilities (stakeholders: principals/assistant principals, teachers, nutrition specialist/dietitian, director of child nutrition)
- Based on my knowledge of the Local School Wellness Policy, I believe it is being appropriately applied in my school district.
- I have been thoroughly trained to properly implement the Local School Wellness Policy.

R3: What is the perception of key school district stakeholders with regard to the impact of local school wellness policy?

Responses intended on gaining knowledge regarding R3:

- There should be a designated person to monitor the Local School Wellness Policy.
- The Local School Wellness Policy will make a positive impact on the students and the US obesity epidemic.
- Local School Wellness Policy can be sustained in schools with interaction from all stakeholders.
- The school district should involve students in developing the Local School Wellness Policy.
- The requirement to implement Local School Wellness Policy is too broad.

R4: What is the perception of key school district stakeholders with regard to the level of support available to implement and/or sustain the local school wellness policy?

Responses intended on gaining knowledge regarding R4:

- The United States Department of Agriculture (USDA) provided unlimited guidance and assistance in the development and implementation of the Local School Wellness Policy.

- Our district has enough financial resources to properly implement the Local School Wellness Policy.
- Based on my knowledge, tremendous efforts were taken to sustain a sound Local School Wellness Policy.
- Our district struggles to properly implement the Local School Wellness Policy.
- Our district has enough staff to properly implement the Local School Wellness Policy.
- Our district has enough money properly implement the Local School Wellness Policy.
- Our district has enough time properly implement the Local School Wellness Policy.
- Our district has active community involvement in order to properly implement the Local School Wellness Policy.

Data Analysis

The Likert-type scale was used to code the stakeholder responses in the instrument. Five ordered levels of response were used (strongly agree = 5, agree = 4, neutral = 3, disagree = 2, strongly disagree = 1). These five responses represent interval-level measurements from five different categories (Bryman, 2001). The results of this instrument were analyzed using mainly the IBM Statistical Package for Social Sciences (SPSS) version 21.

The data collection process took approximately four months following HSIRB approval in October 2017 with collection taking place between November 2017 and February 2018 (to account for holiday breaks). Descriptive statistics and frequencies were examined to view relationships across variables, these helped the researcher make sense of the large body of data derived from this instrument and gave direction to the relationships that should be examined for purposes of this manuscript.

Analysis of variance (ANOVA) were run to determine if significant differences in responses occurred within the stakeholder groups. Once it was determined that differences exist among means, post hoc range tests and multiple comparisons were conducted to determine which means differ. Then, the Bonferroni Correction, or Bonferroni-type adjustment, was used to analyze the results from the data as it is conservative, so as to avoid errors within the tests. Crosstabs, an SPSS procedure, were run to cross-tabulate two variables, and display their relationship in tabular form. In contrast to Frequencies, which summarizes information about one variable, Crosstabs generates information about bivariate relationships.

Limitations of the Study

The limits of this study can be found within the selection of the sample as it is limited to five groups of paid staff/faculty members of the Kent ISD. As they would be responsible for implementation of the local school wellness policy, they were selected. Other groups were not targeted, nor included in this study. This study is not intended to represent other locales, but simply this one, the Kent ISD.

Self-reporting scales should produce valid and reliable measures. Reliable measures of self-report are defined by their consistency; therefore a reliable self-report measure produces consistent results every time it is executed. Self-report measures will generally be more reliable when they have many items measuring a construct therefore each research question was written to extrapolate data for each variable for no fewer than two research questions.

To increase reliability, simple yet detailed instructions were used for the completion of the questionnaire and it was requested that the taker retreat to a quiet environment for focus. This questionnaire is valid as it measures what this study has set out to measure by way of research questions and application to equate construct validity which corroborates the degree to which it

measures the theoretical construct that it was originally supposed to measure through the frameworks selected. A Likert-type scale assumes that the strength/intensity of experience is linear, i.e. on a continuum from strongly agree to strongly disagree, and makes the assumption that attitudes can be measured.

This study was not meant to be administered to constituent groups of students, school board members, superintendents, assistant superintendents, members of the public, or parents. The focus on this study was on the nutrition component only; physical activity might be considered for further consideration as well as the study of snacks and food served at extracurricular events including sports and vending machines available to the student population. This study was limited to the comments, beliefs and assumptions of directors of nutrition services, nutrition specialists, school nurses, school teachers, principals, and nutrition supervisors who are employees of the school districts located within the Kent Intermediate School District. It was pretested with success on 21 people with stakeholder characteristics with small adjustments made to terminology where necessary to achieve understanding in the final draft in the appendix.

The subsequent chapters will provide results and discussion of this study. In Chapter IV data and results are provided. Chapter V focuses on the discussion and conclusions of this study and research.

CHAPTER IV

DATA AND RESULTS

The Child Nutrition and WIC Reauthorization Act, 2004 and the Healthy Hunger-Free Kids Act of 2010 were written in terms that allowed school districts to have certain freedoms to interpret, develop, and ultimately implement the law. Policy in this regard is part of the school lunch program and many of the responsibilities for implementation fall on the nutrition services team. Additionally, support from administrators to develop additional parts of this policy such as creating a community-based advisory board as well as creation of a local school wellness policy were intended to be implemented by said advisory committee with the guidance of nutrition services. Thus, the whole district harbors responsibility for creation and implementation of the local policy based on the federal mandate. This study of stakeholder perceptions brings a deeper understanding to how these mandates, with a goal to allow local districts autonomy to develop and implement local wellness policies is perceived.

This chapter describes the sample and analyzes / interprets the data generated for four of five of research questions through summated scales, the summated scales were created via a Likert scale which was used to code the response of the stakeholders as participants. Please recall the scale used for this study is: strongly agree = 5, agree = 4, neutral/unknown = 3, disagree = 2, strongly disagree = 1. The research questions are as follows:

RQ 1: What is the level of key school district stakeholder familiarity in regard to local school wellness policy?

RQ 2: What is the perception of key school district stakeholders in regard to the failure or success of local school wellness policy implementation?

RQ 3: What is the perception of key school district stakeholders with regard to the impact of local school wellness policy?

RQ 4: What is the perception of school district stakeholders with regard to the level of support available to implement and/or sustain the local school wellness policy?

RQ 5: What, if any, disconnect exists between policy creation and implementation?

Lastly, this chapter serves as a summary of the findings of the survey tool used.

Description of Sample

The population sample for this study included Kent County ISD stakeholders in the following roles: Director/Supervisor of Nutrition or Food Service, Nutrition or Food Service Specialist or Dietitian, School Nurse (included Occupational Therapist, Speech Pathologists and Psychologists), Teacher or Educator (included Parapro designation), and Administrator (directors, principals, secretaries, etc.). Of the 6,779 survey questionnaires sent directly to the survey population, 1,424 emails were returned as “undeliverable,” leaving 5,355 or 79 percent of surveys delivered to inboxes without incident.

There were 669 responses, 262 were incomplete (meaning the respondents completed the first five questions but elected not to finish), one respondent did not answer the first five questions but answered the remaining 25 which left 406 respondents. Of those complete surveys, 34 respondents answered at least one question by selecting more than one option. The multiple responses were recoded to missing and removed from the analysis leaving 372 total surveys that were answered completely or 55.6 percent of completed surveys, creating a total response rate of 13 percent for the study.

Description of Data

Table 2 summarizes the frequency and percentage of responses of the groups relative to their roles, number of years served in that role, number of years served in the district, district size and district locale. Of those surveyed, 25 (6.2%) were Director/Supervisor of Nutrition or Food Service employees, 23 (5.7%) School Nurse (included Occupational Therapist, Speech Pathologists, and Psychologists) employees, 299 (73.6%) Teacher or Educator (included Paraprofessionals) employees, and 58 (14.3%) Administrator (directors, principals, secretaries, etc.).

Of the survey respondents, 19.7% (n=80) had been in their current role for 1-5 years, 12.1% (n=49) had been in their current role for 6-10 years, 18.2% (n=74) had been in their current role for 11-15 years, 19.0% (n=74) had been in their current role for 16-20 years with 30.8% (n=111) serving in their role for 20+ years.

Survey respondents reported being in their current district in the following results: 23.6% (n=96) 1-5 years, 12.3% (n=50) had been in their current district for 6-10 years, 17.5% (n=71) had been in their current district for 11-15 years, 19.2% (n=78) had been in their current district for 16-20 years with 27.3% (n=111) having been in their current district for 20+ years.

The majority of the population that responded to the survey came from school districts with 10,000 students or fewer. Table 2 also lists the district size of the respondents with 52.7% of respondents responding from districts of less than 5,000 students, 37.4% of respondents came from districts of 5,000-9,999 students, 0% reported origin from districts of 10,000-14,999 students, 9.9% came from districts of 15,000-19,999 students, and 0% of respondents reported coming from districts of 20,000+.

For comparison, from the survey results an additional variable was formulated from the existing survey results, described as "Locale," wherein the individual school districts were

evaluated on their proximity to a city or urban center to classify the district size into locale described for the sake of this study as “urban,” “suburban,” and “rural.” From this distribution, 25.6% (n=104) of respondents were from urban locations, 35.5% (n=144) were from suburban locations, and 38.9% (n=158) were classified as rural locations.

Every Kent ISD was represented, the lowest respondent rate from Wyoming Public Schools with three respondents or 0.45% and the largest respondent rate from Forest Hills Public Schools with 89 respondents, with zero respondents choosing “any Kent-ISD Non-Public School.”

Table 2

Frequency and Percent for Selected Variables

Variable	n	%
Role		
Food Service	25	6.2
Nurse	23	5.7
Teacher/Educator	299	73.6
Admin/Principal	58	14.3
Years in Role		
1-5 years	80	19.7
6-10 years	49	12.1
11-15 years	74	18.2
16-20 years	77	19.0
20+ years	125	30.8
Years in District		
1-5 years	96	23.6
6-10 years	50	12.3
11-15 years	71	17.5
16-20 years	78	19.2
20+ years	111	27.3
DistrictSize		
<5,000	214	52.7
5,000-9,999	152	37.4
10,000+	40	9.9
Locale		
Urban	104	25.6
Suburban	144	35.5
Rural	158	38.9

Analysis of Research Questions

In order to have cells properly populated, new variables were recoded. First by creating “agree,” “disagree,” and “neutral” the variables were collapsed into “strongly agree” and “agree” into “agree;” “strongly disagree” and “disagree” into “disagree” allowing tests of significance to be run in crosstabs. This allows for a deeper look at the data and allows relationships to be established statistically on a question-by-question basis to examine where differences may exist.

In order to achieve interval-level data, the survey questions were recoded and added into four scores with ranges for disagree, neutral and agree as follows: RQ1 had four survey questions (6a, 6b, 6c, 6g), with range of scores from 4-20 (disagree=4-10, neutral=11-12, agree=14-20), RQ2 had six survey questions (6d, 6e, 6f, 6h, 6s, 6y) with range of scores from 6-20 (disagree=4, neutral=12, agree=20), RQ3 had five survey questions (6i, 6j, 6k, 6l, 6m) with range of scores from 6-30 (disagree=6, neutral=16-20, agree=20) and RQ4 had ten survey questions (6n, 6o, 6p, 6q, 6r, 6t, 6u, 6v, 6w, 6x) with range of scores from 14-50 (disagree=14, neutral=30, agree=50).

Additionally, this allowed for a more holistic look at the variables and gave a starting point for examination of the particular survey questions that appeared to be significant in nature (see pink in Table 3) and helped direct the analysis toward RQ1-RQ4 observations.

Table 3
Level of Agreement for Survey Question 6 (a-y)

	Disagree		Neutral		Agree	
	<u>1&2</u>				<u>4&5</u>	
	n	%	n	%	n	%
I am familiar with the HHFKA 2010	173	42.5	59	14.5	173	42.5
I am familiar with the LSWP requirements as a result of CNWRA 2004	194	47.7	73	17.9	136	33.4
I am familiar with the LSWP of my district	185	45.5	82	20.1	137	33.7
Local School Wellness Policy is fully implemented	46	11.3	249	61.2	108	26.5
Enforcing the Local School Wellness Policy should be a priority	20	4.9	89	21.9	293	72.0
The Wellness Team assessed the needs of the students prior to developing the wellness policy	58	14.3	271	66.6	77	18.9
Participation in LSWP activities is a requirement under federal law	11	2.7	211	51.8	182	44.7
LSWP has had no impact on stakeholders responsibilities	178	43.7	175	43.0	51	12.5
There should be a designated person to monitor the Local School Wellness Policy	19	4.7	97	23.8	290	71.3
The LSWP will make a positive impact on the students and the US obesity epidemic	93	22.9	176	43.2	137	33.7
LSWP can be sustained in schools with interaction from all stakeholders	23	5.7	136	33.4	247	60.7
The school district should involve students in developing the LSWP	24	5.9	61	15.0	321	78.9
The requirement to implement LSWP is too broad	38	9.3	299	73.5	69	17.0
The USDA provided guidance and assistance in the development and implementation of the LSWP	68	16.7	298	73.2	40	9.8
Our district has enough financial resources to properly implement the LSWP	156	38.3	157	38.6	92	22.6
Based on my knowledge, appropriate efforts were taken to create a sound LSWP	58	14.3	235	57.7	113	27.8
Based on my knowledge, appropriate efforts were taken to implement a sound LSWP	58	14.3	233	57.2	114	28.0
Based on my knowledge, appropriate efforts were/are taken to sustain a sound LSWP	57	14.0	246	60.4	103	25.3
Based on my knowledge of the LSWP, I believe it is being appropriately applied in my district	66	16.2	214	52.6	126	31.0
Our district struggles to properly implement the LSWP	103	25.3	239	58.7	63	15.5
Our district has enough staff to properly implement the LSWP	94	23.1	205	50.4	105	25.8
Our district has enough money to properly implement the LSWP	129	31.7	180	44.2	96	23.6
Our district has enough time to properly implement the LSWP	113	27.8	202	49.6	89	21.9
Our district has active community involvement in order to properly implement the LSWP	133	32.7	198	48.6	74	18.2
I have been thoroughly trained to properly implement the LSWP	311	76.4	68	16.7	23	5.7

Additionally, “director/supervisor of nutrition or food service” and “nutrition or food service specialist/dietician” were combined, and those who responded “other” were

recategorized into the existing roles/titles that they fit most closely into. For example: “parapro” was combined with “teacher/educator,” and “lunch lady” was combined with “food service.”

As respondents answered the district that they work in, the district size was able to be verified through district website data at the ISD level wherein, three categories were created of <5,000, 5,000-9,999, and 10,000+. The district with the fewest students is Kent City with 1,345 (FY 16-17) and most students is Grand Rapids Public School with 16,780 (FY 16-17).

Finally, from Grand Rapids city center, “locale” was established in which districts were recoded into categories “rural,” “suburban,” and “urban” by location to cluster similar districts together in a deliberate manner.

ANOVA

The one-way analysis of variance (ANOVA) was used to determine whether there are any statistically significant differences between the means of two or more independent (unrelated) groups (although you tend to only see it used when there are a minimum of three, rather than two groups). Statistical significance is often referred to as the p-value (short for “probability value”) or simply p in research papers. A small p-value means that the data are unlikely under some null hypothesis. A somewhat arbitrary convention is to reject the null hypothesis if $p < 0.05$.

To counteract the problem of multiple comparison in ANOVA, the Bonferroni correction method was used. Bonferroni uses t tests to perform pairwise comparisons between group means, but controls overall error rate by setting the error rate for each test to the experiment-wise error rate divided by the total number of tests. Hence, the observed significance level is adjusted for the fact that multiple comparisons are being made. It is a conservative correction and requires a

stricter significance threshold for individual comparisons than other corrections, so as to compensate for the number of inferences being made (Weissstein, n.d.).

Cross Tabulation

Cross tabulation is a tool that allows you compare the relationship between two variables. Cross tabulation is a statistical tool that is used to analyze categorical data. Cross tabulation helps us understand how two different variables are related to each other. Using the survey data, the following contingency tables were created which displays the frequency of each of the variables examined.

The following research questions were analyzed using the methods described above:

RQ1: What is the level of key school district stakeholder familiarity in regard to local school wellness policy?

Responses intended on gaining knowledge regarding R1:

- I am very familiar with the Healthy Hunger-Free Kids Act of 2010.
- I am very familiar with Local School Wellness Policy requirements as a result of the Child Nutrition & WIC Reauthorization Act of 2004.
- I am very familiar with the wellness policy of my school district (Local School Wellness Policy or LSWP)
- Participation in Local School Wellness Policy activities is a requirement under federal law.

A one-way ANOVA was conducted to compare stakeholder familiarity to local school wellness policies for selected variables role, years in role, district size, and locale (Table 4). There was significance ($p < 0.05$) at role ($p = 0.000$), district size ($p = 0.001$) and locale ($p = 0.001$) variables.

Table 4

ANOVA Results Stakeholder Familiarity to LSWP for Selected Variables

Variable	N	Mean	SD	F-test	p-value
Role					
Food Service	25	15.32	3.509	16.509	0.000 *
Nurse	23	10.57	3.369		
Teacher/Educator	288	11.43	3.242		
Admin/Principal	57	13.39	3.115		
Total	393	11.91	3.436		
Years in Role					
1-5 years	78	12.24	3.476	1.008	0.403
6-10 years	49	12.08	3.651		
11-15 years	70	11.20	3.500		
16-20 years	75	12.08	3.295		
20+ years	121	11.88	3.367		
Total	393	11.90	3.436		
DistrictSize					
>5000	208	12.33	3.445	7.440	0.001 *
5000-9999	147	11.07	3.274		
10000+	39	12.77	3.422		
Total	394	11.90	3.435		
Locale					
Urban	99	12.53	3.480	7.531	0.001 *
Suburban	140	11.02	3.366		
Rural	155	12.30	3.325		
Total	394	11.90	3.435		

Note. Significance at $p < 0.05$ level.

In Table 4, ANOVA results regarding “role” for the individualized t-tests (the Bonferroni comparisons) results confirm significant differences of the means between food service and teacher/educator ($p=0.000$); and food service and nurse ($p=0.000$); and admin/principal and nurse ($p=0.000$). All other combinations show no significant difference.

ANOVA results regarding “years in role” for the individualized t-tests (the Bonferroni comparison), there is no statistically significant difference in means of year in the role in the district at the time of survey, they are neutral with $p=0.403$.

ANOVA results regarding “districtsize” for the individual t-tests (the Bonferroni comparison) result confirm differences of the means between <5000 and 5000-9999 ($p=0.001$); and 5000-9999 and 10000+ ($p=0.001$). All other combinations show no significant difference. ANOVA results regarding “locale” for the individual t-tests (the Bonferroni comparison) results confirm differences between urban and suburban ($p=0.001$); and suburban and rural ($p=0.001$). All other combinations show no significant difference.

Table 5

Crosstabs Familiarity with Policy by Role Variable

Cross-tabs Familiarity with Policy by Role Variable												
Role	Food Ser		Nurse		Teach/Edu		Adm/Prin		Total		Chi-Sq	Sig
	n	%	n	%	n	%	n	%	n	%		
<i>Familiarity with Policy x Role</i>												
Disagree	4	16.0	15	65.2	136	45.8	16	27.6	171	42.4	20.250	0.002*
Neutral	4	16.0	3	13.0	43	14.5	9	15.5	59	14.6		
Agree	17	68.0	5	21.7	118	39.7	33	56.9	173	42.9		
Total	25	100.0	23	100.0	297	100.0	58	100.0	403	100.0		
<i>Familiarity with Requirements x Role</i>												
Disagree	4	16.0	17	73.9	150	50.7	22	38.6	193	48.1	29.494	0.000 *
Neutral	4	16.0	2	8.7	60	20.3	7	12.3	73	18.2		
Agree	17	68.0	4	17.4	86	29.1	28	49.1	173	42.9		
Total	25	100.0	23	100.0	297	100.0	58	100.0	403	100.0		
<i>Familiarity with District LSWP x Role</i>												
Disagree	3	12.0	14	60.9	154	52.0	13	22.4	184	45.8	46.079	0.000 *
Neutral	4	16.0	3	13.0	64	21.6	10	17.2	81	20.1		
Agree	18	72.0	6	26.1	78	26.4	35	60.3	137	34.1		
Total	25	100.0	23	100.0	296	100.0	58	100.0	402	100.0		

Note. Significance at $p<0.05$ level.

Table 5 considers the survey questions regarding familiarity with policy by role, federal policy requirement knowledge by role, and local/district policy requirement knowledge by role. In this test, significance is met at federal policy requirement knowledge by role ($p=0.000$) and local/district policy requirement knowledge by role ($p=0.000$) with higher levels of familiarity within food service and administrator/principal stakeholders in both federal and local/district nutrition policy and lower levels with nurse and teacher/educator stakeholders. All questions in this crosstab as answered by food service professionals show that they are acutely aware of policy surrounding the LSWP with answering 68% or greater “agree” to all three questions, that they are familiar with the federal requirements regarding LSWP. Inversely, with ranges with 60.9% to 73.9% nurses and 45.8% to 52.0% of teachers answering that they are very not aware of the guidelines and federal requirements regarding LSWP at any level.

Table 6

Crosstabs by DistrictSize Variable

DistrictSize	<5000		5000-9999		10000+		Total		Chi-Sq	Sig
	n	%	n	%	n	%	n	%		
<i>Familiarity x DistrictSize</i>										
Disagree	80	37.70	78	51.30	14	35.00	172	42.60	9.034	0.060
Neutral	32	15.10	22	14.50	5	12.50	59	14.60		
Agree	100	47.20	52	34.20	21	52.50	173	42.80		
Total	212	100.00	152	100.00	40	100.00	404	100.00		
<i>Familiarity with Requirements x DistrictSize</i>										
Disagree	90	42.30	90	60.00	14	35.90	194	48.30	15.602	0.004
Neutral	45	21.10	22	14.70	6	15.40	73	18.20		
Agree	78	36.60	38	25.36	19	48.70	135	33.60		
Total	213	100.00	150	100.00	39	100.00	402	100.00		
<i>Locale x DistrictSize</i>										
Urban	23	10.70	41	27.00	40	100.00	104	25.60	345.624	0.000*
Suburban	33	15.40	111	73.00	0	0.00	144	35.50		
Rural	158	73.80	0	0.00	0	0.00	158	38.90		
Total	214	100.00	152	100.00	40	100.00	406	100.00		

Note. Significance at $p<0.05$ level.

While the crosstab (Table 6) examining familiarity of policy for LSWP and familiarity of requirements for LSWP with regard to district size is not statistically significant, it is worth noting that districts of <5000 and 10000+ have more familiarity with federal policy than do the 5000-9999 schools; however, while the 10000+ have more familiarity also with district (LSWP) the <5000 population schools have less familiarity with their own district policies (LSWP) as implemented. Leaving a gap in the 5000-9999 schools at the implementation level federal and district wide as well as a gap in the <5000 schools district wide.

Table 7

Crosstabs by Locale Variable

Variable	Urban		Suburban		Rural		Total		Chi-Sq	Sig
	n	%	n	%	n	%	n	%		
<i>Familiarity of Policy x Locale</i>										
Disagree	35	34.00	79	54.90	58	36.90	172	42.60	16.248	0.003
Neutral	18	17.50	12	8.30	29	18.50	59	14.60		
Agree	50	48.50	53	36.80	70	44.60	173	42.80		
Total	103	100.00	144	100.00	157	100.00	404	100.00		
<i>Familiarity with Requirements x Locale</i>										
Disagree	44	43.60	84	58.30	66	42.00	194	48.30	13.352	0.010
Neutral	14	13.90	25	14.40	34	21.70	73	18.20		
Agree	43	42.60	35	24.30	57	36.30	135	33.60		
Total	101	100.00	144	100.00	157	100.00	402	100.00		

Note. Significance at $p < 0.05$ level.

While the crosstab (Table 7) run examining familiarity of policy for LSWP and familiarity of requirements for LSWP with regard to locale is not statistically significant it is worth noting the polarizing results which in total for all locales (urban, suburban, and rural) with roughly equal results between disagree and agree with about 20% in the neutral range for all locales regarding both familiarity of policy and requirements.

RQ2: What is the perception of key school district stakeholders in regard to the failure or success of local school wellness policy implementation?

Responses intended on gaining knowledge regarding R2:

- The Local School Wellness Policy is fully implemented in my school district.
- Enforcing the Local School Wellness Policy should be a priority.
- Based on my knowledge, the Local School Wellness Team assessed the needs of the students prior to developing the wellness policy.
- The Local School Wellness Policy has had no impact on stakeholders responsibilities (stakeholders: principals/assistant principals, teachers, nutrition specialist/dietitian, director of child nutrition)
- Based on my knowledge of the Local School Wellness Policy, I believe it is being appropriately applied in my school district.
- I have been thoroughly trained to properly implement the Local School Wellness Policy.

A one-way ANOVA was conducted to compare stakeholder perception of LSWP failure or success for selected variables role, years in role, district size and locale (Table 8). There was significance ($p < 0.05$) at role only ($p = 0.000$); years in role, district size, and locale were not found to be significant.

In Table 8, the individualized t-tests (the Bonferroni comparisons) results confirm significant differences of the means between food service and teacher/educator ($p = 0.000$); and food service and nurse ($p = 0.000$); and admin/principal and nurse ($p = 0.000$).

Table 8

ANOVA Results Perception of LSWP Failure/Success for Selected Variables

Variable	N	Mean	SD	F-test	p-value
Role					
Food Service	25	19.76	3.004	11.654	0.000 *
Nurse	22	17.55	1.845		
Teacher/Educator	284	17.28	2.274		
Admin/Principal	58	18.69	3.218		
Total	389	17.67	2.566		
Years in Role					
1-5 years	75	18.20	2.991	1.288	0.274
6-10 years	48	17.83	2.684		
11-15 years	71	17.61	1.989		
16-20 years	75	17.32	2.489		
20+ years	120	17.55	2.533		
Total	389	17.68	2.555		
DistrictSize					
>5000	208	17.63	2.844	0.071	0.931
5000-9999	147	17.68	2.272		
10000+	39	17.79	1.963		
Total	394	17.66	2.563		
Locale					
Urban	99	18.18	2.229	2.736	0.066
Suburban	137	17.50	2.426		
Rural	154	17.47	2.838		
Total	390	17.66	2.563		

Note. Significance at $p < 0.05$ level.

ANOVA results regarding all other variables for the individual t-tests (the Bonferroni comparison) results show no significant difference in any combination.

Table 9

Crosstabs Perception of Training by Role

Role	Food Ser		Nurse		Teach/Edu		Ad/Prin		Total		Chi-Sq	Sig
	n	%	n	%	n	%	n	%	n	%		
Disagree	9	36.0	19	82.6	242	82.3	40	69.0	310	77.5	72.981	0.000 *
Neutral	6	24.0	3	13.0	47	16.0	12	20.7	68	17.0		
Agree	10	40.0	1	4.3	5	1.7	6	10.3	22	5.5		
Total	25	100.0	23	100.0	294	100.0	58	100.0	400	100.0		

Note. Significance at $p < 0.05$ level.

Table 9 demonstrates perception of training level by role and shows that 77.5% (n=310) of stakeholders do not believe that they were trained properly with regard to federal policy with just 5.5% who believed that they were trained appropriately. The level of agreement in Table 9 is role dependent, even those that are directly responsible for implementation of nutrition policy, the food service stakeholders, were split into thirds with no clear confidence level in training; however, they are the role that responded in agreement that they did have adequate training with all other groups at 10.3% or lower in perception of training received pertaining to the federal policy.

Table 10

Crosstabs Perception of Training by DistrictSize Variable

DistrictSize	<5000		5000-9999		10000+		Total		Chi-Sq	Sig
	n	%	n	%	n	%	n	%		
Disagree	163	76.2	121	81.8	27	69.2	311	77.6	6.830	0.145
Neutral	36	16.8	24	16.2	8	20.5	68	17.0		
Agree	15	7.0	3	2.0	4	10.3	22	5.5		
Total	214	100.0	148	100.0	39	100.0	401	100.0		

Note. Significance at $p < 0.05$ level.

Table 10 demonstrates perception of training level district size and shows that 77.5% (n=311) of stakeholders do not believe that they were trained properly with regard to federal policy with just 5.5% who believed that they were trained appropriately across all population levels. Lack of training does not appear to be tied to population and while this test does not demonstrate a statistical significance between the means, which is simply because they are all in agreement with the lack of training in all sizes of school district with regard to federal policy. Because district size and locale are congruent, it can be reported that lack of training is also not tied to a specific locale, but instead equally lacking in urban, suburban, and rural locales similarly.

RQ3: What is the perception of key school district stakeholders with regard to the impact of local school wellness policy?

Responses intended on gaining knowledge regarding R3:

- There should be a designated person to monitor the Local School Wellness Policy.
- The Local School Wellness Policy will make a positive impact on the students and the US obesity epidemic.
- Local School Wellness Policy can be sustained in schools with interaction from all stakeholders.
- The school district should involve students in developing the Local School Wellness Policy.
- The requirement to implement Local School Wellness Policy is too broad.

A one-way ANOVA was conducted to compare stakeholder perception of LSWP impact for selected variables role, years in role, district size, and locale (Table 11). There was no significance ($p < 0.05$) difference in means at any level.

Table 11

*ANOVA Results Perception with Regard to Impact of LSWP
for Selected Variables*

Variable	N	Mean	SD	F- test	p- value
Role					
Food Service	25	17.88	2.166	1.461	0.225
Nurse	23	18.09	1.621		
Teacher/Educator	299	17.47	2.509		
Admin/Principal	56	18.07	2.035		
Total	403	17.61	2.392		
Years in Role					
1-5 years	79	17.94	2.221	1.72	0.145
6-10 years	49	18.24	2.420		
11-15 years	74	17.57	2.215		
16-20 years	77	17.44	2.479		
20+ years	124	17.36	2.380		
Total	403	17.64	2.353		
DistrictSize					
>5000	213	17.84	2.469	2.142	0.119
5000-9999	152	17.40	2.314		
10000+	39	17.21	2.142		
Total	404	17.61	2.389		
Locale					
Urban	103	17.73	2.272	0.785	0.457
Suburban	143	17.41	2.221		
Rural	158	17.72	2.603		
Total	404	17.61	2.389		

Note. Significance at $p < 0.05$ level.

In Table 11, the individualized t-tests (the Bonferroni comparisons) results confirm significant no significant difference among any means tested.

No significant differences between the means here indicates that perception is neutral or close to neutral in regard to the perceived impact that the local school wellness policy makes.

RQ4: What is the perception of key school district stakeholders with regard to the level of support available to implement and/or sustain the local school wellness policy?

Responses intended on gaining knowledge regarding R4:

- The United States Department of Agriculture (USDA) provided unlimited guidance and assistance in the development and implementation of the Local School Wellness Policy.
- Our district has enough financial resources to properly implement the Local School Wellness Policy.
- Based on my knowledge, tremendous efforts were taken to sustain a sound Local School Wellness Policy.
- Our district struggles to properly implement the Local School Wellness Policy.
- Our district has enough staff to properly implement the Local School Wellness Policy.
- Our district has enough money properly implement the Local School Wellness Policy.
- Our district has enough time properly implement the Local School Wellness Policy.
- Our district has active community involvement in order to properly implement the Local School Wellness Policy.

A one-way ANOVA was conducted to compare stakeholder perception of support available for local school wellness policy for variables role, years in role, district size, and locale (Table 12). In Table 12, the individualized t-tests (the Bonferroni comparisons) results confirm significant differences of the means between teacher/educator and administrator/principal ($p=0.000$). All other combinations show no significant difference.

ANOVA results regarding all other variables for the individual t-tests (the Bonferroni comparison) results show no significant difference in any combination. Significance is demonstrated at the role variable only ($p=0.000$).

Table 12

ANOVA Results for Perception of Support Available for Selected Variables

Variable	N	Mean	SD	F-test	p-value
Role					
Food Service	22	30.82	4.148	6.601	0.000 *
Nurse	23	30.00	4.045		
Teacher/Educator	293	28.98	4.237		
Admin/Principal	57	31.60	4.989		
Total	395	29.52	4.430		
Years in Role					
1-5 years	76	30.24	4.763	1.231	0.297
6-10 years	49	20.14	4.047		
11-15 years	73	28.90	3.532		
16-20 years	76	29.16	4.696		
20+ years	121	29.52	4.574		
Total	395	29.55	4.405		
District Size					
>5000	209	29.26	4.859	3.487	0.032
5000-9999	148	30.21	3.738		
10000+	39	28.38	4.095		
Total	396	29.53	4.426		
Location					
Urban	100	29.80	3.723	0.487	0.615
Suburban	142	29.62	4.165		
Rural	154	29.27	5.049		
Total	396	29.53	4.426		

Note. Significance at $p < 0.05$ level.

Administrator/principal and teacher/educator are the only significant difference.

Teacher/educators are on the negative side of perception of resources available, principals on the positive side of resources available.

RQ5: What, if any, disconnect exists between policy creation and implementation?

Validity is one of the strengths of qualitative research and is based on determining whether the finding are accurate from the standpoint of the researcher, participant, or readers of

an account (Creswell & Miller, 2000). Terms that address validity are trustworthiness, authenticity, and credibility (Creswell, & Miller, 2000). In this quantitative study, of the 669 respondents surveyed, 123 of them opted to take a few minutes at the end of the survey and fill in the “additional comments for researcher.” While some of these were but a few words or a question, many of them were lengthy, insightful and add to the trustworthiness, authenticity, and credibility as Creswell and Miller (2007) note and aid in validating my survey respondents through triangulation, use of “rich, thick descriptives” as Creswell (2014) mentions in his text on mixed methods research design.

As this was rich with information and pursuant to validity and also this research question related to disconnect, comments were sorted into categories/themes which, in addition to the quantitative data previously examined, do give a rich context for this idea of “disconnect” that is present in the literature review between policy creation and policy implementation. A word cloud was created from the top words mentioned in the text analysis and the four major themes that support the literature on the disconnect between policy creation and policy implementation, are as follows:

Figure 8. Word cloud derived from over 125 stakeholder survey comments

Theme 1 - Lack of Policy Knowledge: “I wish I was able to help more - but I have never heard of the policy at my school!” “I knew that this was a "thing"...school nutrition and requirements, but I had NO idea the depth and if we as a district/school are doing well with it! Can you tell me more?” “I would love to know more about this, it seems important to kids learning,” “my previous district talked about this a lot but my current district I haven’t heard a peep,” “I have no idea as to the details of the policies you are talking about. I don't think many educators do,” “I’ve been employed in my district for 37 years and have never heard of such a law or our school implementing wellness policies for students,” and “My knowledge of the policies come from the news (I remember some people excited and others disturbed when M. Obama talked about the need for getting our kids healthier) and from what my own children say about vending machines etc.”

Theme 2 - Lack of Policy Implementation and Training: “We have a policy but there was not

public input into creation. I do not have the time nor the power to implement a wellness policy.”

“This effort needs more money behind it to properly implement true change,” “In spite of all the "personal development" and “As a health/P.E. teacher I would love for our administration to inform us each year about the program and the reasons for it so we could help explain it to our students. Plus, explain it to our students and parents when possible so they understand the reason and benefits. For example, the importance of eating breakfast and lunch in school. Explaining that importance and adding the facts about focusing, passing tests, and falling asleep may help them while in high school,” "in-service" hours we are required to perform, we are NOT well versed in any Local School Wellness Policy - which is a shame,” “local school wellness policy is a joke here, we have a team but no leadership or purpose,” “I don't know anything about it. We have a wellness coordinator, I hope that they are doing their job,” “I am unaware as a teacher and community member what our local wellness policy is or if it is implemented.”

Theme 3 - General Concern for Policy: “Student now have to fill out the free and reduced for online. If service students who do not speak the language and or have transportation to get to a computer. They qualify for the food program and yet are unable to fill out the paperwork to get it. By the time we are able to get them assistance a large bill that they can not pay has built up. When they filled out paper copies it was easier for parents to understand and find support to fill out their paperwork. My district is unreasonable in assuming that all families have the ability to understand the paperwork and or have access to the equipment to fill out to get the work finished. Something has to be done to support the English Language Learners to gain access to the food program,” “kids get fed, but this is not our job at school,” “parents should feed kids at home with their own resources,” “Schools simply cannot be all things to all people. Providing educational opportunities should be our priority. All too often, we are viewed as the resource to

provide all others supports and services, some of which should fall onto families and or other agencies. I fully support wellness initiatives, but feel that we have a responsibility to maintain our primary goal,” and “more nanny state policies,” “The Local School Wellness Policy is another example of government overreach and excessive paperwork.”

Theme 4 - Free and Reduced Lunch Policy Concern (Nutrition & Waste): “Our breakfast program is hurting our kids,” “portions are off, athletes are starving before practice and games - they don’t perform well,” “I find that the free/reduced breakfast that kids are offered isn't very healthy. Still looks like fast food options...just offered at school instead of in their car on the way to school,” “students bring in junk food from outside and do not eat “good” foods at home or school,” ““wellness policy’ in my district seems to focus on Poptarts and fundraiser candy bars,” “if we have a ‘wellness policy’ it seems to dictate a high fat, high sodium diet with no taste. Students throw out almost all of their food. They are probably very hungry,” and “I have seen an incredible amount of food wasted- new containers of juice, packaged cereal, fresh fruit (apples, oranges) all thrown away. They must take a certain number of things from each food group or it is not free or reduced. As a result the kids take things they don't want. They end up throwing it away. I understand not wanting to use food that is spoiled but this is perfectly good and could be given to someone in need. The amount of waste is not good for anyone. Someone has paid for that food and no one is reaping the benefit of it. What is the good of nutritional food if the students don't eat it or take it only to throw it away?” and “our cafeteria is a joke. I won’t even eat the food in there why would kids?”

CHAPTER V

DISCUSSION

Federal mandates often trickle down into school district implementation due to changes in legislation, updates, new funding mechanisms, lack of funding mechanisms, changes in leadership or the elected officials. In that, new tools such as the HHFKA are updated as time passes. Due to changes in the Child Nutrition and WIC Reauthorization Act of 2004 (updates, etc.) school food services and administrators have been faced with implementing changes. The legislative act included a “school wellness provision” or local school wellness policy which was meant to address obesity and promote healthy eating through sound nutritional choices available and increased physical activity within the school environment. The wellness policy provision required that all schools have local school wellness policies enacted by school start in 2006-07 academic year.

As illustrated, drafting and implementing Local School Wellness Policy (LSWP), a requirement of the Healthy, Hunger-Free Kids Act of 2010 (HHFKA), is a complicated process. As demonstrated in Figure 9, and congruent with the survey results, while policy is authored at the individual school level instead of the district, involving many stakeholders from school administrators to community members, may or may not be implemented as the law intends depending on enthusiasm and knowledge levels of staff and supporting groups, and lacks federal funding and policing through the current system. A multitude of influences play into LSWP being successful. Thus, the initiation of this study into attitudes and perceptions of key stakeholders as well as analysis of implementation models against the policy itself in order to create a more inclusive examination of HHFKA implementation.

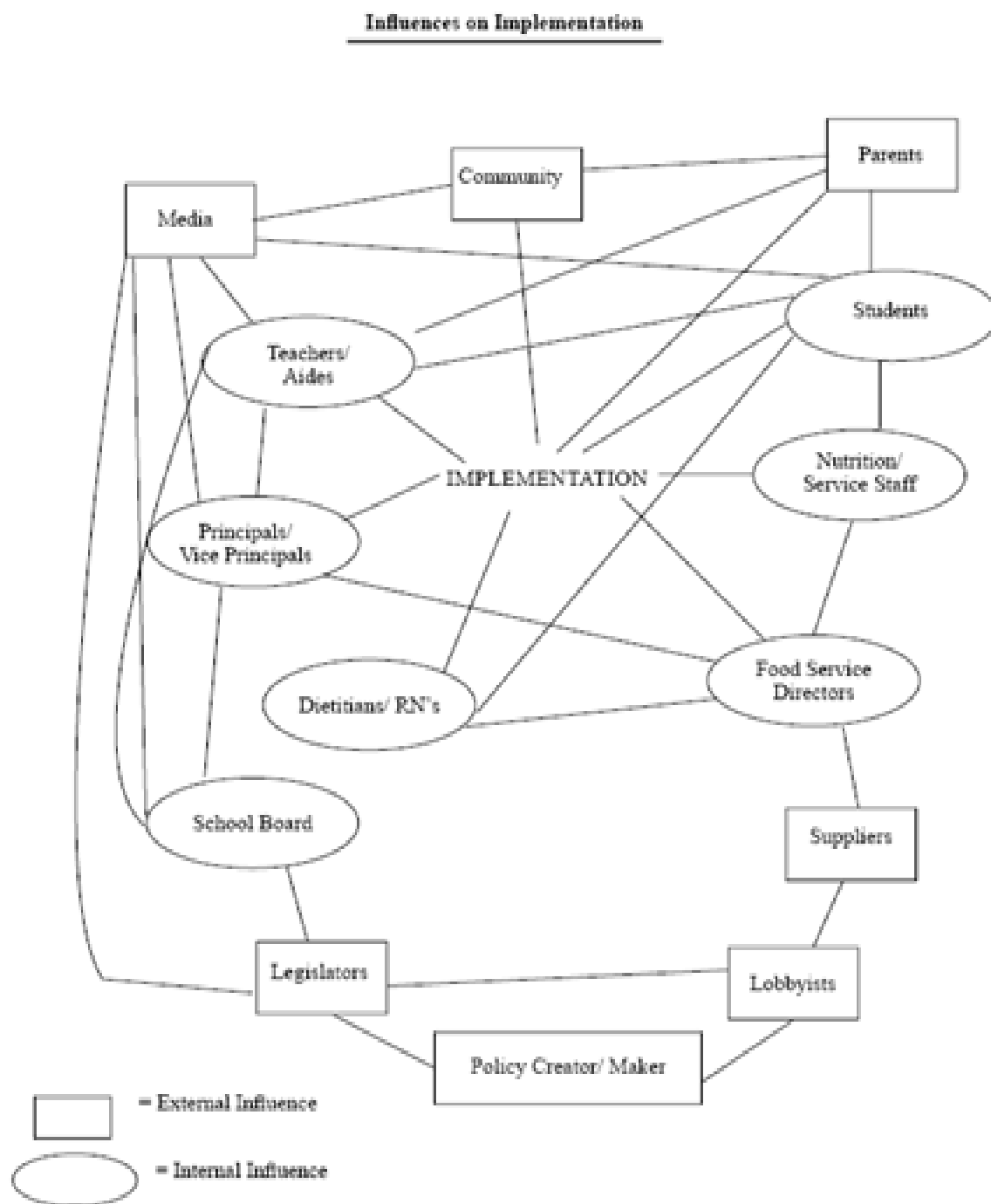


Figure 9. Stakeholder map: internal and external influences on implementation of school policy

Summary of Key Findings

RQ1: What is the level of key school district stakeholder familiarity in regard to local school wellness policy?

While number of years of the stakeholder in a particular role bears no significance in this study, it scores neutral in the matter of familiarity of the policy; however, familiarity does seem to be directly related to the role that the stakeholder plays with regard to the district.

All questions in this survey as answered by food service professionals show that they are acutely familiar with policy surrounding the LSWP and federal requirements regarding LSWP.

Inversely, nurses and teachers answering that they are very not aware of the guidelines and federal requirements regarding LSWP at any level. It comes as no surprise that food service and principal are among the most familiar with regard to local school wellness policy. In terms of implementation, food service personnel do receive some training about the policies and administrators/principals would be directly responsible for the outputs and outcomes associated with the subsequent evaluations and likely among the first to become aware of policy change at the federal level due to their role.

This study reveals that stakeholders working in districts that are urban and rural are more likely to have familiarity with the policy than suburban. It is worth also noting that districts of <5,000 and 10,000+ have more familiarity with federal policy than do the 5,000-9,999 schools these populations nearly mirror the rural, suburban, urban results; however, while the 10,000+ have more familiarity also with district (LSWP) the <5,000 population schools have less familiarity with their own district policies (LSWP) as implemented. Leaving a gap in the 5,000-9,999 schools at the implementation level federal and district wide as well as a gap in the <5,000 schools district wide. It appears that those in suburban areas appear to be either not involved in or not concerned by matters of food policy when it comes to their district.

RQ2: What is the perception of key school district stakeholders in regard to the failure or success of local school wellness policy implementation?

Stakeholder perception in this study with regard to failure or success of local school wellness policy found that role only seems to factor into belief. Similar to familiarity with policy, which was addressed in RQ1, analysis confirms food service and administrator/principal show a more positive perception of failure or success of the implementation piece of LSWP while nurse and teacher/educator have a slightly negative perception. This finding is not surprising given that it would be logical that, just as in RQ1, the administrator/principal and food service staff would have a direct relationship with the policy implementation success aspect of this policy with nurse and teacher/educator having less of a role of implementation and more of a supporting role. Regardless, according to the policy, implementation should accompany a wellness committee, which should comprise of those from all stakeholder perspectives, which would include nurse and teacher/educator. Ownership of policy implementation is referred to in the literature as having an impact on measures of success (Reeve, et al., 2018).

Which leads to a finding that helps explain why perception among those parties mentioned in regard to success or failure of the LSWP is suspect, 77.5% (n=310) of stakeholders do not believe that they were trained properly with regard to federal policy with just 5.5% who believed that they were trained appropriately. The level of agreement is role dependent, even those that are directly responsible for implementation of nutrition policy, the food service and administrator/principal stakeholders, were split into thirds with no clear confidence level in training; however, they are the roles that responded in agreement that they did have adequate training with all other groups at 10.3% or lower in perception of training received pertaining to the federal policy.

Backing up this role perception does not appear to be tied to enrollment and while this study does not demonstrate a statistical significance between the means that is simply because they are all in agreement with the lack of training in all sizes of school district with regard to federal policy. Because district size and locale are congruent, training is also not tied to a specific locale, but instead equally lacking in rural, suburban, and urban locales similarly.

RQ3: What is the perception of key school district stakeholders with regard to the impact of local school wellness policy?

Stakeholder perception of LSWP impact for selected variables role, years in role, district size and locale shows no difference in means at any level. No significant differences between the means here indicates that perception is neutral or close to neutral concerning the perceived impact that the local school wellness policy makes. Even in districts with the most resources, a group of stakeholders that is motivated in policy learning and advocating for the policy makes for stronger policy implementation.

RQ4: What is the perception of school district stakeholders with regard to the level of support available to implement and/or sustain the local school wellness policy?

Stakeholder perception of support available for local school wellness policy for variables role, years in role, district size and locale confirm significant differences of the means between teacher/educator and administrator/principal. All other combinations show no significant difference. Teacher/educators are on the negative side of perception of resources available, while principals on the positive side of resources available.

A technical report written for the National Food Service Institute at University of Southern Mississippi by Cody and Nettles (2013), to build on the Wood, Cody, and Nettles (2010) and the Osowski and Nettles (2013) studies to explore successful strategies to sustaining school wellness as well as the monitoring activities and evaluation practices used for measuring

progress concluded that: “most professionals have implemented mandated LSWPs, but there was a lack of funding for implementation and a lack of tools for proper monitoring and evaluation of the initiatives” (p. 21). Given the results of this study, and the very nature of unfunded mandates in general, asking educators, nurses, and nutrition professionals to do more to comply with federal policy without appropriate distribution of funding, hampers efforts at the district level. Administrators/principals are in a unique position to assist in the lobbying of training resources to assist those who believe that the level of support available is insufficient.

RQ5: What, if any, disconnect exists between policy creation and implementation? If disconnect exists, what characteristics should be considered by future policy makers for implementation at the local level?

As the survey feedback from question seven was rich with information and pursuant to validity and also this research question related to disconnect, comments were sorted into categories/themes which, in addition to the quantitative data previously examined, do give a rich context for this idea of “disconnect” that is present in the literature review between policy creation and policy implementation. The themes are: lack of policy information, knowledge, and training for stakeholders; general concern for policy implementation process and; concern for free and reduced lunch – nutrition and waste. It is within these themes that the instrument demonstrated the obvious disconnect between policy creation and implementation; and even resulted in new areas of disconnect not previously mentioned in the literature.

RQ6: How do policy implementation models make for a more comprehensive policy as analyzed?

Policy researchers use frameworks to deepen understanding of different methods of policy analysis as matched to tools in governance contexts (Howlett, Ramesh & Perl, 2009). Richardson and Jordan, (1983); Van Waarden, (1995); Howlett, (2000) encourage the use of

alternate or complementary techniques such as frequent use of public consultation or stakeholder participation, or simply the view of an entrenched preference for the specific use of this type of policy instrument, as proposed in this study. Policy analysis uses rational policy analysis as an approach to evaluating new and proposing alternatives to existing policy. By collecting stakeholder data, this study aimed to identify and analyze the attitudes and perceptions of policy implementation in order to bring about a more effective understanding of the mandate and stakeholder relationship that fuel local school wellness policy implementation in Kent County. This information allowed for critique, evaluation, and potential improvement of implementation, of an important federal policy that impacts school-aged boys and girls in the United States.

Theory is critical lens in which to provide context to facts and observations of study, moreover, a sense of relevance, and a place in history in order to determine importance of the research. Taking policy from theory to practice is a complex process particularly when considering all the moving parts associated with the HHFKA. Theoretical approaches used in implementation science have three overarching aims: describing and/or guiding the process of translating research into practice (process models); understanding and/or explaining what influences implementation outcomes (determinant frameworks, classic theories, implementation theories); and evaluating implementation (evaluation frameworks) (Nilsen, 2015).

In the case of the Healthy, Hunger-Free Kids Act of 2010, before action was taken (which was still considered controversial through party lines) the country experienced an epidemic with costs and health effects that are predicting that for the first time ever in history, parents will most likely outlive their children as a result of obesity, diabetes and other detrimental health-related outcomes (Taskforce on Childhood Obesity, 2010).

One of the best strategies for approaching complex phenomena as discussed in this paper is to employ frameworks, theories, or models that can help organize or explain complexity. The drawback of course is that any singular framework, theory, or model will fail to capture the full range of factors that shape or underlie policy processes. Thus, policy process researchers must understand and be able to apply the diverse analytical approaches that are available to them to have a comprehensive perspective on policy processes.

Policy change occurs because of collective action, not just in holding a collective belief. The Multiple Streams Model (MSM) pays the least attention to collective action as a process of people coming together in order to satisfy a common goal. Instead, in applying MSM, we know and use information based upon key individuals at what point they intersect with overlapping variables and think to make action as opportunity arises. Kingdon maintains that policy entrepreneurs do not control events, but they can anticipate them and bend events to their purposes to some degree (1995).

Advocacy Coalition Framework (ACF) identifies the inner workings of situations via individuals and their belief systems based from his/her individual actions. The basic values of the individual, not the situational margins determine coalition dissemination which is the basis for the collective action or policy making. While we are not able to surmise through this theory, how the coalitions are created (Schlager, 1995), we do know that they are defined specifically and lead to coordination of activities or action among the entities of the coalition itself.

Schlager (2007) states frameworks like MSM and ACF point to similar types of events and factors that set the stage for major policy change. These factors include dramatic events or crises, changes in governing coalitions, and administrative and legislative turnover (p. 310). These points make it easy to see why they were selected in the analysis of the Healthy, Hunger-

Free Kids Act of 2010 (HHFKA). While major changes seemingly occur overnight to the general population, the descriptions previous show that policymakers collect and analyze data through a series of portholes over years, sometimes decades in this case when USDA did not see changes to the program in question for over 30 years. This is a testament to the fact that in the world of policymaking, even if major buildup of data, proof, information, support, etc. occurs, it does not in any way promise that change will be forthcoming.

MSM and ACF are both “popular” mechanisms for analysis of complex or “messy” issues where multiple variables, groups of influencers, and actions occur over time. ACF is particularly useful where two or more coalitions are competing on an issue to have their positions be politically dominant. These coalitions are often based on differing strongly held core beliefs; in this example public health versus food coalitions/lobbying. In this sense, then, the conditions imposed by the problem will motivate the approach employed which is precisely what this paper attempted to do. Model analysis outcome will vary and should aid in the assistance of more effective or sound policy making by actors and policymakers.

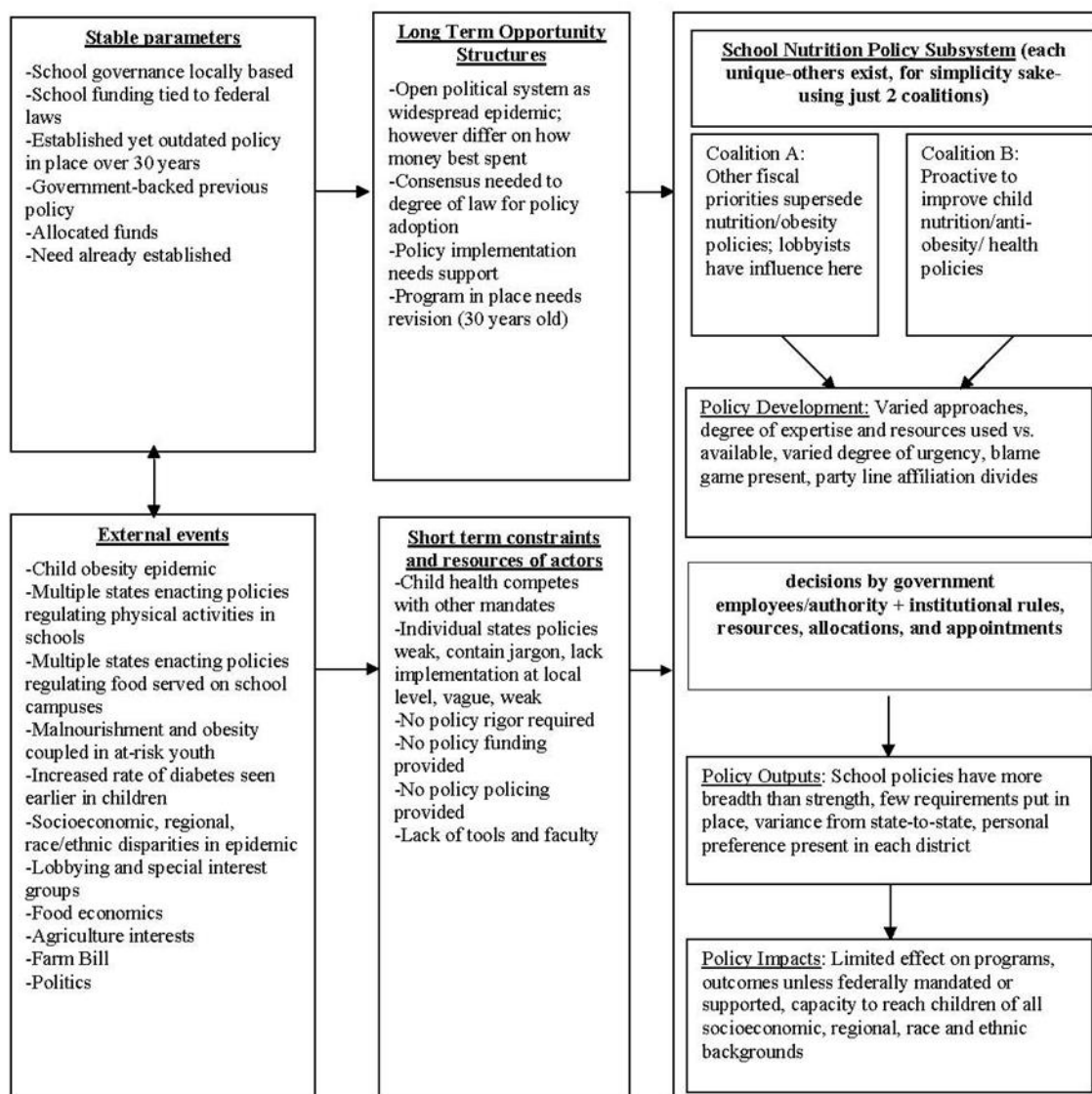


Figure 10. Use of ACF model with HHFKA data inserted for analysis

Based on the research provided, Advocacy Coalition Framework appears to be the “best fitting” model for analysis and understanding of the attitudes surrounding the Healthy, Hunger-Free Kids Act of 2010 in Kent ISD for a number of reasons (Figure 10):

- It allows for flexibility within the framework for change to the framework itself AND for the collaboration of other theories to be integrated such as Alternative Dispute Resolution (ADR) which contributes to the ability for policy change to

come in the form of a negotiated agreement between actors or agencies. With many agencies having an investment in this outcome, collaboration, and flexibility must be taken into account. Rigidity certainly would lead to failure in this scenario.

- It is relatively simple to outline and understand particularly with regard to an otherwise messy or as Sabatier (2007) describes, “wicked” situation with multiple actors and agendas. While critics think that it might be oversimplified by “stating the obvious” this seems to be a benefit in that more actors can take a role in policymaking and positive change. This is of particular importance with varying levels of policy experience and educational levels that might be impacted by this policy-evaluation exercise.
- ACF makes equal use of qualitative and quantitative data with multiple entry points available for simplistic or complex policy analysis. A wide-variety of participants needs a wide variety of analysis points. Value in regard to this policy is subjective as health is at stake. People vary and so must the policy analysis in this case.
- Weible, Sabatier & McLean (2009) discuss the ACF's causal logic and resulting hypotheses build from a set of assumptions: (i) a central role of scientific and technical information in policy processes; (ii) a time perspective of 10 years or more to understand policy change; (iii) policy subsystems as the primary unit of analysis; (iv) a broad set of subsystem actors that not only include more than the traditional iron triangles' members but also officials from all levels of government, consultants, scientists, and members of the media; and (v) a

perspective that policies and programs are best thought of as translations of beliefs (Sabatier & Jenkins-Smith, 1999, pp. 118-20).

- Additionally, the ACF specifies a model of the individual who is boundedly rational with limited abilities to process stimuli; relies on beliefs as the principal heuristic to simplify, filter, and sometimes distort stimuli; and remembers losses more than gains (Lord, Ross, & Lepper, 1979; Quattrone & Tversky, 1988; Scholz & Pinney, 1995; Simon, 1985).

Contribution to the Field

Keeping consistent with the spirit in which other studies that have sought to gather similar, though not same, data on nutrition and wellness policy creation and/or impact in other areas across the United States (Sanchez, Hale, Andrews, et al., 2014; Schwartz, Henderson, Falbe, et al., 2012; Larson, Davey, Hoffman, et al, 2016; Wu, 2008; Lucarelli, Alaimo, Belansky, et al., 2015); and understanding that Lucarelli, et al.'s (2015) first of its kind Michigan-wide study concluded that “there is room for improvement in the quality of written school wellness policies” that “ambiguous language can make implementation of wellness policy provisions difficult” (p.199) this study attempted to gauge the status of stakeholder perception in regard to the template policies (Appendix I) that most schools are adopting without modification. “Districts may also intentionally keep written policies vague so that each building can tailor the policy to their specific needs or for fear of auditing of wellness practices” (p. 199) which, as noted in this study simply leads to confusion and frustration within the stakeholder contingency.

This study confirms and builds on the existing historical data that indicates a general disconnect between policy formation and implementation which supports the age old paradox of

policy analysis, policy making, and policy implementation. Research questions 1-5 of this study corroborate that level of key school district stakeholder familiarity in regard to local school wellness policy is low to nonexistent (RQ1); the perception of key school district stakeholder familiarity in regard to the failure or success of local school wellness policy implementation is poor (RQ2); the perception of key school district stakeholders with regard to the impact of local school wellness policy is neutral (RQ3), the perception of key school district stakeholders with regard to level of support available to implement and/or sustain the local school wellness policy is likewise negative (RQ4), and the quantitative data supporting research questions 1-4 coupled with the qualitative data collected by the instrument indicates that yes, a disconnect does exist between policy creation and implementation (RQ5) with regard to local school wellness policy and the mandates that govern these policies.

While there is plenty of research done on evaluating federal policy, local school wellness policy, and nutritional impact of federal policy, there is not a body of empirical evidence based on multi-stakeholder perspectives centered around implementation of federal school food or nutrition policy in the state of Michigan or any other state. This study changes that by filling in the gap in the literature that exists for specific data regarding nutritional policy implementation based on unfunded mandates created at the federal level but implemented at the local or district level. No other federal nutrition law study has observed the perception of stakeholders in implementation of local school wellness policy. This is the first of its kind, bridging the implementation paradox discussed in the literature review, between policy creation and policy implementation through the stakeholders responsible for implementation.

This study adds to the body of literature available examining nonspecific unfunded federal policies in the United States and could easily be replicated in other counties across

Michigan and the United States to draw comparisons between variables studied as well as add additional variables that are already studied nation-wide (such as nutritional impact, health, etc.) for greater understanding of implementation of nutrition-based unfunded and funded mandates across all socioeconomic levels.

Likewise, it adds to the literature available that demonstrates lack of stakeholder involvement in policy implementation will likely mean the demise to the success of said policy. This is a perfect example of how public policy analysts (scholars) and public policy makers (legislators) should and could work effectively together for stronger policy outcomes at both federal and local levels if they worked with stakeholders to create sound policy from the beginning. This research was economically feasible to conduct and could be replicated at the state level without demanding additional resources.

Limitations of this Study

As with all studies that are mixed methods in approach, this research design sought to discover perspective it is relied on that stakeholders are able to articulate their knowledge, feelings, and observations into a measure on a Likert scale.

The selection of only one model organization does narrow the responses and this prohibits the researcher's ability to generalize the perceptions of this population to a more broad generalization. This research, while limited in this particular study by a singular survey could be recreated in multiple districts all through the United States at a low resource expenditure.

While chancing the normal issues of survey taking, like survey fatigue (Porter, Whitcomb, & Weitzer, 2004) or response burden (Sharp and Frankel, 1983), the choice to distribute surveys electronically knowingly falls into a response collection bias that can

potentially impede results collected due to web privacy concerns, fear of outside links or general web literacy involved; however, given the budgetary constraints of this study, it was chosen as the most economical option possible and still netted a valid response rate.

The limitations in the analysis of HHFKA and policy literature lies in the following areas:

- Social theory is tremendously "sticky" with multiple actors & influences.
- Frameworks/models each have individual limitations.
- HHFKA policy is relatively new with major revisions occurring annually with multiple actors administering the policy in various environments.
- Multiple models literature involved in public health but not specifically HHFKA evaluation.
- New policy makes for limited studies of longevity.
- The nature of this policy is both political and polarizing in nature.
- Literature is scattered in dozens of policy arenas making for research complexity with high volume of scholarly activity.

Overall, policy frameworks are suited to the policy of study but do not directly identify the actions for policy. In other words we can analyze what has happened but not always how to influence it. ACF comes closest to addressing this conundrum. Big problems and tasks seldom follow neat borders but rather, cut across administrative levels, sectors, and units, creating a lot of challenges for political and administrative leaders. Thus, there is a need for new steering mechanisms focusing on broad social outcomes to handle this challenge. Questions still remain

in ACF about the membership, stability, and defection of coalition members; about the causal mechanisms linking external events and policy change; and about the conditions that facilitate cross-coalition learning (Weible, Sabatier, & McLean, 2009).

Future Study, Recommendations, and Other Implications

While there is a “best fit” among the options present in this study based on models chosen for analysis, the real benefit to examining policy making under multiple models lies in the positive and negative attributes of each model to produce a different or “best fit” scenario which is not typically blatantly obvious in terms of outcome. As a result of study, it is certain that hybrid policy models exist and could be utilized to create better policy-based outcomes especially as it applies to the disruption between policy and implementation governance.

Additionally, the ability to ponder models with regard to implementation or take theory to practice only helps legislators, both elected and appointed, gain perspective on the policy process; with the lasting impact being creation of better or “best fit” policy for the wicked problems that are faced in society.

As with many studies of a specific population, the ability to generalize over larger populations is not always a sound idea as many factors bound attitudes and perspectives in a region and so it is that I would recommend additional study and replication of this study in order to more broadly generalize the information obtained to other geographical locales as well as pursuant to other states’, district and local policy matters.

In future studies, it is recommended that one might add another layer of insight to this process creating a mixed methods study; perhaps interviews and/or observation to this study to better understand the stakeholder perspective of the implementation process in schools. This

could add additional insight to the policy implementation process and potentially aid legislative formation.

Advocacy coalitions attempt to realize a set of shared policy beliefs by influencing the behavior of multiple government situations over time. It is within the timeline of formulation from the first act nearly 30 years ago to present that the potential lies for future exploration. ACF identifies the inner workings of situations via individuals and their belief systems based from his/her individual actions. The basic values of the individual, not the situational margins determine coalition dissemination which is the basis for the collective action or policy making. American regime values from past to present in the formulation of this policy would be something of interest to research as very little has been done in terms of analysis of the Health Hunger-Free Kids Act of 2010 to date and even less done regarding the “gap” from 30 years previously to present.

The current state of updates and roll outs to HHFKA are fragmented and irregular. As the USDA releases guidance to state agencies and school food authorities (SFAs) to improve or amend their local policies with regularity, the digital era governance should in theory improve processes if given the appropriate resources or network powers to extend the programming. Digital era policy-making and management would be an area of examination to consider based on the resource limitations per region of the nation and per SFA.

Finally, while there is an abundance of evidence in the role of stakeholders in the literature reviewed in this study, little has been developed or created on which strategies work best for engagement of different stakeholder groups. It seems that this would be the next logical place to visit following this study.

As “wicked” big problems and social issues rarely follow neat borders but rather, cut across administrative levels, sectors and units, creating a lot of challenges for political and administrative leaders there is a need for new steering mechanisms focusing on broad social outcomes to handle this challenge. New Public Management (NPM) measures are mostly an incomplete picture and tend to ignore qualitative measures or outcomes. The author feels that working within post-NPM frameworks have greater hope for this policy aggregate. Performance measures in this framework could show a greater impact than just a singular output/line. The sum in the case of HHFKA is greater than the individual or line item outputs. In this case individual and holistic nutrition indicators are neither measurable/quantifiable in the beginning as required by the resource-effectiveness goals as required by NPM measures which dictates centrality of citizens who were the recipient of the services or customers to the public sector (Hood, 1995).

In general, there is a mismatch between the way public administration is organized in contemporary democracies (NPM standard heavy) and the wicked issues that the public sector organization are set to handle – neither work well if un-moderated or if the variables for measurement are inflexible. In the case of HHFKA, cost efficiency is not the goal of the policy; it is a goal of the administrators. The goal of the policy is to fund and sets policy for USDA's core child nutrition programs in order to reduce obesity and diabetes rates in children. Objectives solely set by NPM-inspired reforms would serve to increase, rather than reduce corruption in this sector/policy.

Promotion of core values such as equality, individual dignity, linking society to self, personal realization is a way to increase the success rate of public policy such as the HHFKA of 2010; however it could be interpreted to ignore those cultural values such as self-interest, private solutions/"true" liberty, limited administration, & true individualism by passing down nutrition

standards and forcing compliance in individual households. The disconnect between the sound public policy and questionable policy in the case of HHFKA could come down to implementation in each SFA. Therefore, the future of this type of policy, or “safety net” depends on implementation at the local level and buy-in or participation of each community. Additional areas of research include: include policy subsystem interdependencies and coordination within, and between, coalitions.

Additionally, other theoretical frames may exist that shine light on the “wicked” problem of nutrition/health policy in the United States as it relates to stakeholder engagement. Use of multiple models only helps to tune in to the issues, motivations, and methods of creation and implementation and should be studied or observed for improved outcomes.

Conclusion

In 1983, Timmer, Falcon, and Pearson wrote about the dynamics of food policy and the cornerstone role it plays to economic development efforts worldwide. They discuss that food problems are immersed in the broader problems of economic development and involve a long-run vision of how food systems evolve under “alternative policy environments” (p. vii). Governments attempting to confront their food problems big and small have shown that these issues are foundational to governance itself; yet those who posit food policy “do not typically form a critical mass or have sufficient access to political power to have an influence on policy” (p. viii).

When Timmer, Falcon, and Pearson’s policy manual was published the world was facing the human problem of hunger. Fast forward two or three decades and food systems again are struggling, but this time, at least in the United States, the issue has become government policing

issues that are largely as a result of consuming too much food. In both cases, too little and too much, policy analysis is critical to understand positive potential at national levels.

As identified in this literature review and study, there is much research done on policy outcomes and policy economics, but what was successfully studied here and lacking in previous policy research, is the role that stakeholders have and how they perceived the policy as it was dictated to them. In a school district, stakeholder engagement with policy, is not discrete, disembodied events occurring in isolation from one another (Weible, 2012). On the contrary, policy decisions and their impacts are interlocked making it increasingly difficult for one policy area to function independently of other areas (Greenberg et al., 1977) and therefore, in this study, it is clear that stakeholder perception is a valid construct in the role of public policy formation and should be regarded as such.

This study was developed in order to develop evidence-backed recommendations from for policy implementation analysis, policy improvements, and criticisms; and lastly, to show gaps in current literature and make recommendations for future study as a result of analysis of stakeholder perceptions, attitudes, and further evaluation. These frameworks help consider the relationship between public policy formation/creation and implementation. Poor theoretical underpinning makes it difficult in understanding and explaining how and why implementation succeeds or struggles, thus restraining opportunities to identify factors that predict the likelihood of implementation success and develop better strategies to achieve more successful future implementation (Nilsen, 2015). “Of course, many unanswered questions remain. We recognize the challenges facing policy process researchers (Greenberg et al., 1977) and the numerous theories characterizing the field, some of which are stronger than others (Sabatier, 1991;

Sabatier, 2007). The persistence of some theories over others is possibly one indication of growth and progress in the field” (Villalobos, 2012).

This study collected, examined, and evaluated the literature present in relationship to key public policy/analysis models: Policy Implementation Framework, Multiple Streams Model (MSM), and Advocacy Coalition Framework (ACF); demonstrated that there are tools available to examine things like policy strength, comprehensiveness, effectiveness, reporting, monitoring and policing LSWPs and even present is a growing body of literature evaluating studies post implementation for outcomes present. It also polled stakeholders to illuminate the policy formulation/formation and operation “in real life.”

It has lent evidence to the idea in policy implementation of “disconnect” between policy making and policy implementation which is a time-tested paradigm in public administration literature, in one ISD in the state of Michigan and it corroborates that while a substantial amount of effort has been put into this type of food policy including wellness programs, those that implement these policies are unsure if the policies are effective as implemented. This paper serves as the first of its kind to discuss perception of stakeholders in implementing LSWP.

Finally, the paradox of policy analysis is addressed that instead of relying on stakeholder expertise in regard to policy creation, legislators use insider information instead of outside expertise and have little use for any information that relates to the outcomes desired in the society where the policy will impact it. The information from this study, paired with the literature review emphasize what Whiteman (1995) and Shulock (1999) also discovered in that “the more salient an issue is to constituents, the less analytical information is used” (p. 227).

It would seem that while governments have a critical role in the development and implementation of policies, which would include resources, funding, evaluation, etc., successful

adoption, implementation, and monitoring of that policy falls to the stakeholders and therefore, should emphasize involvement and cooperation of numerous stakeholders from creation to implementation, particularly training in said areas as this study emphasizes, in order to achieve successful outcomes. Stakeholder perception is a valid construct in the role of public policy formation and should be regarded as such going forward.

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Appendix A: 1966 Law

H. R. 10222

PUBLIC LAW 88-525



Eighty-eighth Congress of the United States of America

AT THE SECOND SESSION

*Began and held at the City of Washington on Tuesday, the seventh day of January,
one thousand nine hundred and sixty-four*



An Act

To strengthen the agricultural economy; to help to achieve a fuller and more effective use of food abundances; to provide for improved levels of nutrition among low-income households through a cooperative Federal-State program of food assistance to be operated through normal channels of trade; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as "The Food Stamp Act of 1964".

DECLARATION OF POLICY

SEC. 2. It is hereby declared to be the policy of Congress, in order to promote the general welfare, that the Nation's abundance of food should be utilized cooperatively by the States, the Federal Government, and local governmental units to the maximum extent practicable to safeguard the health and well-being of the Nation's population and raise levels of nutrition among low-income households. The Congress hereby finds that increased utilization of foods in establishing and maintaining adequate national levels of nutrition will tend to cause the distribution in a beneficial manner of our agricultural abundances and will strengthen our agricultural economy, as well as result in more orderly marketing and distribution of food. To effectuate the policy of Congress and the purposes of this Act, a food stamp program, which will permit those households with low incomes to receive a greater share of the Nation's food abundance, is herein authorized.

DEFINITIONS

SEC. 3. As used in this Act—

- (a) The term "Secretary" means the Secretary of Agriculture.
- (b) The term "food" means any food or food product for human consumption except alcoholic beverages, tobacco, those foods which are identified on the package as being imported, and meat and meat products which are imported.
- (c) The term "coupon" means any coupon, stamp, or type of certificate issued pursuant to the provisions of this Act.
- (d) The term "coupon allotment" means the total value of coupons to be issued to a household during each month or other time period.
- (e) The term "household" shall mean a group of related or non-related individuals, who are not residents of an institution or boarding house, but are living as one economic unit sharing common cooking facilities and for whom food is customarily purchased in common. The term "household" shall also mean a single individual living alone who has cooking facilities and who purchases and prepares food for home consumption.
- (f) The term "retail food store" means an establishment, including a recognized department thereof, or a house-to-house trade route which sells food to households for home consumption.
- (g) The term "wholesale food concern" means an establishment which sells food to retail food stores for resale to households.
- (h) The term "State agency" means the agency of the State government which has responsibility for the administration of the federally aided public assistance programs.
- (i) The term "bank" means member or nonmember banks of the Federal Reserve System.
- (j) The term "State" means the fifty States and the District of Columbia.

Appendix B: Child Nutrition and WIC Reauthorization Act of 2004



S. 2507

One Hundred Eighth Congress of the United States of America

AT THE SECOND SESSION

*Begun and held at the City of Washington on Tuesday,
the twentieth day of January, two thousand and four*

An Act

To amend the Richard B. Russell National School Lunch Act and the Child Nutrition Act of 1966 to provide children with increased access to food and nutrition assistance, to simplify program operations and improve program management, to reauthorize child nutrition programs, and for other purposes.

*Be it enacted by the Senate and House of Representatives of
the United States of America in Congress assembled,*

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Child Nutrition and WIC Reauthorization Act of 2004”.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; Table of contents.

TITLE I—AMENDMENTS TO RICHARD B. RUSSELL NATIONAL SCHOOL LUNCH ACT

- Sec. 101. Nutrition promotion.
- Sec. 102. Nutrition requirements.
- Sec. 103. Provision of information.
- Sec. 104. Direct certification.
- Sec. 105. Household applications.
- Sec. 106. Duration of eligibility for free or reduced price meals.
- Sec. 107. Runaway, homeless, and migrant youth.
- Sec. 108. Certification by local educational agencies.
- Sec. 109. Exclusion of military housing allowances.
- Sec. 110. Waiver of requirement for weighted averages for nutrient analysis.
- Sec. 111. Food safety.
- Sec. 112. Purchases of locally produced foods.
- Sec. 113. Special assistance.
- Sec. 114. Food and nutrition projects integrated with elementary school curricula.
- Sec. 115. Procurement training.
- Sec. 116. Summer food service program for children.
- Sec. 117. Commodity distribution program.
- Sec. 118. Notice of irradiated food products.
- Sec. 119. Child and adult care food program.
- Sec. 120. Fresh fruit and vegetable program.
- Sec. 121. Summer food service residential camp eligibility.
- Sec. 122. Access to local foods and school gardens.
- Sec. 123. Year-round services for eligible entities.
- Sec. 124. Free lunch and breakfast eligibility.
- Sec. 125. Training, technical assistance, and food service management institute.
- Sec. 126. Administrative error reduction.
- Sec. 127. Compliance and accountability.
- Sec. 128. Information clearinghouse.
- Sec. 129. Program evaluation.

TITLE II—AMENDMENTS TO CHILD NUTRITION ACT OF 1966

- Sec. 201. Severe need assistance.
- Sec. 202. State administrative expenses.
- Sec. 203. Special supplemental nutrition program for women, infants, and children.

Appendix C: Healthy Hunger-Free Kids Act of 2010



PUBLIC LAW 111–296—DEC. 13, 2010

124 STAT. 3183

Public Law 111–296
111th Congress

An Act

To reauthorize child nutrition programs, and for other purposes.

Dec. 13, 2010
[S. 3307]

*Be it enacted by the Senate and House of Representatives of
the United States of America in Congress assembled,*

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Healthy,
Hunger-Free Kids Act of 2010”.

(b) **TABLE OF CONTENTS.**—The table of contents for this Act
is as follows:

Healthy, Hunger-
Free Kids Act of
2010.
42 USC 1751
note.

Sec. 1. Short title; table of contents.
Sec. 2. Definition of Secretary.

TITLE I—A PATH TO END CHILDHOOD HUNGER

Subtitle A—National School Lunch Program

Sec. 101. Improving direct certification.
Sec. 102. Categorical eligibility of foster children.
Sec. 103. Direct certification for children receiving Medicaid benefits.
Sec. 104. Eliminating individual applications through community eligibility.
Sec. 105. Grants for expansion of school breakfast programs.

Subtitle B—Summer Food Service Program

Sec. 111. Alignment of eligibility rules for public and private sponsors.
Sec. 112. Outreach to eligible families.
Sec. 113. Summer food service support grants.

Subtitle C—Child and Adult Care Food Program

Sec. 121. Simplifying area eligibility determinations in the child and adult care
food program.
Sec. 122. Expansion of afterschool meals for at-risk children.

**Subtitle D—Special Supplemental Nutrition Program for Women, Infants, and
Children**

Sec. 131. Certification periods.

Subtitle E—Miscellaneous

Sec. 141. Childhood hunger research.
Sec. 142. State childhood hunger challenge grants.
Sec. 143. Review of local policies on meal charges and provision of alternate meals.

**TITLE II—REDUCING CHILDHOOD OBESITY AND IMPROVING THE DIETS
OF CHILDREN**

Subtitle A—National School Lunch Program

Sec. 201. Performance-based reimbursement rate increases for new meal patterns.
Sec. 202. Nutrition requirements for fluid milk.
Sec. 203. Water.
Sec. 204. Local school wellness policy implementation.
Sec. 205. Equity in school lunch pricing.
Sec. 206. Revenue from nonprogram foods sold in schools.

Appendix D: HSIRB Approval Letter

WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: October 3, 2017

To: Matthew Mingus, Principal Investigator
Adrienne Wallace, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number 17-09-26

This letter will serve as confirmation that your research project titled "Stakeholder Perspectives and Attitudes: Implementation of Local School Wellness Policies in the Kent Intermediate School District" has been **approved** under the **exempt** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., ***you must request a post approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study."*** Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination:

October 2, 2018

1903 W. Michigan Ave., Kalamazoo, MI 49008-5456
PHONE: (269) 387-8293 FAX: (269) 387-8276
CAMPUS SITE: 251 W. Walwood Hall

Appendix E: Email Opt In

Greetings! You are invited to participate in an on-line survey entitled, “Stakeholder perspectives and attitudes: implementation of local school wellness policies in the Kent Intermediate School District” designed to research background related to implementation of unfunded mandates and the impact on employees in schools, specifically the Kent ISD. The study is being conducted by Dr. Matthew S. Mingus and Adrienne Wallace from Western Michigan University, School of Public Affairs and Administration. This research is being conducted as part of the dissertation requirements for Adrienne Wallace. This survey is comprised of multiple choice and open ended questions and will take approximately 15 minutes to complete.

Your participation in this study is completely voluntary and replies will remain anonymous. Data from this research project will be reported only in the aggregate. This means that no individual, job function/title, or office names/locations will be used in the research report.

When you begin the survey, you are consenting to participate in the study. If you do not agree to participate in this research project simply exit now. If, after beginning the survey, you decide that you do not wish to continue, you may stop at any time. You may choose to not answer any question for any reason. Please do not participate in this study after (October 3, 2018). Participating in this survey online indicates your consent for use of the answers you supply. There are no foreseeable risks associated with this project, however, if you feel uncomfortable answering any questions you may withdraw from participating at any point or chose not to participate.

If you have any questions prior to or during the study, you may contact Dr. Matthew S. Mingus, at matthew.mingus@wmich.edu, director of graduate programs in the Western Michigan University School of Public Affairs and Administration, the Human Subjects Institutional Review Board (269-387-8293) or the vice president for research (269-387-8298). This study was approved by the Western Michigan University Human Subjects Institutional review Board (HSIRB) on (October 3, 2017).

Thank you for your time and consideration! By continuing, you are providing consent for your responses to be recorded and analyzed as part of this research project.

Appendix F: Survey

1. Your current role - Answers: Director/Supervisor of Nutrition or Food Service, Nutrition or Food Service Specialist/Dietician, School Nurse, Teacher/Educator, Administrator/Principal, Other (please define)
2. Number of years in the role above - Answers: 1-5, 6-10, 11-15, 16-20, 20+
3. Number of years worked in your current district - Answers: 1-5, 6-10, 11-15, 16-20, 20+
4. Enrollment in your district - Answers: <5000, 5000-9999, 10000-14999, 15000-19999, 20000+
5. What is the name of your school district? Remember NO identifying information will be included in the report. Data will ONLY report out in aggregate. Answers:

Byron Center Public

Caledonia Community

Cedar Springs Public

Comstock Park Public

East Grand Rapids Public

Forest Hills Public

Godfrey Lee Public

Godwin Heights Public

Grand Rapids Public

Grandville Public

Kelloggsville Public

Kenowa Hills Public

Kent City Community

Kentwood Public

Lowell Area

Northview Public

Rockford Public

Sparta Area

Thornapple-Kellogg Public

Wyoming Public

ANY KENT ISD NON-PUBLIC SCHOOL

OTHER: Please specify

6. Level of policy agreement -

Answer Scale: Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree

- a. I am familiar with the Healthy Hunger-Free Kids Act of 2010.
- b. I am familiar with Local School Wellness Policy requirements as a result of the Child Nutrition & WIC Reauthorization Act of 2004.
- c. I am familiar with the wellness policy of my school district (Local School Wellness Policy or LSWP)
- d. The Local School Wellness Policy is fully implemented in my school district.
- e. Enforcing the Local School Wellness Policy should be a priority.
- f. Based on my knowledge, the Local School Wellness Team assessed the needs of the students prior to developing the wellness policy.
- g. Participation in Local School Wellness Policy activities is a requirement under federal law.
- h. The Local School Wellness Policy has had no impact on stakeholders responsibilities (stakeholders: principals/assistant principals, teachers, nutrition specialist/dietitian, director of child nutrition)
- i. There should be a designated person to monitor the Local School Wellness Policy.
- j. The Local School Wellness Policy will make a positive impact on the students and the US obesity epidemic.
- k. Local School Wellness Policy can be sustained in schools with interaction from all stakeholders.
- l. The school district should involve students in developing the Local School Wellness Policy.
- m. The requirement to implement Local School Wellness Policy is too broad.
- n. The United States Department of Agriculture (USDA) provided unlimited guidance and assistance in the development and implementation of the Local School Wellness Policy.
- o. Our district has enough financial resources to properly implement the Local School Wellness Policy.

- p. Based on my knowledge, tremendous efforts were taken to *create* a sound Local School Wellness Policy.
- q. Based on my knowledge, tremendous efforts were taken to *implement* a sound Local School Wellness Policy.
- r. Based on my knowledge, tremendous efforts were/are taken to *sustain* a sound Local School Wellness Policy.
- s. Based on my knowledge of the Local School Wellness Policy, I believe it is being appropriately applied in my school district.
- t. Our district struggles to properly implement the Local School Wellness Policy.
- u. Our district has enough staff to properly implement the Local School Wellness Policy.
- v. Our district has enough money properly implement the Local School Wellness Policy.
- w. Our district has enough time to properly implement the Local School Wellness Policy.
- x. Our district has active community involvement in order to properly implement the Local School Wellness Policy.
- y. I have been thoroughly trained to properly implement the Local School Wellness Policy.

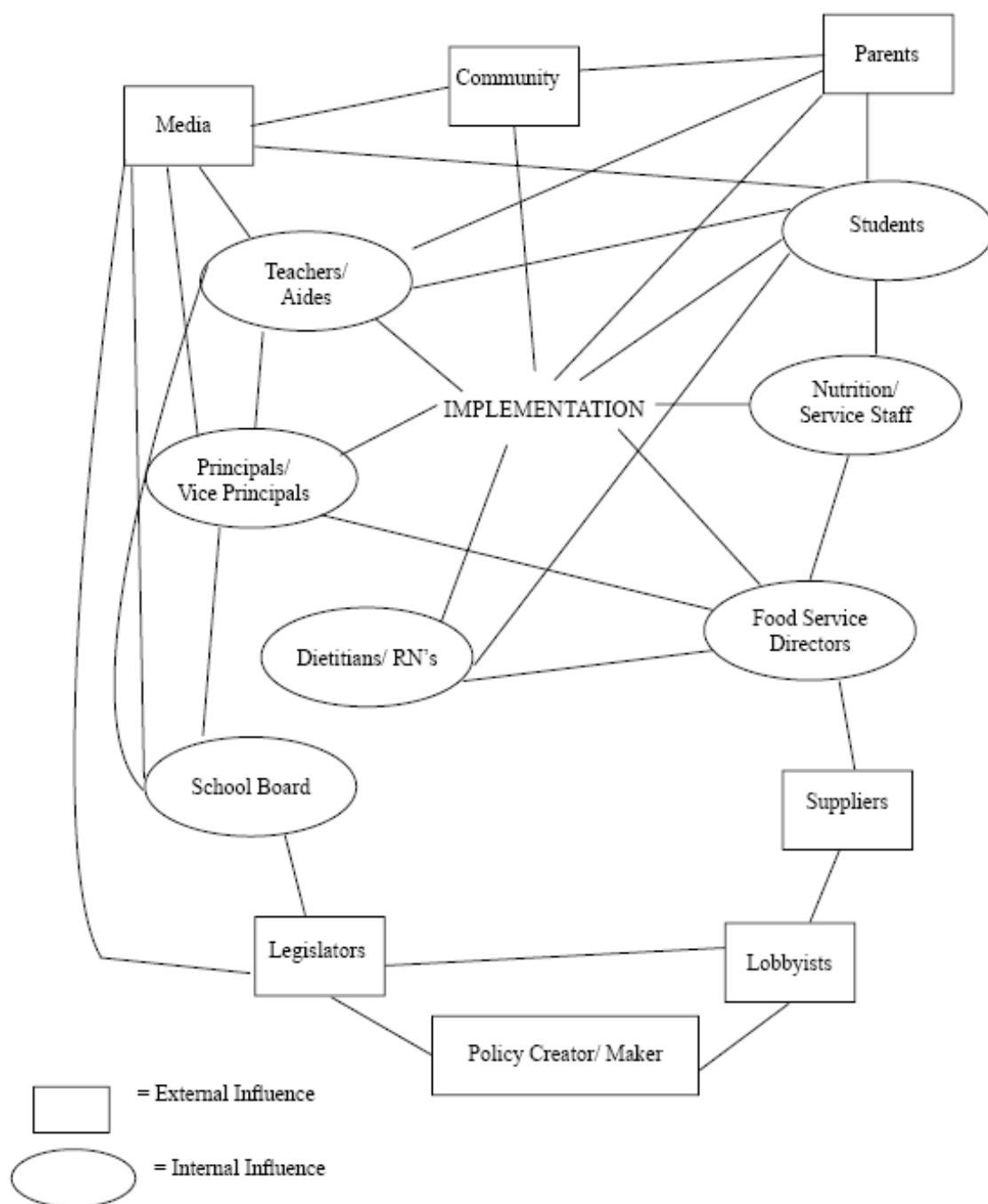
Additional comments for the researcher

Open feedback box.

Appendix G: Variable to Model/Framework

Variable Name/Definition	Independent (I) or Dependent (D)	Pertaining to Research Question #	Model/Framework Corresponding: MSM, ACF, PIF
Policy Standards/ Objectives	D	1,3,4,5,6	PIF, ACF
Policy Resources	I	1,4,5,6	PIF
Interorganizational Communication and Enforcement	D	2,3,4,5,6	PIF
Characteristics of Agency	I	3,4,5	MSM, ACF, PIF
Conditions: Economic, Social, Political	D	2,3,4,5,6	MSM, ACF, PIF
Disposition	I	2,4,5,6	PIF, MSM
Participation	I	1,3	MSM
Learning	I	1,4,6	ACF
Sub-Systems	D	2,3,4,5,6	ACF
Implementer Characteristics	I	1,2	PIF
Experience	I	4,5,6	MSM, ACF, PIF
Nutrition Policy Implementation Knowledge (Familiarity)	D	1,3,6	MSM, ACF, PIF
Impact	D	3,4,5,6	MSM, ACF, PIF

Appendix H: Stakeholder Map + Influencers



Appendix I: Monitoring Process

Monitoring Process:	
Districts should keep <i>Supporting Documentation</i> on file.	
Documentation will be requested in electronic format prior to onsite visit.	
Monitoring Language	Expectation – What to provide to AR Analyst
Provide a copy of the current Local School Wellness Policy. *1000	Provide a copy of the current Local School Wellness Policy Example – Emailed to analyst in a PDF or Word document. NOT faxed or mailed.
How does the public know about the Local School Wellness Policy?	Provide documentation demonstrating the Local School Wellness Policy has been made available to the public.
Provide documentation to support the response (or appropriate web address(es)). *1001	Example - If on a webpage, provide the direct link; if part of a handbook, provide documentation on how the public has access. Provide documentation of the district's efforts to review and update the Local School Wellness Policy.
When and how does the review and update of the Local School Wellness Policy occur?	
Provide documentation to support the response (or appropriate web address(es)). *1002	Example - This may include meeting minutes listing specific topics discussed and reviewed and a copy of any associated assessments. If on a webpage, provide the direct link.
Who is involved in reviewing and updating the Local School Wellness Policy?	Provide a list of who is involved in the update of the Local School Wellness Policy and their relationship to the SFA.
What is their relationship with the School Food Authority (SFA)?*1003	Example - This may include meeting minutes listing of attendees and each person's role. Provide documentation of the methods the district uses to make stakeholders aware of their ability to participate in the development, review and update of the Local School Wellness Policy.
How are potential stakeholders made aware of their ability to participate in the development, review, update, and implementation of the Local School Wellness Policy?	
Provide documentation to support the response (or appropriate web address(es)). *1004	Example - A copy of an announcement alerting stakeholders of their ability to participate in a print or email newsletter - If on a webpage, provide the direct link. Provide documentation demonstrating that assessment on the implementation of the Local School Wellness Policy occurred.
Provide a copy of the most recent assessment on the implementation of the Local School Wellness Policy. *1005	Example - A copy of an assessment of a specific policy goal, objective or activity
How does the public know about the results of the most recent assessment on the implementation of the Local School Wellness Policy?	Provide documentation demonstrating that the district's most recent assessment on the implementation of the Local School Wellness Policy has been made available to the public.
Provide documentation to support the response (or appropriate web address(es)). *1006	Example - If on a webpage, provide the direct link; if a part of a newsletter or other electronic/print announcement, provide documentation on how the public has access.

*Administrative Review Offsite Assessment Question Numbers

Appendix J: School District Wellness Policy Model Template

[School District] Wellness Policy

Note: This “Basic” district-level wellness policy template meets the minimum Federal standards for local school wellness policy implementation under the final rule of the [Healthy, Hunger-Free Kids Act of 2010](#), the Alliance for a Healthier Generation Healthy Schools Program Bronze-level award criteria, and minimum best practice standards accepted in the education and public health fields. Where appropriate, the template includes optional policy language school districts can use to establish a stronger policy that meets the Healthy Schools Program Silver or Gold award levels. School districts should choose policy language that meets their current needs and also supports growth over time] If you are using this tool to compare your policy against, you should include the language in italics as the strongest examples for comparison.

Preamble

[Insert School District name] (hereto referred to as the District) is committed to the optimal development of every student. The District believes that for students to have the opportunity to achieve personal, academic, developmental and social success, we need to create positive, safe and health-promoting learning environments at every level, in every setting, throughout the school year.

Research shows that two components, good nutrition and physical activity before, during and after the school day, are strongly correlated with positive student outcomes. For example, student participation in the U.S. Department of Agriculture’s (USDA) School Breakfast Program is associated with higher grades and standardized test scores, lower absenteeism and better performance on cognitive tasks.^{i,ii,iii,iv,v,vi,vii} Conversely, less-than-adequate consumption of specific foods including fruits, vegetables and dairy products, is associated with lower grades among students.^{viii,ix,x} In addition, students who are physically active through active transport to and from school, recess, physical activity breaks, high-quality physical education and extracurricular activities – do better academically.^{xi,xii,xiii,xiv} Finally, there is evidence that adequate hydration is associated with better cognitive performance.^{15,16,17}

This policy outlines the District’s approach to ensuring environments and opportunities for all students to practice healthy eating and physical activity behaviors throughout the school day while minimizing commercial distractions. Specifically, this policy establishes goals and procedures to ensure that:

- Students in the District have access to healthy foods throughout the school day – both through reimbursable school meals and other foods available throughout the school campus– in accordance with Federal and state nutrition standards;
- Students receive quality nutrition education that helps them develop lifelong healthy eating behaviors;
- Students have opportunities to be physically active before, during and after school;
- Schools engage in nutrition and physical activity promotion and other activities that promote student wellness;
- School staff are encouraged and supported to practice healthy nutrition and physical activity behaviors in and out of school;

- The community is engaged in supporting the work of the District in creating continuity between school and other settings for students and staff to practice lifelong healthy habits; and
- The District establishes and maintains an infrastructure for management, oversight, implementation, communication about and monitoring of the policy and its established goals and objectives.

This policy applies to all students, staff and schools in the District. Specific measureable goals and outcomes are identified within each section below.

[Recommended Optional language includes:

- *The District will coordinate the wellness policy with other aspects of school management, including the District's School Improvement Plan, when appropriate.*
- *NOTE: Will also include any relevant data or statistics from state or local sources supporting the need for establishing and achieving the goals in this policy.]*

I. School Wellness Committee

Committee Role and Membership

The District will convene a representative district wellness committee (hereto referred to as the DWC or work within an existing school health committee) that meets at least **four** times per year *[or specify frequency of meetings, with a minimum of four meetings per year]* to establish goals for and oversee school health and safety policies and programs, including development, implementation and periodic review and update of this district-level wellness policy (heretofore referred as "wellness policy").

The DWC membership will represent all school levels (elementary and secondary schools) and include (to the extent possible), but not be limited to: parents and caregivers; students; representatives of the school nutrition program (e.g., school nutrition director); physical education teachers; health education teachers; school health professionals (e.g., health education teachers, school health services staff [e.g., nurses, physicians, dentists, health educators, and other allied health personnel who provide school health services], and mental health and social services staff [e.g., school counselors, psychologists, social workers, or psychiatrists]; school administrators (e.g., superintendent, principal, vice principal), school board members; health professionals (e.g., dietitians, doctors, nurses, dentists); and the general public. When possible, membership will also include Supplemental Nutrition Assistance Program Education coordinators (SNAP-EDEDSNAP-Ed). To the extent possible, the DWC will include representatives from each school building and reflect the diversity of the community.

[Optional additional policy language:

- *Each school within the District will establish an ongoing School Wellness Committee (SWC) that convenes to review school-level issues, in coordination with the DWC.]*

Leadership

The Superintendent or designee(s) will convene the DWC and facilitate development of and updates to the wellness policy, and will ensure each school's compliance with the policy.

The designated official for oversight is (Title and contact information)

The name(s), title(s), and contact information (email address is sufficient) of this/these individual(s) is(are):

Name	Title / Relationship to the School or District	Email address	Role on Committee
Ima Example	Community Member	ImaExample@community.org	Assists in the evaluation of the wellness policy implementation

Each school will designate a school wellness policy coordinator, who will ensure compliance with the policy. Refer to Appendix for a list of school-level wellness policy coordinators.

II. Wellness Policy Implementation, Monitoring, Accountability and Community Engagement

Implementation Plan

The District will develop and maintain a plan for implementation to manage and coordinate the execution of this wellness policy. The plan delineates roles, responsibilities, actions and timelines specific to each school; and includes information about who will be responsible to make what change, by how much, where and when; as well as specific goals and objectives for nutrition standards for all foods and beverages available on the school campus, food and beverage marketing, nutrition promotion and education, physical activity, physical education and other school-based activities that promote student wellness. It is recommended that the school use the [Healthy Schools Program online tools](#) to complete a school-level assessment based on the Centers for Disease Control and Prevention's School Health Index, create an action plan that fosters implementation and generate an annual progress report.

This wellness policy and the progress reports can be found at: *INSERT URL for DISTRICT's WEBSITE.*

Recordkeeping

The District will retain records to document compliance with the requirements of the wellness policy at [District's Administrative Offices, Room #] and/or on [District's central computer network]. Documentation maintained in this location will include but will not be limited to:

- The written wellness policy;
- Documentation demonstrating that the policy has been made available to the public;
- Documentation of efforts to review and update the Local Schools Wellness Policy; including an indication of who is involved in the update and methods the district uses to make stakeholders aware of their ability to participate on the DWC;
- Documentation to demonstrate compliance with the annual public notification requirements;
- The most recent assessment on the implementation of the local school wellness policy;
- Documentation demonstrating the most recent assessment on the implementation of the Local School Wellness Policy has been made available to the public.

Annual Notification of Policy

The District will actively inform families and the public each year of basic information about this policy, including its content, any updates to the policy and implementation status. The District will make this information available via the district website and/or district-wide communications. The District will provide as much information as possible about the school nutrition environment. This will include a summary of the District's (or schools') events or activities related to wellness policy implementation. Annually, the District will also publicize the name and contact information of the District/school officials leading and coordinating the committee, as well as information on how the public can get involved with the school wellness committee.

Triennial Progress Assessments

At least once every three years, the District will evaluate compliance with the wellness policy to assess the implementation of the policy and include:

- The extent to which schools under the jurisdiction of the District are in compliance with the wellness policy;
- The extent to which the District's wellness policy compares to the Alliance for a Healthier Generation's model wellness policy; and
- A description of the progress made in attaining the goals of the District's wellness policy.

The position/person responsible for managing the triennial assessment and contact information is _____ (*list the person responsible here, their title, and their contact information*)

The DWC, in collaboration with individual schools, will monitor schools' compliance with this wellness policy.

The District [or school] will actively notify households/families of the availability of the triennial progress report.

Revisions and Updating the Policy

The DWC will update or modify the wellness policy based on the results of the annual School Health Index and triennial assessments and/or as District priorities change; community needs change; wellness goals are met; new health science, information, and technology emerges; and new Federal or state guidance or standards are issued. **The wellness policy will be assessed and updated as indicated at least every three years, following the triennial assessment.**

Community Involvement, Outreach and Communications

The District is committed to being responsive to community input, which begins with awareness of the wellness policy. The District will actively communicate ways in which representatives of DWC and others can participate in the development, implementation and periodic review and update of the wellness policy through a variety of means appropriate for that district. The District will also inform parents of the improvements that have been made to school meals and compliance with school meal standards, availability of child nutrition programs and how to apply, and a description of and compliance with Smart Snacks in School nutrition standards. The District will use electronic mechanisms, such as email or displaying notices on the district's website, as well as non-electronic mechanisms, such as newsletters, presentations to parents, or sending information home to parents, to ensure that all families are actively notified of the content of, implementation of, and updates to the wellness policy, as well as how to get involved and support the policy. The District will ensure that communications are culturally and linguistically appropriate to the community, and accomplished through means similar to other ways that the district and individual schools are communicating important school information with parents.

The District will actively notify the public about the content of or any updates to the wellness policy annually, at a minimum. The District will also use these mechanisms to inform the community about the availability of the annual and triennial reports.

III. Nutrition

School Meals

Our school district is committed to serving healthy meals to children, with plenty of fruits, vegetables, whole grains, and fat-free and low-fat milk; that are moderate in sodium, low in saturated fat, and have zero grams *trans* fat per serving (nutrition label or manufacturer's specification); and to meeting the nutrition needs of school children within their calorie requirements. The school meal programs aim to improve the diet and health of school children, help mitigate childhood obesity, model healthy eating to support the development of lifelong healthy eating patterns and support healthy choices while accommodating cultural food preferences and special dietary needs.

All schools within the District participate in USDA child nutrition programs, including the National School Lunch Program (NSLP), the School Breakfast Program (SBP), and *[include here any additional Federal child nutrition programs in which the district participates, possibly including the Fresh Fruit & Vegetable Program (FFVP), Special Milk Program (SMP), Summer Food Service Program (SFSP), Supper programs, or others]*. The District also operates

additional nutrition-related programs and activities including *[if applicable, insert here a list of other programs such as Farm to School programs, school gardens, Breakfast in the Classroom, Mobile Breakfast carts, Grab 'n' Go Breakfast, or others]*. All schools within the District are committed to offering school meals through the NSLP and SBP programs, and other applicable Federal child nutrition programs, that:

- Are accessible to all students;
- Are appealing and attractive to children;
- Are served in clean and pleasant settings;
- Meet or exceed current nutrition requirements established by local, state, and Federal statutes and regulations. (The District offers reimbursable school meals that meet [USDA nutrition standards](#).)
- Promote healthy food and beverage choices using at least ten of the following [Smarter Lunchroom techniques](#):
 - Whole fruit options are displayed in attractive bowls or baskets (instead of chaffing dishes or hotel pans).
 - Sliced or cut fruit is available daily.
 - Daily fruit options are displayed in a location in the line of sight and reach of students.
 - All available vegetable options have been given creative or descriptive names.
 - Daily vegetable options are bundled into all grab-and-go meals available to students.
 - All staff members, especially those serving, have been trained to politely prompt students to select and consume the daily vegetable options with their meal.
 - White milk is placed in front of other beverages in all coolers.
 - Alternative entrée options (e.g., salad bar, yogurt parfaits, etc.) are highlighted on posters or signs within all service and dining areas.
 - A reimbursable meal can be created in any service area available to students (e.g., salad bars, snack rooms, etc.).
 - Student surveys and taste testing opportunities are used to inform menu development, dining space decor and promotional ideas.
 - Student artwork is displayed in the service and/or dining areas.
 - Daily announcements are used to promote and market menu options.

[Optional additional policy language includes:

- *Menus will be posted on the District website or individual school websites, and will include nutrient content and ingredients.*
- *Menus will be created/reviewed by a Registered Dietitian or other certified nutrition professional.*
- *School meals are administered by a team of child nutrition professionals.*
- *The District child nutrition program will accommodate students with special dietary needs.*
- *Students will be allowed at least 10 minutes to eat breakfast and at least 20 minutes to eat lunch, counting from the time they have received their meal and are seated (meets Healthy Schools Program Gold-level criteria).*
- *Students are served lunch at a reasonable and appropriate time of day.*
- *Lunch will follow the recess period to better support learning and healthy eating.*

- *Participation in Federal child nutrition programs will be promoted among students and families to help ensure that families know what programs are available in their children's school.*
- *The District will implement at least four of the following five Farm to School activities (meets Healthy Schools Program Gold-level criteria; mark/circle the four activities the District plans to do):*
 - *Local and/or regional products are incorporated into the school meal program;*
 - *Messages about agriculture and nutrition are reinforced throughout the learning environment;*
 - *School hosts a school garden;*
 - *School hosts field trips to local farms; and*
 - *School utilizes promotions or special events, such as tastings, that highlight the local/regional products.]*

Staff Qualifications and Professional Development

All school nutrition program directors, managers and staff will meet or exceed hiring and annual continuing education/training requirements in the [USDA professional standards for child nutrition professionals](#). These school nutrition personnel will refer to [USDA's Professional Standards for School Nutrition Standards website](#) to search for training that meets their learning needs.

Water

To promote hydration, free, safe, unflavored drinking water will be available to all students throughout the school day* and throughout every school campus* ("school campus" and "school day" are defined in the glossary). The District will make drinking water available where school meals are served during mealtimes.

[Optional additional policy language may include:

- *Water cups/jugs will be available in the cafeteria if a drinking fountain is not present.*
- *All water sources and containers will be maintained on a regular basis to ensure good hygiene and health safety standards. Such sources and containers may include drinking fountains, water jugs, hydration stations, water jets and other methods for delivering drinking water.]*
- *Students will be allowed to bring and carry (approved) water bottles filled with only water with them throughout the day.*

Competitive Foods and Beverages

The District is committed to ensuring that all foods and beverages available to students on the school campus* during the school day* support healthy eating. The foods and beverages sold and served outside of the school meal programs (e.g., "competitive" foods and beverages) will meet the USDA Smart Snacks in School nutrition standards, at a minimum. Smart Snacks aim to improve student health and well-being, increase consumption of healthful foods during the school day and create an environment that reinforces the development of healthy eating habits. A summary of the standards and information, as well as a Guide to Smart Snacks in Schools are available at: <http://www.fns.usda.gov/healthierschoolday/tools-schools-smart-snacks>. The

[Alliance for a Healthier Generation](http://www.foodplanner.healthiergeneration.org) provides a set of tools to assist with implementation of Smart Snacks available at www.foodplanner.healthiergeneration.org.

[NOTE: In some cases, states have passed more stringent nutrition standards for competitive foods and beverages in addition to the USDA Smart Snacks in School nutrition standards. In these states, districts and schools must also comply with their state standards.]

To support healthy food choices and improve student health and well-being, all foods and beverages outside the reimbursable school meal programs that are sold to students on the school campus during the school day* [*and ideally, the extended school day**] will meet or exceed the USDA Smart Snacks nutrition standards [*or, if the state policy is stronger, “will meet or exceed state nutrition standards”*]. These standards will apply in all locations and through all services where foods and beverages are sold, which may include, but are not limited to, à la carte options in cafeterias, vending machines, school stores and snack or food carts.

Celebrations and Rewards

All foods offered on the school campus will meet or exceed the USDA Smart Snacks in School nutrition standards [*or, if the state policy is stronger, “will meet or exceed state nutrition standards”*], including through:

1. Celebrations and parties. The district will provide a list of healthy party ideas to parents and teachers, including non-food celebration ideas. Healthy party ideas are available from the [Alliance for a Healthier Generation](http://www.foodplanner.healthiergeneration.org) and from the [USDA](http://www.usda.gov).
2. Classroom snacks brought by parents. The District will provide to parents a [list of foods and beverages that meet Smart Snacks](#) nutrition standards.
3. Rewards and incentives. The District will provide teachers and other relevant school staff a [list of alternative ways to reward children](#). Foods and beverages will not be used as a reward, or withheld as punishment for any reason, such as for performance or behavior.

[Meets Healthy Schools Program Silver-level criteria]

Fundraising

Foods and beverages that meet or exceed the USDA Smart Snacks in Schools nutrition standards may be sold through fundraisers on the school campus* during the school day*. The District will make available to parents and teachers a list of healthy fundraising ideas [*examples from the [Alliance for a Healthier Generation](http://www.foodplanner.healthiergeneration.org) and the [USDA](http://www.usda.gov)*].

[Given the pervasiveness of food fundraisers in many schools and the wide availability of profitable, healthy fundraising options, additional policy language is encouraged:

- *Schools will use only non-food fundraisers, and encourage those promoting physical activity (such as walk-a-thons, Jump Rope for Heart, fun runs, etc.).*
- *Fundraising during and outside school hours will sell only non-food items or foods and beverages that meet or exceed the Smart Snacks nutrition standards. These fundraisers may include but are not limited to, donation nights at restaurants, cookie dough, candy and pizza sales, market days, etc. (Meets Healthy Schools Program Gold-level criteria)]*

Nutrition Promotion

Nutrition promotion and education positively influence lifelong eating behaviors by using evidence-based techniques and nutrition messages, and by creating food environments that encourage healthy nutrition choices and encourage participation in school meal programs. Students and staff will receive consistent nutrition messages throughout schools, classrooms, gymnasiums, and cafeterias. Nutrition promotion also includes marketing and advertising nutritious foods and beverages to students and is most effective when implemented consistently through a comprehensive and multi-channel approach by school staff, teachers, parents, students and the community.

The District will promote healthy food and beverage choices for all students throughout the school campus, as well as encourage participation in school meal programs. This promotion will occur through at least:

- Implementing at least ten or more evidence-based healthy food promotion techniques through the school meal programs using [Smarter Lunchroom techniques](#); and
- Ensuring 100% of foods and beverages promoted to students meet the USDA Smart Snacks in School nutrition standards. Additional promotion techniques that the District and individual schools may use are available at <http://www.foodplanner.healthiergeneration.org/>.

Nutrition Education

The District will teach, model, encourage and support healthy eating by all students. Schools will provide nutrition education and engage in nutrition promotion that:

- Is designed to provide students with the knowledge and skills necessary to promote and protect their health;
- Is part of not only health education classes, but also integrated into other classroom instruction through subjects such as math, science, language arts, social sciences and elective subjects;
- Includes enjoyable, developmentally-appropriate, culturally-relevant and participatory activities, such as cooking demonstrations or lessons, promotions, taste-testing, farm visits and school gardens;
- Promotes fruits, vegetables, whole-grain products, low-fat and fat-free dairy products and healthy food preparation methods;
- Emphasizes caloric balance between food intake and energy expenditure (promotes physical activity/exercise);
- Links with school meal programs, cafeteria nutrition promotion activities, school gardens, Farm to School programs, other school foods and nutrition-related community services;
- Teaches media literacy with an emphasis on food and beverage marketing; and
- Includes nutrition education training for teachers and other staff.

[Optional additional policy language includes:

- *In elementary schools, nutrition education will be offered at each grade level as part of a sequential, comprehensive, standards-based health education curriculum that meets state and national standards (meets Healthy Schools Program Silver/Gold-level criteria).*

- *All health education teachers will provide opportunities for students to practice or rehearse the skills taught through the health education curricula (meets Healthy Schools Program Silver/Gold-level criteria).]*

Essential Healthy Eating Topics in Health Education

The District will include in the health education curriculum a minimum of 12 of the following essential topics on healthy eating:

- Relationship between healthy eating and personal health and disease prevention
- Food guidance from [MyPlate](#)
- Reading and using FDA's nutrition fact labels
- Eating a variety of foods every day
- Balancing food intake and physical activity
- Eating more fruits, vegetables and whole grain products
- Choosing foods that are low in fat, saturated fat, and cholesterol and do not contain *trans* fat
- Choosing foods and beverages with little added sugars
- Eating more calcium-rich foods
- Preparing healthy meals and snacks
- Risks of unhealthy weight control practices
- Accepting body size differences
- Food safety
- Importance of water consumption
- Importance of eating breakfast
- Making healthy choices when eating at restaurants
- Eating disorders
- [The Dietary Guidelines for Americans](#)
- Reducing sodium intake
- Social influences on healthy eating, including media, family, peers and culture
- How to find valid information or services related to nutrition and dietary behavior
- How to develop a plan and track progress toward achieving a personal goal to eat healthfully
- Resisting peer pressure related to unhealthy dietary behavior
- Influencing, supporting, or advocating for others' healthy dietary behavior

Food and Beverage Marketing in Schools

The District is committed to providing a school environment that ensures opportunities for all students to practice healthy eating and physical activity behaviors throughout the school day while minimizing commercial distractions. The District strives to teach students how to make informed choices about nutrition, health and physical activity. These efforts will be weakened if students are subjected to advertising on District property that contains messages inconsistent with the health information the District is imparting through nutrition education and health promotion efforts. It is the intent of the District to protect and promote student's health by permitting advertising and marketing for only those foods and beverages that are permitted to be sold on the school campus, consistent with the District's wellness policy.

Any foods and beverages marketed or promoted to students on the school campus* during the school day* will meet or exceed the USDA Smart Snacks in School nutrition standards *[or, if stronger, “state nutrition standards”]*, such that only those foods that comply with or exceed those nutrition standards are permitted to be marketed or promoted to students.

Food and beverage marketing is defined as advertising and other promotions in schools. Food and beverage marketing often includes an oral, written, or graphic statements made for the purpose of promoting the sale of a food or beverage product made by the producer, manufacturer, seller or any other entity with a commercial interest in the product.^{xv} This term includes, but is not limited to the following:

- Brand names, trademarks, logos or tags, except when placed on a physically present food or beverage product or its container.
- Displays, such as on vending machine exteriors
- Corporate brand, logo, name or trademark on school equipment, such as marquees, message boards, scoreboards or backboards (Note: immediate replacement of these items are not required; however, districts will replace or update scoreboards or other durable equipment when existing contracts are up for renewal or to the extent that is financially possible over time so that items are in compliance with the marketing policy.)
- Corporate brand, logo, name or trademark on cups used for beverage dispensing, menu boards, coolers, trash cans and other food service equipment; as well as on posters, book covers, pupil assignment books or school supplies displayed, distributed, offered or sold by the District.
- Advertisements in school publications or school mailings.
- Free product samples, taste tests or coupons of a product, or free samples displaying advertising of a product.

As the District/school nutrition services/Athletics Department/PTA/PTO reviews existing contracts and considers new contracts, equipment and product purchasing (and replacement) decisions should reflect the applicable marketing guidelines established by the District wellness policy.

IV. Physical Activity

Children and adolescents should participate in at least 60 minutes of physical activity every day. A substantial %age of students’ physical activity can be provided through a comprehensive school physical activity program (CSPAP). A CSPAP reflects strong coordination and synergy across all of the components: quality physical education as the foundation; physical activity before, during and after school; staff involvement and family and community engagement and

the district is committed to providing these opportunities. Schools will ensure that these varied physical activity opportunities are in addition to, and not as a substitute for, physical education (addressed in “Physical Education” subsection). All schools in the district will be encouraged to participate in *Let’s Move! Active Schools* (www.letsmoveschools.org) in order to successfully address all CSPAP areas.

Physical activity during the school day (including but not limited to recess, classroom physical activity breaks or physical education) **will not be withheld** as punishment for any reason *[insert if appropriate: “This does not include participation on sports teams that have specific academic requirements”]*. The district will provide teachers and other school staff with a [list of ideas](#) for alternative ways to discipline students.

To the extent practicable, the District will ensure that its grounds and facilities are safe and that equipment is available to students to be active. The District will conduct necessary inspections and repairs.

[Optional additional policy language:

- *Through a formal joint- or shared-use agreement, indoor and outdoor physical activity facilities and spaces will be open to students, their families, and the community outside of school hours (meets Healthy Schools Program Gold-level criteria). [Change Lab Solutions](#) provides guidance regarding joint- or shared-use agreements.*
- *The District will work with schools to ensure that inventories of physical activity supplies and equipment are known and, when necessary, will work with community partners to ensure sufficient quantities of equipment are available to encourage physical activity for as many students as possible.]*

Physical Education

The District will provide students with physical education, using an age-appropriate, sequential physical education curriculum consistent with national and state standards for physical education. The physical education curriculum will promote the benefits of a physically active lifestyle and will help students develop skills to engage in lifelong healthy habits, as well as incorporate essential health education concepts (discussed in the “*Essential Physical Activity Topics in Health Education*” subsection). The curriculum will support the essential components of physical education.

All students will be provided equal opportunity to participate in physical education classes. The District will make appropriate accommodations to allow for equitable participation for all students and will adapt physical education classes and equipment as necessary.

All District **elementary students** in each grade will receive physical education for at least 60-89 minutes per week throughout the school year. *[NOTE: Additional optional policy language substitutions include: All [District] elementary students in each grade will receive physical education for at least 90-149 minutes per week throughout the school year (Meets Healthy Schools Program Silver-level criteria). OR All [District] elementary students in each grade will receive physical education for at least 150 minutes per week throughout the school year (meets Healthy Schools Gold-level criteria).]*

All [District] **secondary students** (middle and high school) are required to take the equivalent of one academic year of physical education.

[NOTE: For additional rigor, optional language substitutions include: All [District] secondary students (middle and high school) are required to take more than one academic year of physical education (meets Healthy Schools Silver-level criteria). OR All [District] secondary students (middle and high school) are required to take physical education throughout all secondary school years (meets Healthy Schools Gold-level criteria).]

The District physical education program will promote student physical fitness through individualized fitness and activity assessments (via the [Presidential Youth Fitness Program](#) or other appropriate assessment tool) and will use criterion-based reporting for each student.

[Additional policy language includes:

- *Students will be moderately to vigorously active for at least 50% of class time during most or all physical education class sessions (meets Healthy Schools Program Silver-level criteria).*
- *All physical education teachers in [District] will be required to participate in at least a once a year professional development in education (meets Healthy Schools Program Silver-level criteria).*
- *All physical education classes in [District] are taught by licensed teachers who are certified or endorsed to teach physical education (meets Healthy Schools Program Gold-level criteria).*
- *Waivers, exemptions, or substitutions for physical education classes are not granted.*

Essential Physical Activity Topics in Health Education

Health education will be required in all grades (elementary) and the district will require middle and high school students to take and pass at least one health education course. The District will include in the health education curriculum a minimum of 12 the following essential topics on physical activity:

- The physical, psychological, or social benefits of physical activity
- How physical activity can contribute to a healthy weight
- How physical activity can contribute to the academic learning process
- How an inactive lifestyle contributes to chronic disease
- Health-related fitness, that is, cardiovascular endurance, muscular endurance, muscular strength, flexibility, and body composition
- Differences between physical activity, exercise and fitness
- Phases of an exercise session, that is, warm up, workout and cool down
- Overcoming barriers to physical activity
- Decreasing sedentary activities, such as TV watching
- Opportunities for physical activity in the community
- Preventing injury during physical activity
- Weather-related safety, for example, avoiding heat stroke, hypothermia and sunburn while being physically active
- How much physical activity is enough, that is, determining frequency, intensity, time and type of physical activity
- Developing an individualized physical activity and fitness plan

- Monitoring progress toward reaching goals in an individualized physical activity plan
- Dangers of using performance-enhancing drugs, such as steroids
- Social influences on physical activity, including media, family, peers and culture
- How to find valid information or services related to physical activity and fitness
- How to influence, support, or advocate for others to engage in physical activity
- How to resist peer pressure that discourages physical activity.

Recess (Elementary)

All elementary schools will offer at least **20 minutes of recess** on all days during the school year (*Insert as appropriate any language such as: This policy may be waived on early dismissal or late arrival days*). If recess is offered before lunch, schools will have appropriate hand-washing facilities and/or hand-sanitizing mechanisms located just inside/outside the cafeteria to ensure proper hygiene prior to eating and students are required to use these mechanisms before eating. Hand-washing time, as well as time to put away coats/hats/gloves, will be built in to the recess transition period/timeframe before students enter the cafeteria.

Outdoor recess will be offered when weather is feasible for outdoor play. *[Depending on regions or weather conditions, districts may insert weather guidelines or guidelines for outside play here. OR District could create new ones such as: “Students will be allowed outside for recess except when outdoor temperature is above/below District-set temperature, inclusive of wind chill factors, during “code orange” or “code red” days, during storms with lightening or thunder, or at the discretion of the building administrator based on his/her best judgment of safety conditions.”]*

In the event that the school or district must conduct **indoor recess**, teachers and staff will follow the indoor recess guidelines that promote physical activity for students, to the extent practicable. *[District can insert indoor recess guidelines here, which might delineate a minimum amount of time for activity opportunities during indoor recess. If these guidelines do not yet exist, the district wellness council will create them or facilitate their development on a school-by-school basis and include them here.] [If District opts for school-by-school indoor recess guidelines, insert: Each school will maintain and enforce its own indoor recess guidelines.]*

Recess will complement, not substitute, physical education class. Recess monitors or teachers will encourage students to be active, and will serve as role models by being physically active alongside the students whenever feasible.

Classroom Physical Activity Breaks (Elementary and Secondary)

The District recognizes that students are more attentive and ready to learn if provided with periodic breaks when they can be physically active or stretch. Thus, students will be offered **periodic opportunities** to be active or to stretch throughout the day on all or most days during a typical school week. The District recommends teachers provide short (3-5-minute) physical activity breaks to students during and between classroom time at least three days per week. These physical activity breaks will complement, not substitute, for physical education class, recess, and class transition periods.

The District will provide resources and links to resources, tools, and technology with ideas for classroom physical activity breaks. Resources and ideas are available through [USDA](#) and the [Alliance for a Healthier Generation](#).

Active Academics

Teachers will incorporate movement and kinesthetic learning approaches into “core” subject instruction when possible (e.g., science, math, language arts, social studies and others) and do their part to limit sedentary behavior during the school day.

The District will support classroom teachers incorporating physical activity and employing kinesthetic learning approaches into core subjects by providing annual professional development opportunities and resources, including information on leading activities, activity options, as well as making available background material on the connections between learning and movement. Teachers will serve as role models by being physically active alongside the students whenever feasible.

Before and After School Activities

The District offers opportunities for students to participate in physical activity either before and/or after the school day (or both) through a variety of methods. The District will encourage students to be physically active before and after school by: *[District should choose appropriate and reasonable options such as physical activity clubs, physical activity in aftercare, intramurals or interscholastic sports, and insert approaches here.]*

Active Transport

The District will support active transport to and from school, such as walking or biking. The District will encourage this behavior by engaging in *six or more* of the activities below; including but not limited to: *[District will select from the list below and insert them here as policy]*.

- Designate safe or preferred routes to school
- Promote activities such as participation in International Walk to School Week, National Walk and Bike to School Week
- Secure storage facilities for bicycles and helmets (e.g., shed, cage, fenced area)
- Instruction on walking/bicycling safety provided to students
- Promote safe routes program to students, staff, and parents via newsletters, websites, local newspaper
- Use crossing guards
- Use crosswalks on streets leading to schools
- Use walking school buses
- Document the number of children walking and or biking to and from school
- Create and distribute maps of school environment (e.g., sidewalks, crosswalks, roads, pathways, bike racks, etc.)

V. Other Activities that Promote Student Wellness

The District will integrate wellness activities across the entire school setting, not just in the cafeteria, other food and beverage venues and physical activity facilities. The District will

coordinate and integrate other initiatives related to physical activity, physical education, nutrition and other wellness components so all efforts are complementary, not duplicative, and work towards the same set of goals and objectives promoting student well-being, optimal development and strong educational outcomes.

Schools in the District are encouraged to *[Optional language: Schools in the District will...]* coordinate content across curricular areas that promote student health, such as teaching nutrition concepts in mathematics, with consultation provided by either the school or the District's curriculum experts.

All efforts related to obtaining federal, state or association recognition for efforts, or grants/funding opportunities for healthy school environments will be coordinated with and complementary of the wellness policy, including but not limited to ensuring the involvement of the DWC/SWC.

All school-sponsored events will adhere to the wellness policy guidelines. All school-sponsored wellness events will include physical activity and healthy eating opportunities when appropriate.

Community Partnerships

The District will *[insert as appropriate to current efforts: develop, enhance, or continue]* relationships with community partners (e.g., hospitals, universities/colleges, local businesses, SNAP-Ed providers and coordinators, etc.) in support of this wellness policy's implementation. Existing and new community partnerships and sponsorships will be evaluated to ensure that they are consistent with the wellness policy and its goals.

Community Health Promotion and Family Engagement

The District will promote to parents/caregivers, families, and the general community the benefits of and approaches for healthy eating and physical activity throughout the school year. Families will be informed and invited to participate in school-sponsored activities and will receive information about health promotion efforts.

As described in the "Community Involvement, Outreach, and Communications" subsection, the District will use electronic mechanisms (e.g., email or displaying notices on the district's website), as well as non-electronic mechanisms, (e.g., newsletters, presentations to parents or sending information home to parents), to ensure that all families are actively notified of opportunities to participate in school-sponsored activities and receive information about health promotion efforts.

Staff Wellness and Health Promotion

The DWC will have a staff wellness subcommittee that focuses on staff wellness issues, identifies and disseminates wellness resources and performs other functions that support staff wellness in coordination with human resources staff. *The subcommittee leader's name is _____ (list here).*

Schools in the District will implement strategies to support staff in actively promoting and modeling healthy eating and physical activity behaviors. *Examples of strategies schools will use, as well as specific actions staff members can take, include _____ (list 3-*

4 strategies here). The District promotes staff member participation in health promotion programs and will support programs for staff members on healthy eating/weight management that are accessible and free or low-cost.

[Optional language includes:

- *The District will use a healthy meeting policy for all events with available food options, created by the SWC/DWC or one that currently exists that optimizes healthy food options with a variety of choices and selections of healthy foods for a variety of dietary needs.]*

Professional Learning

When feasible, the District will offer annual professional learning opportunities and resources for staff to increase knowledge and skills about promoting healthy behaviors in the classroom and school (e.g., increasing the use of kinesthetic teaching approaches or incorporating nutrition lessons into math class). Professional learning will help District staff understand the connections between academics and health and the ways in which health and wellness are integrated into ongoing district reform or academic improvement plans/efforts.

Glossary:

Extended School Day – the time during, before and afterschool that includes activities such as clubs, intramural sports, band and choir practice, drama rehearsals and more.

School Campus - areas that are owned or leased by the school and used at any time for school-related activities, including on the outside of the school building, school buses or other vehicles used to transport students, athletic fields and stadiums (e.g., on scoreboards, coolers, cups, and water bottles), or parking lots.

School Day – the time between midnight the night before to 30 minutes after the end of the instructional day.

Triennial – recurring every three years.

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