

An Investigation into the Impact of Support from Action for Healthy Kids on School Health
Index Module Scores

Culminating Experience Paper

Autumn N Crowe

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**This paper fulfills the requirements outlined by the MPH program at Northwestern University*

Abstract

The current study investigated the impact of funding and technical assistance from AFHK on schools' implementation of school health policies and practices. The AFHK SHI was used to assess if schools improved their rates of implementation and if improvement occurred at similar rates across all 8 modules. Baseline and final SHI module percent scores of 601 elementary schools in the United States that received support from AFHK between the years of 2015 and 2018 were examined. Descriptive statistics were employed to assess which modules had the highest and lowest implementation rates at the final time point and to examine which module experienced the greatest and least growth in score. Paired samples t-tests assessed if changes in score from the baseline to the final time point were significantly different from each other. School Counseling, Psychological, and Social Services had the highest rates of implementation while Health Promotion for Staff had the lowest rates of implementation at the final time point. Family and Community Involvement experienced the greatest growth in score while School Counseling, Psychological and Social Services experienced the least amount of growth. All percent scores increased significantly from the baseline to the final time point. These findings inform AFHK of the impact of their support on schools' implementation of health practices and policies as all areas of school health improved significantly. The findings can guide AFHK's future efforts regarding how to best support schools to address areas where schools need the greatest support to bolster school health.

Keywords: Action for Healthy Kids, School Health Index, school health, child health, school implementation of health policies and practices

Introduction

Role of Schools in Bolstering Child Health

There are about 130,000 schools in the United States which employ nearly 6 million staff which educate 55 million students (Kolbe, 2019). According to the Centers for Disease Control and Prevention (CDC), children spend at least 6 hours in school per day (2019a). As children spend a great deal of their formative years in school, schools have the opportunity to play a key role in supporting the health of school-aged children. According to Kolbe, school health programs provide education that promotes the establishment of healthy behaviors in addition to providing services that support healthy childhood development, such as access to physical activity, health services, counseling, psychological services, and the provision of nutritious meals, (2019).

Action for Healthy Kids

Action for Healthy Kids (AFHK) is a national nonprofit working to improve child health by supporting school health. In order to improve child health, AFHK works to mobilize schools, caregivers, and communities to create healthy schools. Two methods utilized by the organization to support schools are by providing funding and technical assistance (Action for Healthy Kids). Funding of one thousand dollars per year enabled schools to purchase supplies and materials to implement school-based health initiatives whereas technical assistance equipped schools and caregivers with resources and tools which aid in the implementation and sustainability of school-based practices and policies. Technical assistance from AFHK provides schools with one-on-one assistance, informational webinars, and workshops for school staff and caregivers to support the implementation of school health practices and policies. Funding and technical assistance from

AFHK prioritize improving (1) school health, safety policies, and environment, (2) physical education and physical activity programs, (3) nutrition services, and (4) family and community involvement.

Prior Literature

Prior literature investigating school-based health initiatives pertaining to AFHK's four priority areas has found that such initiatives are associated with positive physical, social, and emotional health outcomes as well as increased academic performance for school-aged children. It is important to note that social and emotional health involves self-regulation skills, self-awareness, and understanding of others, and having safe relationships (Social Emotional Health). According to the article "School Health as a Strategy to Improve Both Public Health and Education", school health and safety policies may include what food is provided to students, how food is prepared, as well as outlining how students will be provided opportunities to participate in physical activity. Other policies include those to prevent or respond to student or staff injury and those which outline how to respond to and manage school emergencies (Kolbe, 2019). In sum, the existence of school health and safety policies ensures the health and safety of students, staff, and families on school grounds, and policies work to promote open communication among the school community about school health and safety.

The school environment plays a role in student health and performance. A prior study investigating the impact of schools' physical environments has found that high-quality school facilities are associated with better outcomes for children, including fewer allergy symptoms, decreased upper respiratory infections, and fewer behavioral problems in the classroom. Findings from this study found that poor air circulation and lighting in classrooms were associated with increased absenteeism and an increased number of problem behaviors demonstrated by students.

Moreover, poor lighting and acoustics were related to decreased attentional capacity and information retainment which may ultimately impact student's health and academic performance (Filardo et al., 2016).

Positive school environments are connected to student's social and emotional health and academic performance. According to the CDC, schools which focus on fostering caring and supportive relationships as well as opportunities to participate in school activities are associated with increased connectedness to and greater engagement in schools. In addition to positive school environments as a whole, support from school staff is associated with fewer behavior problems in the classroom and increased student engagement in learning and other school activities (Centers for Disease Control and Prevention, 2009).

Literature examining the impact of physical education and activity programs in schools has found that the existence of such programs is associated with positive outcomes for children. Opportunities for physical activity within schools can play a role in reducing the risk of deleterious health conditions associated with physical inactivity like childhood obesity (Janssen & Leblanc, 2010 & Kolbe, 2019). Prior literature has found that school-based physical activity and physical education are associated with fewer problem behaviors demonstrated by students in the classroom as well as higher academic achievement (Rasberry et al., 2011 & Kolbe, 2019).

Nutrition services including nutrition education and the provision of nutritious meals by schools are impactful for school-aged children. Prior studies examining the impact of school nutrition programs on student performance have found that the existence of such programs is associated with higher academic performance, increased attention, and fewer problem behaviors demonstrated by students (Frisvold, 2015 & Kolbe, 2019). Nutrition education programs that instruct students about healthy eating are associated with students demonstrating healthy

behavioral patterns in school, for example, selecting healthy food options (Kolbe, 2019).

Moreover, prior studies have found that providing meals during the school day is associated with decreased absenteeism and higher test scores (CDC, 2021). Finally, both nutrition education and access to healthy food choices are associated with the prevention of health conditions associated with poor nutrition such as childhood obesity and malnutrition (Kolbe, 2019).

Involvement from families and communities plays a key role in the development and later implementation of school health programs. According to Kolbe, family and community advocacy efforts and their support of school health can help schools improve their health initiatives. Additionally, parental involvement in schools is associated with greater success of school programs seeking to bolster the health of students (Kolbe, 2019). As family and community involvement is associated with better school health programs, involvement can enable schools to implement high-quality programs which can foster healthy childhood development.

Public Health Relevance

Prior literature has demonstrated that schools are a key stakeholder in influencing child health by supporting the healthy development of school-aged children. The presence of school-based health, programs, practices, and policies impacts not only the physical, social, and emotional health of children but academic outcomes as well. Schools may improve child health by instructing children about the importance of engaging in healthy behaviors and aiding students in establishing healthy behavior patterns. Knowledge about how to live a healthy lifestyle as well as the establishment of healthy behaviors during childhood may help to reduce poor health outcomes during childhood and later during adulthood. Considering the role that

schools play in promoting child health, it is vital to investigate methods that support and aid schools in improving health policies and practices which may ultimately improve child health.

Current Study

The current study sought to examine if funding and technical assistance from AFHK influenced the implementation of school health policies and practices. To examine the impact of funding and technical assistance, the current study examined SHI module percent scores of schools that received funding and technical assistance from AFHK between the years of 2015 to 2018. SHI module percent scores were obtained from schools before receiving support and after the final year of support from the organization. The overarching goal was to understand if schools improved module scores at similar rates or if there were different rates of improvement across modules. This overarching goal guided the three aims for the current study. The first aim was to examine which module had the highest rate of implementation and which had the lowest rate of implementation at the final time point. The second aim was to identify if there were meaningful and statistically significant increases in the percent scores when comparing the baseline and final module percent scores to one another. The third aim was to examine which module had the greatest growth from the baseline to the final time point.

Hypothesis

It was hypothesized that the four priority areas for AFHK would experience statistically significant increases in percent scores from the baseline to the final time point. It was hypothesized that priority areas for AFHK would experience the greatest growth when examining the differences in score from the baseline to the final time point.

Methods

Sample

Between the years of 2015 and 2018, a total of 1181 schools were funded by AFHK. The sample for the current study was a convenience sample as schools who were to receive support from AFHK were asked to complete the AFHK SHI prior to receiving support and after each year of support. Of 1181 funded schools, a total of 1073 schools had a completed SHI, 85 schools were excluded because they were private schools, and the organization was interested in examining public schools. 387 additional schools were excluded as the baseline and final SHI scores could not be matched. Therefore, the sample for the current study was 601 schools.

School SHI module percent scores were excluded if either a baseline or final SHI percent score was entered as zero. Zero values were excluded from the current study as it was unclear if zero signified a missing percent score or if zero was a valid percent score. As the meaning of zero values was unclear, a school module score of zero for the baseline score, the final score, or both were dropped from the final analysis. Module baseline percent scores and final percent scores were excluded for the following modules: health education (N=590), school health services (N=598), health promotion for staff (N=591), school counseling, psychological, and social services (N=596), and family and community involvement (N=600). No baseline or final module percent scores were excluded for the modules: school health, safety policies, and environment, physical education and other physical activity programs, or nutrition services. Figure 1 illustrates the number of schools and number of module SHI percent scores that were excluded from the current study.

Measure

The measure used for the current study was the CDC-developed School Health Index (SHI). According to the CDC, the SHI is a planning and assessment tool developed by the CDC in partnership with school administrators, staff, health experts, parents, and national education and health organizations. This tool is based on CDC evidence-based guidelines for school health programs and identifies school-based policies and practices which are believed to be effective in improving child health. The purpose of the assessment was to enable schools to self-identify and assess the strengths and weaknesses and to develop plans to address areas of weakness (Centers for Disease Control and Prevention, 2019b).

AFHK utilizes an abbreviated version of the SHI which was adapted by the organization. The AFHK SHI contains at least one question from each of the eight modules with questions focusing on nutrition, physical activity, and cross-cutting questions to address school policies and practices regarding various school health topics of interest to AFHK. The adapted AFHK SHI measure has eight modules which focus on (1) school health, safety policies, and environment, (2) health education, (3) physical education and other physical activity programs, (4) nutrition services, (5) school health services, (6) school counseling, psychological and social services, (7) health promotion for staff, and (8) family and community involvement. Schools were encouraged to complete the electronic AFHK SHI with their school health team of diverse stakeholders which could have included staff, administrators, caregivers, students, and community members. Schools were asked to complete the AFHK SHI questionnaire before receiving funding and technical assistance as well as at the end of each year that schools received support. The measure asked schools to identify the degree to which school-based health practices and policies were in place in their school. Percent scores were calculated by having schools sum the total number of points earned per module and then dividing this amount by the total number

of points possible for the module. Higher SHI percent scores indicated greater implementation of health policies and practices pertaining to each of the SHI modules. Appendix A contains the AFHK adapted SHI measure. Table 1 provides a description of each module as well as the number of questions per module. The percent module scores before receiving funding served as the baseline scores while the scores obtained following the final year of support served as the final scores.

Data Analysis

The first goal was to examine which module had the highest percent score and which had the lowest percent score at the final time point. Descriptive statistics were used to examine which modules had the highest and lowest final mean percent scores.

The second goal was to examine if the baseline and final percent scores were significantly different from one another. The utilization of paired samples t-tests examined if the baseline percent scores were significantly different from the final percent scores.

The third goal was to examine SHI differences in module percent scores from baseline to final. The current project sought to identify which modules had the largest difference from baseline to final as well as which had the smallest difference from baseline to final. This was accomplished by creating a new field that calculated differences by subtracting the final percent score from the baseline percent score for each module and school. To assess growth, descriptive statistics were used to examine which module had the greatest mean difference, indicating the greatest growth in addition to which had the lowest mean difference, indicating the least growth. An Analysis of variance (ANOVA) with multiple comparisons was used to assess if differences in module SHI percent scores were significantly different from one another.

Results

School Demographics

A total of 601 schools were included in the current study; demographic characteristics of included schools are reported in Table 2. The majority of schools were funded by AFHK for one year (78.20%) and were elementary schools (75.54%). The mean percentage of schools' student body who qualified for free or reduced lunch was 62.3%. Schools were almost equally represented from each of the metro types: suburban, urban, and rural/town. Of schools included in the current study, 33.28% were predominantly non-White with 70% or more of the student body identifying as non-White. As compared with available US public school data from the U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics (NCES) from the years of 2015-2018 (N=84,300), schools included in this study were more likely to be elementary schools, located in urban and suburban communities, and had a higher percentage of children qualifying for free or reduced lunch.

AFHK Final Module Percent Scores

The first aim of the current study was to determine which module had the highest mean percent score and which had the lowest final mean percent score at the final time point. Descriptive statistics indicated that the School Counseling, Psychological, and Social Services module had the highest final mean percent score (M=84.48, SD=17.18). Health Promotion for Staff had the lowest final mean percent score (M=59.87, SD=27.11). School Health, Safety Policies, and Environment had the second highest final percent score (M=81.76, SD=12.90), Nutrition Services had the third highest final percent score (M=80.15, SD=13.25), and Family

and Community Involvement had the second lowest final percent score ($M=72.63$, $SD=19.26$).

Figure 2 illustrates the final mean percent score for each of the eight modules.

Growth in AFHK SHI Module Percent Scores

The second aim of the current study was to examine if the baseline and final SHI percent scores were significantly different from one another within each module, while the third aim of the study was to determine which modules had the greatest and least growth in scores. A paired-samples t-test was used to compare the baseline and final percent score of each of the eight modules. As shown in Figure 3, all modules experienced an increase in the SHI score. Further, these increases were statistically significant across all 8 modules (Table 3). The Family and Community Involvement module experienced the greatest growth from baseline to final (mean difference=3.56, $SD=9.79$), $p<0.001$. In contrast, School Counseling, Psychological, and Social Services, experienced the least growth ($M=1.68$, $SD=9.22$), $p<0.001$. An analysis of variance with multiple comparisons indicated that the growth of Family and Community Involvement was significantly higher than School Counseling, Psychological and Social Services with $p = .03$. Moreover, an analysis of variance with multiple comparisons indicated that the amount of growth of Health Promotion for Staff ($M=3.46$, $SD=14.11$) was significantly higher than the growth of School Counseling, Psychological, and Social Services ($M=1.68$, $SD=9.22$) with $p = .05$.

Discussion

Final Percent Scores and Percent Score Differences

Findings from the current study indicated that schools increased their mean module percent scores after receiving funding and technical assistance from AFHK. The current study

was interested in examining which modules had the highest and lowest rates of implementation at the final time point, in addition to which modules had the greatest growth from baseline to final. It was hypothesized that AFHK priority areas would experience the greatest growth in scores. The results indicated of the four priority areas for AFHK, (1) School Health, Safety Policies and Environment had the fourth highest growth ($M=3.00$, $SD=8.19$), (2) Nutrition Services had the second lowest growth ($M=2.61$, $SD=7.07$), (3) Physical Education and other Physical Activity Programs had the third highest growth ($M=3.01$, $SD=7.04$), and (4) Family and Community involvement had the greatest growth ($M=3.56$, $SD=9.79$).

Findings from the current study indicated that School Counseling, Psychological, and Social Services had the highest final mean percent score when compared to the other seven AFHK SHI final module percent scores. Despite this module having the highest final mean percent score, it had the least amount of growth in score from the baseline to the final time point. School Counseling, Psychological, and Social Services is not a priority area for AFHK's funding and technical assistance efforts, therefore, it can be expected that there would be little improvement in this area of school health. An additional consideration is that this module had the highest rates of implementation of school-based health practices and policies at both the baseline and final time points. Therefore, a lack of growth could be due to there being limited room for growth considering the high implementation rates at the baseline and final time point.

Health Promotion for Staff had the lowest final mean percent score and the second highest growth in score. This finding indicates that this is an area of school health where there is a high need for intervention to bolster schools' implementation of practices and policies which promote the health of school staff. This module had the second highest growth from the baseline to final time point. This implies that AFHK support addresses high-need areas where schools

need the greatest assistance to increase their implementation of school-based health practices and policies.

Family and Community Involvement experienced the greatest growth when examining the mean difference in AFHK SHI module scores from baseline to final and had the second lowest baseline and final mean percent scores. As this module had the highest growth in score and the second lowest baseline and final score, it appears that AFHK support not only impacts the organization's priority areas but that AFHK efforts are addressing areas of school health where schools need the greatest support to improve their implementation of school health policies and practices.

Comparison of Baseline Mean Percent Scores to Final Mean Percent Scores

It was hypothesized that AFHK priority areas would have significant increases in AFHK SHI module percent scores from baseline to final. A comparison of baseline mean percent scores to final mean percent scores indicated that schools experienced significant changes in scores from the baseline to the final time point across all eight modules. These findings indicate that schools not only experienced an improvement in SHI module scores after receiving funding and technical assistance from AFHK but importantly that this improvement was significant for each of the eight AFHK SHI modules. Significant increases in score from the baseline to the final time point suggest that AFHK's efforts are not only impactful in bolstering school health policies and practices for the four priority areas but that efforts are significantly impacting implementation in nonpriority areas. Thus, implying that funding and technical assistance is comprehensively addressing all of the eight areas of school health.

Limitations

The current study had limitations. First, a total of 988 public schools received support from AFHK between the years of 2015 and 2018, however only 601 schools were included final in the current study thus, a significant number of schools that received support were excluded from the current study. Furthermore, a small number of module scores had to be excluded from the final analysis as it could not be determined if zero signified a missing module score or a valid score, thus we were unable to examine all the module baseline and final scores for the 601 schools. Moreover, a major limitation of the current study was the utilization of percent scores for each of the eight modules. Each of the modules had a different number of questions per module. The difference in the number of questions per module could have had an impact on the percent scores utilized for analysis as fewer questions for a particular module could have inflated the percent score. Finally, about 22% percent of schools were funded for more than one year. The current study did not examine the impact of multiple years of funding and technical assistance on AFHK SHI module percent scores. Therefore, multiple years of support from AFHK may have served as a potential confounding factor.

Dissemination to Stakeholders

In collaboration with the Director of Research and Evaluation and a programmatic staff member at AFHK, the author of the current study developed a PowerPoint presentation to be presented to AFHK staff during a virtual lunch and learn event. The goal of the presentation was to share a background of the AFHK SHI, the aims of the current study, methodology, findings, interpretations of findings, and how the findings translate to the organization's current and future funding and technical assistance efforts. The portion of the PowerPoint and presenter notes presented by the author of the current study is included as appendix B.

Implications for Public Health Programming

The findings from the current study can inform future public health practice, specifically the future of AFHK's efforts to support schools. An increase in scores across all eight modules informs AFHK that their funding and technical assistance comprehensively addresses all areas of school health and not merely the four priority areas. Moreover, significant increases in the percent module SHI scores from baseline to final indicates that AFHK efforts are supporting schools in enhancing their implementation of school health practices and policies. Finally, findings inform the organization of high-need areas where schools need support in order to improve their implementation of school health practices and policies. Moreover, findings from the current study point to the AFHK SHI being a useful tool to help schools identify strengths and the greatest opportunities for improvement. In sum, the current study can inform future AFHK programming efforts as the current study identified that funding and technical assistance from AFHK were impactful for all areas of school health and not solely priority areas. The findings can also inform future directions regarding the provision of funding and technical assistance to support areas of school health where there is the greatest need to enhance the implementation of school health practices and policies.

Conclusion

The current study sought to examine the impact of funding and technical assistance provided to schools by AFHK on schools' implementation of school health policies and practices. Findings from the current study indicated that schools increased their implementation of school-based health policies and practices across all eight AFHK SHI modules. The findings also illustrated that support was impactful for AFHK priority and nonpriority areas and that support had a great impact on modules with the lowest rates of implementation. Ultimately the current study can inform AFHK of the impact of their funding and technical assistance on

schools' implementation of health policies and practices, and importantly can help the organization identify areas to prioritize in the future as they continue to provide support to schools.

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Figure 1

Excluded Schools and Modules

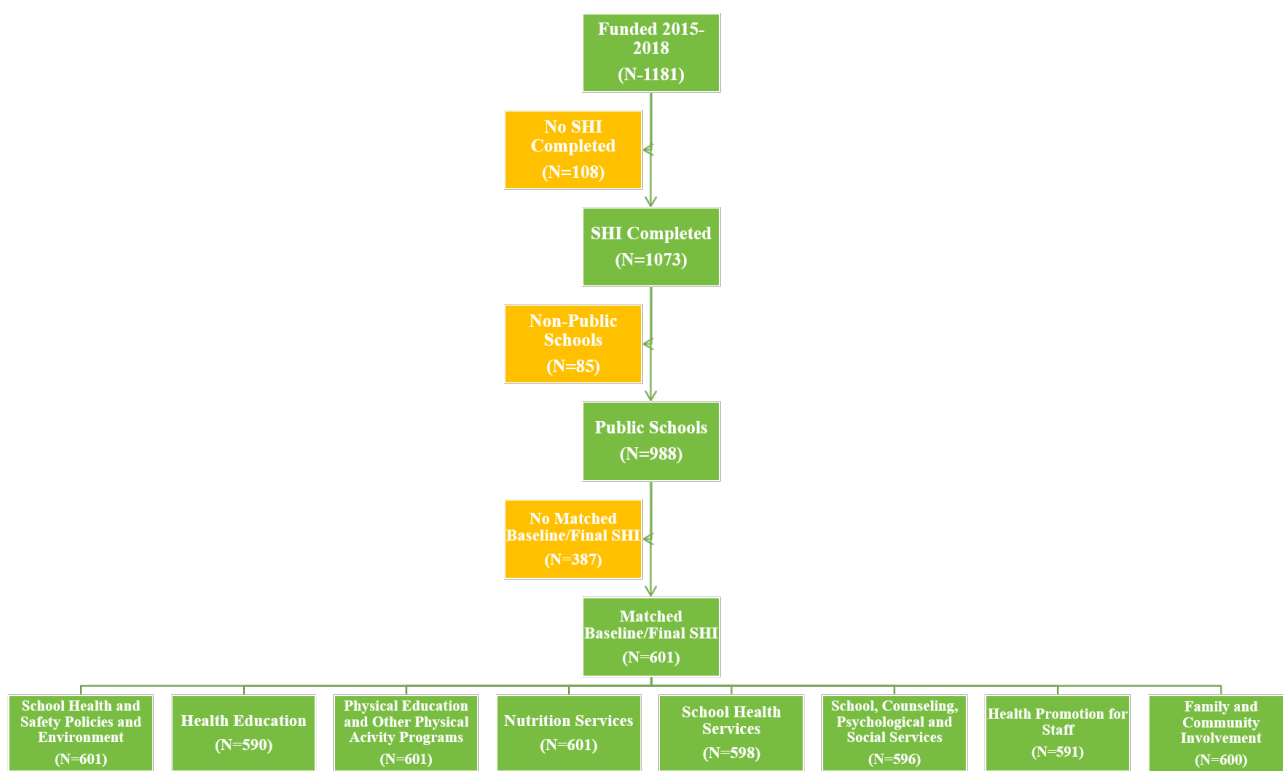


Table 1

Description of AFHK SHI Modules and Number of Questions Per Module

| Module Name | Number of Questions Per Module | Description |
|----------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| School Health, Safety Policies, and Environment | 27 | Assesses schools' implementation of school health and safety policies related to school nutrition services, physical activity, crisis plans, and school wellness. Assesses the physical and social environment of the school, discipline methods used, and communication with families and communities about school health and safety policies. |
| Health Education | 11 | Inquiries about how health education is provided in schools such as, who provides health education, if healthy eating and physical education are taught, as well as teaching and learning strategies utilized to instruct students about health topics. |
| Physical Education and Other Physical Activity Programs | 19 | Assesses how physical activity is offered in schools, the amount of physical activity offered to students, amount of time students are physically active, opportunities for extracurricular physical activity programs, and the skills or training of physical education teachers. |
| Nutrition Services | 11 | Assesses the types of nutrition services in schools, types of food offered to students, ongoing training, and collaboration among school staff regarding school nutrition, and methods to promote healthy food choices within the school. |
| School Health Services | 8 | Focuses on identifying types of services offered, who provides health services, presence of referral systems to other health providers, methods for managing food allergies, and tracking students with chronic health conditions. |

| Module Name | Number of Questions Per Module | Description |
|--------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| School Counseling, Psychological, and Social Services | 6 | Inquiries if there are staff members who can provide services to students, such as a psychologist, counselor, or social worker. Assesses if and to what extent referral systems in place, methods used to support students during transitions, and methods to support children with emotional, behavioral, and mental health needs. |
| Health Promotion for Staff | 9 | Identifies programs in place to support school staff: health education programs, health assessments, those which promote the physical and emotional wellbeing, and providing healthy food options. |
| Family and Community Involvement | 7 | Assesses the degree to which schools communicate with families. Assessed the degree to which families and communities are involved with school programs and in decision making. |

Table 2

Distribution of Characteristics of Schools that Received Support from Action For Healthy Kids, 2015-2018

| | Sample | Population |
|-----------------------------------|-----------------|-------------------|
| Number of Schools | 601 | 84300 |
| | Mean(SD) | |
| Free and Reduced Lunch (%) | 62.3(25.7) | 53.6 (27.9) |
| | Count(%) | |
| Metro Code/Region | | |
| Rural/Town | 192(31.9) | 31026 (36.80) |
| Suburban | 205(34.10) | 28533 (33.85) |
| Urban | 196(32.60) | 24741 (29.35) |
| Non-White | | |
| ≤ 21% Non-White | 200(33.28) | — |
| 22-69% Non-White | 201(33.34) | — |
| ≥ 70% Non-White | 200(33.28) | — |
| Number of Years Funded | | |
| Funded 1 Year | 470(78.20) | — |
| Funded >1 Year | 131(21.80) | — |
| Enrollment Size | | |
| ≤ 365 | 200(33.28) | — |
| 366-549 | 201(33.44) | — |
| >549 | 200(33.28) | — |
| Grades | | |
| Elementary | 448(74.54) | 49407 (58.61) |
| Non-Elementary | 153(25.26) | 34893 (41.39) |

Note. Population data was obtained from U.S. Department of Education. Institute of Education Sciences, National Center for Education Statistics

Note: data is not available for the fields that are blank

Table 3*AFHK SHI Difference in Module Scores Baseline to Final 2015 -2018*

| Module | N | Mean Difference(SD) | Time Point | Mean(SD) | <i>t</i> | P |
|------------------------------------------------------------------------|-----|------------------------|-----------------------------------------------|------------------------------|----------|---------|
| School Health and Safety Policies and Environment | 601 | 3.00(8.19) | <i>Baseline</i> <i>Final</i> | 78.76(14.71) 81.76(12.90) | 8.989 | < 0.001 |
| Health Education | 590 | 2.95(13.35) | <i>Baseline</i> <i>Final</i> | 72.32(24.98) 75.27(22.91) | 5.367 | < 0.001 |
| Physical Education and Other Physical Activity Programs | 601 | 3.01(7.04) | <i>Baseline</i> <i>Final</i> | 76.42(13.63) 79.43(11.77) | 10.489 | < 0.001 |
| Nutrition Services | 601 | 2.61(7.07) | <i>Baseline</i> <i>Final</i> | 77.54(14.32) 80.15(13.25) | 9.044 | < 0.001 |
| School Health Services | 598 | 2.75(8.97) | <i>Baseline</i> <i>Final</i> | 76.10(18.36) 78.92(16.72) | 7.506 | < 0.001 |
| School Counseling, Psychological, and Social Services | 596 | 1.68(9.22) | <i>Baseline</i> <i>Final</i> | 82.80(19.01) 84.46(17.18) | 4.444 | < 0.001 |
| Health Promotion for Staff | 591 | 3.46(14.11) | <i>Baseline</i> <i>Final</i> | 56.41(27.47) 59.87(27.11) | 5.957 | < 0.001 |
| Family and Community Involvement | 600 | 3.56(9.79) | <i>Baseline</i> <i>Final</i> | 69.06(20.84) 72.63(19.26) | 8.915 | < 0.001 |

Figure 2

AFHK SHI Final Mean Percent Score by Module 2015-2018

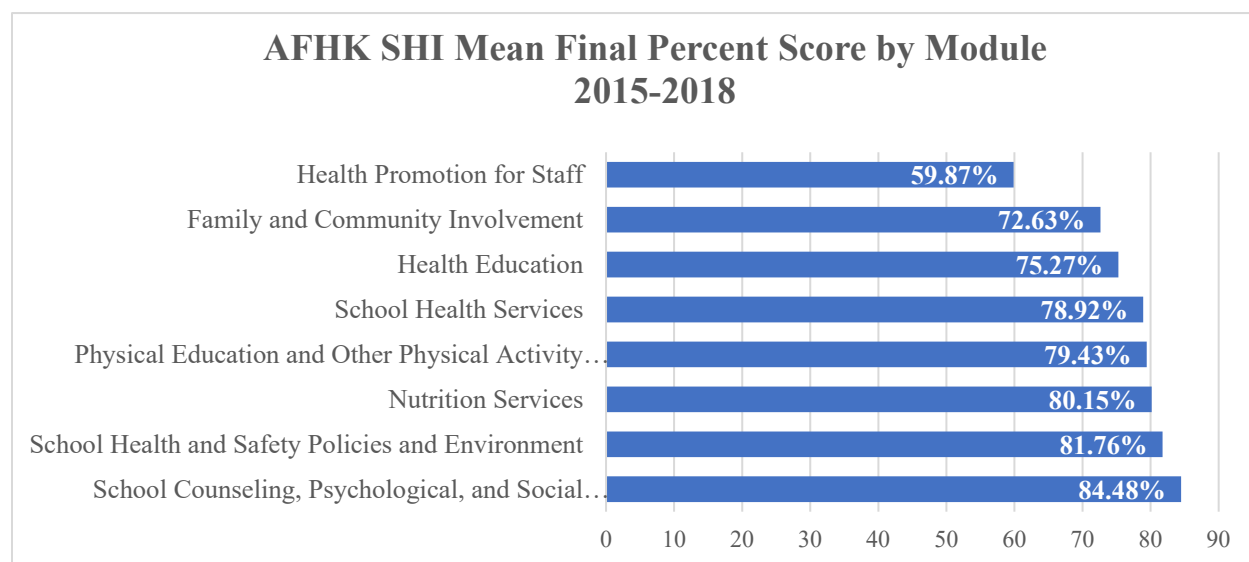


Figure 3

AFHK Baseline to Final SHI Module Scores for 2015-2018

