Health and Physical Educators’ Roles in Promoting and Implementing the WSCC Model

Introduction to Feature Series

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Whole School, Whole Community, Whole Child Overview

The Whole School, Whole Community, Whole Child (WSCC) model was introduced in 2014, and it combines the Centers for Disease Control and Prevention’s (CDC) Coordinated School Health (CSH) approach with the ACSD’s Whole Child Initiative (ACSD, 2014). The CSH model was created in 1987 in an effort to emphasize a comprehensive approach to teaching children’s health. This strong approach for teaching health was supported in the health education community without broader support from the education community. The opposite was true for the ACSD’s Whole Child Initiative, where educational leaders recognized the importance of educating the whole child but their initiative did not specifically collaborate with the health community. In 2014, the WSCC model was created as a collaborative effort between the CDC and ACSD to unite their separate models and engage more stakeholders in the efforts to improve children’s health and academic success (ACSD, 2014). The WSCC model seeks to address the individual needs of children in a holistic way, emphasizing that healthy students can more fully realize their academic potential (CDC, 2021). The child-centered model is composed of 10 separate, yet interconnected components that are driven by evidence-based practices (Figure 1). Through the collaborative efforts of schools and the community, the WSCC model is used to guide policies and practices in schools that positively impact student learning outcomes. The following 10 components are included in the WSCC model:

1. Physical education and physical activity
2. Nutrition environment and services
3. Health education
4. Social and emotional climate
5. Physical environment
6. Health services
7. Counseling, psychological and social services
8. Employee wellness
9. Community involvement
10. Family engagement.

Purpose of Feature

This feature both describes the components of the WSCC model and highlights the unique role that health and physical educators play as facilitators of the model in their schools. Though the components of the model have often been studied independently in their separate fields (i.e., nursing, counseling, health education, etc.), there is a need to bring the components together in a way that highlights how health and physical educators can successfully be facilitators of the model in their schools. Although the WSCC model should be integrated into schools with adequate support from a variety of staff members and community stakeholders (e.g., teachers, school nurses, counselors, etc.), we recognize that not all schools have equitable access to these supports. With that in mind, we know there is a need to advocate for health educators, physical educators and other school physical activity leaders to have a stronger awareness of the components in the WSCC model, so they can act as advocates and leaders for whole child learning.

The feature series kicks off with an article written by Dauenhauer and Steopker, who highlight the physical education and physical activity components of the WSCC model by first introducing the Comprehensive School Physical Activity Program model and

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discussing the importance of physical education and physical activity during school. Practical recommendations and examples for health and physical educators to facilitate these two WSCC components throughout their school communities are provided.

In the second article, Evans and Wilkinson highlight the WSCC components of nutrition environment and services, as well as health education. Federal policies regarding nutrition and environmental health in school and best practices in teaching health education are highlighted. The role of the health and physical educator as leaders on a school’s health advisory council are also discussed.

The third article focuses on the two WSCC components of social and emotional climate and physical environment, which can assist practitioners in facilitating a healthy, supportive, and safe PK–12 learning atmosphere that promotes social and emotional learning. Authors Goh, Egan, and Merica review relevant research and provide strategies for practitioners to develop and sustain these components in schools.

The fourth article focuses on two components of the WSCC model, health services and counseling, psychological and social services. In this article, Fleming and Kearns advocate for health and physical educators to assist students in reducing physical and mental health barriers that may impede their learning and promote the implementation of strategies to create positive learning environments for all students.

The fifth article outlines strategies for enhanced employee wellness in schools. Adams, Graham, and Chavarria-Soto emphasize the need to emphasize employee wellness, leading to improvements in productivity, morale and performance, among other benefits. The article provides strategies for health and physical education teachers to plan, engage stakeholders and seek additional resources for employee wellness programs.

The sixth and final article of the feature, written by McMullen and Walton-Fisette, focuses on two related components of the WSCC model, community involvement and family engagement, where they discuss the “vital” role that communities and families have in the development of children. The article, written with an equity-minded lens, provides strategies and considerations for health and physical education teachers and physical education teacher educators to implement and engage these important stakeholders.

Feature Series Article Components

Readers of this WSCC feature series can anticipate common themes embedded within each article. Each article will help answer the following questions specific to the article’s targeted WSCC model component(s):

- How does this WSCC model component(s) relate to theory, research and evidence-based practice?
- How is this WSCC model component(s) applied and implemented?
- How can health and physical educators engage other stakeholders (e.g., public health practitioners) and local resources (e.g., local agriculture programs) in the process of implementing this WSCC component(s)?
- What are strategies to prepare preservice health and physical education teachers to lead this component(s) of WSCC?
- What are useful recommendations for health and physical educators regarding this WSCC component(s)?
- What are some practical concrete examples of how this WSCC model component can be implemented and promoted in a school through true/fictitious narratives, short practitioner question and answer, or short case study?

Conclusion

We invite you to engage with each of these feature articles written by purposefully selected WSCC component experts. We believe this feature provides you with the tools necessary to confidently champion the Whole School, Whole Community, Whole Child model components within the PK–12 setting. Additionally, we hope that teacher educators use this feature as a resource to train future practitioners in implementing all 10 components. The ultimate goal of this student-centered model is to address health and academic achievement in the PK–12 environment through utilizing community support and evidence-based school practices and policies (CDC, 2021). We hope you will join the effort!

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References