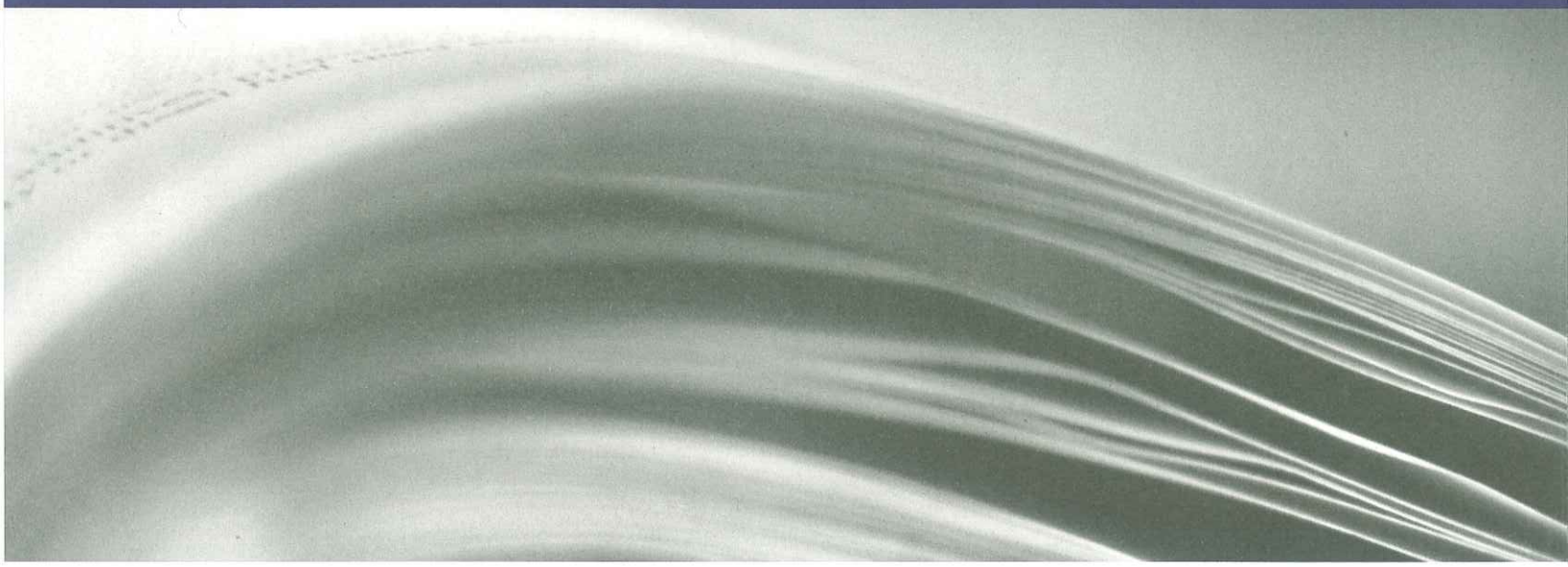

Healthy Schools Program Evaluation

Year 1 Update

Prepared for

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January 2008

RMC RESEARCH

Healthy Schools Program Evaluation

Year 1 Update

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RMC RESEARCH

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Executive Summary

The Alliance for a Healthier Generation, a joint initiative of the American Heart Association and the William J. Clinton Foundation, began implementation of the Healthy Schools Program in 2006 with funding from the Robert Wood Johnson Foundation. The Healthy Schools Program, one of four major initiatives of the Alliance, has set the goal of halting the increase in childhood obesity in the United States within 5 years and reversing the trend within 10 years. Through the Healthy Schools Program, the Alliance aims to impact policy and encourage changes within school environments by helping schools meet criteria-based standards for healthy foods and beverages, physical education programs and physical activity, health education, after-school programs, and staff wellness programs. The Healthy Schools Program provides technical assistance, resource brokering, and a wide variety of online tools for participating schools. In addition, the Healthy Schools Program recognizes and rewards schools that meet the standards.

Methods

The Alliance recruited 285 schools in 13 states from an initial sample of 307 to participate as pilot sites for the Healthy Schools Program during the 2006–2007 school year. Of these schools, 230 agreed to participate in the program. Over the course of the school year, 187 of the schools logged onto the Alliance web site and completed the Healthy Schools Program Inventory, an online survey of school practices, at least once. This report includes data from only those 187 schools.

The primary instrument used to evaluate the first year of the Healthy Schools Program is the Inventory, an online school self-report survey developed by the Alliance to collect data on school policies and practices. Later reports will include results from two student measures developed by RMC Research to measure behavior change and body mass index among students, as well as site visit protocols used with the intensive study schools.

Schools participating in the Healthy Schools Program are required to complete the Inventory, which the Alliance developed based on their best practice framework for policies, programs, and practices that promote physical activity and healthy eating among students and staff. Science professionals at the American Heart Association reviewed and approved these criteria. The instrument included 34 items organized into eight scales (see the Appendix). The scoring rubric designated three levels of recognition for achievement: Bronze, Silver, and Gold. Although no measurement model for such a scoring rubric exists, RMC Research conducted a conventional item analysis to determine both intra- and interscale item correlation.

Results

Baseline Inventory results varied widely across schools, reflecting strong differences in the conditions in these schools and prior efforts before joining the Healthy Schools Program. Figure 2 (see page 10) shows the percentage of schools achieving a Bronze, Silver, or Gold level on each scale at baseline. Most schools did well on at least one scale, but very few scored high enough overall to attain a Bronze, the lowest level of achievement recognition, on the Total scale. The range of scores reflects the fact that all types of schools were recruited as pilot schools for the Healthy Schools Program. These baseline scores are generally low enough that it should be possible to assess change over time.

Similar baseline results were observed for elementary, middle schools, and high schools across the scales. Although there are some minor differences among a few scales, such as competitive foods and health education, there are no overriding patterns.

Figure 4 (see page 15) shows the total percentages of schools that attained an increase in recognition level on each Inventory scale. The figure includes results from 117 schools that completed a pretest prior to March 1, 2007, and a posttest after March 1, 2007.

There were few differences in the percentage of schools showing an improvement by sampling characteristic. There was little difference in improvement, for example, between schools with high and low socioeconomic status. There were only modest differences in results for rural schools compared to suburban or urban schools. However, schools that had participated in Jump Rope for Heart or Hoops for Heart tended to score lower than schools that had not participated. High schools tended to improve less than elementary schools, presumably because high schools are larger and have more complex educational agendas.

Discussion

The Healthy Schools Program represents an important addition to the growing efforts nationally to address the problem posed by the expanding tide of child obesity. The Alliance drew a large sample of schools to participate in the Healthy Schools pilot program. Despite the fact that the Alliance did not provide funding for schools to participate in this program, a rather surprising number agreed to participate.

The initial Inventory responses suggest that the schools recruited varied considerably in their level of implementation of the desired policies and procedures before participation in the Healthy Schools Program. While most schools rated at least a Bronze on the reimbursable meals, physical activity, and after-school programs scales before the program, only a little over a third (37%) rated a Bronze level or higher on staff wellness. Moreover, only 15 of the 187 schools reached at least Bronze on the total score because these were the only ones to reach that level in every domain.

The gains achieved by the 117 schools that did submit both pretest and posttest responses were quite strong. A number of schools reported an increase of 10 levels or more. Only six schools reported a decline in their Inventory responses during the year. Given the level of effort required to make measurable change, these results reflect well on this pilot effort.

Introduction

The dramatic increase in prevalence of childhood obesity nationally led to the formation of the Alliance for a Healthier Generation. Currently as many as one in five students in many states meet the criteria for obesity.

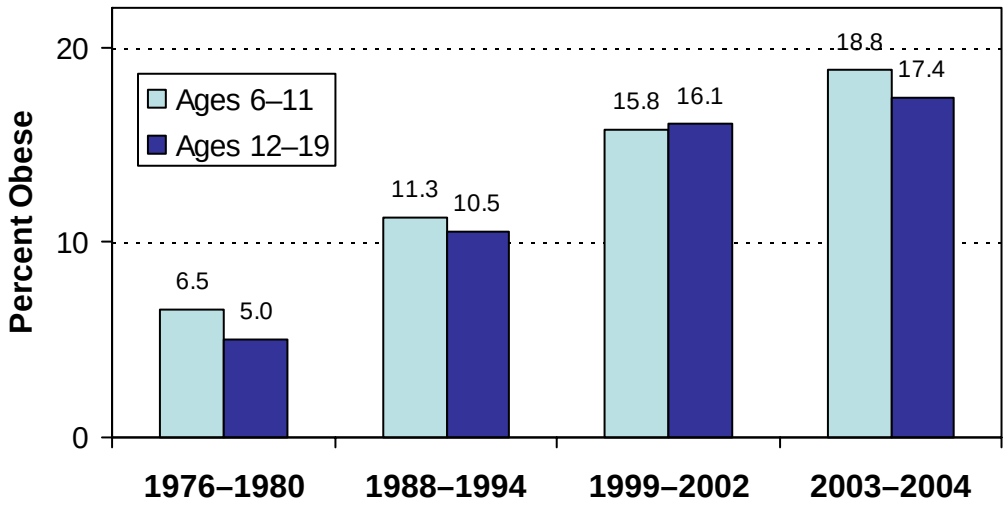

Figure 1. Increasing prevalence of overweight children by year. Source: Centers for Disease Control (2005) http://www.cdc.gov/nchs/products/pubs/pubd/hestats/overweight/overwght_child_03.htm

The Alliance, a joint initiative of the American Heart Association and the William J. Clinton Foundation, began implementation of the Healthy Schools Program in 2006 with funding from the Robert Wood Johnson Foundation. The Healthy Schools Program, one of four major initiatives of the Alliance, has set the goal of halting the increase in childhood obesity in the United States within 5 years and reversing the trend within 10 years. Because 54 million children and 6 million adults (e.g., teachers, administrators, nurses, counselors) spend a substantial amount of time in the nation's schools, Healthy Schools Program staff believe that assisting schools to provide healthy environments is one of the most efficient ways to improve the well-being of children. Through the Healthy Schools Program, the Alliance aims to impact policy and encourage changes within school environments by helping schools meet criteria-based standards for healthy foods and beverages, physical education programs and physical activity, health education, after-school programs, and staff wellness programs. The Healthy Schools Program provides technical assistance, resource brokering, and a wide variety of online tools for participating schools. Schools lacking resources could apply for mini-grants of up to $2,000 to help them implement activities in their action plans. In

addition, the Healthy Schools Program recognizes and rewards schools that meet the standards.

In June 2006, after a competitive award process, the American Heart Association contracted with RMC Research Corporation to conduct an evaluation of the Healthy Schools Program. This report describes the methods and instruments used in the evaluation and presents results from the first year of the program.

Methods

Healthy Schools Program Schools

The Alliance recruited 285 schools in 13 states from an initial sample of 307 to participate as pilot sites for the Healthy Schools Program during the 2006–2007 school year. Of these schools, 230 agreed to participate in the program. Over the course of the school year, 187 of the schools logged onto the Alliance web site and completed the Healthy Schools Program Inventory, an online survey of school practices, at least once. This report includes data from only those 187 schools.

Table 1 lists the total number of pilot schools targeted for recruitment by state. Schools were recruited as feeder chains consisting of elementary-middle-high schools within a school district. Feeder chains of schools were recruited because of their potential to produce longitudinal data as students progress from elementary through high school.

The table also includes the number of these that agreed to participate as signified by signing a Memorandum of Understanding. The last column gives the number of schools that completed the Inventory and are the focus of this report.

Table 1. Number of Pilot Schools Recruited by State

State	Number of Pilot Schools Selected	Number Agreeing to Participate	Number Completing Inventory
Arkansas	15	5	2
California	54	35	32
Connecticut	13	12	11
Delaware	7	2	0
Florida	53	39	39
Illinois	29	24	14
Indiana	11	11	8
Michigan	17	17	14
Minnesota	10	10	9
New Jersey	19	13	12
New York	19	4	3
Pennsylvania	40	38	26
Wisconsin	20	20	17
Total	307	230	187

Pilot schools were selected according to several criteria.

- Fifty percent of the schools recruited were participants in Jump Rope for Heart or Hoops for Heart, American Heart Association programs that promote physical activity among youth.
- Seventy-five percent of the schools recruited had free and reduced lunch rates above their state averages, a marker for poverty.
- Twenty-five percent of the schools recruited served predominantly African-American students, 25% of the schools recruited served predominantly Hispanic students, 5% of the schools recruited served predominantly Asian students, 5% of the schools recruited served Native American students, and 40% of the schools recruited served Caucasian students.
- Recruited schools were equally divided between rural, suburban, and urban areas.

The sampling frame over-sampled schools with a majority of non-Caucasian students to ensure that these schools were well represented. Table 2 summarizes the primary ethnic groups represented among students in schools that completed the Inventory.

Table 2. Ethnic Distribution of Pilot Schools Completing the Inventory

Ethnic Majority	Number of Schools
Caucasian	84
Hispanic	50
African American	37
Asian	10
American Indian	6
Total	187

A large number of schools (266) that were not recruited as part of the pilot site sample enrolled in the program through the Alliance web site and completed the Inventory. These schools received limited assistance from the Alliance and are not considered in the current report. A virtual relationship manager was, however, hired to provide online assistance to these schools later in the school year. A subsequent report will discuss the results for the virtual support schools.

Instrumentation

The instruments developed for the Healthy Schools Program evaluation include the Inventory, a online school self-report survey developed by the Alliance to collect data on school policies and practices; two student measures developed by RMC Research to measure behavior change and body mass index among students in a subset of pilot schools randomly selected for more intensive study; and site visit instruments, including

interview and focus group protocols and food observation and physical education and physical activity protocols, also for use with the intensive study schools.

Inventory

Schools participating in the Healthy Schools Program are required to complete the Inventory, which the Alliance developed based on their best practice framework for policies, programs, and practices that promote physical activity and healthy eating among students and staff. These criteria were reviewed and approved by the science professionals at the American Heart Association. The instrument included 34 items organized into eight scales (see the Appendix). The scoring rubric designated three levels of recognition for achievement: Bronze, Silver, and Gold. Although no measurement model for such a scoring rubric exists, RMC Research conducted a conventional item analysis to determine both intra- and interscale item correlation.

Alliance staff, with input from the Healthy Schools Program Expert Panel, made extensive changes to the instrument for the 2007–2008 school year. The next annual report will discuss these changes and the implications for the evaluation.

Reliability

Table 3 presents the results of an item analysis using the baseline Inventory responses from the pilot schools. Several scales performed well in terms of internal consistency reliability estimates (Coefficient Alpha) with reliabilities in the .6 to .8 range, which is good given the number of items on these scales.

Table 3. Internal Scale Reliability of Inventory Scales at Baseline (Coefficient Alpha)

Domain	No. of Items	Reliability
Policy	8	0.61
Reimbursable meals	6	0.43
Competitive foods	3	0.57
Health education[a]	2	0.60
Physical education[a]	2	0.06
Physical activity	4	0.31
After-school programs	3	0.31
Staff wellness	6	0.78
Total (sum of items)	34[b]	0.73
Total (sum of scales)	8	0.63

Note. N = 187. Any block consisting of several related yes/no (binary) responses was treated as a single item.
[a]These scales had a set of 3 items, each intended for elementary, middle, or high schools. Typically a school only answered one question in the set. [b]No schools responded to one item so it was ignored in the scoring.

Low reliabilities are evident for the physical education, physical activity, and after-school programs scales. Inspection of the results for the physical education scale suggested that the two items were not strongly correlated, probably because one of the two usually reflects a decision that is usually made at the district level, not the school level. The low reliability of the physical activity and after-school programs scales may have been due to the fact that most schools scored high on these scales thus there was a restriction of range that may have limited the size of the reliability estimate.

RMC Research conducted a separate reliability analysis for the total sum of scales, treating each scale as an individual item. This analysis revealed that the eight scales are highly, but not perfectly, correlated.

Factor Analysis

Factor analysis was used to examine the extent to which the items in each scale measured variation among the schools. Table 4 provides the results of a five-factor solution, which seemed optimal based on a plot of eigenvalues (an index indicating the variance of the factor explained by that item). The results suggest five factors (primary sources of variation) in the baseline Inventory results. These may be interpreted as: (1) staff wellness, (2) beverage and food standards compliance plus physical activity, (3) school wellness council, (4) reimbursable meals, and (5) health education and physical education.

In general, the results of the factor analysis suggest that the items vary as intended along several dimensions. Thus these scales are useful in describing various sources of variation across schools. Although all of the original scales were correlated, schools tended to respond more similarly to the items highlighted within each of the factors summarized in this table.

Student Measures

RMC Research developed two instruments to collect student information for the evaluation: the Healthy Schools Survey and the Height and Weight Form. Copies of these instruments will be included in a future report. The Healthy Schools Survey measures student health behaviors such as eating choices and physical activity. The Height and Weight Form collects students' height and weight for computation of their body mass index. These instruments will be administered only in schools selected for intensive study (beginning in fall 2007). Preliminary results from these intensive study sites will be reported in the next annual report.

Table 4. Factor Structure of Baseline Inventory Responses (Eigenvalues)

	Factor				
Item	**1**	**2**	**3**	**4**	**5**
Q1	.045	.198	*.430*	*.416*	.070
Q2	-.004	*.434*	*.450*	.224	.060
Q3	.212	-.083	**.725**	.001	-.051
Q4	.273	-.025	**.731**	.068	-.058
Q5	.158	.244	**.548**	.058	.214
Q6	.227	.217	.252	.227	.096
Q7	.092	*.386*	.274	.229	.143
Q8	.087	-.096	-.011	**.801**	-.019
Q9	.093	-.067	-.057	**.611**	-.120
Q10	-.024	-.034	.093	**.762**	.025
Q11	-.024	.271	.112	*.405*	.147
Q12	.178	.269	.077	-.065	.119
Q13	.034	*.384*	-.006	*.440*	*.383*
Q14	.098	**.712**	-.189	.038	-.137
Q15	.001	**.785**	-.190	.029	-.163
Q16	-.014	*.346*	.150	.044	.177
Q17–19	.042	.026	.119	-.089	*.394*
Q20	.187	.155	.048	.024	**.661**
Q21	.142	.435	.074	-.043	.249
Q22–24	.011	-.212	.040	.059	**.623**
Q25	.165	.075	.009	.093	**.784**
Q26A	*.432*	.121	.047	.133	.226
Q26B	**.778**	-.041	.059	.016	.063
Q27	**.890**	.084	.129	-.005	.105
Q28	**.852**	.024	.070	.055	-.021
Q29	**.878**	.069	.141	.034	.110
Q30	.029	*.451*	.215	-.174	.009
Q31	-.006	.008	.266	.024	.238
Q32	-.111	.167	*.484*	-.119	.199
Q33	-.065	*.506*	.188	.066	-.084

Note. Extraction method: principal component analysis. Rotation method: Varimax. Factors: 1 = staff wellness, 2 = beverage and food standards compliance plus physical activity, 3 = school wellness council, 4 = reimbursable meals, and 5 = health education and physical education. High values that suggest an item is associated with a common source of variation appear in boldface. Values that suggest an item is moderately associated with a factor appear in italics.

Site Visit Instruments

The interview and focus group instruments developed for the Healthy Schools Program evaluation collect the following data:

- Pre-Interview Information Request Form—Interviewees' understanding of the Healthy Schools Program and documentation of the school or district wellness plan, health and physical education curricula, and cafeteria menus.
- Interview Protocol—Interviewees' role in the implementation of the Healthy Schools Program; satisfaction with the food offerings, physical education and activity, and health education in the school; and improvements to nutrition and physical activity in the school.
- School Wellness Council Focus Group Protocol—The goals set by the school wellness council and facilitators and barriers to implementing the Healthy Schools Program in the school.

The interview and focus group participants include school or district curriculum or health education specialists, principals, Healthy Schools Program or staff wellness coordinators, school food service managers or district food services directors, and physical education staff.

The observation forms developed for the evaluation collect the following data:

- Physical Activity Observation Checklist—Description of the play areas and facilities that support physical activity and physical education; observations of physical education.
- Cafeteria Observation Record—Description of the reimbursable meals and competitive foods and beverages available for breakfast (if applicable) and lunch.
- Other Food Area Observation Record—Description of the food and beverages available in other areas of the school (e.g., snack bars, stores).
- Vending Inventory Form—Description of the food and beverages available in vending machines in the student and staff areas of the school.
- Summary of Vending Observations Form—The number and locations of the vending machines throughout the school.
- Incidental Foods Observation Form—Description of the observed parties or fundraisers at which food or beverages were available.
- Food and Beverage Marketing Form—Description of the food and beverage marketing observed throughout the school.

Results

This section presents the evaluation results from the first year (2006–2007) of the Healthy Schools Program including the characteristics of the 187 pilot schools, their Inventory results, and the changes they reported.

Characteristics of the Pilot Schools

Table 5 summarizes the characteristics of the 187 pilot schools. The sample included 55 elementary schools, 53 middle schools, 59 high schools, and 20 schools with a broader range of grades (e.g., K–8). Half of the schools were participants in the American Heart Association's Jump Rope for Heart or Hoops for Heart programs. The sample included 114 low socioeconomic status schools, a finding that most likely reflects the fact that schools with primarily non-Caucasian students were intentionally oversampled. The schools were well distributed geographically: 60 rural, 76 suburban, and 51 urban schools participated.

Table 5. Characteristics of the Pilot Schools That Completed the Inventory

	Number of Schools				
Characteristic	**Elementary (*n* = 55)**	**Middle (*n* = 53)**	**High (*n* = 59)**	**Other (*n* = 20)**	**Total (*N* = 187)**
Jump[a] status					
Not Jump	30	28	31	4	93
Jump	25	25	28	16	94
Socioeconomic status					
High SES	21	17	27	8	73
Low SES	34	36	32	12	114
Primary ethnicity[b]					
African American	11	11	12	3	37
Caucasian	24	24	26	8	82
Hispanic	16	15	14	6	51
Other	4	3	6	3	16
Community setting					
Rural	18	18	18	6	60
Suburban	22	21	25	8	76
Urban	15	14	16	6	51

Note. Elementary School = Grades K–5/6, Middle School = Grades 6–8, High School = Grades 9–12.
SES = socioeconomic status.
[a]Jump refers to Jump Rope for Heart or Hoops for Heart participants. [b]One high school did not report on the school's primary ethnicity.

Baseline Inventory Results

Figure 2 summarizes the baseline Inventory results of these 187 pilot schools on each subscale. Most schools did well on at least one scale, but few scored high enough overall to attain Bronze, the lowest level of achievement recognition. The range of scores reflects the fact that all types of schools were recruited as pilot schools for the Healthy Schools Program. These baseline scores are generally low enough that it should be possible to assess change over time.

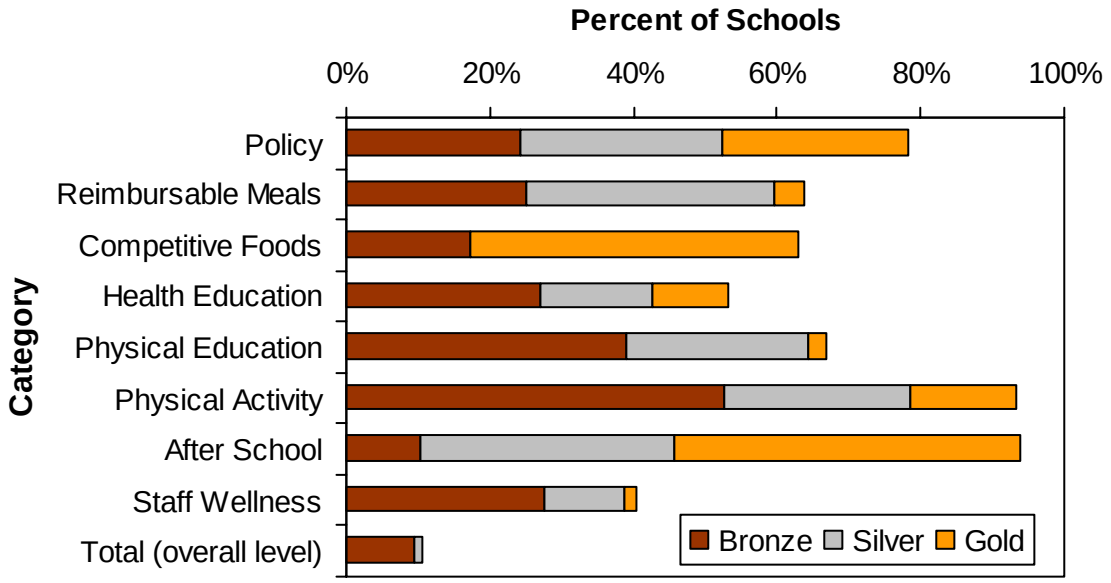

Figure 2. Schools achieving recognition levels on Inventory scales at baseline.

The wide range of scores is striking. Clearly, the schools varied significantly in terms of their prior efforts to promote good health among students and staff. A high percentage of schools attained Gold on the competitive foods (44%) and after-school programs (47%) scales, and about half of the schools attained Bronze on the physical activity scale. However, very few schools (8%) attained Bronze or better overall because most schools failed to attain recognition on one or more scales. The scales with the lowest scores at baseline were reimbursable meals, health education, physical education, and staff wellness.

Table 6 summarizes the first Inventory results obtained by school type. Only modest differences by grade level are evident: compared to the middle and high schools, the elementary schools scored higher on the competitive foods scale and lower on the physical education scale.

Table 6. Level Attained at Baseline by School Type

Baseline Recognition Level	Percent of Schools				
	Elementary (*n* = 55)	Middle (*n* = 53)	High (*n* = 59)	Other (*n* = 20)	Total (*N* = 187)
Policy					
Bronze	16	21	29	15	21
Silver	31	23	22	30	26
Gold	24	21	20	25	22
Reimbursable meals					
Bronze	35	17	22	5	23
Silver	29	34	25	45	31
Gold	2	4	7	0	4
Competitive foods					
Bronze	13	25	15	10	17
Gold	71	32	32	40	44
Health education					
Bronze	13	28	46	11	27
Silver	9	21	10	32	15
Gold	15	6	7	11	9
Physical education					
Bronze	49	43	25	26	38
Silver	9	26	41	21	25
Gold	0	2	3	5	2
Physical activity					
Bronze	40	49	66	35	50
Silver	29	30	10	35	24
Gold	26	11	10	20	16
After-school programs					
Bronze	11	11	7	5	9
Silver	26	38	48	50	39
Gold	58	51	39	35	47
Staff wellness					
Bronze	22	27	27	25	25
Silver	11	8	14	5	10
Gold	0	2	2	10	2
Total					
Bronze	7	4	9	15	8
Silver	0	2	0	5	1

Note. Elementary School = Grades K–5/6, Middle School = Grades 6–8, High School = Grades 9–12, Other = Atypical schools (i.e., Grades K–8 or K–12).

The differences observed for other sampling variables are also minor. Ethnic distribution was the school characteristic that appeared to be most predictive of results. The small sample of schools with predominately Native American student populations performed very well, and schools with predominately Asian populations performed well. In contrast, schools with predominately African American populations scored the lowest.

Item Results

The baseline Inventory results varied widely by item. Figure 3 shows the percentages of schools that responded positively to selected items.

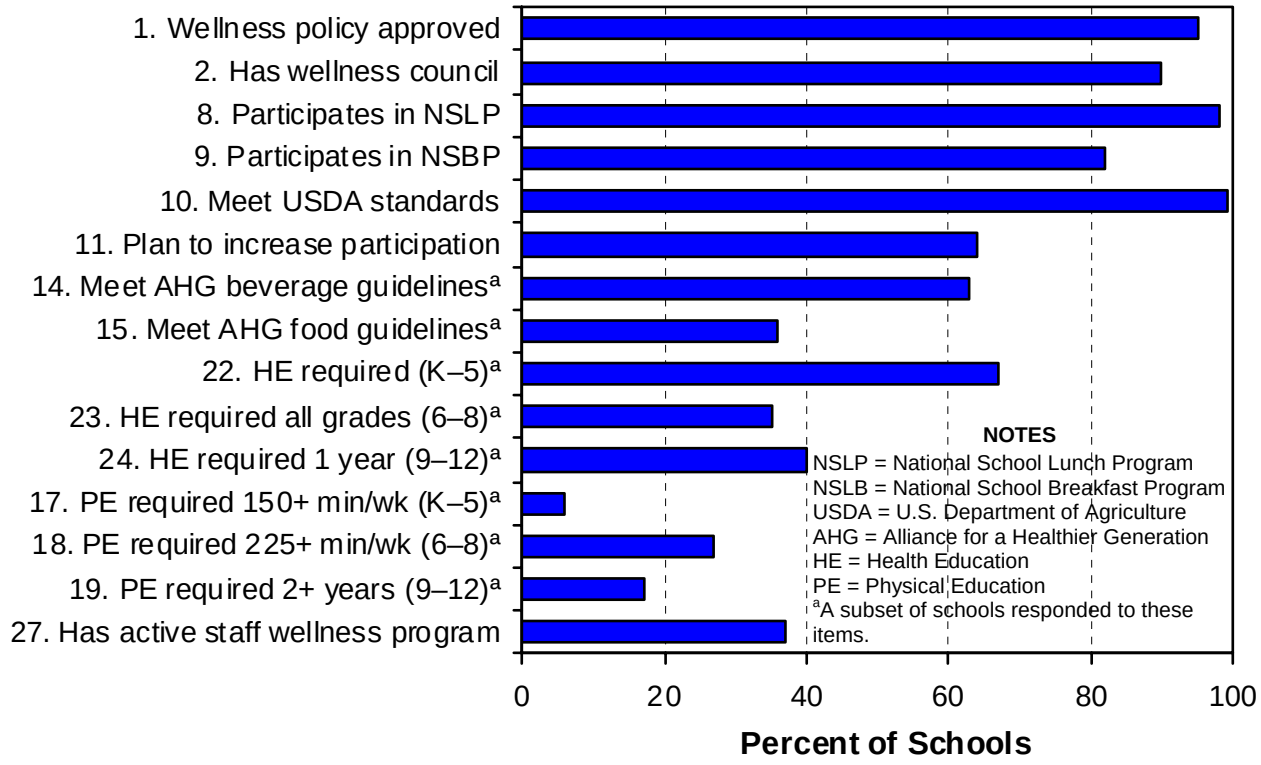

Figure 3. Positive responses to selected Inventory items at baseline. Percentages are based on the number of schools that responded to a given item.

Although virtually all of the schools responded positively to several items on the policy scale, relatively few schools responded positively to items on the health education, physical education, and staff wellness scales. Distinct differences by school type were evident on the health education and physical education scales.

Change Over the School Year

Schools were asked to complete both an initial Inventory response and an update during the 2006–2007 school year. For this report Inventory results submitted before March 1, 2007, are considered pretest results. Responses submitted after March 1, 2007, and before November 1, 2007, are considered first year posttest results. Table 7 shows the numbers of schools in terms of the timing of their Inventory completion. Just over one third of the schools (37%) did not meet the criteria for inclusion in computing change during their first year with the Healthy Schools Program.

Table 7. Pretest and Posttest Completion

Inventory Completion Status	Number of Schools
Pretest only	64
Pretest and posttest[a]	117
Pretest/posttest untimely	6
Total	187

[a]Inventory first completed before 3/1/07 and follow-up completed after 3/1/07.

One hundred seventeen schools (63%) completed both a pretest and posttest within the date ranges established. The completion of both a pretest and a posttest allows for the quantitative observation of change over the course of the first year of Healthy Schools Program implementation. Alliance staff efforts to encourage participation were helpful in obtaining this response rate. It is not clear how many additional schools out of the remaining 64 did not respond because their scores had not changed but staff efforts to encourage updates helped reduce the number of non-respondents. In the redesign of the Inventory, a number of changes were implemented to encourage schools to make periodic updates.

RMC Research conducted *t* tests to determine whether the pretest scores of the schools that completed both a pretest and a posttest differed significantly from the pretest scores of the schools that completed the pretest only. No significant differences in the mean pretest scores of the groups were evident on any scale. A series of chi square tests were used to compare the schools that completed a posttest on the school variables used in drawing the sample. The only significant difference was that low socioeconomic status schools were less likely to complete a posttest than high socioeconomic status schools. These results suggest that there were no important differences between the schools that completed both a pretest and posttest and the schools that completed the pretest only.

Table 8. Percentage of Schools with Increase of One or More Recognition Levels on Inventory Scales

Characteristic	Percent of Schools									
	Policy	Reimbursable Meals	Competitive Foods	Health Education	Physical Education	Physical Activity	After School	Staff Wellness	Total	Sum of Scales
School type										
Elementary (*n* = 37)	35	35	19	41	30	38	16	57	38	86
Middle (*n* = 34)	47	38	29	35	35	24	26	38	44	76
High (*n* = 35)	29	31	34	26	14	17	20	43	26	60
Other (*n* = 11)	18	9	9	30	30	27	18	36	27	55
Jump[a] participation										
Not Jump (*n* = 59)	46	31	27	41	32	29	25	59	44	81
Jump (*n* = 58)	24	34	24	26	21	24	16	31	26	64
Socioeconomic status										
High (*n* = 43)	35	35	19	38	17	19	9	37	30	72
Low (*n* = 74)	35	31	30	31	32	31	27	50	38	73
Geographic setting										
Rural (*n* = 43)	30	40	37	40	30	30	23	53	40	72
Suburban (*n* = 43)	42	33	28	30	23	26	28	47	40	77
Urban (*n* = 31)	32	23	6	30	27	23	6	32	23	68
Total percentage	35	32	26	34	27	26	21	45	35	73

Note. n = 117.
[a]Jump refers to Jump Rope for Heart or Hoops for Heart participants.

Table 8 displays the percentages of schools that attained an increase of one or more recognition level on each Inventory scale by the sampling variables. While 25% to 35% of the schools improved on most of the scales, 45% improved on the staff wellness scale. Most schools scored very low on this scale at pretest and many appear to have made staff wellness a priority. The promotion of staff wellness may be less subject to district policies than health education and physical education and this may have been frequently targeted by schools as an area to be addressed in the first year.

RMC Research added a final measure called sum of scales, which represents the sum of all the scale scores including the total score. The sum of scales is the score of primary interest to the evaluation. It reflects the weighting of individual items intended by the Alliance and shows overall change more clearly than the total score. A majority of schools (73%) improved on the sum of scales measure. This means that nearly all of the pilot schools improved at least one level on at least one scale, although many improved much more. This confirms that all but a small number of schools showed measurable change over this first school year despite a slower start than anticipated.

Figure 4 shows the total percentages of schools that attained an increase in recognition level on each Inventory scale. Only the 117 schools with both a baseline prior to March 1, 2007, and a follow-up response after March 1, 2007 are included.

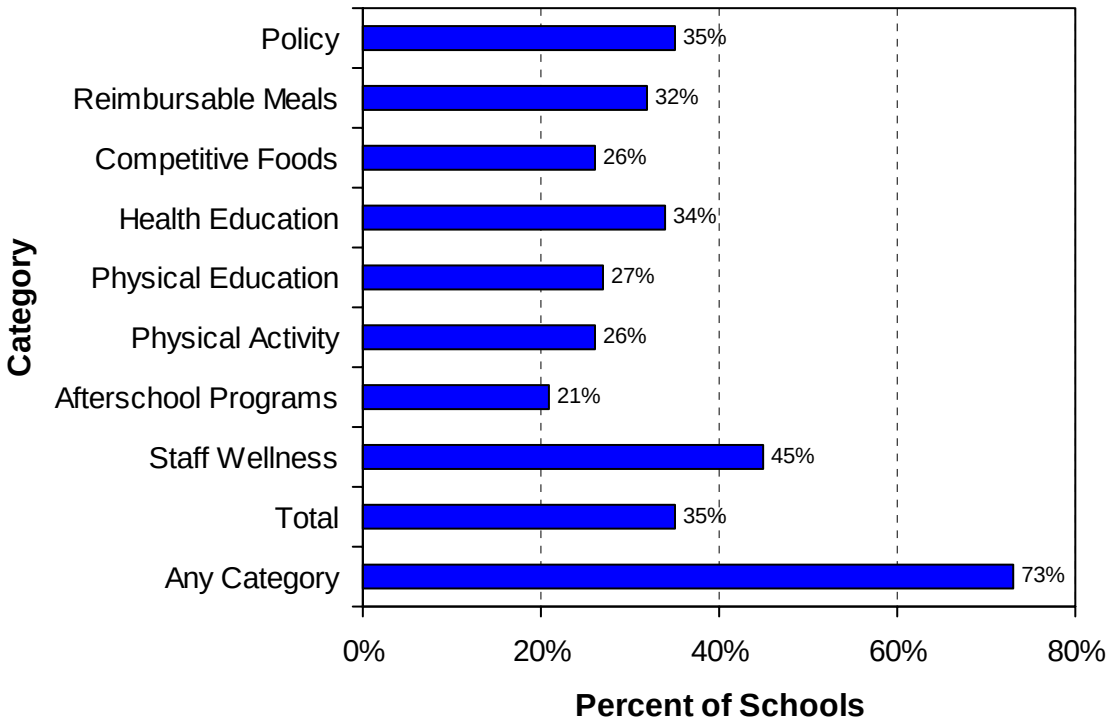

Figure 4. Schools reporting an increase of at least one recognition level on Inventory scales (*n* = 117).

To check whether these schools differed in some way from the schools that completed only a pretest, *t* tests were conducted on the baseline scale values and chi square tests on the school descriptor variables. The only significant difference observed was that schools with a posttest scored slightly higher on the Policy scale at baseline. This result suggests that these 117 schools were generally representative of the total sample of schools, although it is possible that they differed in some other unmeasured way.

Figure 5 shows the distribution of gains on the sum of scales for the 117 schools that completed a pretest and a posttest within the established time periods. Each increment represents an increase of one recognition level on one scale. Across all of the scales, several schools attained a total increase of 10 levels or more, a dramatic increase.

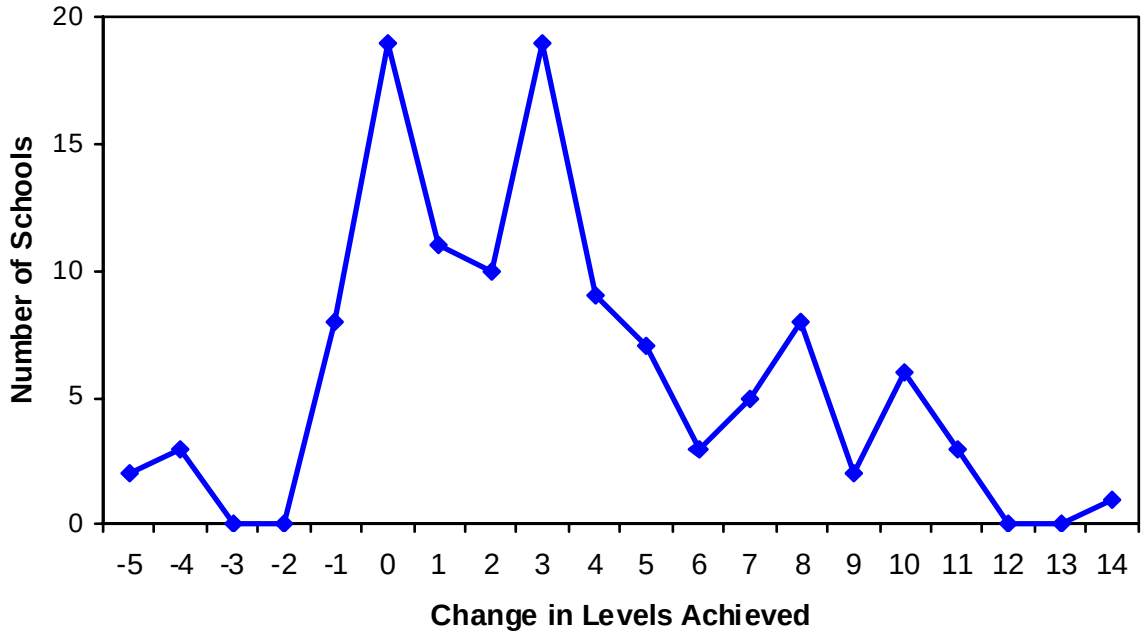

Figure 5. Distribution of change in sum of levels achieved between the baseline and follow-up Inventory responses (*n* = 117). Many schools reported substantial improvement during their first year of involvement with the program.

However, 32 schools did not show an increase in levels achieved by the follow-up assessment. While most simply reported no change, five schools appeared to be correcting their baseline responses.

Figure 6 shows the percentage of schools showing a change by each sampling characteristic. In general, there were only modest differences for each characteristic. Differences among rural, suburban, and urban schools were quite small. There was no difference between schools with high and low socioeconomic status. Results were very similar among schools with different racial/ethnic majorities. However, there were two

differences worth mentioning. First, despite expectations to the contrary, schools that do not participate in Jump Rope for Heart or Hoops for Heart did quite well compared to their Jump counterparts (81% compared to 64%). Second, about 60% of the high schools showed improvement compared to 86% of the elementary schools. This is likely due in part to the much greater size and greater complexity of issues facing high schools.

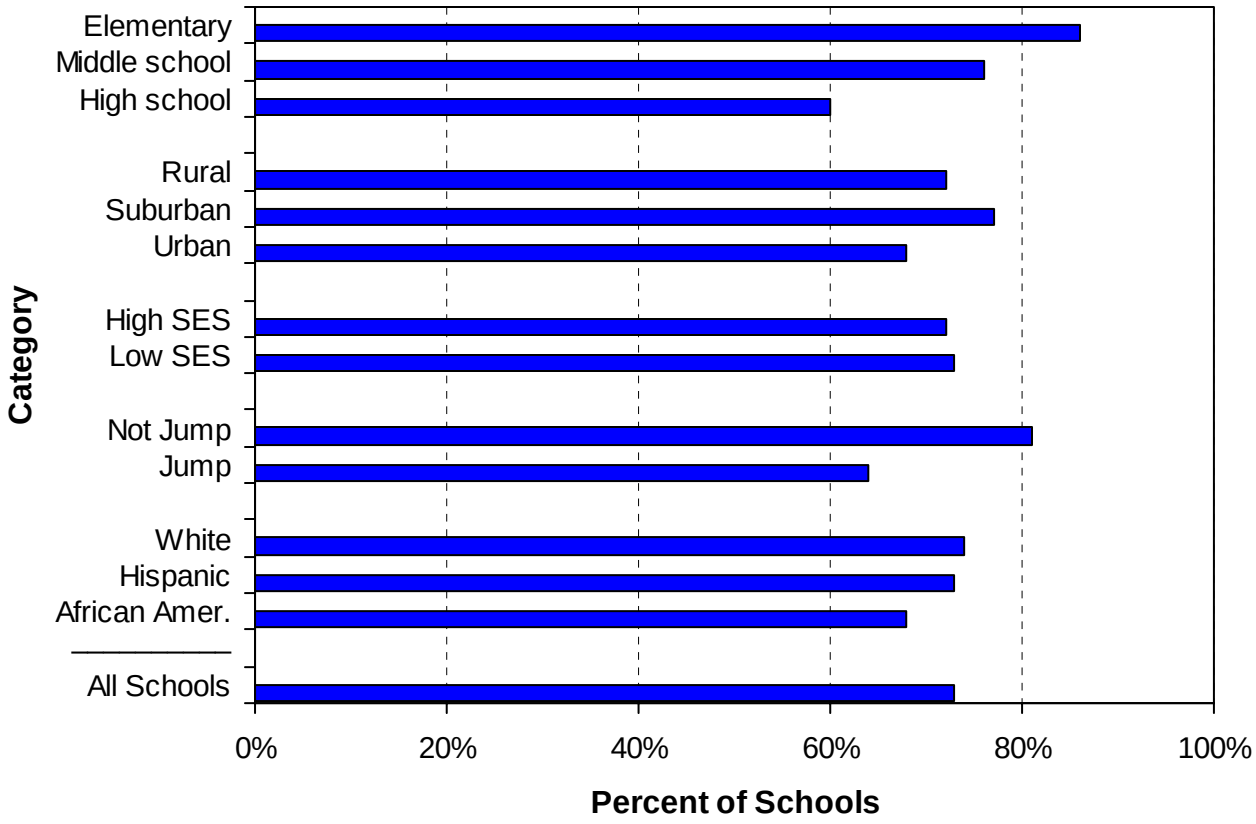

Figure 6. Distribution of change in sum of levels achieved between the baseline and follow-up Inventory responses by sampling characteristic (*n* = 117). Overall, there were only modest differences between characteristics. Note: Jump refers to Jump Rope for Heart or Hoops for Heart participants.

Satisfaction with Technical Assistance

Inventory respondents answered three questions about their satisfaction with the technical assistance they had received at baseline and follow-up. Figure 7 illustrates the responses of 116 respondents who responded to these questions. At follow-up 55% reported receiving *considerable* or *extensive* assistance compared to 26% at baseline. At follow-up 64% reported that the technical assistance was *fairly* or *very instrumental* in improving the health of their students and staff. Figure 6 summarizes these findings.

The results suggest that most respondents thought favorably of the assistance they received. Although some schools had assistance prior to their involvement with the Alliance, the timing of the baseline response for many schools was later then expected thus their answers may reflect some early assistance from Alliance staff as well as prior assistance from other resources.

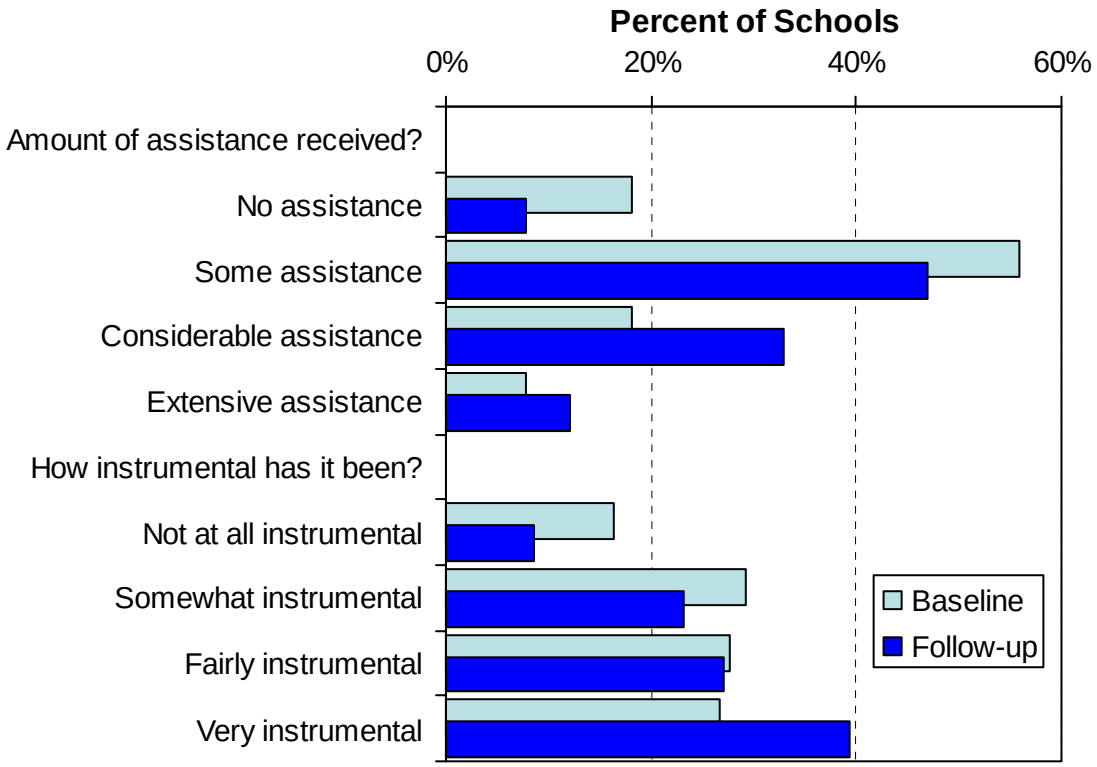

Figure 7. Satisfaction with technical assistance (*n* = 116 schools).

Site Visit Results

During 2006–2007 the evaluation team conducted a site visit in one school district. All three schools in this small, rural school district participated. The site visit team met with the principal and Healthy Schools Program contact at each school, toured the buildings and grounds, examined the food service and physical education facilities and programs, interviewed school staff, and conducted a focus group with members of the district wellness committee. This section summarizes the site visit results in terms of food and beverages, physical education and physical activity, health education, and staff wellness, and future plans.

Food and Beverages

After approving a district wellness policy in summer 2006, the district made considerable progress toward improving the quality of the school meals and the competitive food and beverages offerings available to students and staff. The cafeterias introduced more whole grain foods and more fresh fruits and vegetables. The cafeterias served locally grown food to the extent possible and half of the cafeteria offerings were prepared from scratch on site. The district renegotiated its vending machine contract so that the machines available to students at the middle and high schools offered only low-fat, low-sugar snacks and 100% fruit juices, spring water, and flavored water. The vending machines at the high school also included two choices of diet soda. The staff vending machines in all of the schools contained a full array of sodas and both high- and low-fat snacks. Barriers to serving healthy food in the district's schools included inconsistent availability of high-quality fresh fruits and vegetables, low-fat cheese, and other healthy foods from the government commodities program and the lack of a local supplier of 1% or skim milk products in 8-ounce cartons.

Physical Education and Physical Activity

The elementary and middle schools each had two certified physical education instructors, and the high school had one certified physical education instructor. Kindergarteners participated in physical education twice a week, and students in Grades 1 through 4 participated in a 30-minute physical education class four times a week. Students at the middle school alternately participated in physical education on 2 days one week and 3 days the next. At the high school level physical activity was offered 5 days a week for 50 minutes each day for half the school year; however, physical education was an elective for students in Grades 11 and 12. The National Association for Sports and Physical Education's National Standards served as a guide for the district's physical education curriculum. Barriers to offering more physical education and activity opportunities included pressure to focus school resources on academic instruction and significant budget cuts at the district level.

Health Education

Students at both the middle and high school levels participated in health education. Students in Grades 7 and 8 participated in health education classes 2 days a week for half of the school year. Due to budget cuts, separate health education classes will not be offered at the middle school in 2007–2008; instead, health education topics will be incorporated into physical education classes. At the high school, completion of a health education course in Grade 10 or 11 is required for graduation. The course's daily, 50-minute classes span a 20-week time period. The high school health education curriculum is aligned with state standards. The state recently dropped health education as a graduation requirement, but the district will continue to require the course through the class of 2009 school year.

Staff Wellness

In fall 2006 the district wellness committee solicited from staff suggestions for staff wellness program activities. Volleyball, yoga, aerobics, walking, and weight loss groups were established and met throughout the school year. The committee relied primarily on volunteers to lead the groups. At the elementary school a treadmill, stationary bicycle, and weights were available for staff use. At the middle and high schools a fully equipped fitness room was available for staff use.

Future Plans

This district planned to eliminate the use of trans fats in food preparation, providing all food service staff with training on techniques to reduce fat and sodium in food offerings, and introducing more whole grain foods. The schools received mini-grants from the Alliance for a Healthier Generation and the funds will be used to provide incentives for students and teachers to participate in an after-school walking program and to produce a nutrition newsletter for elementary school students and their parents. Elementary school teachers intend to implement the Work Out, Low Fat (WOLF) program, a Centers for Disease Control and Prevention coordinated school health program that promotes behavior changes to prevent diabetes among children.

Discussion

The Healthy Schools Program represents an important addition to the growing efforts nationally to address the problem posed by the expanding tide of child obesity. This report describes results from the first year's operation of the program with a large number of pilot schools.

The Alliance drew a large sample of schools to participate in the Healthy Schools pilot program. Despite the fact that the Alliance did not provide grant funds to cover participation in this program, a rather surprising number agreed to participate. While low socioeconomic status schools could apply for a small grant, it was clear to schools that the Alliance would primarily provide only technical assistance. Thus the 187 pilot school responses to the Inventory suggests that a large number of schools decided to take advantage of the opportunity to participate in the program.

The initial Inventory responses suggest that the selected schools varied considerably in their level of implementation of the desired policies and procedures before participation in the Healthy Schools Program. While most schools rated at least a Bronze on the reimbursable meals, physical activity, and after-school programs scales before the program, only a little over a third (37%) rated a Bronze level or higher on staff wellness. Moreover, only 15 schools reached Bronze on the total score at baseline.

Unfortunately the number of schools submitting both pretest and posttest Inventory responses during this first year was smaller than expected. Hopefully changes in the design of the web site will improve the response rate in the second year of the program.

The gains achieved by the 117 schools that did submit both pretest and posttest responses were quite strong. Eight schools reported an increase of 10 levels or more. Only six schools reported no improvement in their Inventory responses during the year. Given the level of effort required to make measurable change, these results reflect well on this pilot effort.

RMC Research expects that interviews with staff members and preliminary findings from site visits at pilot sites would generally support the results from the Inventory. However, attempts to conduct site visits with selected pilot schools have proceeded much more slowly than expected. The goal was to make visits to five school districts each year. So far only one site visit has taken place, although negotiations continue with the remaining first year sites. Discussions with the districts selected for a visit during the 2007–2008 school year have proceeded much more smoothly and some of these visits are already scheduled for fall 2007. Only one district has been unresponsive to inquiries about participation in the evaluation.

Issues Identified

As with any pilot project, there were several implementation issues encountered during this first year of the Healthy Schools Program. There were also challenges encountered in conducting the evaluation.

Implementation Issues

Implementation of the Inventory

Although the Alliance's technical assistance protocol directed schools to complete the Inventory at the beginning and end of the school year (i.e., pretest and posttest), there were no online cues to reinforce this. Furthermore, the system saved only the most current update, so it was necessary for RMC Research staff to extract and save the data monthly to capture the history of the schools' Inventory results. Hopefully the revision of the Inventory will address these problems.

Slow Startup

The Alliance's regional relationship managers were to conduct a sequence of three technical assistance training sessions for the pilot schools during the first school year. Two additional sessions will take place in each additional year. Although there was no set timetable for these sessions, scheduling them appears to have required more time than expected.

Participation Data

Although Alliance staff collected data on school participation in program activities, the results collected so far are incomplete. A project is underway to automate some aspects of the data collection using the American Heart Association messaging system. However, it is not clear how much this will improve the process as the system is complex and not specific to the needs of the Alliance so staff may find it hard to use.

Evaluation Issues

Modest Inventory Posttest Response Rate

The number of schools that completed both a pretest and a posttest assessment was less than anticipated. Late in the school year, RMC Research provided Alliance staff with school-level reports for distribution to encourage completion of a posttest. As a result, the response rate improved slightly. Changes to the Inventory for 2008–2009 should clearly indicate that responses are expected at the beginning and end of the school year. This change is one of several the Alliance is planning, but it is not clear yet whether an adequate solution has been implemented.

Recruiting Schools for Intensive Study

The process of recruiting schools for intensive study and planning site visits has been slow and difficult. This difficulty is more a reflection of the lack of strong, centralized Healthy Schools Program contacts in the schools than lack of interest in participating in the evaluation. The lack of financial incentives is also a factor. To entice schools to participate in the intensive study, RMC Research is now offering a modest incentive to offset any costs incurred through participation plus a cash incentive that is disbursed after the schools complete the first round of data collection. These incentives appear to have increased schools' interest in participating in the evaluation.

The evaluation team began recruiting schools in December 2006. The process of recruitment appears, however, to require between 2 and 6 months. In some cases the evaluation team has needed to submit research review applications to the school district to gain approval to conduct the study. RMC Research conducted one site visit late in the 2006–2007 school year, and efforts to arrange site visits early in the 2007–2008 school year been fairly successful. Data collection has been scheduled with all or some schools in feeder chains in seven districts. Research review applications are pending in two other districts.

Redesign of the Inventory

A substantially revised version of the Inventory was recently presented to the participating schools by Alliance staff. The new version will replace the original Inventory used during 2006–2007. Although these changes appear to improve the instrument, revision poses a significant problem for the evaluation because the evaluation team will not have a good way to measure change from the baseline and there is no control group in the study against which to compare the results. It will be difficult to argue that second year results are due to the Healthy Schools Program rather than the revised wording of the Inventory. RMC Research has a strategy for dealing with the change in versions but argues against any further significant changes, at least during this evaluation.

Appendix
Healthy Schools Inventory

N.B. The item numbers in the attached survey reflect what the respondent saw, whereas the numbers in parentheses indicate the original numbering. Scoring criteria appear in a box after each section and refer to the original numbering.

Healthy Schools Inventory

Policy

1. (1) My district has a wellness policy that has been approved by the school board/committee.

   - ☐ Yes (A)
   - ☐ No (B)

2. (2) My district or school has adopted administrative regulations that are aligned to our district wellness policy.

   - ☐ Yes (A)
   - ☐ No (B)

3. (3) My school has a wellness council/committee.

   - ☐ Yes (A)
   - ☐ No (B)

4. (4) My school's wellness council/committee meets at least every other month.

   - ☐ Yes (A)
   - ☐ No (B)
   - ☐ My school does not have a wellness committee/council (C)

5. (5) Student health and wellness is a standing agenda item on my school's (please mark all that apply):

   - ☐ Site Council meeting agenda (A)
   - ☐ Parent organization meeting agenda (B)
   - ☐ None of the above (C)

6. (6) My district or school has dedicated funds to implement the wellness policy.

   - ☐ Yes (A)
   - ☐ No (B)
   - ☐ My school does not have a policy (C)

7. (7) My school or district has a plan to evaluate and report progress on the implementation of the district wellness policy.

- Yes (A)
- No (B)

8. (35) Over the last 12 months, has your school received training or technical assistance on school health or obesity prevention program from a consultant, Alliance relationship manager, or other person outside the school?

- Yes (A)
- No (B)
- Don't Know

9. (36) If so, how much assistance has your school received?

- No assistance (A)
- Some assistance (B)
- Considerable assistance (C)
- Extensive assistance (D)

10. (37) How instrumental has this assistance been in helping your school take steps that will improve the health of your school environment?

- Not at all instrumental (A)
- Somewhat instrumental (B)
- Fairly instrumental (C)
- Very instrumental (D)

Recognition Conditions for Policy	
Gold	1A and 2A and 3A and 4A and (5A or 5B) and 6A and 7A
Silver	1A and 2A and 3A and 4A and (5A or 5B)
Bronze	1A and 2A and 4A
No Level	Anything else

Reimbursable Meals

1. (8) My school participates in the National School Lunch Program.

- Yes (A)
- No (B)

2. (9) My school participates in the National School Breakfast Program.

- Yes (A)
- No (B)

3. (10) Reimbursable meals served at my school meet the USDA School Meals Initiative standards.

- ☐ Yes (A)
- ☐ No (B)

4. (11) My school has an action plan in place to increase participation in the National School Breakfast and Lunch programs

- ☐ Yes (A)
- ☐ No (B)

5. (12) Drinking fountains that are well-functioning and dispense safe drinking water are available to students at all times during the school day

- ☐ Yes (A)
- ☐ No (B)

6. (13) Please check all of the following reimbursable meals features that exist in your school.

- ☐ Offers only fat-free or low-fat milk (flavored or unflavored) (A)
- ☐ Offers whole grains daily at breakfast and lunch (B)
- ☐ Offers at least 2 fruits with breakfast (C)
- ☐ Offers at least 4 non-fried, no-added-sugar fruits and/or vegetables daily (salad bar can serve as one of the four) (D)
- ☐ Offers at least one reimbursable meal at each meal with <35% calories from fat, <9% calories from saturated fat, < 1% of calories from *trans* fat and <575 mg sodium for breakfast and <767mg sodium for lunch (E)
- ☐ Uses only unsaturated, zero trans fat oils in food preparation (F)
- ☐ Uses no deep fat frying in food preparation (G)
- ☐ Offers non-fried fish at least 1 time/week (H)
- ☐ Serves only lean protein products such as lean red meat, skinless poultry, lean deli meats, fat-free or low-fat cheese, beans, tofu, etc. (I)
- ☐ Has an annual training program completed by ALL food service staff covering techniques to reduce fat, sodium, etc. in food preparation (J)
- ☐ Offers daily salad bar with at least 5 different fresh vegetable and/or fruit options available (K)

Recognition Conditions for Reimbursable Meals	
Gold	If 8A and 9A, and 10A and 11A and 12A and all of 13A-K checked
Silver	If 8A and 9A, and 10A and 11A and 12A and any 6 of 13A–K checked
Bronze	If 8A and 9A, and 10A and 12A and any 4 of 13A-K checked
No Level	Anything else

Competitive Foods

7. (14) All beverages sold during the regular and extended school day meet the Alliance for a Healthier Generation beverage guidelines.

   - Yes (A)
   - No (B)
   - No beverages are sold in this school (C)

8. (15) All foods (outside of the reimbursable meals program) sold during the regular and extended school day meet the AHG competitive foods guidelines.

   - Yes (A)
   - No (B)
   - No food is sold outside the reimbursable meals program (C)

9. (16) My school is actively trying to improve the nutritional quality of competitive foods served.

   - Yes (A)
   - No (B)
   - My school does not sell or offer competitive foods (C)

Recognition Conditions for Competitive Foods	
Gold	If (14A or 14C) and (15A or 15C) and (16A or 16C)
Silver	No silver
Bronze	If (14A or 14C) and (16A or 16C)
No Level	Anything Else

Health Education

1. (22) My school requires that every student enrolled in the Kindergarten through 5th grades receive health education that includes instruction on healthy eating and physical activity at every grade level.

   - Yes (A)
   - No (B)
   - My school does not contain these grades (C)

2. (23) My school requires that every student enrolled in the 6th through 8th grades receive health education that includes instruction on healthy eating and physical activity:

   - At least one term at one grade level (A)
   - At least one term at two grade levels (B)
   - At least one term at all grade levels (C)

- ☐ My school does not require health education (D)
- ☐ My school does not contain these grades (E)

3. (24) My school requires that every student enrolled in the 9th through 12th grades receive health education that includes instruction on healthy eating and physical activity:

   - ☐ One term (A)
   - ☐ Equivalent to at least 1 year (B)
   - ☐ My school does not require health education (C)

4. (25) Which of the following are true of the Health Education programs at your school?
   (please mark all that apply)

   - ☐ Planned healthy eating and physical activity instruction is aligned to the national/state health education standards (A)
   - ☐ Planned healthy eating and physical activity instruction is aligned to the characteristics of effective health education curricula (B)
   - ☐ Health education is taught by trained teachers at the elementary level or certified/licensed teachers at the secondary level (C)
   - ☐ Teachers who teach health education have annual professional development on effective practices for physical activity and healthy eating instruction (D)
   - ☐ There is a written plan to integrate healthy eating and physical activity instruction into other subject areas (E)
   - ☐ Health education electives are offered at the middle and high school levels (F)

Recognition Conditions for Health Education	
Gold	If (22A or 22C) and (23C or 23E) and (24B or 24D) and (all of 25A–F)
Silver	If (22A or 22C) and (23B or 23C or 23E) and (24B or 24C or 24D) and (any 4 or more of 25A–F)
Bronze	If (22A or 22C) and (23A or 23B or 23C or 23E) and (24 A or 24B or 24D) and (any 3 or more of 25A–F)
No Level	Anything else

Physical Education

1. (17) Please mark the number of minutes of Physical Education that your school requires for all students enrolled in Kindergarten through 5th grades:

   - ☐ Less than 50 minutes per week (A)
   - ☐ 51-100 minutes per week (B)
   - ☐ 101-149 minutes per week (C)
   - ☐ 150 minutes or more per week (D)
   - ☐ My school does not contain these grades (E)

2. (18) Please mark the number of minutes of Physical Education that your school requires for all students enrolled in the 6th through 8th grades:

- □ Less than 90 minutes per week (A)
- □ 91–134 minutes per week (B)
- □ 135–224 minutes per week (C)
- □ 225 minutes or more per week (D)
- □ My school does not contain these grades (E)

3. (19) How much Physical Education is required for graduation for all students enrolled in 9th through 12th grades?

- □ Less than 1 year (A)
- □ Equivalent to 1 year (B)
- □ Equivalent to 1.5 years (C)
- □ Equivalent to 2 years or more (D)
- □ My school does not contain these grades (E)

4. (20) Which of the following are true of the Physical Education program at your school? (please mark all that apply)

- □ PE is based on a sequential curriculum map that is aligned to the national and state (if applicable) standards for PE (A)
- □ Students are moderately to vigorously active for at least 50% of PE class time (B)
- □ Students receive a PE grade on report card every year based on improvement in fitness and cognitive development. (C)
- □ PE is taught by licensed or certified Physical Educators or appropriately trained classroom teachers at the elementary school level (D)
- □ PE is taught by licensed or certified physical educators at the middle and high school levels (E)
- □ Student/teacher ratio is comparable with other subject areas (e.g. language arts and math) at the middle and high school levels (F)
- □ The PE program has a dedicated budget for equipment and professional development (G)
- □ High school has elective PE offerings (H)
- □ Teachers who teach physical education have annual professional development on effective practices (I)
- □ District or schools utilize the CDC's Physical Education Curriculum Analysis Tool (PECAT) to asses PE curriculum (J)
- □ Physical education credits toward high school graduation are not waived for other activities (K)

Recognition Conditions for Physical Education	
Gold	If (17D or 17E) and (18D or 18E) and (19D or 19E) and ((17D and all of 20A, 20B, 20C, 20D, 20G, 20I, 20J) or ((18D or 19D) and all of 20A, 20B, 20C, 20E, 20F, 20G, 20H, 20I, 20J, 20K))

Silver	If (17C or 17D or 17E) and (18C or 18D or 18E) and (19C or 19D or 19E) and (((17C or 17D) and any 5 or more of 20A, 20B, 20C, 20D, 20G, 20I, 20J) or ((18C or 18D or 19C or 19D) and any 6 or more of 20A, 20B, 20C, 20E, 20F, 20G, 20H, 20I, 20J, 20K))
Bronze	If (17B or 17C or 17D or 17E) and (18B or 18C or 18D or 18E) and (19B or 19C or 19D or 19E) and (((17B or 17C or 17D) and any 3 or more of 20A, 20B, 20C, 20D, 20G, 20I, 20J) or ((18B or 18C or 18D or 19B or 19C or 19D) and any 4 or more of 20A, 20B, 20C, 20E, 20F, 20G, 20H, 20I, 20J, 20K))
No Level	Anything else

Physical Activity

5. (21) My school provides the following physical activity opportunities for students (please mark all that apply):

    - ☐ Incorporates physical activity or “fitness breaks” once daily into the school day (A)
    - ☐ Has an annual plan for integrating physical activity into most subject areas (B)
    - ☐ Offers at least 20 minutes of recess daily at the elementary level (C)
    - ☐ Offers a range of physical activity opportunities (including Intramural, interscholastic, and non-competitive sports) after the school day (D)

Recognition Conditions for Physical Activity	
Gold	If 3 or more of 21A, 21B, 21C, or 21D
Silver	If 2 of 21A, 21B, 21C, or 21D
Bronze	If 1 of 21A, 21B, 21C, or 21D
No Level	Anything else

Afterschool Programs

1. (31) My school opens its grounds to outside programs that provide physical activity opportunities to students, their families, and the community.

    - ☐ Yes (A)
    - ☐ No (B)

2. (32) Physical activity is an integral part of afterschool program offerings at my school.

    - ☐ Yes (A)
    - ☐ No (B)
    - ☐ My school does not offer afterschool programs (C)

3. (33) Food and beverages offered as a part of afterschool programs meet the AHG beverage and competitive foods guidelines.

- Yes (A)
- No (B)
- My school does not offer afterschool programs (C)

Recognition Conditions for Afterschool Programs	
Gold	If (31A and (32A or 32C)) and (33A or 33C)
Silver	If ((any 1 of 31B or 32B or 33B) and (none of 31C or 32C or 33C)) or (31B and (32A or 32C) and (33A or 33C))
Bronze	If ((any 2 of 31B or 32B or 33B) and (none of 31C or 32C or 33C)) or (31A and (32B or 32C) and (33B or 33C))
No Level	Anything else

Staff Wellness

1. (26) My school has (please mark all that apply):

- Conducted a needs assessment on staff wellness (A)
- Developed a staff wellness action plan (B)
- None of the above (C)

2. (27)My school has an active staff wellness program.

- Yes (A)
- No (B)

3. (28) My school's staff wellness program activities are evaluated.

- Yes (A)
- No (B)
- My school does not have a staff wellness program (C)

4. (29) My school's staff wellness program includes physical activity and healthy eating opportunities.

- Yes (A)
- No (B)
- My school does not have a staff wellness program (C)

5. (30) My school requires that food and beverages served at school-sponsored staff functions meet the AHG beverage and competitive foods guidelines.

- Yes (A)
- No (B)

Recognition Conditions for Staff Wellness	
Gold	If 26A and 26B and 27A and 28A and 29A and 30A
Silver	If 26A and 26B
Bronze	If 26A
No Level	Anything else

Platinum Level*

Note: Schools should only be directed to these questions if they have achieved Gold status

1. (34) Which of the following are true of your school (please mark all that apply)?

- ☐ Goals in the school wellness action plan are integrated into the overall school improvement plan (A)
- ☐ The cafeteria is used as a 'nutrition education' learning laboratory on a weekly basis via programs, promotions, nutrition labeling, special demos or guests, etc.(B)
- ☐ District or school requires that student rewards meet the AHG beverage and competitive foods guidelines.(C)
- ☐ District or school restricts food marketing to those foods and beverages that meet AHG beverage and competitive food guidelines.(D)
- ☐ District or school prohibits food branding in non-food environments such as recreational facilities, classrooms, and hallways. (E)
- ☐ District or school requires that food and beverages served at school parties meet the AHG beverage and competitive foods guidelines (F)
- ☐ Healthy eating and physical activity knowledge and skills taught in health education are reinforced through instruction in Family and Consumer Sciences courses (G)
- ☐ Non-traditional physical activity-promoting programming aimed at engaging non-intramural athletes in fun, recreational, and life-long learning opportunities (e.g. dance, karate, aerobics, hiking or walking clubs, games, etc.) is provided. (H)
- ☐ Staff wellness program is evaluated and revised annually by the School Wellness Council. (I)
- ☐ District Wellness Policy includes a staff wellness component and program(s) are offered to district staff (J)
- ☐ Schools track their student and staff BMI and fitness levels and report those numbers annually, like academic scores (K)
- ☐ Requires three or four years of Physical Education for high school graduation (L)
- ☐ Two full years of health education are required for high school graduation (M)

Exemplary Recognition Criteria
Meets gold level criteria and any 4 of 34A–M