METHODS DOCUMENT FOR THE

CDC and Bridging the Gap Local School Wellness Policy Briefs

METHODS

Background

The Child Nutrition and WIC Reauthorization Act of 2004[1] and, more recently, the Healthy, Hunger-Free Kids Act of 2010[2] required all school districts participating in the federal Child Nutrition Programs (e.g., National School Lunch Program, School Breakfast Program, Special Milk Program, Afterschool Snack Program) to adopt and implement a local school wellness policy (i.e. wellness policy) beginning in school year 2006–2007. The wellness policies are required to include the following:

- goals for nutrition promotion and education, physical activity (PA), and other activities that support student wellness;
- nutrition guidelines for all foods and beverages available during the school day outside of school meals (i.e., competitive foods);
- requirements to allow stakeholder involvement in policy development, implementation, and reporting and to update the community on policy content and implementation efforts; and
- a provision to designate officials responsible for ensuring compliance.

Since the beginning of the wellness policy mandate, the Robert Wood Johnson Foundation-funded Bridging the Gap (BTG) program at the University of Illinois at Chicago (UIC) has been conducting the largest, ongoing evaluation of the strength, comprehensiveness, and content of the congressionally mandated district wellness policies and all associated state codified statutory and administrative laws. BTG's wellness policy work is nationally recognized as the primary source of information on the current status of and trends in wellness policy progress. BTG provides the only nationally representative data on wellness policy progress and opportunities annually since the mandate took effect at the beginning of school year 2006–2007 along with the concomitant state laws.

Sample Design

The sample frame for this study was based on the National Center for Education Statistics' Common Core of Data (CCD) which lists all school districts in the U.S. The CCD includes both public and private school districts; for this study, only public schools were considered.[3] The data presented in the companion briefs were based on data from school year 2012–2013. For sampling purposes, the 2009–2010 CCD was used. Districts were sampled by using probability proportionate to size of student enrollment (PPS) sampling methodology to ensure a nationally representative sample of districts for which inferences could be made at each school level—elementary, middle, and high school levels. The samples were compiled for BTG by the Survey Research Operations Department at the Institute for Social Research (ISR) at the University of Michigan.

Policy Collection

Both district policies and state laws effective as of the beginning of school year 2012–2013 were compiled for this study. The day after Labor Day (i.e., September 3, 2012) was used as a proxy for the beginning of the school year.

At the district level, BTG researchers obtained hard copies of written wellness policies from public school districts via Internet research and direct communication with the districts. The school year 2012–2013 study included a nationally representative sample of 704 districts. A 95.45% policy collection rate was achieved (n = 672 districts). All data were weighted by ISR to account for nonresponding districts and to enable inferences about the proportion of public school districts nationwide with a given policy.

For the purposes of this study, **WELLNESS POLICY** was defined to include the following: a) the actual district wellness policy; b) the associated administrative policies, including implementation regulations, rules, procedures, or

administrative guidelines; and c) any district, state, or other policies (e.g., state Board of Education model policies) that were incorporated by reference within the wellness policy or administrative documents.

At the state level, codified statutory (legislative) and administrative (regulatory) laws for each state and the District of Columbia (hereafter referred to collectively as "states") were obtained through primary legal research by using subscription-based legal research databases available from Lexis-Nexis[4] and Westlaw.[5] The searches were conducted between September and May of school year 2011–2012. All state law collection was validated against existing secondary source compilations of state laws, including but not limited to the National Cancer Institute's Classification of Laws Associated with School Students (CLASS) system,[6] the National Conference of State Legislatures Childhood Obesity Legislative Tracking database,[7] the Centers for Disease Control and Prevention's Chronic Disease State Policy Tracking System,[8] the National Association of State Boards of Education School Health Policy Database,[9] and the Trust for America's Health annual *F as in FAT*[10] compilation.

Policy Coding

All district policies and state laws were analyzed by two trained analysts by using an adaptation of a wellness policy coding scheme developed by Schwartz and colleagues,[11] and originally presented in a report by Chriqui and others.[12] A detailed explanation of the coding methodology can be found in the Appendix included in Chriqui's report.[12] All of the policy provisions were coded as having: (a) a strong policy; b) a weak policy; or c) no policy. **STRONG POLICY PROVISIONS** were those that were definitely required and that specified an implementation plan or strategy. Strong policy provisions included language such as *shall, must, will, require, comply,* and *enforce*. **WEAK POLICY PROVISIONS** included vague terms, suggestions or recommendations, as well as those that required action, but noted exceptions for certain grade levels or certain times of day. Weak policy provisions included language such as *should, might, encourage, some, make an effort to, partial,* and *try*. For certain competitive food and beverage topics such as those relating to sugar or fat content in competitive foods, **"strong policy provisions"** were divided to reflect: (a) required provisions that did not meet the Institute of Medicine's (IOM) 2007 *Nutrition Standards for Foods Sold in Schools,*[13] (b) required provisions that met the IOM standard, or (c) complete bans on the item (e.g., prohibit soda from being sold) or prohibitions on the location of sale (e.g., prohibiting vending machines altogether). For the purposes of these briefs, all of these categories were collapsed into the **strong policy provision** category. All collected policies and state laws were coded and analyzed by BTG researchers. Results were provided to CDC and the series of briefs were developed collaboratively to focus on the content and strength of district wellness policies (and state laws, in the case of one brief, *Policy Strategies to Support Recess in Elementary Schools*).*

Analyses

All analyses were conducted by using the survey commands in STATA version 12.0 and used the nonresponse adjusted weights. Summary statistics were used to generate the data for the briefs, and tests for statistical significance were not performed. Bridging the Gap researchers conducted all analyses and provided the data to CDC for each of the briefs.

*Funding for the state and district policy data contained in these brief reports was provided through the Robert Wood Johnson Foundation to the Bridging the Gap (BTG) Research Program at the University of Illinois (UIC) at Chicago. The brief reports were developed through collaborative funding from CDC as part of a subcontract from McKing Consulting Corporation to UIC (Prime Contract Number 200-2012-F-53729, Subcontract 01-04568) and BTG.

References

[1] Child Nutrition and WIC Reauthorization Act, Pub. L. No. 108-265, § 204, 118 Stat. 729, 780-781 (2004).

[2] Healthy, Hunger-Free Kids Act of 2010, Pub. L. No. 111-296, § 204, 124 Stat. 3183, 3236-3238 (2010).

[3] National Center for Education Statistics. Common Core of Data. Available at: http://nces.ed.gov/ccd

[4] Lexis-Nexis. Available at: https://www.lexisnexis.com

[5] Westlaw. Available at: http://web2.westlaw.com

[6] National Cancer Institute. Classification of Laws Associated with School Students. Available at: http://class.cancer.gov/

[7] National Conference of State Legislatures. Childhood Obesity – 2011 Update of Legislative Policy Options. Available at: http://www.ncsl.org/issues-research/health/childhood-obesity-2011.aspx

[8] Centers for Disease Control and Prevention. Chronic Disease State Policy Tracking System. http://apps.nccd.cdc.gov/CDPHPPolicySearch/Default.aspx

[9] National Association of State Boards of Education. State School Health Policy Database. Available at: http://www.nasbe.org/healthy_schools/hs/index.php

[10] Trust for America's Health. F as in Fat: How Obesity Threatens America's Future, 2011. Available at: http://www.healthyamericans.org/assets/files/TFAH2011FasInFat10.pdf

[11] Schwartz MB, Lund AE, Grow HM, McDonnell E, Probart C, Samuelson A, Lytle L. A comprehensive coding system to measure the quality of school wellness policies. J Am Diet Assoc 2009;109(7):1256-1262.

[12] Chriqui JF, Schneider L, Chaloupka FJ, Ide K, Pugach O. Local Wellness Policies: Assessing School District Strategies for Improving Children's Health. School Years 2006–07 and 2007–08. Chicago, IL: Bridging the Gap Program, Health Policy Center, Institute for Health Research and Policy, University of Illinois at Chicago; 2009.

[13] Institute of Medicine. Nutrition Standards for Food in Schools: Leading the Way Toward Healthier Youth. Washington, D.C.: The National Academies Press; 2007.

Suggested citation: Bridging the Gap Research Program. *Methods Document for the CDC and Bridging the Gap Local School Wellness Policy Briefs, Update for the 2012–13 School Year.* Available at: http://www.cdc.gov/healthyyouth/policy/pdf/methodsforwellnesspolicybriefs.pdf.