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<th>Acronym</th>
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<tr>
<td>BHS</td>
<td>Behavioral Health Services</td>
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<td>BIMAS</td>
<td>Behavior Intervention and Monitoring Assessment System</td>
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<td>BMI</td>
<td>Body Mass Index</td>
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<td>BPHC</td>
<td>Boston Public Health Commission</td>
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<td>BPS</td>
<td>Boston Public Schools</td>
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<td>BSAC</td>
<td>Boston Student Advisory Council</td>
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<td>BTU</td>
<td>Boston Teacher’s Union</td>
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<td>CAT</td>
<td>Condom Accessibility Team</td>
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<td>CBHM</td>
<td>Comprehensive Behavioral Health Model</td>
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<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
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<td>CPC</td>
<td>Citywide Parent Council</td>
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<td>CHE</td>
<td>Comprehensive Health Education</td>
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<td>CLSP</td>
<td>Culturally and Linguistically Sustaining Practices</td>
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<td>CSPAP</td>
<td>Comprehensive School Physical Activity Program</td>
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<td>DESE</td>
<td>Department of Elementary &amp; Secondary Education</td>
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<td>DWC</td>
<td>District Wellness Council</td>
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<td>EPS</td>
<td>Expectant and Parenting Student</td>
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<td>FNS</td>
<td>Food and Nutrition Services</td>
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<td>FTE</td>
<td>Full-time Equivalent</td>
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<td>GSA</td>
<td>Gay Straight Alliance or Gender/Sexuality Alliance</td>
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<td>HPV</td>
<td>Human Papilloma Virus</td>
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<td>HS/MS</td>
<td>High School/Middle School</td>
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<td>HSE</td>
<td>Healthy School Environment</td>
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<td>OHW</td>
<td>Office of Health and Wellness</td>
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<td>IC</td>
<td>Instructional Coaching</td>
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<td>IPM</td>
<td>Integrated Pest Management</td>
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<td>PreK</td>
<td>Pre-Kindergarten</td>
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<tr>
<td>LGBTQ</td>
<td>Lesbian, Gay, Bisexual, Transgender and Queer/Questioning</td>
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<td>MCIEA</td>
<td>MA Consortium for Innovative Assessment</td>
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<td>MTSS</td>
<td>Multi-tiered Systems of Support</td>
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<td>ODA</td>
<td>Office of Data &amp; Accountability</td>
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<td>OHC</td>
<td>Office of Human Capital</td>
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<td>OG</td>
<td>Office of Opportunity Gaps</td>
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<td>PA</td>
<td>Physical Activity</td>
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<td>PD</td>
<td>Professional Development</td>
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<td>PE</td>
<td>Physical Education</td>
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<td>QSP</td>
<td>Quality School Plan</td>
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<td>SBIRT</td>
<td>Screening Brief Intervention &amp; Referral for Treatment</td>
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<td>SEA</td>
<td>School Environmental Audit</td>
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<td>SEL</td>
<td>Social and Emotional Learning</td>
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<td>SpedPac</td>
<td>Special Education Parent Advisory Council</td>
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<td>SRTS</td>
<td>Safe Routes To School</td>
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<td>SST</td>
<td>Student Support Team</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<td>SWC</td>
<td>School Wellness Council</td>
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<td>SY</td>
<td>School Year</td>
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<td>TA</td>
<td>Technical Assistance</td>
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<td>USDA</td>
<td>United States Department of Agriculture</td>
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<td>WAP</td>
<td>Wellness Action Plan</td>
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<td>WSCC</td>
<td>Whole School, Whole Community, Whole Child Model</td>
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<td>YRBS</td>
<td>Youth Risk Behavior Survey</td>
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Executive Summary

Students who are health literate, have access to healthcare and support services, and can freely practice health-promoting behaviors can engage more readily in the process of learning. In other words - healthy students are better learners. In a school year where we faced a global public health crisis that has had significant impacts on our local community, it is vital that we take the time to examine how we've measured up to our commitment to wellness policies and practices, how we adapted to the challenges of the COVID-19 pandemic, and how we will expand what worked in order to help our schools return, recover, and reimagine a better way forward. We must attend to the physical, social, and emotional well-being and development of our students, honoring and building on the rich cultural and community assets they and their families bring to our schools, and developing their knowledge, skills, and self-efficacy to succeed in the pursuit of a healthy and happy life.

BPS strives to be one of the healthiest school districts in the country. Our goal is to actively promote the physical, social, and emotional wellness of all students to support their healthy development and readiness to learn. BPS aims to create safe, healthy, and sustaining learning environments for every child in every classroom at every school. Our Comprehensive District Wellness Policy provides the roadmap for implementing that goal.

The District Wellness Policy is comprised of eight policy areas: 1) Cultural Proficiency, 2) School Food and Nutrition Services, 3) Comprehensive Physical Activity and Physical Education, 4) Comprehensive Health Education, 5) Safe and Supportive Schools, 6) Health Services, 7) Healthy School Environment, and 8) Staff Wellness.

This quantitative annual report details School Year 2019-2020 findings by policy area, drawing comparisons to previous years when possible and highlighting success and challenges. Prior to examining each policy area, the report takes a closer look at district and individual school wellness council (SWC) functionality. Student outcomes related to health behaviors, perceptions and attitudes, and the prevalence of obesity and asthma across the district are presented at the end. The report concludes with a discussion of findings and recommendations for improved wellness policy implementation.

This report is submitted to the Superintendent of Schools and School Committee by the District Wellness Council (DWC) per the Massachusetts Standards for School Wellness Councils annual report requirement and will be submitted to the Department of Elementary and Secondary Education (DESE) as a part of the reporting requirement for the DESE audit of the Food and Nutrition Services Department.

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1 Basch, C.E., 2011. Healthier students are better learners: A missing link in school reforms to close the achievement gap. Journal of school health, 81(10), pp.593-598.
Key Findings by Policy Area

Council Section:

- Functionality of School-based Wellness Councils: 85% of school submitted a Wellness Action Plan (106 WAPs submitted); 65% identified co-chairs for the councils to ensure coordination of the council and 94% delegated action steps to multiple members to build shared leadership and commitment to the work of the council; 76% identified goals that are specific, measurable, actionable, realistic, and time-bound (SMART).

- Saw a reduction in the number of councils working on Cultural Proficiency goals. While all schools must have Cultural Proficiency goals in their QSP, we would hope to see more CP goals specifically in the WAP, especially since family and student participation on the wellness councils is so low.

Cultural Proficiency:

- Need to increase family and student participation in the wellness councils: 4 schools engaged student representatives and 14 schools engage with family representatives. Fifty percent of school leaders report engaging students’ families to help develop or implement policies and programs related to school health in the past two years.

- All schools and central office departments are incorporating goals to support the implementation of the OAG Policy and CLSP throughout the district.

- Cultural Proficiency standards and practices and equity protocols continue to be rolled out across the district through centralized training and school-based professional development; 79% of school leaders reported that all of their staff had received training in the past two years on addressing equity in education outcomes for students of color; however, only 38% of school leaders reported the same for training on creating a supportive learning environment for LGBTQ+ students in the past two years (2020 Profiles).

School Food & Nutrition Promotion:

- 100% of schools providing Breakfast after the Bell, increase from 87% in SY17-18.

- 23% of schools receiving vended meals (15 out of 66) were converted to My Way Café to be able to provide bulk, freshly prepared, on-site meal service, an increase from 3% in SY17-18 to 21% of all schools (FNS Records).

- The FNS department is continuing to improve sourcing local foods and systems to plan and track meals at each school and continuously improve the cultural relevance of meals offered.

- Compliance to BPS nutritional guidelines for food sold in vending machines or at a school store, fundraisers, canteen, or snack bar is weak: 67% of schools reported these foods not meeting guidelines and only 47% of schools prohibit less nutritious foods and beverages from being sold for fundraising purposes.
• FNS was able to quickly pivot to continue providing meals to students and families as soon as schools closed in March of 2020 and throughout the summer, continuously improving their model based on feedback to reach our students and families.

**Comprehensive Physical Activity & Physical Education:**

• **Physical Education:** 90% of schools serving grades PreK-8 reported meeting or exceeding the PE policy requirement of 45 minutes of PE per week for each grade, though nearly all those schools are staffed to provide the required amount. 58% of high schools report offering at least 1 semester of PE in each grade; 75% of high schools are staffed to offer some PE and 33% are staffed to meet the policy requirements.

• **Recess:** There have been improvements in providing time for recess for grades 6-8. Across the district, 83% of grade 6 has recess and 77% of grades 7 and 8. However, only 42% of schools with grades 6-8 provide the minimum 20 minutes of daily recess for those grades. 75% of schools containing grades PreK-5 have at least 20 min of recess daily as required by the policy, though all students in those grades have some amount of recess weekly.

• **Movement in the Classroom:** 80% of schools report that all or many of their teachers implement movement breaks or classroom lessons that involve movement.

• The percentage of schools that report withholding PA as a punishment (22%) has not changed since SY17-18; the Code of Conduct was updated in Fall 2019 to reflect the language in the PA policy and was communicated to school superintendents and school leaders.

• Central Office continues to provide strong supports for school PE programs, including in-depth instructional coaching for new and veteran teachers, as well as lessons, curriculum, and equipment. The OHW PE-PA team worked with PE teachers to provide at-home lessons and activities to keep students and families moving during the remote learning.

**Comprehensive Health Education:**

• **Staffing:** Only 20% of middle and high schools have a lead health education teacher certified, licensed, or endorsed by the state to teach health education.

• **Elementary Grades:** 39% of all BPS schools with grades PreK-5 did not offer any health instruction to students; 36% provided health instruction in three or more grade levels with PreK-5.

• **Middle and High School Grades:** 42% of schools serving middle and high school grades did not require students to take any health education course; K-8 and middle schools were least likely to require any amount of health education instruction (55%) and high schools were most likely to provide some form of health education (73%).

• **Policy Compliance:** Only 18% of schools across the district followed the minimum required health education policy: 33% of elementary schools met the minimum requirements, 12% of schools serving grades 6-8 required two semesters taught by a licensed health educator, and 8% of schools serving grades 9-12 required 1 semester taught by a licensed health educator.
• Central Office continues to provide strong support for school CHE programs, including in-depth instructional coaching for teachers, as well as lessons, curriculum, and materials. The OHW HE Team provided virtual lessons and resources for teachers and students to support caring for their physical, social, and emotional health during remote learning.

Healthy School Environment:
• BPS Sustainability trained 400 custodians on sustainability, environment, health, and safety issues during the 2017, 2018, and 2019 annual BPS Custodial Training. While in-person training was cancelled in summer 2020 due to COVID-19, all custodians still completed their annual mandatory 2-hour online AHERA training and received the BPS Sustainability presentation to remotely access individually.
• 78% of school leaders report reviewing their School Environmental Audit, 66% report coordinating with their wellness council to address needs raised in the report, and only 18 schools identified HSE goals in their WAP.
• Communication of Green Cleaner Policy and Integrated Pest Management (IPM) Program to school staff: 73% of school leaders reported informing their staff about the green cleaner policy, which includes safer sanitizer for Early Ed Programs and 90% inform staff on how to record pest sightings to improve IPM.
• Zero Waste Programs are running at all schools and BPS Sustainability continues to build programming and supports for schools and the district to move toward greater environmental sustainability.
• Investments were secured to improve access to tap water for drinking at all schools; Between 2021-2025 100% of schools will receive varying levels of first-time installations or upgrades to existing systems.

Safe & Supportive Schools:
• Strong district-wide commitment from school leaders to support student SEL with explicit systems in place to develop student’s SEL competencies. There is a need for a district plan to fully articulate, implement and coordinate MTSS structures that support student and staff SEL and mental health and that are in alignment with our CLSP and equity vision.
• Only 28% of schools serving grades 6-12 identified an Expectant and Parenting Students policy liaison
• Only 28% of schools reported having at least two trained Bullying Prevention Liaisons, a decrease from 71% in SY17-18. Further, compared to SY2017-18, the share of schools reporting all staff at their school completed an annual bullying prevention intervention training decreased from 42% to 22% while the proportion that said no staff were trained increased significantly from 7% to 39%.
• Most schools take a MTSS approach and have a student support team, and the district is investing in important mental health support services staff at the schools.
• BPS K-12 Transformative SEL standards are being rolled out through the district and embedded in health ed, physical ed, and the arts.

• BPS Homeless Education Resource Network continues to improve on systems to identify and support student experiencing homelessness and housing insecurity.

• Behavioral Health Services provided remote services and connected students and families to mental health supports after schools closed in March; Opportunity Youth mobilized outreach and support services for homeless students and families experiencing house instability during the pandemic.

Health Services:

• Nearly all school buildings staffed with at least 1 school nurse: 131 FTE school-based nurse making a 1:355 nurse to student ratio and there has been an increase in health screenings.

• 77 Schools with students in grades 6-12 participated in the Menstrual Access Pilot Program made possible by initial funding from the City of Boston. Products were chosen based on student focus group feedback. 3,767 school nurse visits for menstrual product distribution were recorded between September and March.

• All high schools have active Condom Accessibility Teams.

• BPS continues to improve school nurse staffing capacity at school buildings and the Health Services Department is continuously improving systems to ensure student medical records are up-to-date and students are receiving the services and health care they need.

• 32 schools have a student immunization compliance rate of less than 85% and there has been no increase in the number of completed Individual Health Care Plans on file for students with chronic conditions.

Staff Wellness:

• 97% of school leaders agree their school actively supports staff members’ social and emotional well-being, yet only 53% of schools report offering programs to promote the physical, social, and emotional well-being of school-based staff.

• Staff Wellness efforts have been largely happening in isolated pockets throughout the district and there has been a lack of collaboration with the District Wellness Council to implement practices and initiatives to promote the physical, social, and emotional well-being of all BPS employees.

Recommendations

To ensure equity for all BPS students, they must have access to an environment that provides quality health and wellness education, programs, and services, we must continue to implement the policy across the district’s diverse schools. We suggest the following action steps:
1. **Improve communication of the policy to district leaders, schools, youth, and families:**
   a. Develop an overall communication plan to disseminate information about the Wellness Policy to increase awareness and knowledge among district leadership, school leaders, school-based staff, students, and families
      i. Continue to make use of existing communication channels within the district and use new ones as they are available.
      ii. With changing leadership in the district, ensure understanding and adoption of the policy at all levels of BPS.
   b. Outline multiple approaches to engaging parents and caregivers and consistently take their feedback into account to further engage these stakeholders in SWCs

2. **Strengthen District Wellness Council and subcommittees:**
   a. Maintain diverse representation of stakeholders as DWC members, as defined in the policy.
   b. Improve the functionality of the subcommittees for Cultural Proficiency, Health School Environment, Health Services, and Staff Wellness.
      i. Continue to improve the information and data sharing between the Office of Opportunity Gap and the DWC to better align the work of the Opportunity and Achievement Gap Policy and the District Wellness Policy.
      ii. Strengthen collaboration between the District Wellness Council and efforts to improve staff well-being and organizational health.
   c. Improve data systems for evaluating the implementation of the Wellness Policy.
      i. To improve sustainability of the evaluation process and improve collective impact, systems for collaboration and data sharing must be improved.

3. **All departments and offices responsible for the implementation of areas of the policy should include wellness policy implementation strategies and benchmarks into their work plans and strategic plans to improve alignment with department and district wellness goals:**
   a. Convene an internal committee with department and office heads to meet quarterly to discuss strategic plans and benchmarks to implement the BPS District Wellness Policy.

4. **All department responsible for the implementation of areas of the policy should address the following key implementation issues to improve district and school-level implementation of the wellness policy:**
   a. **Cultural Proficiency:**
      i. Increase the representation of students and families on DWC and school-based wellness councils and work in tandem with the district and school-based Equity Roundtables and the wellness councils to achieve health equity goals for students.
      ii. Improve schools’ abilities to collectively assess their organizational structure, policies, and school-wide practices for bias(es) as well as examine their physical environment, classroom curricula, instructional materials, and wellness promotions.
   b. **School Food & Nutrition Promotion:**
      i. Increase culinary processes to include more culturally relevant meals and implement a process for a continuous feedback from students
ii. Increase opportunities for nutrition education training through OHW Health Ed Team

iii. FNS should return to managing the contracts for vending machines in the schools to ensure that the food and beverages in the vending machines meet district guidelines.

iv. Improve communication and reinforcement healthy food environment practices outlined in the policy for schools and central office.

c. **Comprehensive Physical Activity & Physical Education:**
   i. Increasing time in the schedule for recess for middle grades, as well as training, equipment, and resources to support schools in managing recess for these grades.
   ii. Improve PE offerings for high schools by funding additional PE staff, space improvements, additional equipment, curriculum, and professional learning.
   iii. Improve communication of the benefits of PA on student behavior and attention and reduce the number of schools withholding or using PA as a punishment.
   iv. Improve funding and centralized coordination in the Transportation Dept for Safe Routes to School Boston to better promote and support active transportation for BPS.

d. **Comprehensive Health Education:**
   i. Increase the number of licensed Health Education teachers teaching CHE in grades 6-12 and the number of trained teachers teaching CHE in grades PreK-5.
   ii. Improve schools’ master schedule planning to include time for Health Education.

e. **Healthy School Environment:**
   i. Improve communication of HSE policies to school leaders and provide more opportunities for training and information sharing between facilities and school leaders.
   ii. Increase school engagement in sustainability efforts across the district.

f. **Safe & Supportive Schools:**
   i. Increase awareness and understanding of Expectant & Parenting Student (EPS) Policy through EPS liaison trainings and easy access to resources and information.
   ii. Continue to build on and improve support for LGBTQ+ students and students experiencing homelessness.
   iii. Strengthen tier 1 social-emotional supports through investments in Transformative SEL professional development and instructional coaches to increase supports for adult SEL and integration of SEL into academics.
   iv. Provide intensive training and development support to new mental health support staff and family liaisons in the schools to strengthen the multi-tiered systems of support approach
   v. Improve coordination and alignment across central office divisions to strengthen tier I MTSS approach through a district strategic plan for SEL, including learnings from the Boston Hub School roll out.

g. **Health Services:**
i. Continue to increase the capacity of school nurses to provide health services to students and the capacity of the Health Services Department to support data collection and professional development of nurses.

ii. Increased focus on improving existing immunization compliance in schools.

iii. Increase trainings, resources, and supports to school nurses to provide sexual health services and referrals to middle and high school students.

h. Staff Wellness:
   i. Establish a district-level lead for staff wellness to coordinate a plan for sustainable staff wellness promotion and a menu of district supports.
**Introduction**

Students who are health literate, have access to healthcare and support services, and can freely practice health-promoting behaviors can engage more readily in the process of learning. In other words - healthy students are better learners. In a school year where we faced a global public health crisis that has had significant impacts on our local community, it is vital that we take the time to examine how we’ve measured up to our commitment to wellness policies and practices, how we adapted to the challenges of the COVID-19 pandemic, and how we will expand what worked in order to help our schools return, recover, and reimagine a better way forward. Schools can improve student health by increasing opportunities to practice health promoting skills. What is more, reducing health-related barriers to learning plays a critical role in addressing racial inequality in education, uniquely positioning schools to address preventable health conditions as well as developing strengths and assets to excel in learning. If we are to imagine a school district where every child has the opportunity to achieve their dreams, where every child has the same unfettered access to every conceivable resource to unlock the greatness within them, we must attend to the whole child. We must attend to the physical, social, and emotional well-being and development of our students, honoring and building on the rich cultural and community assets they and their families bring to our schools, and developing their knowledge, skills, and self-efficacy to succeed in the pursuit of a healthy and happy life.

BPS strives to be one of the healthiest school districts in the country. Our goal is to actively promote the physical, social, and emotional wellness of all students to support their healthy development and readiness to learn. BPS aims to create safe, healthy, and culturally and linguistically sustaining learning environments for every child in every classroom at every school. The BPS District Wellness Policy provides the roadmap for implementing that goal. This report provides information that allows BPS to evaluate how we are doing in implementing the BPS Wellness Policy and thus achieving this goal.

**Background**

BPS initially approved a District Wellness Policy in 2006. The policy has been updated in June 2013 and June 2017. The federal wellness policy requirement was established by the Child Nutrition and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Reauthorization Act of 2004 and further strengthened by the Healthy, Hunger-Free Kids Act of 2010 (HHFKA). It requires each school district participating in the National School Lunch Program and/or School Breakfast Program to develop a wellness policy. The Massachusetts Standards for School Wellness Advisory Committees (M.G.L. c. 111, § 223, 105 CMR 215.000) further details requirements for the establishment and functions of a district wellness council.

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1 Basch, C.E., 2011. Healthier students are better learners: A missing link in school reforms to close the achievement gap. Journal of school health, 81(10), pp.593-598.
The BPS District Wellness Policy was created to align with the Centers for Disease Control and Prevention (CDC) and ASCD's Whole School, Whole Community, Whole Child (WSCC) model (Figure 1.1). The BPS District Wellness Policy seeks to ensure all students are safe, healthy, welcomed, engaged, supported, and challenged. The eight content sections of the policy are: (1) cultural proficiency, (2) school food and nutrition promotion, (3) comprehensive physical activity and physical education, (4) comprehensive health education, (5) healthy school environments, (6) safe and supportive schools, (7) health services and (8) staff wellness. The policy requires schools to establish school-based wellness councils that are responsible for assessing the school on implementation of the wellness policy, developing an action plan, and implementing the action plan.

The District Wellness Policy also requires that BPS maintain a Superintendent-appointed District Wellness Council (DWC). The DWC develops, recommends, reviews, and advises on implementation of school district policies that address student and staff wellness. The council is made up of BPS Central Office department heads, school-based staff and administration, community partners, and students and family representatives, all of whom offer expertise in the various health-related issues addressed by the policy (see Member List in Appendix B). General membership to and attendance at the DWC is open to all stakeholders and the public. The wellness policy outlines the requirements for the DWC establishment, functioning, and policy monitoring, assessment, and reporting.

Purpose

This report presents the data for school year 2019-2020 (SY19-20) related to implementation of the BPS District Wellness Policy at the district- and school-level. The data presented here cover both district- and school-level metrics, as well as some student-level health outcomes and behaviors. Our social-ecological (Figure 1.2) theory of action is that by improving the environment, programs, and services at schools through successful implementation of the wellness policy components, we expect to contribute to improved student outcomes (measured by student-level metrics). School-level outcomes measure policy implementation and compliance, whereas student-level outcomes tell us about students’ health status and
about how students themselves gauge their safety, health, and behaviors. We must understand the steps the district and individual schools are taking to implement the policy components, in addition to understanding health-outcomes at the student level. The DWC sees change at the school level as one of the precursors for change at the student level. The DWC submits this report to the Superintendent of BPS and the School Committee per the annual report requirement of the Massachusetts Standards for School Wellness Councils. This report will also be submitted to the Department of Elementary and Secondary Education (DESE) as a part of the reporting requirement for the DESE audit of the Food and Nutrition Services Department.

**Monitoring & Evaluation Plan**

The District Wellness Policy Monitoring and Evaluation Plan was first developed by the DWC during SY13-14. The goal of this plan was to assess school-level policy implementation outcomes and student-level health outcomes over time. After the wellness policy was updated in June 2017, the DWC made one of its major goals in SY17-18 to update the policy’s Monitoring and Evaluation Plan. To develop a more robust evaluation, the DWC subcommittees were charged with developing a logic model for their respective policy area (Figure 1.3).

Using the logic models as a guidance tool, the DWC subcommittees developed metrics aligned with the policy language and reflective of the work required in each policy area. In addition to school-level policy outcomes and student health outcomes, these logic models include metrics on activities and outputs at
the district-level that support policy implementation. To the extent possible, existing data collection tools and systems aligned with other district indicators were identified as data sources in order to ensure the sustainability and feasibility of monitoring and evaluating policy implementation. There were interruptions in data collection due to the COVID-19 pandemic and the closing of schools in March 2020. Data gathering and compiling of this report during the 2020-2021 school year was also challenging because of the changing capacity to engage in the District Wellness Council and the policy subcommittees; some metrics were not able to be gathered. The Monitoring & Evaluation Plan was reviewed by the DWC and DWC leaders and included in the Superintendent’s Circular HWD-01 (see Appendix D for full list of metrics).

### Methods

The metrics captured in the monitoring and evaluation plan are drawn from a variety of sources and managed by several BPS departments, as illustrated in the table below. Several data sources used previously were not available this year. Given that some data systems remain under development and because of disruptions in data collection due to COVID and school closures, several metrics were not tracked in SY19-20. For a full list see Appendix D.

<table>
<thead>
<tr>
<th>Data Source Descriptions and Collection Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Data Source</strong></td>
</tr>
<tr>
<td>School Health Profiles (Profiles)</td>
</tr>
<tr>
<td>School Climate Survey</td>
</tr>
</tbody>
</table>
### Data Source Descriptions and Collection Methods

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher Survey: n=2,362</td>
<td>Students who did complete the survey, results are available for schools who had at least 7 responses and a response rate of at least 10%. Additionally, the data were compiled differently than previous. For each question, participants were asked to respond using a 5-point scale where responses 1-3 of the scale were considered least favorable (e.g., 1 = “not at all important”, 2 = “slightly important”, and 3 = “somewhat important”) and responses 4 and 5 were considered “favorable” (e.g., 4 = “quite important” and 5 = “extremely important”). The report displayed the percent of favorable results. The teacher climate survey was not administered, and this report contains results from the Teacher Distance Learning Survey in its place; however, overlap between the MCIEA survey and the Distance learning survey was slim. Further, the parent climate survey was not administered during SY19-20. A “Family Needs Survey” was administered in Spring 2020; however, the information was not pertinent to this report and therefore not included.</td>
</tr>
<tr>
<td>Office of Human Capital Records</td>
<td>Office of Human Capital (OHC) records were accessed and cross-referenced with departmental records. These data were used to calculate staffing FTE.</td>
</tr>
<tr>
<td>Youth Risk Behavior Survey (YRBS)</td>
<td>The YRBS is a component of the CDC’s national surveillance system and is used to monitor critical health-related behaviors of adolescents. This is an anonymous and confidential survey administered biennially to a randomized sample of students by paper and pencil. High school students are surveyed in the spring of odd-numbered years and middle school students in the fall of odd-numbered years. Boston has been administering the high school YRBS since 1993. We first administered the middle school YRBS in 2013 and then again in 2017 and 2019. Survey administration and data collection are coordinated by HWD. Data analysis is performed by Westat and the CDC. BPS has a history of achieving high response rates which allows our data to be weighted and ensures it is representative of all high school and middle school students in the district.</td>
</tr>
<tr>
<td>SNAPNurse</td>
<td>SNAPNurse is an electronic health record system used by the BPS Health Services Department and school nurses. SNAPNurse was the primary data source for health services metrics as well as multiple student health indicators including student Body Mass Index (BMI) screened in grades 1, 4, 7 and 10 and student Asthma Diagnoses across the district.</td>
</tr>
</tbody>
</table>
Data Source Descriptions and Collection Methods

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness Action Plans (WAP; n=106)</td>
<td>A Wellness Action Plan is a tool to guide each school’s implementation of the District Wellness Policy. WAPs are developed by school wellness councils and submitted in the Fall to the Office Health and Wellness as a required component of each school’s Quality School Plan. The Office of Health &amp; Wellness reviews all WAPs, and tracks data included.</td>
</tr>
</tbody>
</table>

### SY19-20 BPS Grade Configurations

<table>
<thead>
<tr>
<th>Grade Categories</th>
<th>Grade Configurations</th>
<th>Number of Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elementary</td>
<td>K-1, K-2, K-3, K-5</td>
<td>49</td>
</tr>
<tr>
<td>K-8</td>
<td>K-6, K-8, 3-8</td>
<td>32</td>
</tr>
<tr>
<td>Middle</td>
<td>6-8</td>
<td>7</td>
</tr>
<tr>
<td>Middle/High</td>
<td>6-12, 7-12, K-12</td>
<td>10</td>
</tr>
<tr>
<td>High</td>
<td>9-12, 10-12, 11-12</td>
<td>26</td>
</tr>
<tr>
<td>School Containing Any Grades K-5</td>
<td>Elementary, K-8, K-12</td>
<td>83</td>
</tr>
<tr>
<td>Schools Containing Any Grades 6-8</td>
<td>K-8, Middle, MS/HS</td>
<td>51</td>
</tr>
<tr>
<td>School Containing Any Grade 9-12</td>
<td>MS/HS, High</td>
<td>38</td>
</tr>
<tr>
<td>Schools Containing Any Grades 6-12</td>
<td>K-8, Middle, High, K-12</td>
<td>78</td>
</tr>
</tbody>
</table>

### Total Number of Schools in SY19-20

125

### Survey Response Rates

<table>
<thead>
<tr>
<th>Survey</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020 Profiles – Principals (grades 6-12)</td>
<td>97% (n=75)</td>
</tr>
<tr>
<td>2020 Profiles – Elementary Principal</td>
<td>96% (n=47)</td>
</tr>
<tr>
<td>2020 Profiles – Lead Health Ed Teacher (6-12)</td>
<td>99% (n=74)</td>
</tr>
<tr>
<td>the 2020 Profiles – Phys Ed Teacher (all schools)</td>
<td>99% (n=123)</td>
</tr>
<tr>
<td>2020 School Climate Survey - Student</td>
<td>18% (n=5,406)</td>
</tr>
<tr>
<td>2020 Teacher Distance Learning Survey</td>
<td>n=2,362</td>
</tr>
<tr>
<td>2019 High School YRBS</td>
<td>76%</td>
</tr>
<tr>
<td>2019 Middle School YRBS</td>
<td>88%</td>
</tr>
</tbody>
</table>

1 High response rate allows for statistically weighted data from the CDC

Data Analysis & Reporting

For this report, schools were placed into five grade configuration categories including Elementary, K-8, Middle, Middle/High, and High Schools. In some instances, data have been reported by grade and not grade configuration or grouped into schools containing K-5, schools containing 6-12, or schools containing 9-12 based on the requirements in the policy language. In which case, schools may be represented in more than one category.

Throughout this report, data sources used to inform each metric are denoted parentheses. For each policy metric, percentages are calculated by dividing the number of schools meeting the policy requirement by total number of schools responding. Many metrics are assessed using Profiles data or other surveys that require schools to self-report. As a result, response rates differ by both data source and individual questions within the same data source. Several steps were taken to ensure that the data reported here were both valid and reliable (i.e., reflective of all BPS schools). Results from the YRBS Surveys and CDC-specified Profiles questions have been analyzed and weighted by Westat/CDC Statisticians. All unweighted Profiles data included in this report had a response rate of >90%, unless specifically noted. Overall, responses rates for each survey used in this report are presented in the table above.
Policy Overview

DISTRICT-LEVEL The BPS shall maintain a Superintendent-appointed District Wellness Council (DWC). This advisory group will develop, recommend, review and advise on implementation of school district policies that address student and staff wellness. The District Wellness Policy shall be reviewed once yearly by the DWC and considered for updates based on other model school wellness policies and best practices, annual report findings and recommendations, input from schools and the community, research evidence, and regulations.

SCHOOL-LEVEL All BPS schools shall establish and maintain a school-based wellness council (SWC). SWCs shall act as a shared leadership team to implement wellness-related district policies. SWCs must assess their school’s implementation of the wellness policy and create and implement an annual Wellness Action Plan (WAP) as a part of the Quality School Plan. Principals shall name a wellness council chair(s) to coordinate the wellness council and act as a liaison to the District, community, and families.

### SY19-20 District Wellness Council Activities

**✓** DWC membership (see Appendix B) includes representatives from families, students, school and district instructional and operational administrators, relevant central department heads, school food and nutrition services staff, physical education and health education teachers, school nurses and other school health professionals (e.g. psychologists, guidance counselors, social workers) a school committee member, community youth serving agencies, Boston Public Health Commission representatives, healthcare providers and the general public.

**✓** DWC membership and meeting dates & times are posted publicly.

**✓** The policy (HWD-01) is shared via The Guide to Boston Public Schools for Students & Families and the BPS webpage.

**✖** The Qualitative Annual Report for SY18-19 was not compiled due to changing priorities resulting from COVID school closure.

**DWC Action Plan Accomplishments (Appendix C)**

**✓** Discussed Vaping Prevention and updated the Tobacco & Nicotine Policy; Formed a working group to discuss updates to the Expecting & Parenting Student Policy; Provided updates to the Code of Conduct regarding the prohibition of the use of physical activity as punishment.

**✓** Shared updates in all areas of the wellness policy in the fall and after the school shutdown in March 2020.

**✓** Shared the new Strategic Vision and BPS organizational structure; provided council feedback to the Superintendent about the Strategic Vision.

### DWC Meetings

<table>
<thead>
<tr>
<th>Dates</th>
<th># of Attendees</th>
<th>Public Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/27/19</td>
<td>30</td>
<td>None</td>
</tr>
<tr>
<td>1/21/20</td>
<td>31</td>
<td>Yes</td>
</tr>
<tr>
<td>3/24/20</td>
<td>CANCELLED</td>
<td></td>
</tr>
<tr>
<td>5/26/20</td>
<td>56</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Presentation of the SY17-18 Annual Report to the School Committee took place in October 2020.
School Based Wellness Councils (SWC)

<table>
<thead>
<tr>
<th>Wellness Policy Training Opportunities</th>
<th>Schools Reached</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness Council 101 (3-part series)</td>
<td>6</td>
</tr>
<tr>
<td>Wellness Champion Program</td>
<td>38</td>
</tr>
<tr>
<td>Health Food Environment</td>
<td>3</td>
</tr>
<tr>
<td>Social Emotional Learning</td>
<td>11</td>
</tr>
<tr>
<td>Empowering Teens Through Health (sexual health ed, sexual health services &amp; LGBTQ+ supports for high schools)</td>
<td>13</td>
</tr>
<tr>
<td>Active Recess (Playworks)</td>
<td>7</td>
</tr>
<tr>
<td>Health School Environment (MassCOSH)</td>
<td>8</td>
</tr>
</tbody>
</table>

(Source: OHW)

All school were sent an individualized Wellness Action Plan template for their school which included a link to their school’s biennial Wellness Profiles Report (Source: OHW)

65%  
Schools that send a communication about the policy home to parents (Source: Profiles)

76%  
Schools that communicate policy to school staff (Source: Profiles)

65%  
Schools identified wellness council co-chairs to facilitate their council (Source: WAP Records)

94%  
Schools demonstrated shared leadership with delegating action steps towards WAP goals (Source: WAP Records)

60%  
Schools that connect their WAP goals to their school’s Instructional Focus (Source: WAP Records)

Diversity of Stakeholder Involvement (Source: WAP Records)

<table>
<thead>
<tr>
<th>Stakeholder Role</th>
<th>% SWC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE teacher</td>
<td>71%</td>
</tr>
<tr>
<td>Nurse</td>
<td>65%</td>
</tr>
<tr>
<td>Other classroom teacher</td>
<td>58%</td>
</tr>
<tr>
<td>School Leader</td>
<td>54%</td>
</tr>
<tr>
<td>Other school administration</td>
<td>33%</td>
</tr>
<tr>
<td>Social worker / Guidance counselor</td>
<td>22%</td>
</tr>
<tr>
<td>Community Partners</td>
<td>21%</td>
</tr>
<tr>
<td>Community Field Coordinator</td>
<td>20%</td>
</tr>
<tr>
<td>Family Rep</td>
<td>15%</td>
</tr>
<tr>
<td>Student Support Coordinator</td>
<td>12%</td>
</tr>
<tr>
<td>Psychologist</td>
<td>11%</td>
</tr>
<tr>
<td>Health teacher</td>
<td>9%</td>
</tr>
<tr>
<td>Paraprofessional</td>
<td>9%</td>
</tr>
<tr>
<td>FNS Staff</td>
<td>7%</td>
</tr>
<tr>
<td>Librarian</td>
<td>5%</td>
</tr>
<tr>
<td>Students</td>
<td>4%</td>
</tr>
<tr>
<td>Custodian</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>38%</td>
</tr>
</tbody>
</table>

Figure 2.1 Schools submitting Wellness Action Plan

% of SWC that listed representative from each role as members in their action plan

Student & Family Participation in SWC

Figure 2.2 Three school wellness councils with 2 or more students represented on the wellness council (1 school had 1)

<table>
<thead>
<tr>
<th>3</th>
<th>102</th>
<th></th>
</tr>
</thead>
</table>

Figure 2.3 Ten school wellness councils with 2 or more family members represented on the wellness council (6 schools had 1)

<table>
<thead>
<tr>
<th>6</th>
<th>10</th>
<th>90</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Rep</td>
<td>2+ Reps</td>
<td>No Reps</td>
</tr>
</tbody>
</table>

(Source: WAP Records)
### School Wellness Action Plan Goals (Source: WAP Records)

**98%**

Schools with at least two goals listed in their WAP

**76%**

WAPs with SMART Goals

#### Figure 2.4 Percent of wellness action plan goals in each policy area

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>SY17-18</th>
<th>SY19-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE / Physical Activity</td>
<td>27%</td>
<td>22%</td>
</tr>
<tr>
<td>Safe &amp; Supportive</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>Health Ed</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>Food &amp; Nutrition</td>
<td>12%</td>
<td>16%</td>
</tr>
<tr>
<td>Staff Wellness</td>
<td>9%</td>
<td>4%</td>
</tr>
<tr>
<td>Health Services</td>
<td>16%</td>
<td>10%</td>
</tr>
<tr>
<td>Cultural Proficiency</td>
<td>4%</td>
<td>8%</td>
</tr>
<tr>
<td>Well ness Council</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>Healthy School Environment</td>
<td>22%</td>
<td>8%</td>
</tr>
</tbody>
</table>

#### Figure 2.5 Number of schools with goals in each policy area

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Number of Schools</th>
<th>SY17-18</th>
<th>SY19-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE / Physical Activity</td>
<td>80</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>Safe &amp; Supportive</td>
<td>59</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Ed</td>
<td>53</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food &amp; Nutrition</td>
<td>54</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Wellness</td>
<td>39</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Services</td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural Proficiency</td>
<td>55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellness Council</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy School Environment</td>
<td>19</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Community Partners Listed as SWC Members

- **FoodCorp (5)**
- **BPHC (3)**
- **City Connects (9)**
- **Scholar Athletes (3)**
- **Playworks (4)**
- **MassCOSH**

- **Brigham & Women's Hospital**
- **BCYF Quincy**
- **UMass-Boston**
- **Harvard Medical School**
- **Allston Brighton Substance Abuse Task Force**
- **Franciscan Children's**
Policy Overview

Cultural Proficiency is an approach that raises awareness of individual and institutional culture and bias, encourages cultural learning and relationship building, and implements Culturally and Linguistically Sustaining Practices (CLSP) in order to respect, celebrate and build on cultural strengths and diversity. The District supports the development of staff and administrators’ competencies to build cultural proficiency in schools, classrooms and central office departments. Schools shall collectively assess their organizational structure, policies and school-wide practices for bias(es) as well as examine their physical environment, classroom curricula, instructional materials and wellness promotions.

The District and the schools shall include student, family and community participation on decision-making bodies and create structures for feedback from students, families and communities about wellness-related policies.

Intended Impacts on Student Health

Culturally and Linguistically Sustaining Practices help to create a safe, healthy and welcoming environment that supports all students’ social, emotional, physical and academic learning as well as their health and well-being. By calling out and committing to cultural proficiency in relationship to the health and wellness outcomes of Boston Public School students, BPS hopes to increase health equity among youth in Boston and decrease health disparities that impact learning. Culturally-responsive and inclusive practices throughout the school and the district will lead to better academic and health outcomes for all students, especially the most vulnerable.

Centralized Profession Learning Opportunities

Implementing Equity Policy & Practices (Source: Office of Equity)

- **20** Equity Protocols Training Sessions
- **10** Racial Equity Planning Tool training sessions in partnership with Office of Opportunity Gaps
- **8** Welcoming Schools* training sessions
- **6** Racial Equity and Hiring sessions in partnership with Office of Recruitment, Cultivation, and Diversity
- **2** LGBTQ+ Student Support Sessions (training on BPS Policy)

* Welcoming Schools is a program that all staff in a school engage with to develop LGBTQ+ competencies and to transform school culture. The program consists of 7 90-minute Professional Development modules covering a range of topics from Family Diversity to Laws & Policies. This program has been developed by the Human Rights Campaign.

Assessing Organizational Structure, Policies, and School-Wide Practices for Cultural Proficiency

- **24** Schools with at least one Cultural Proficiency goal listed in their WAP; 4 schools specifically mention CLSP (Source: WAP Records)

Under development: A system for all staff to be trained in CLSP during employee onboarding when they first begin working at BPS.

Trainings on CLSP and the Racial Equity Planning Tool (REPT) are offered monthly and are available for all staff, partners, and students who serve centrally; attendance is not mandatory. The Office of Opportunity Gaps (OG) also provides coaching upon request.

All schools are expected to use the REPT when developing their Quality School Plan (QSP).

- Nearly every school has identified a QSP goal aligned to CLSP
- Nearly every school leader has identified a hiring goal aligned to the Opportunity & Achievement Gaps (OAG) Policy

All BPS central divisions, offices, and departments are expected to set OAG Policy goals. (Source: OG)
Schools-based Trainings

Figure 3.1 Percent of schools in which staff have received trainings in the past two years on the following topics (Source: Profiles)

- Addressing equity in education outcomes for students of color: 17% Some Staff, 79% All Staff
- Creating a supportive learning environment for LGBTQ+ students: 30% Some Staff, 38% All Staff
- Integrating community service with academic study to enrich learning, teach civic responsibility, & strengthen communities: 25% Some Staff, 23% All Staff

Family & Student Participation in Wellness Councils

Engagement of students, family members, and community partners in school-based wellness councils (Source: WAP records)

<table>
<thead>
<tr>
<th>Number of Members</th>
<th>Number of Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td>14</td>
</tr>
<tr>
<td>Family Members</td>
<td>63</td>
</tr>
<tr>
<td>Community Partners</td>
<td>12</td>
</tr>
</tbody>
</table>

85%

School leaders that agree/strongly agree teachers at their school implement SEL approaches that are culturally responsive (Source: Profiles)

Figure 3.2 Schools that report engaging students’ families to help develop or implement policies and programs related to school health in the past two years (Source: WAP records)

Classroom Culture and Climate: Student Feedback

During school year 2019-2020, the MCIEA Culture & Climate Survey and the Student Feedback Survey administrations were interrupted by school closures. As a result, the program ended earlier than planned and results are incomplete. For more information, review the Methods section (n=5,406 responses)

Cultural Relevance 45% Average

- See people like them represented in what they study quite often or a great deal: 33%
- See many different kinds of people represented in what they study quite often or a great deal: 37%
- Think all students' home cultures and languages are quite valued or tremendously valued in the school curriculum: 55%
- Think their home culture and language are quite valued or tremendously valued in the school curriculum: 53%
- Agree or strongly agree that their teachers encourage them to talk freely about differences and inequalities: 51%
Policy Overview

Boston Public Schools believes the cafeteria is an essential setting to educate and promote healthy eating habits. Boston Public Schools is committed to serving students nutritious and delicious food that is less processed, more locally sourced, and culturally responsive to reflect the diverse student population. We believe that students deserve meals reflective of their culture and tastes. BPS is also committed to ensuring food sold or served outside of the cafeteria meets high nutritional standards. A healthy school food environment makes it easier for students to make healthy choices by giving them access to nutritious and appealing foods and beverages, consistent and accurate messages about good nutrition, and ways to learn about and practice healthy eating.

Key areas for creating a healthy school food environment are:

- School Meals Program
- Food Safety
- Nutrition Education, Promotion and Food & Beverage Marketing
- Competitive Food & Beverages (i.e. food/beverages sold, provided, or served within school buildings or on school grounds outside of the school meals program)

Teaching healthy eating habits in health education, physical education, and other subjects

Nutrition Education Professional Development offered through the central office Health Education Team (Source: OHW)

1 Training
17 PE Teachers

Schools serving the following grade levels that are teaching nutrition education through Comprehensive Health Education (Source: Profiles)

- Grades K-5 (n=79) 86%
- Grades 6-12 (n=68) 71%

Food Safety Compliance
Maintained 100% of schools with:
+ Cafeteria staff with all required food safety certifications,
+ Complete bi-annual kitchen inspections and compliant facilities, and
+ A Hazard Analysis and Control Points plan

Building Capacity for Policy Implementation

The Healthy Food Environment (HFE) Wellness Champion Program has open enrollment for any interested school staff member. Schools are allowed only two champions total and each champion must be working in different program domains. Staff interest in the HFE program domain dropped significantly in SY19-20. (Source: OHW)
School Meals Program

All schools offered free meals to all students using different models based on the infrastructure at the school site. The District is decreasing the number of schools receiving prepackaged vended meals, meaning the meals are prepared off-site by an external vendor. (Source: FNS)

Breakfast After the Bell

BPS has achieved its goal of providing Breakfast After the Bell at 100% of schools in accordance with DESE requirements, an increase from 87% in SY17-18. (Source FNS). 57% percent of schools (75 sites) used a cafeteria only. The other 43% used Grab & Go Carts (5 sites), Breakfast in the Classroom (BIC; 15 sites), or a BIC/Cafeteria hybrid (34 sites) model. (Source: FNS)

Figure 4.1 Percent of school sites by meal service model

<table>
<thead>
<tr>
<th></th>
<th>SY17-18</th>
<th>SY19-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Way Cafe</td>
<td>35%</td>
<td>21%</td>
</tr>
<tr>
<td>Cafeteria service</td>
<td>62%</td>
<td>29%</td>
</tr>
<tr>
<td>Vended Meals</td>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>

23% of schools receiving vended meals (15 out of 66) were converted to My Way Café to be able to provide bulk, freshly prepared, on-site meal service, an increase from 3% in SY17-18 to 21% of all schools (FNS Records)

Student Participation Rates in School Meals Program

<table>
<thead>
<tr>
<th>(Source: FNS)</th>
<th>Students Served (SY17-18)</th>
<th>Students Served (SY19-20; Sept-March)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Breakfast</td>
<td>39%</td>
<td>45%</td>
</tr>
<tr>
<td>School Lunch</td>
<td>67%</td>
<td>72%</td>
</tr>
<tr>
<td>Dinner Meals</td>
<td>n/a</td>
<td>481,264</td>
</tr>
</tbody>
</table>

8.65% Food items procured by the district are locally source. All milk is locally sourced, so when milk is removed from the equation, the percent of locally sourced food items falls to 3.5% (Source: FNS).

Reported School Activities

(Source: Profiles)

37% Collected suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating

34% Conducted taste tests to determine food preferences for nutritious items

25% Offered a self-serve salad bar to students

School Closure Response (March-Aug)

During remote learning and into the summer months, grab & go meal sites were available throughout Boston for families to pick up breakfast and lunch meals.

Meals Served During School Shutdown

- 486,502 Breakfasts
- 499,555 Lunches

Summer Meals

- 117,150 Breakfasts
- 163,397 Lunches
**Figure 4.3** Percent of schools that offer a free source of drinking water in the following locations (source: Profiles)

<table>
<thead>
<tr>
<th>Location</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallways throughout the school</td>
<td>88%</td>
<td>12%</td>
</tr>
<tr>
<td>Outdoor physical activity facilities or sports fields</td>
<td>70%</td>
<td>30%</td>
</tr>
<tr>
<td>Gymnasium or other indoor physical activity facilities</td>
<td>94%</td>
<td>6%</td>
</tr>
<tr>
<td>Cafeteria during breakfast &amp; lunch</td>
<td>96%</td>
<td>4%</td>
</tr>
</tbody>
</table>

**Food Marketing Policy Adherence**

Schools that report prohibiting advertisements for candy, fast food restaurants, or soft drinks in each of the following locations (n=122; Source: Profiles)

- **82%** In school buildings
- **81%** On school grounds including on the outside of the school building, on playing fields, or other areas of the campus
- **79%** In school publications (e.g., newsletters, newspapers, web sites, other school publications)
- **75%** In curricula or other educational materials (including assignment books, school supplies, book covers, and electronic media)

**47%** Schools prohibited less nutritious foods and beverages (e.g., candy, baked goods) from being sold for fundraising purposes (Source: Profiles)

**FNS-03 Policy Communication**

Schools that reported communicating any of the following components of the Competitive Food & Beverage Policy FNS-03 (n=122; Source: Profiles)

- **76%** All foods sold, provided, or served within school buildings or on school grounds outside of the school meal program must follow the BPS nutrition guidelines
- **73%** Food sold in competition with school meals, including food-based fundraisers and vending machines, during school mealtimes is prohibited
- **75%** The use of food alternatives for school fundraisers, school parties, and classroom celebrations is encouraged
- **73%** The use of food and beverages as a reward or means of discipline is prohibited
**Policy Overview**

BPS recognizes and promotes the benefits of a Comprehensive School Physical Activity Program, where quality Physical Education is the cornerstone and additional physical activity is integrated throughout the school day and into before and after school programs.

**Physical Education (PE)** is a planned, sequential program of curricula and instruction that helps students develop the knowledge, attitudes, motor skills, self-management skills and confidence needed to adopt and maintain physically active lifestyles.

- Grades PreK-8: Required to provide at least 45 min. of weekly, standards-based PE (best practice recommendation is 80 min. per week)
- Grades 9-12: Required to provide at least one semester (the equivalent of a half school year)

**Physical Activity (PA)** includes recess, movement breaks, and academic lessons that incorporate PA.

- Schools must offer at least 150 minutes of in-school physical activity weekly in grades PreK-8
- Students in grades PreK-8 must have at least 20 minutes of daily recess.
- Opportunities for physical activity before and after school include school athletics programs, physical activity clubs, physical activity in before/after school programs, intramurals and interscholastic sports, and active transportation to and from school.

**Impacts on Student Health**

Numerous studies indicate that regularly engaging in moderate-to-vigorous exercise contributes to overall physical and mental health and that nurturing an exercise habit among children lays the foundation for lifelong fitness. Research also shows that increased physical activity increases children's cognitive function, ability to concentrate in class, and academic performance. PE develops physically literate individuals who have the competence, confidence and desire to enjoy a lifetime of healthful physical activity.

**School Support Resources**

**Online Materials:** The PE Team works with teachers across the district to maintain and improve resources for PE teachers, such as the PE Teacher Toolkit, PE Equipment Lending Library, and PE Unity Library with lessons and instructional videos

**PA Program Coordinator:** This grant-funded position was filled in April and provided much needed support for improving PA opportunities during school time

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**Comprehensive Physical Activity & Physical Education**

**76 Hours**

Professional Development

5 trainings reaching 119 teachers across 67 schools.

**72 Teachers**

Instructional Coaching

Two PE instructional coaches provided in-depth support to new & veteran teachers across 52 schools; A total of 748 hours of instructional coaching were delivered across 574 IC sessions.

**164 Hours**

Technical Assistance

259 sessions assisting 135 teachers across 86 schools.

(Source: OHW)

**PE: Cohesion & Consistency Across Schools**

The mission of the Physical Education Department is to ensure equitable and standards-based PE for all BPS students. Professional learning, in-depth instructional coaching, timely technical assistance, and the frequent development and dissemination of resources are key to ensuring high-quality PE and consistency across schools.

10 Active PA Partnerships serving 78 Schools

6 Schools received PE curricula

82 Schools received PE equipment

---

(Source: OHW)
Standards-based Physical Education

92%  95%
Implement Standards-based PE  Use at least 1 district-endorsed curriculum

107 schools report implementing standards-based PE. 95% of schools use at least one district-endorsed curriculum such as Project Adventure, OPEN, and/or SPARK.

Physical Education in Grades PK-8 (Source: Profiles)

90% of schools serving students in grades PK-8 across the district reported meeting or exceeding the PE Policy requirement for those grades. K-8 and K-12 schools were most likely to fall short of the minimum 45 minutes of weekly PE for each grade.
**Physical Education in Grades 9-12**

While the percentage of schools meeting the PE Policy for high school students has remained unchanged between SY17-18 and SY19-20, fewer schools reported offering at least 1 semester of PE to 10th and 11th grade students, but a slightly greater percentage met the 1 semester requirement for 12th grade students.

58% Schools serving students grades 9-12 provided at least one semester of PE to students each year. *(Source: Profiles)*

**Total Students**

Received physical education during SY19-20, accounting for about 78% of BPS Students *(Source: ODA)*

41,675

**Recess in Grades PreK-8** *(Source: Profiles)*

All schools offered recess for students in grades PK-5. Overall, 75% of schools provided a minimum of 20 minutes of daily recess in all elementary grades. While fewer schools offer recess for grades 6, 7, and 8, the percentages have increased over the past few years (Figure 5). The amount of recess for middle school students ranged from 71 to 78 minutes per week. Only 42% of schools met the recess policy requirement for grades 6 through 8; school compliance with minimum daily minutes has increased slightly from 38% in SY17-18.

**Recess in Grades K-8** *(Source: Profiles)*

<table>
<thead>
<tr>
<th>Average Weekly Min</th>
<th>% Offer Any Recess</th>
<th>% Provide 20 min/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>K1</td>
<td>131</td>
<td>100%</td>
</tr>
<tr>
<td>K2</td>
<td>129</td>
<td>100%</td>
</tr>
<tr>
<td>1</td>
<td>113</td>
<td>100%</td>
</tr>
<tr>
<td>2</td>
<td>107</td>
<td>100%</td>
</tr>
<tr>
<td>3</td>
<td>109</td>
<td>100%</td>
</tr>
<tr>
<td>4</td>
<td>109</td>
<td>100%</td>
</tr>
<tr>
<td>5</td>
<td>110</td>
<td>100%</td>
</tr>
<tr>
<td>6</td>
<td>78</td>
<td>83%</td>
</tr>
<tr>
<td>7</td>
<td>71</td>
<td>77%</td>
</tr>
<tr>
<td>8</td>
<td>71</td>
<td>77%</td>
</tr>
</tbody>
</table>

**Improving the quality of recess**

7 schools actively worked to increase the quality of recess for students. These schools received training on active recess from Playworks through opting into the Wellness Champion Program. An additional 38 schools partnered with Playworks outside of the Wellness Champion Program.

(Source: Playworks)
**Movement in the Classroom**

Across schools, weekly movement in the classroom ranges from an average 30 minutes for 11th and 12th grade to 59 minutes in PreK and Kindergarten. 80% of schools report that all or many of their teachers implement movement breaks or classroom lessons that involve movement.

*Previously, part-time staff lead a Movement in the Classroom Wellness Champion domain; unfortunately, we did not have staffing capacity to run this domain for SY19-20.*

**Withholding Physical Activity**

78% of schools do not withhold physical activity as punishment. The percentage of schools withholding PA as punishment has not changed since SY17-18. The BPS Code of Conduct was updated in fall 2019 to reflect the language in the PE-PA policy circular:

*It is prohibited for any BPS staff member to stop students from participating in physical activity (including recess) as a disciplinary consequence, to provide academic support, or for any other reason other than illness or safety. Exemptions for illness or safety must be approved by the school administrator.*

**150 Minutes of Comprehensive Physical Activity**

69% of schools provided PreK-8 students with a total of 150 minutes of physical activity; however only 48% of schools met all components of the 150-minute PA policy, including at least 45 minutes of PE per week, movement in the classroom, and 20 minutes of recess daily (Figure 8). The majority of schools met or exceeded at least 2 of the physical activity requirements. Elementary schools were most likely to meet or exceed all PA requirements (65%). In contrast, none of the Middle-High Schools met all 3 components of the PA policy for grades 6-8.

The percentage of schools meeting all minimum PA requirements for all grades has increased slightly from 43% in SY17-18 (Figure 9). This increase is attributable to the increase in schools meeting the minimum PE requirement. In comparison, the percentage of schools offering 20 minutes of daily recess and 150 minutes of PA have declined slightly since SY17-18.

(Source: Profiles)
Physical Activity Before & After School

Opportunities for physical activity before and after school include school athletics programs, physical activity clubs, physical activity in before/after school programs, intramurals and interscholastic sports, and active transportation to and from school.

83% Schools offered opportunities for students to participate in intramural sports programs or physical activity clubs.

(Source: Profiles)

Safe Routes to Schools

SRTS aims to create safe, convenient, and fun, opportunities, for children to walk and bike to and from school. The program was launched in 2015.

Limited funding for the BPS SRTS program was available in SY19-20, however targeted technical assistance was provided. Four schools received 43 hours of targeted supports; an additional 8 schools partnered with MA SRTS. Priority walking routes have been identified at 22 schools; however, no additional routes were identified in SY19-20. 14 schools participated in Walk to School Day hosted in the Fall and Winter during SY19-20.

(Source: OHW)

Athletics

The Department of Athletics is an innovative program that not only focuses on the physical development of student-athletes but also their social and emotional health and well-being. The mission of the department is to provide all students (grades 6-12) with student-centered, culturally-responsive programming that uses athletic competition to teach values and skills young student-athletes will need to be successful now and in the future.

The BPS Athletics Program consisted of 3 middle school programs and 13 high school programs in the Fall and Winter. The SY19-20 spring season was cancelled due to COVID-19.

Athletics Programs Participation

<table>
<thead>
<tr>
<th>Sports Programs</th>
<th>Middle School</th>
<th>High School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseball, Softball, Outdoor Track &amp; Field*, Boy’s Volleyball, Girls’ and Boys’ Tennis</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

* Indicates co-ed program; † Indicates a middle school and high school program

BPS offers 18 different athletic programs, 6 boys’ programs, 7 girls’ programs, and 7 coed programs. 32 Schools hosted at least 1 middle school athletic team and 17 schools hosted at least 1 high school athletic team. 5 schools offered an equal number of boys’ and girls’ athletic teams.

Physical Activity Community Partners

BOKS released 20 new virtual and socially-distanced resources that serve all ages and abilities. These resources include video follow-along workouts (Lessons on Demand), movement breaks (Bursts), and Mindfulness and Movement Flows. They awarded $50K to 34 BPS BOKS programs to support their programming.

BPHC launched a new COVID-19 Physical Activity Mini-Grant Program to support local and faith-based organizations in their efforts to continue accessible active living programming throughout the pandemic.

(Source: PE-PA Subcommittee Partners)

PE and PA during School Closures

PE Team facilitated online professional learning community groups for PE teachers to support, collaborate, and exchange best practices.

PE At Home Resource Folder with online curriculum and curriculum guidelines, activity ideas, and physical activity at home safety protocols was updated weekly and shared with all PE teachers.

Student and family facing PE and PA lesson packets were posted on the BPS website. These lesson packets were also shared with PE teachers directly; new curriculum came out on a weekly basis by grade group (K-2, 3-5, 6-8, 9-12)
Health Ed: Cohesion & Consistency Across Schools

The mission of the Health Education Department (HE team) is to increase access to rigorous, culturally and linguistically affirming curriculum and instruction and fully integrate student wellness into the educational experience. Building teacher capacity to deliver engaging, skills-based health education through professional learning, instructional coaching, technical assistance, and the provision of resources is paramount to the equitable delivery of CHE across all BPS schools.

New Resources for Schools

**Health education resource library:** This online resource contains skills and standards-based lessons by grade-band that include engaging activities, like virtual classrooms, as well as social emotional learning (SEL) best practices. All lessons follow Universal Design for Learning and provide a variety of strategies and resources to help meet diverse learning needs and improve accessibility to learning opportunities.

**Health Ed Instructional Coach for Students with Disabilities:** This member of the HE team supports school staff in the implementation of CHE for students with disabilities, develops and delivers professional development, and partners closely with the Special Education Department.
Staff Capacity to Provide Health Education

The Office of Health and Wellness recommends that health education in elementary school be provided by a DESE licensed teacher with a Health Educator license or K-5 General Educator license. In grades 6 through 12, policy requires that health education be taught by a DESE licensed health educator.

Elementary Grades

Across BPS elementary schools, health instruction is primarily taught by PE teachers and school nurses. Less than 50% of elementary schools report health education is taught by classroom teachers. Nearly 40% of elementary schools report health is delivered by school support staff and 26% report that HE is delivered by community partners.

Figure 6.1 Percentage of schools in which elementary health education staff held the following roles: (Source: Profiles)

Middle & High School Grades

BPS has 23 Licensed Health Education teachers, of those only 5 taught health ed full-time and the remaining taught aspects of health ed through other subject areas like PE and science. Only 20% of middle and high schools had a lead health education teacher certified, licensed, or endorsed by the state to teach health education. (Source: OHC/OHW)

Figure 6.2 Percentage of schools in which the major emphasis of the lead health education teacher’s professional preparation was on the following:

Community Partners Supporting Health Education

American Heart Association • BAGLY • Boston Public Health Commission • Boys and Girls Clubs of Boston • Cambridge College • Codman Academy • GLASS • MAHPERD • Planned Parenthood League of Mass • Peer Health Exchange • Project HERE • One Love • Sociedad Latina

52 schools report having community partners directly deliver Health Ed instruction.

Partnership Highlight: BPHC Recovery Services & The Cope Code Challenge

The CopeCode Club Campaign - championed by the Mayor’s Office of Recovery Service, BPHC, Mass General Hospital and Mass DPH - is a program for middle and high school youth that promotes the use of healthy, productive methods to manage feelings caused by stressful situations. The Campaign promotes 9 methods grounded in stress science for managing stress: Move, Create, Sing, Think, Share, Rest, Breathe, Write and Bond. The City of Boston Recovery Services worked directly with the HE Team to support BPS teachers in bringing the CopeCode Challenge to students across the district.

CHE Professional Learning Community

The new CHE Professional Learning Community (PLC), led by the HE Team, meets monthly to share ideas, skills and standards-based lessons, and best practices for classroom facilitation. During the Professional Learning Community (PLC) meetings, teachers also engage in critical conversations and new learning which stimulates innovation and unearths teaching solutions.
Implementation of Health Ed Instruction

**Elementary Grades (PreK-5)**

39% of all BPS schools with grades PreK-5 did not offer any health instruction to students (Figure 3). An additional 10% report only offering instruction in 1 elementary grade-level. On average, fewer than 35% of schools taught health education in grades PreK-3 (Figure 4). 54% of schools taught health education in grade 4 and 62% taught health in grade 5.

**Middle & High School Grades (6-8 & 9-12)**

61% of schools with any grades 6-12 required health instruction, either as part of a required health education course or another required subject (Figure 5). K-8 and middle schools were least likely to require any health instruction and high schools were most likely to require some form of health for students.

42% of schools serving middle and high school grades did not require students to take any health education courses (Figure 6). Only 33% required students to take 2 or more courses.

**Hours of Health Ed Instruction**

BPS recommends 27 hours per year (45 minutes per week) of CHE in all grades PreK-5. For students in grades 6-8, the recommendation is 54 hours (two 27-hour semesters) of CHE. Students in grades 9-12 should receive 1 semester of health education (about 27 hours), however the median was 18 hours of health education instruction. A median of 16.5 hours of health education per year are offered across all BPS schools.

Schools with required health education were most likely to require a course in 9th grade; however, only 54% required health education for that grade. Fewer than 40% of schools required a course for 7th, 11th, and 12th grade students.
Health Education According To Policy

Policy requires that all BPS schools follow relevant promotion and graduation requirements that include health education with a minimum of:
- The Healthy and Safe Body Unit in elementary school
- Two semesters of Health Education in grades 6 through 8 taught by a licensed Health Education teacher
- One semester of Health Education in grades 9 through 12 taught by a licensed Health Education teacher

Figure 6.8 Percentage of schools meeting the minimum health education policy requirements by school category

<table>
<thead>
<tr>
<th>Category</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elementary</td>
<td>87%</td>
<td>33%</td>
</tr>
<tr>
<td>K-8/Middle</td>
<td>82%</td>
<td>8%</td>
</tr>
<tr>
<td>High School (inc. K-12)</td>
<td>89%</td>
<td>3%</td>
</tr>
<tr>
<td>District</td>
<td>79%</td>
<td>18%</td>
</tr>
</tbody>
</table>

Fewer than 20% of schools in the district followed the minimum health education policy. High schools were least likely to meet the minimum requirements (8%). Compliance was highest in elementary schools, 33% met the minimum health education requirement.

District-Developed Elementary Lessons

Only 32% of schools reported teaching the district-developed Healthy Relationships, Personal Boundaries and Safety Unit recommended for grades PK-3 and 50% taught the BPS Healthy & Safe Body Unit in required grades 4-5.

District-Approved Health Ed Curriculum

20% Used a written HE curriculum

BPS provides district-approved health education curricula, yet only 20% of schools reported using a written health education curriculum to guide health education at their school.

Most schools that offer health education report implementing standards-aligned health (80%). Few schools use at least one district-endorsed curriculum, such as:
- 13% Health Smart
- 6% Michigan Model for Health
- 28% Rights Respect & Responsibility (sexual health education curriculum)

(Source: Profiles)

32% Grades PK-3

50% Grades 4-5

(Source: Profiles)
Policy Overview
To address environmental risk factors for chronic and infectious disease, each school will receive an Annual Environmental Audit to evaluate health and safety conditions such as leaks, mold, pests, chemical storage and cleanliness. The District shall maintain a Healthy School Environment (HSE) Subcommittee to promote and raise awareness of the health of the built environment and ensure continuous improvement of BPS healthy school environment policies and programs.

District departments and all schools shall comply with existing federal and state regulations, city ordinances and District policies related to promoting and managing healthy school environments.

Schools shall regularly assess the quality and quantity of BPS facilities for active transportation, physical activity, and physical education, including schoolyards, and report maintenance needs for these facilities.

Intended Impacts on Student Health
Healthy physical environments are critical to the prevention of asthma and other chronic and infectious diseases that impact learning. Additionally, changes to the physical environment can serve to promote healthy choices and facilitate safe opportunities to be physically active. BPS is committed to providing high-performing school buildings and grounds that are clean, in good repair, have healthy indoor air quality and water quality, have sanitary and accessible bathrooms, and use resources efficiently.

SEA = School Environmental Audit
In collaboration with the Boston Public Health Commission, BPS completes an environmental health inspection at all schools. **100%** of schools had SEAs at the beginning of school. **50%** SEAs were completed during school year 2019-2020 before the closure of schools in March. (Source: Facilities Mgmt)

Centralized Custodian Training: Summer 2019 (Facilities Mgmt)
100% of school custodians were trained on the following topics:

- Reviewing Your SEA
- Submitting Work Orders
- Integrated Pest Management (IPM)
- Promoting Green Cleaning
- Zero Waste Efforts
- Universal & Hazardous Waste
- Supporting with Drinking Water
- Energy Savers & Know Your Utilities
- School Yard Maintenance

78% School leaders reported reviewing their school’s SEA report
66% Coordinated with their school’s Wellness Council to follow-up on needs identified in the SEA report
(Source: Profiles)

18 Schools with HSE goals in their Wellness Action Plan

Building Capacity for Policy Implementation
The HSE Wellness Champion domain has open enrollment for any interested school staff member. Schools are allowed only two champions total and each champion must be working in different program domains. This domain was led by our community partner MassCOSH (Source: OHW)

<table>
<thead>
<tr>
<th></th>
<th>SY17-18</th>
<th>SY18-19</th>
<th>SY19-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schools with a HSE Champion</td>
<td>11</td>
<td>11</td>
<td>8</td>
</tr>
</tbody>
</table>
Green Cleaner Policy
School custodians can provide all school staff with BPS-approved green cleaners for the classrooms and offices. In addition to cleaners, they can provide Hydrogen Peroxide-based sanitizer sprays to early education classrooms & after school programs.

73% Schools where staff were informed of the Green Cleaning Policy by school leaders (Source: Profiles)

77% Schools that reported all cleaning supplies complied with the Green Cleaning Policy (Source: Profiles)

108 Early childhood classroom educators at 7 schools were trained to properly use safer sanitizer; total of 51 school programs trained since SY17-18 (Source: Early Ed)

63% of BPS Early Ed Programs and 100% of after-school programs that serve food and YMCA school-based programs used Oxivir (Source: Early Ed)

Integrated Pest Management Program
A comprehensive strategy to manage pests by using multiple control tactics with the least cost and environmental impact; Includes increased monitoring, improving sanitation, eliminating pest harborage sites, and using lowest impact pesticides as necessary.

★ All schools must have an IPM Plan (Indoor & Outdoor) and designated IPM Coordinator.
★ Plans must be registered with the State.
★ All pest related complaints must be entered into the IPM Logbook, located in every school's main office; The pest control contractor uses the logbook to inspect and treat the reported areas.
★ State regulation requires all Boston Public Schools to use less-toxic pesticides found on the State's approved list.
  ▶ Can only be applied by a licensed pest control contractor on school property.

100% Schools had IPM Plans and an assigned licensed IPM vendor (Source: Facilities)

89% Schools identified an IPM Coordinator
90% Schools informed all staff on how to record pest sightings (Source: Profiles)

Decluttering & Zero Waste Policy (Source: Facilities Mgmt)
Decluttering schools is important, especially classrooms and storage areas. Clutter provides pests with spaces to live and breed, harbors asthma triggers like dust, and takes up valuable school space that could otherwise be used for teaching, learning, and organized storage.

In addition to all the items recycled by the City of Boston, BPS coordinates recycling yard waste, electronics, textiles, and chemical and motor oil containers

100% Schools have active recycling programs
5 Schools with book recycling bins
9 Schools with textile recycling bins

New operational equipment delivered to schools who requested equipment

129 95-gal curbside carts
105 32-gal recycling barrels
1043 7-gal classroom bins

30 tons Recycled
820 95-gal carts
Recycled waste at each school per week
Water Policy

Free, safe water for all BPS students and staff, throughout the school day including meals is required for all BPS schools. All water sources of drinking and food preparation are tested annually. There are clear standard operational procedures for maintaining water fountains and water bottle dispensers with cups.

Big News

In November 2020, BPS announced its new 3-4 year Drinking Water Initiative, thanks to a commitment of $10.36M in capital funds from Mayor Walsh and a $6.215 million U.S. EPA grant. The initiative will install and test approximately 1400 new filtered bottle refill stations across the district and move BPS schools from bottled water to tap water for drinking access.

Water Testing

BPS tested 733 units across 80 schools, a total of 425 water fountains and 308 pieces of food prep equipment.

Figure 7.1 Thirty-seven BPS school buildings have online drinking water fountains and use tap water as their primary source of drinking water; 17 are new since 2016. Facilities installed 82 new fountains/refill stations and 51 new filter boxes. (n=125; Source: Facilities Mgmt)

Zero drinking water infrastructure improvements in 2019-2020; Between 2021-2025 100% of schools will receive varying levels of first-time installations or upgrades to existing systems

Water Testing

99.3% of water testing samples (728 out of 733) did not have lead or copper exceedances. Five out of 733 samples did have lead exceedances (elevated lead levels, greater than 15 ppb): One drinking water fountain and four pieces of food prep equipment. All exceedances were addressed. (Source: Facilities Mgmt)

Tobacco & Nicotine Free Policy

The District has a tobacco and nicotine-free campus policy for all BPS properties. It is the responsibility of all building supervisors and school leaders to help communicate and implement this policy.

WHO: Students, staff, administrators, and visitors
WHAT: Prohibited from using, consuming, displaying or selling any tobacco products or tobacco paraphernalia, including e-cigarettes and vaping devices
WHEN: At any time before, after, or during school
WHERE: On school property, at off-campus, school sponsored events and extra-curricular activities, within vehicles located on school property, and within 50 feet of school property.

Transportation

50% of active BPS bus fleet runs on propane; BPS Transportation is only purchasing propane-fueled buses when buying new, instead of diesel
All BPS students in grades 7-12 will receive free “My7 MBTA passes
115 schools that have bike racks or other storage systems for students and staff (Source: Facilities)

Schools report they have adopted the policy prohibiting tobacco (Source: Profiles)
Policy Overview:
The Boston Public Schools seeks to create a safe and supportive school environment for all students that is culturally proficient, engaging, and inclusive, provides skills-based education to promote healthy relationships and development and provides access to support services. Prevention, promotion and intervention-based work will address and integrate social-emotional health and behavioral health. Schools shall meet the needs of students by creating safe and inclusive climates that are responsive to all forms of bullying and violence, specifically for vulnerable student populations.

Impacts on Student Health:
Creating safe and supportive school environments impacts the social-emotional wellbeing and mental health of students. These efforts improve school connectedness and school climate and decrease incidents of bullying and violence, including bias-based incidents, suicide, intimate partner violence, and sexual harassment and assault. Safe and supportive schools foster a climate that improves learning for all students and specifically vulnerable student populations.

Multi-tiered Systems of Support
Boston Public Schools creates systems that align with the district-accepted Multi-tiered System of Supports (MTSS) framework to ensure that all students have access to key resources and services in a safe and supportive environment. The MTSS Framework supports the development of a continuum of behavioral health supports and interventions falling across three tiers—Tier I: Prevention and promotion, Tier II: At-risk interventions and services, and Tier III: Intensive interventions and services. 61% of schools have tiered services for students’ social, emotional, and behavioral development fully in place.

Student Support Teams
A key component of MTSS is the Student Support Team (SST) is a school-level, problem-solving team that matches interventions to individual student needs in order to supplement, enhance, support and provide access to the core curriculum of the school. The SST reviews background data, identifies potential supports, and decides collaboratively which intervention(s) to implement and how the progress of that intervention will be monitored.
Increasing school capacity to implement social emotional learning

The Social Emotional Learning and Instruction (SEL & I) team leads the district in alignment of SEL strategies and practices through the Safe and Welcoming Schools initiative and the implementation of the Partnership for SEL grant. The SEL & I team held a told of 31 professional learning opportunities:

- 10 district PDs reaching nearly 1300 staff including 300 teachers.
- 9 Safe and Welcoming Schools (SAWs) PDs were provided to 147 staff including 90 teachers.
- 12 PDs for PSELI schools reached over 330 teacher across 7 schools.
- Over 300 teachers at PSELI schools were also supported via coaching and consultation.

Social Emotional Instruction in Schools

97% of school leaders somewhat or strongly agreed they were committed to supporting students SEL and development; however, only 80% somewhat or strongly agreed there were explicit systems in place that engage and collaborate with families to develop students’ SEL competencies.

![Figure 8.3 Percent of school leaders that somewhat or strongly agree to the following statement:

Teachers use explicit SEL instruction strategies to increase students' social-emotional competencies: 88%

Teachers implement SEL approaches that are culturally responsive: 85%

Teachers are proficient in providing explicit SEL instruction to all students: 79%

97% Committed to supporting students’ SEL

80% Have explicit systems to develop students’ SEL competencies

Partnership for SEL Initiative (PSELI) Year 3 Results

Implementation of the 6-year PSELI grant began in SY17-18. Through this partnership 14 PSELI schools receive intensive on-site support from Instructional Coaches and engage in the process of developing school-wide SEL leadership practices aligned with SEL best practices.

Year 3 results show that PSELI is having a positive impact on SEL practices and instruction. SEL instruction in lessons throughout the schools increased. 73% of observed sessions included SEL practices such as welcoming rituals, calming transitions, and optimistic closures. Quality of instruction and staff modeling of SEL skills still have room for improvement, according to observations.

Among students in early elementary (K-3), increases across all four SEL domains (social problem-solving, social perspective-taking, self-control, and emotion regulation) were evident. Among students in late elementary (4-5), increases were seen across three domains. (Source: RAND)

Transformative SEL: Ensuring to equity-based SEL

In spring of 2020, BPS began implementing Transformative SEL, an equity and CLSP-aligned approach through which youth and adults learn essential life skills and competencies that promote a positive identity, a well-managed self, healthy relationships and agency to successfully navigate their future.

By threading Transformative SEL throughout the day and the building, young people and adults build strong, respectful, and lasting relationships that facilitate co-learning in order to critically examine root cause of inequity, and to develop collaborative solutions that lead to personal, community and societal well-being. This Tier I approach to SEL was prioritized in our planning and response to the COVID-19 pandemic.
**Student Support**

**Staff In Schools**

School staffing capacity to serve students social, emotional, and mental health needs

**FTE student social, emotional, mental health support positions**

<table>
<thead>
<tr>
<th>Position</th>
<th>FY18</th>
<th>FY19</th>
<th>FY20</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Psychologists (not including the 2 capacity builders)</td>
<td>65</td>
<td>70.3</td>
<td>70.5</td>
</tr>
<tr>
<td>Pupil Adjustment Counselors</td>
<td>5</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>Clinical Coordinators</td>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Guidance Advisors</td>
<td>21</td>
<td>21</td>
<td>19.8</td>
</tr>
<tr>
<td>Guidance Counselors &amp; Student Development Counselors</td>
<td>81.9</td>
<td>84.5</td>
<td>80.6</td>
</tr>
<tr>
<td>Social Workers/Coordinators</td>
<td>53.1</td>
<td>58.2</td>
<td>59.6</td>
</tr>
<tr>
<td>Student Services Coordinator</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total FTE</strong></td>
<td>235</td>
<td>248</td>
<td>246.5</td>
</tr>
</tbody>
</table>

*As of 10/1 of that fiscal year (Source: OHC)

In spring 2020, an additional 57 social workers were hired along with a Director of Social Work. For SY21-22, every school will have a social worker.

**Hub School Model**

Planning for a Full-Service Hub School model began in SY19-20; an equity-based Boston Hub School model will be rolled out in 13 schools with 12 new Hub School manager positions. The district also invested in family liaisons for 33 schools and will be hiring an additional 80.5 FTE for SY21-22.

**Behavioral Health Services (BHS)**

13 professional development opportunities

**Partnerships for Behavioral Health Services**

In SY2019-20, nearly all schools collaborated with a behavioral health community partner. Deepening these relationships and increasing access to all students remain top priority.

28 Behavioral Health Community Partners

94% Schools collaborated with a behavioral health community partner

**Comprehensive Behavioral Health Model (CBHM)**

CBHM was developed in collaboration between BPS BHS Dept, the Boston Children’s Hospital, and UMass Boston School Psychology Program. It is a multi-tiered model that is implemented within schools in partnership with principals, school staff, community agencies, students and families. The number of schools implementing CBHM has increased from 60 schools in SY2017-18 to 74 BPS schools (57% of all schools).

74 CBHM Schools

89% Provide Tier I with Fidelity

58% Provide explicit SEL Instruction

BIMAS is a measure of social, emotional, and behavioral functioning in children and adolescents ages 5 to 18 years. The BIMAS was only conducted in the Fall of 2019 due to school closure.

20,468 Students were screened using the Behavior Intervention Monitoring Assessment System (BIMAS).

**BHS Support During School Closure**

**CONNECTING:** All families of students who previously accessed behavioral health services (e.g. individual or group counseling) at school were contacted via phone and email to check-in on individual family needs and resources.

**OFFERING SERVICES:** Any student who had been accessing supports in school were offered the opportunity to access similar supports remotely.

**COLLABORATING:** Supported school-based mental health providers (e.g. clinical coordinators, school social workers, etc.) to ensure consistency in telehealth practices. In addition, the office coordinated a cohesive response from both BPS providers and partner agencies providing services within our schools. The Boston Area School-Based Behavioral Health Collaborative was critical to providing coordination and consistency.
Targeted Supports for Vulnerable Populations

LGBTQ+ Youth
51% of schools with grades 6-12 had gay straight alliances (GSA) up from 42% in SY2017-18.

Expectant and Parenting Teens
Schools with grades 6-12 must identify a school-based policy liaison for expectant and parenting students. Liaisons are responsible for informing the school community about this policy and sharing resources for expectant and parenting students from the district and community partners. Only 28% of schools had identified an EPS liaison and of those only 29% had posted the EPS Liaison contact on their school website.

28% Schools identified an Expectants and Parenting Student Policy Liaison
(Source: Profiles)

Bullying Prevention and Intervention

School Capacity to Address Bullying
51 Professional Development opportunities
Succeed Boston held 21 Bullying Prevention PDs reaching 348 participants and 30 Restorative Justice trainings attended by 314 participants.
(Source: Succeed)

Only 28% of schools reported having at least two trained Bullying Prevention Liaisons, a decrease from 71% in SY17-18. Further, compared to SY2017-18, the share of schools reporting all staff at their school completed an annual bullying prevention intervention training decreased from 42% to 22% while the proportion that said no staff were trained increased significantly from 7% to 39%.

Figure 8.4 Proportion of staff completed annual bullying prevention and intervention training at each school
(Source: Profiles).

Percentage of schools providing additional supports and resources to vulnerable populations

<table>
<thead>
<tr>
<th></th>
<th>Sy17-18</th>
<th>Sy19-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Court-involved students</td>
<td>60%</td>
<td>77%</td>
</tr>
<tr>
<td>EL students and EL students with disabilities</td>
<td>80%</td>
<td>95%</td>
</tr>
<tr>
<td>Refugee, asylee, documented and undocumented immigrant students</td>
<td>51%</td>
<td>73%</td>
</tr>
<tr>
<td>LGBTQ+ Students</td>
<td>55%</td>
<td>72%</td>
</tr>
<tr>
<td>Students experiencing homelessness</td>
<td>84%</td>
<td>98%</td>
</tr>
<tr>
<td>Students experiencing trauma</td>
<td>89%</td>
<td>98%</td>
</tr>
</tbody>
</table>

(Source: Profiles)

Compared to SY2017-18, there have been increases in supports across the district for all vulnerable student groups. Overall, 55% of schools provided additional supports to all vulnerable student populations listed above.

Succeed Boston Program
Succeed Boston at the Counseling and Intervention center provides short-term counseling and intervention BPS students who have violated the most severe offences of the BPS Code of Conduct.
536 students participated in the Succeed Boston program before school closure. 242 students were referred for violence related offences and a total of 490 students had been suspended.

Bullying Incidents
The number of bullying incidents reported is lower than SY2017-18 by 25 cases; this decrease may be attributable to school closures in March -June. The rate of closed cases increased slightly from 84%.

219 Bullying cases reported
86% Bullying reports closed
(Source: Succeed)
Identification of unaccompanied youth has increased significantly, from less than 20 three years ago to over 70 unaccompanied students experiencing homelessness in SY19-20. Each of these students were provided case management services and referrals through integral partnerships with YouthHarbors and Rising to the Challenge Youth Homelessness Initiative.

Identification of unaccompanied youth has increased significantly, from less than 20 three years ago to over 70 unaccompanied students experiencing homelessness in SY19-20. Each of these students were provided case management services and referrals through integral partnerships with YouthHarbors and Rising to the Challenge Youth Homelessness Initiative.

Support systems at the school level
To help students, families, and school staff navigate complex systems complex and disjointed systems that limit access to support and resources, HERN, relies on a consultative and responsive approach that leverages the network of school homeless liaisons to quickly disseminate resources and services to families at the school level.

HERN developed a Youth Triage Tool to guide school homeless liaisons in providing relevant resources and referrals, while establishing the Housing Peer Navigator Program to provide case management, wraparound services, and stabilization support.

Identification of students experiencing homelessness
With improved identification and support systems at the school level, identification of students experiencing homelessness increased from about 2,900 in SY16-17 to over 4,500 in SY18-19 (Figure 5). In SY19-20, 4,200 students experiencing homelessness were identified. It is difficult to decipher whether the cause of lower identification was a result of lost touch points due to the pandemic or improved stabilization of services across the city.

Identification of unaccompanied youth has increased significantly, from less than 20 three years ago to over 70 unaccompanied students experiencing homelessness in SY19-20. Each of these students were provided case management services and referrals through integral partnerships with YouthHarbors and Rising to the Challenge Youth Homelessness Initiative.

Over 1,000 families received housing vouchers through a partnership with Boston Housing Authority. To date, over 300 families have been housed and counting.

Summer Enrichment
Through a partnership with Expanded Learning Opportunities, students experiencing homelessness receive priority access to summer enrichment programming which helps to overcome barriers like transportation and proximity. Over 1,000 students experiencing homelessness – more than ever before – participated in summer learning.

Student perceptions of school climate
During school year 2019-2020, the MCIEA Culture & Climate Survey and the Student Feedback Survey administrations were interrupted by school closures. As a result, the program ended earlier than planned and results are incomplete. The data points below represent the average percentage of student responses in the two most favorable response categories (n=5,406; Appendix E for survey questions).

**Supports for students experiencing homelessness**
BPS Homeless Education Resource Network (HERN) builds capacity at the school level, provides responsive services, and prioritizes access to critical programs and services to ensure equitable access and opportunity for students and families experiencing housing insecurity.

**Support systems at the school level**
To help students, families, and school staff navigate complex systems complex and disjointed systems that limit access to support and resources, HERN, relies on a consultative and responsive approach that leverages the network of school homeless liaisons to quickly disseminate resources and services to families at the school level.

HERN developed a Youth Triage Tool to guide school homeless liaisons in providing relevant resources and referrals, while establishing the Housing Peer Navigator Program to provide case management, wraparound services, and stabilization support.
Policy Overview

The Boston Public Schools nurses are responsible for evaluating and managing the health needs of all students. That includes the following:

- Case management of students with special health needs
- Monitoring and administering medications and medical procedures as prescribed by a student’s primary care provider or medical specialist
- Providing first aid and emergency care
- Screening students for height, weight, Body Mass Index, vision, hearing, scoliosis, substance use (screening, brief intervention, and referral to treatment)
- Managing student medical records and immunization records
- Managing the control of communicable diseases
- Coordinating medical transportation for students
- Coordinating special dietary accommodations for students with food allergies
- Working with other school-based groups to provide safe and healthy environments

Additionally, BPS High Schools shall provide access to condoms, with appropriate reproductive health counseling for students. Each high school will have a Condom Accessibility Team (CAT); members may be any school staff. Parents and legal guardians may exempt their children from receiving condoms by notifying the school. This exemption to not receive condoms does not apply to other confidential health services.

Intended Impacts on Student Health

The Boston Public School Health Services support students to be healthy, engaged, safe, and academically challenged by providing high-quality, cost-effective in-school health care. School nurses ensure that all students are ready to learn by attending to and supporting their health and medical needs. School nurses also help create a culture of health and wellness throughout the school by promoting positive health behaviors among students and staff with lifelong impacts.

Improving the quality of systems & protocols

Health Services continued to make updates to electronic medical record documentation to align with standardization of care and equitable delivery of services.

Health services continued its revision of the formula for staffing school nurses based on factors including, student health acuity, equity, student enrollment, and special health care needs.

Increased care management supports for students with chronic illness, including asthma, sickle cell disease, diabetes, life-threatening allergies and seizure disorders:

- A newly created position, Care Management Resource Nurse was filled in October 2019.
- All school nurses were surveyed to identify students with chronic illness and to ask about professional development needs
- Development of community linkages including specialty providers at Children’s Hospital Boston, Boston Medical Center, Community Health & Boston Public Health Commission.
- Professional development opportunities provided

Increasing school nurse staffing to meet the health care needs of students

During SY19-20, BPS made a commitment to fund 1 nurse in every school. Health Services facilitated the increase of 31 FTE nurses across the district. The ratio of nurses to students increased from 1 nurse to every 440 students to 1 nurse to every 355 students.

99% Appropriately staffed schools

131 FTE School-based Nurses

1:355 Nurse to student-ratio

(Source: Health Services)
Increasing capacity of school-based staff to deliver high-quality nursing services

Professional Development  
BPS Health Services provided monthly professional development programs through February 2020 with an average participation rate of 20%. Additional professional development opportunities for school nurses included diabetes education through Joslin Diabetes Center; Asthma and Life-Threatening Allergies with Children’s Hospital and BPHC Asthma Prevention Control. In February, 44 school nurses attended the Community Health Learning Series: Asthma, Allergy and Care Coordination.

BPS Nurses are required to receive 18 hours of professional development by attending monthly exemplar practice PD. This information is currently tracked at the school level; ways to measure district-wide compliance centrally are underway.

Changes in Technical Assistance for School Nurses

BPS Health Services received funding through the Comprehensive School Health Services (CSHS) grant, with the goal of building on the centralized capacity-building infrastructure. The primary focus of this grant is to address coordination of care for students with chronic health conditions. As a result, Care Coordination support nurse positions were created to provide technical assistance and support for school nurses caring for students with chronic conditions. These positions were advertised but not filled given challenges related to the COVID-19 pandemic.

Student Health Records and Compliance

Figure 9.1 Schools with immunization compliance rate in the following categories. 73 schools had a 90% or greater of immunization compliance among students.

<table>
<thead>
<tr>
<th>Immunization Compliance Rate</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 90%</td>
<td>73</td>
</tr>
<tr>
<td>85-89%</td>
<td>20</td>
</tr>
<tr>
<td>&lt; 85%</td>
<td>32</td>
</tr>
</tbody>
</table>

Source: Health Services

Figure 9.2 Percent of student with diabetes, sickle cell, and life-threatening allergies that have completed Individual Health Care Plan (IHCP) on file. These plans are an important component of providing care to students with chronic conditions.

Source: Health Services
Direct Student Services

School Nurse Activities

Direct services to students were only recorded in SNAPNurse through March. At that time, encounters in each area were similar to the SY17-18 totals. As with SY17-18 the most common reason for school nurse visits were treatments and medications; and acute disease management.

### Comparison of school nurse activities completed in SY2017-18 and SY2019-20

<table>
<thead>
<tr>
<th>Type</th>
<th>SY17-18</th>
<th>SY19-20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>69,281</td>
<td>50,291</td>
</tr>
<tr>
<td>Illness management</td>
<td>141,682</td>
<td>107,398</td>
</tr>
<tr>
<td>Chronic illness mgmt</td>
<td>15,503</td>
<td>13,568</td>
</tr>
<tr>
<td>Treatments and medications</td>
<td>233,192</td>
<td>139,080</td>
</tr>
<tr>
<td>Case management</td>
<td>130,460</td>
<td>106,510</td>
</tr>
</tbody>
</table>

(Source: SNAPNurse)

91% of students visiting the school nurse are returning to class for learning

Source: SNAPNurse

### Nursing Remote Learning Innovations

School nurses quickly shifted to supporting students and families within their school communities by:

- Delivering food, school supplies, and computers
- Participating in their school's newly developed Equity Round Table
- Continuing their participation on Student Support Teams
- Holding Virtual Health Office hours and creating Virtual Health Offices in order to elevate important information and resources to students and families

Several BPS school nurses also worked with BPHC Infectious Disease Bureau to support contact tracing efforts. This work began during the school year and carried on throughout the summer.

In preparation for school reopening, a group of school nurses worked to develop COVID protocols and staff training with Boston Children’s Hospital’s Global Health Unit and Pediatric Primary Care Team.

### Improving school-wide Management of Chronic Diseases and Illness

The primary focus of CSHS grant is to address coordination of care for students with chronic health conditions. The priority in the first year of this grant was to increase care management supports for students with chronic illness.

The Nurse Liaison for Students with Special Health Care continues to support this work. The primary responsibilities of this role are to perform nursing assessments for students entering BPS with identified special health care needs, collaborate with the Special Education department, and work with private duty nursing agencies to secure 1:1 nursing support and provide technical assistance to school nurses.

### Student Health Services Referrals

School nurses completed a total of 23,248 referrals to outside care including 129 referrals to school-based health centers.

Source: SNAPNurse

### Student and Community Education

BPS Nurses held 1:1 sessions with students to provide counseling on behavioral health and general health promotion.

### Number of visits and students reached via 1:1 sessions by topic

<table>
<thead>
<tr>
<th></th>
<th>Visits</th>
<th>Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>8,313</td>
<td>3,912</td>
</tr>
<tr>
<td>General Health</td>
<td>72,657</td>
<td>27,245</td>
</tr>
</tbody>
</table>

(Source: SNAPNurse)
School Health Screenings

School Health screenings serve as an important early intervention on health barriers to learning. Schools are required to provide vision, hearing, body mass index (BMI), postural, and Brief Intervention and Referral to Treatment (SBIRT) health screenings to all students. 22% of students were referred for failed hearing or vision screenings. Slightly over 5% of students completed those referrals.

Provisions of Sexual Health Services and Referrals

According to the 2020 Principal School Health Profiles Survey, nurses at BPS High Schools (grades 9-12) were more likely to provide sexual health services and referrals when compared to all schools with grades 6 through 12. Blanks in the table represent items not included in the survey. Improvement in referrals for these services is need across all schools serving students in grades 6-12.

<table>
<thead>
<tr>
<th>Percentage of schools that provide students with the following services and/or referrals</th>
<th>Services</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Schools (gr. 6-12)</td>
<td>High Schools</td>
<td>All Schools (gr. 6-12)</td>
</tr>
<tr>
<td>HIV testing</td>
<td>13%</td>
<td>38%</td>
</tr>
<tr>
<td>HIV treatment</td>
<td>8%</td>
<td>23%</td>
</tr>
<tr>
<td>nPEP (non-occupational post-exposure prophylaxis for HIV)</td>
<td>44%</td>
<td>77%</td>
</tr>
<tr>
<td>PrEP (pre-exposure prophylaxis for HIV)</td>
<td>43%</td>
<td>77%</td>
</tr>
<tr>
<td>STD testing</td>
<td>17%</td>
<td>52%</td>
</tr>
<tr>
<td>STD treatment</td>
<td>13%</td>
<td>36%</td>
</tr>
<tr>
<td>Pregnancy testing</td>
<td>13%</td>
<td>36%</td>
</tr>
<tr>
<td>Provision of condoms</td>
<td>41%</td>
<td>100%</td>
</tr>
<tr>
<td>Provision of condom-compatible lubricants</td>
<td>14%</td>
<td>47%</td>
</tr>
<tr>
<td>Provision of contraceptives other than condoms</td>
<td>8%</td>
<td>23%</td>
</tr>
<tr>
<td>Prenatal care</td>
<td>10%</td>
<td>32%</td>
</tr>
<tr>
<td>Human papillomavirus (HPV) vaccine administration</td>
<td>6%</td>
<td>14%</td>
</tr>
<tr>
<td>Assessment for substance use, abuse, or dependency</td>
<td>58%</td>
<td>82%</td>
</tr>
<tr>
<td>Alcohol or other drug abuse treatment</td>
<td>68%</td>
<td>100%</td>
</tr>
<tr>
<td>Daily medication administration for students with chronic health conditions</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>“As needed” medication for a health emergency</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>Case management for students with chronic health conditions</td>
<td>89%</td>
<td>91%</td>
</tr>
</tbody>
</table>
Condom Accessibility  (Source: OHW)
The BPS Condom Accessibility Policy states that all BPS high schools must have an active Condom Accessibility Team (CAT). CATs should have at least the following three roles represented on the team: school nurse(s); a school administrator; and a school-based staff member. Schools are encouraged to add more members to their CAT to create more access points within the school.

CATs have two primary responsibilities: 1) to make condoms available to BPS high school students who are not opted out of the program; and 2) to provide appropriate sexual and reproductive health care referrals for students seeking to access sexual health services. To gain expertise and skills in health care referrals, all CAT members must complete the CAT training. Over Summer 2020, a self-paced, virtual training was developed for CAT members.

Referrals for sexual health services and condom dispersal was only tracked within 18 Empowering Teens through Health (ETTH) priority schools. ETTH, a grant managed by Health and Wellness, aims to prevent HIV/AIDS, STIs, and teen pregnancy through access to sexual health education, sexual health services, and safe and supportive school environments.

Menstrual Access Program
The BPS Menstrual Access Program (MAP) aims to promote menstrual equity by providing schools with grades 6-12 with free menstrual products. Research shows that 1 in 5 female students have missed school due to lack of period protection.1 To ensure that no students miss school due to lack of access to menstrual products, the City of Boston granted the BPS Health Services $100,000 to implement a pilot program.

BPS Health Services designed the Menstrual Access Pilot Program for school year 2019-2020. 77 schools participated in the pilot program and were delivered Always and Aunt Flow pads. The menstrual products started off in the school nurse’s office and each school nurse was expected to create a team of school staff, who would each have menstrual products available for students. The teams were meant to increase the access points for products in their school.

An education pamphlet, promotional flyers, and promotional posters were developed, translated and given to the 77 schools to raise program awareness. The educational pamphlet described the pilot program and offered instructions on how to use a pad, how to dispose of a pad, and ways to take care of yourself when menstruating. The products purchased and the information in the educational pamphlet were chosen based on focus group feedback from menstruating students at BPS.

Vision Boston
A pilot program in partnership with New England College of Optometry (NECO), 2020 Onsite, and Warby Parker, offered BPS students in grades 4 through 12 free, comprehensive vision examinations and eyeglasses in January 2020. (Source: Health Services)

13 BPS schools participated (selected for their need, opportunity index scores, and strength of program support at the school level)
1,887 students were screened by BPS staff and NECO
450 eye exams were performed over 20 days
291 pairs of free Warby Parker glasses were dispensed; free glasses were also provided to students in K-3 with an up-to-date eyeglasses’ prescription.

73 Sexual Health Referrals at ETTH priority schools
876 Condoms dispersed at ETTH priority schools
3,767 School nurse visits for menstrual product distribution (Sept-March)

1 Always Confidence and Puberty Wave VI Study, Nov. 2017
Community Partner Services

School-based Health Centers

School-Based Health Centers (SBHCs) are converted school spaces which operate as fully-functional medical offices to provide comprehensive, trauma-informed health care to students where they are – at school. SBHCs aim to address inequitable access to healthcare, particularly those who are disconnected from the health care system or are uninsured or underinsured.

Of SBHCs operated by BPHC, approximately 37% of students are enrolled in the program, consistent with previous years. Over 59 average daily visits prior to school closure; mental health clinicians were the most frequently visit providers. A total of 5,430 students were seen.

### School-Based Health Centers

<table>
<thead>
<tr>
<th>SBHC Sites</th>
<th>Operating Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCLA / New Mission</td>
<td></td>
</tr>
<tr>
<td>Boston Latin Academy</td>
<td></td>
</tr>
<tr>
<td>Brighton High</td>
<td>Boston Public Health Commission</td>
</tr>
<tr>
<td>Burke</td>
<td></td>
</tr>
<tr>
<td>Madison Park</td>
<td></td>
</tr>
<tr>
<td>Snowden</td>
<td></td>
</tr>
<tr>
<td>Tech Boston</td>
<td>Codman Square CHC</td>
</tr>
<tr>
<td>Charlestown High</td>
<td>North End Waterfront Health</td>
</tr>
<tr>
<td>Blackstone Elementary</td>
<td>South End CHC</td>
</tr>
<tr>
<td>Young Achievers K-8</td>
<td>Mattapan CHC</td>
</tr>
</tbody>
</table>

**Figure 9.4 BPHC average monthly utilization by provider at the BPS SBHC** (Source: BPHC)

- **Health Educator**: 1021 (SY18-19), 491 (SY19-20)
- **Mental Health Clinician**: 3399 (SY18-19), 2965 (SY19-20)
- **Nurse Practitioner/Physician Assistant**: 3615 (SY18-19), 1974 (SY19-20)

Health Resource Centers

The Health Resource Centers (HRC) are a collaboration between the Boston Public Health Commission and Boston Public Schools to bring sexual health education, in-school health counseling, and referrals to community health care resources to students at Boston Arts Academy, CASH, Excel, Another Course to College, O’ Bryant, Fenway, and English High School. HRCs held office hours and outreach events during Sept to mid-March.

- 7 HRCs at BPS Schools
- 665 Students educated
- 6,212 Students came to office hours and outreach events
- 140 condom packets distributed
- 34 STI tests conducted at 3 school sites.

(Source: Health Services)

Additional Community Partnerships

Compared to SY2017-18, far fewer schools partnered with primary healthcare and dental health care agencies. However, these disparities may be due to the COVID pandemic and school closures. We also acknowledge that while the numbers here only represent those agencies registered in the partnership portal, our schools may partner with many other health service providers within their communities.

**Number of community agencies providing health services and number of receiving schools by type.**

<table>
<thead>
<tr>
<th>Services</th>
<th>Agencies</th>
<th>Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Care</td>
<td>2</td>
<td>unknown</td>
</tr>
<tr>
<td>Vision Care</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
<td>Dental Health</td>
<td>3</td>
<td>22</td>
</tr>
</tbody>
</table>

(Source: Partnership Portal)
Policy Overview
The Boston Public Schools cares about the well-being of staff members and understands the influence that staff actions have on all student health behaviors. All staff shall promote a school environment supportive of healthy behaviors. Adults are encouraged to model healthy behaviors, especially on school property and at school-sponsored meetings and events. Schools are encouraged to support staff wellness initiatives.

Strategic Vision Commitment 5: Cultivate Trust
The Boston School Committee approved the BPS 2020-2025 Strategic Vision presented by Superintendent Cassellius on April 29, 2020. One of the priorities of Commitment 5 is that in order to cultivate trust through caring and competent staff that reflect our students and are focused on service, we must make BPS a place where educators and staff want to be employed because they feel valued and supported in their work. District leaders are working on an organizational culture survey to help guide coordinated, strategic efforts to improve staff well-being.

School Closure & Supports to Staff
School closures in March 2020 created heightened stress and concern among staff for both health and safety of themselves and their students, while also completely upending normal operations and modes of teaching and learning. The Teacher Culture & Climate Survey was administered as usual; a tailored survey was sent to teachers in the spring to ask about remote learning after the close of schools (n=2,362; Source: ODA). The survey guided school-based and district support for developing remote teaching skills and connecting with colleagues, students, and families.

42% Felt favorably about their ability to teach virtually
39% Believed they could foster academic rigor in a virtual classroom
45% Thought they taught a well-rounded curriculum virtually
54% Had the technology and the confidence to use the tools to provide rigorous remote learning
82% Felt connected to their colleagues and were able to collaborate
61% Were in frequent communication with students’ families (though it was somewhat challenging)
Recruitment, Cultivation & Diversity (RCD) Programs

The RCD Team in the Office of Human Capital supports the district’s workforce diversity strategy by developing and delivering retention programming for educators of color and by partnering with other departments to promote their retention supports.

For the district to continue to reduce the racial/cultural and linguistic diversity gap between students and staff, BPS believes strategic change is needed at both the central office and individual schools. All of our efforts to recruit highly effective and racially, culturally, and linguistically teachers and school leaders are futile if we do not have a similar and robust effort to retain and develop these educators.

(Source: OHC-RCD)

SY19-20 Retention Strategies

• Executive Coaching Leadership Programs for Women Educators of Color (WEOC) & Male Educators of Color (MEOC)
• ALANA (African, Latinx, Asian, and Native American) Educators Program
• School Leaders of Color Network
• Central Office Affinity Groups
• MTEL Prep and ESL Mentoring Program
• Educators of Color Monthly Newsletter
• Outreach & Individual License Support for Provisional Teachers
• Degree Completion Support (Higher Ed Partnerships)

Exemplar Staff Wellness Work: Frederick Middle School

The Lilla G. Frederick Middle School Wellness Council effectively collaborated to implement staff wellness in their school. The council sent out surveys to staff at the beginning of the school year to better understand what types of initiatives would most interest their colleagues. The survey revealed that many staff members wanted a relaxing space in the school that was only for staff. Many staff members also want to have a school-wide initiative that was related to their health and encouraged physical activity.

In collaboration with the school administration, the wellness council identified a classroom in their building that could be converted into a large staff lounge. The council emailed the school staff asking for donations to help set up the room. Staff enthusiastically responded and donated many items, including mini-fridges, Keurig coffee machines, electric tea pots, paper goods, books, a microwave, and decorations. They then worked to make the space feel welcoming. They created a “Wall of Fame” with each staff member’s favorite photo from the summer, and they posted a map of all the places staff had traveled. The staff lounge has a reading corner with a book suggestions board, and there is a bulletin board with staff updates and upcoming events. Staff have been able to use the lounge for celebrations, meals, and breaks during the day. They appreciate having a space where they can go to decompress.

The wellness council also facilitated a movement competition to encourage physical activity among staff and organized teams based on hallways. Participation and friendly competition was incentivized by offering a prize to the hallway and the individual with the highest average steps. The competition started in early March and was originally supposed to be three weeks, but they decided to continue the competition after school closures. After eight weeks of competition, the individual winner had an average of 76,937 steps per week with a total of 549,307 steps or 245 miles! Additionally, the council encouraged physical activity during quarantine with the “20for20 Challenge” on the school’s Instagram and Facebook pages. Council members, other staff, and school administrators posted videos of themselves doing 20 reps or 20 seconds of an exercise and challenged the students to do the same. The month and a half challenge inspired school-wide physical activity, camaraderie, and fun!

The Lilla G. Frederick greatly improved staff wellness within just one year thanks to a functional wellness council, dedicated council members, and the support of school administration and staff.
Student Impacts

When students have access to a safe, healthy, and sustaining learning environment that provides quality education, programs, and services, they will gain the knowledge and skills necessary to make healthy choices, ultimately leading to improved health outcomes. Through implementing aWSCC approach grounded in healthy equity, we expect to see an increase in the prevalence of protective behaviors, a decrease in the prevalence of risky behaviors, and improved social and emotional well-being and health outcomes. To understand the extent to which the District Wellness Policy impacts student health over time, the DWC selected key student outcome indicators aligned with the various components of the policy. The student-level outcomes presented here provide information on student behaviors, student health status, and student knowledge, skills, attitudes, and perceptions.

Youth Risk Behavior Survey (YRBS)

Youth Risk Behavior Survey

The YRBS is a component of the CDC’s national surveillance system and is used to monitor critical health-related behaviors of adolescents. The surveys are conducted biennially in a randomized sample of students. High school students complete anonymous surveys in the spring of odd-numbered years and the middle school students in the fall of odd-numbered years. The most recent weighted results available are from 2019.

Results of the YRBS provide data for three major student-level outcomes: (1) reducing the prevalence of risk behaviors, including sexual risk behaviors, substance use, and sedentary behaviors; (2) increasing the prevalence of protective behaviors, including increasing physical activity and positive dietary behaviors; and (3) improving social and emotional well-being by increasing school connectedness, decreasing violence, injury, and bullying, and reducing self-harm and suicidality.

The high school YRBS results for these key student impacts are displayed in the following tables. Each table presents percentages for 2017 and 2019, and any significant subgroup differences by sex¹, race², and sexual orientation³. Significant changes from 2017 to 2019 are indicated by an asterisk and color coded: green indicates an improvement and orange indicates an adverse change. See Appendices F for detailed table of comparisons of 2019 BPS, state, and national data and Appendix G for 2019 BPS subgroup differences by sex, race/ethnicity, and sexual identity. Middle School YRBS is shared at the end of section.

Sexual Health

Boston has seen many positive long-term trends regarding sexual health behaviors despite seeing small increases in risky sexual behaviors since 2015 (Table 11.1). Since 1993, there have been statistically

¹ 49% Female students (F); 51% Male students (M).
² 34% Black students (B); 41% Hispanic/Latinx Students (L); 10% Asian Students (A); and 12% White students (W).
³ 15% Lesbian, gay, or bisexual students (LGB); 80% Straight students; 1.4% of BPS students identify as transgender and 1.5% are unsure if they are transgender, this subgroup population is too small to include in statistical analysis.
significant, long-term decreases in the percentage of students who have ever had sexual intercourse (60.6% to 37.6%); students who are currently sexually active (42.0% to 26.4%); students who have had four or more sexual partners in their life (25.9% to 11.0%); and students who have been pregnant or gotten someone else pregnant (11.1% to 5.7%). There are disparities between LGB students and their straight peers and Black and Latinx students compared to their white and Asian peers in each of four sexual risk behaviors (Table 11.1). There was a significant increase in students who have been tested for HIV or AIDS; female students and Black and Latinx students were more likely to engage in this protective behavior than their male and White and Asian counterparts.

<table>
<thead>
<tr>
<th>Percentage of students who…</th>
<th>2017 %</th>
<th>2019 %</th>
<th>2019 Significant Subgroup Differences (more likely than)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intended Outcome: Decrease Risky Sexual Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever had sexual intercourse</td>
<td>43.2</td>
<td>37.6</td>
<td>B&gt;A; B&gt;W; L&gt;A; L&gt;W LGB&gt;Straight</td>
</tr>
<tr>
<td>Were currently sexually active (at least once in previous 3 months)</td>
<td>30.6</td>
<td>26.4</td>
<td>B&gt;A; L&gt;A; L&gt;W LGB&gt;Straight</td>
</tr>
<tr>
<td>Had intercourse with 4+ persons during their life</td>
<td>12.4</td>
<td>11.0</td>
<td>M&gt;F B&gt;A; L&gt;A; L&gt;W</td>
</tr>
<tr>
<td>Had been pregnant or gotten someone pregnant</td>
<td>4.1</td>
<td>5.7</td>
<td>B&gt;A; B&gt;W; L&gt;W LGB&gt;Straight</td>
</tr>
<tr>
<td><strong>Intended Outcome: Increase Protective Sexual Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used a condom during last sexual intercourse (among students who were currently sexually active)</td>
<td>52.2</td>
<td>52.0</td>
<td>Straight&gt;LGB</td>
</tr>
<tr>
<td>Used effective hormonal birth control to prevent pregnancy during last sexual intercourse (among students who were currently sexually active)</td>
<td>36.3</td>
<td>28.3</td>
<td>None</td>
</tr>
<tr>
<td>Used a condom and effective hormonal birth control during last sexual intercourse (among students who were currently sexually active)</td>
<td>8.5</td>
<td>6.0</td>
<td>None</td>
</tr>
<tr>
<td>Were ever tested for HIV (not including tests done when donating blood)</td>
<td>16.4</td>
<td>23.5*</td>
<td>F&gt;M B&gt;A; B&gt;W; L&gt;A; L&gt;W</td>
</tr>
<tr>
<td>Were tested for a STD other than HIV (in the past 12 months)</td>
<td>--</td>
<td>20.1</td>
<td>F&gt;M B&gt;A; B&gt;W; L&gt;A; L&gt;W</td>
</tr>
</tbody>
</table>

- Indicates data not available; * Indicates a significant difference as compared to 2015 based on t-test analyses, p<.05
1 Effective hormonal birth control defined here as birth control pills, an IUD or implant, a shot, a patch, or a birth control ring

![Table 11.1](https://example.com/table11.1)

Table 11.1. High School YRBS Results: Prevalence of risk behaviors related to sexual health. The green data points indicate an improved change. Reported 2017-2019 changes and subgroup analysis were completed by Westat on behalf of the CDC (Source: YRBS)

The prevalence of the use of pregnancy and HIV/STD protection among sexually active students have not improved since 2017. Between 1993-2005, there was a significant increase in the percentage of students who used a condom during the last sexual intercourse (63.9% to 74.2%). However, the percentage has continued to significantly decrease between 2005-2019. Just over half of sexually active students reported using a condom during last sexual intercourse. Additionally, 72% of sexually active students did not use an effective hormonal birth control method and 94% did not use both condoms and effective hormonal birth control to prevent pregnancy and HIV and STDs (Table 11.1). BPS students
were significantly less likely to engage in these protective behaviors than their peers in MA (Appendix F). The percentage of students who have ever been tested for HIV significantly increased from 2017, though there remains a significant long-term decrease in testing since 2009. In 2019, we began asking about testing for other STDs (such as chlamydia or gonorrhea) in the past 12 months. Both Female students and Black and Latinx students are significantly more likely to engage in testing behaviors compared to their male and Asian and white peers, respectively. Students in BPS were more likely than their peers in both MA and the nation to engage in testing behaviors (Appendix F).

**Middle School YRBS Data:** About 8% of middle school students have ever had sexual intercourse, 3.2% before the age of 11 years and 2.3% ever had sexual intercourse with three or more persons (significant increase from 2017, 1.2%).

### Substance Use

<table>
<thead>
<tr>
<th>Intended Outcome: Decrease Substance Use</th>
<th>2017 %</th>
<th>2019 %</th>
<th>2019 Significant Subgroup Differences (more likely than)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently smoked cigarettes</td>
<td>3.1</td>
<td>2.8</td>
<td>L&gt;W</td>
</tr>
<tr>
<td>Currently used electronic vapor products</td>
<td>5.7</td>
<td>12.2*</td>
<td>L&gt;B; W&gt;B</td>
</tr>
<tr>
<td>Currently drank alcohol</td>
<td>22.9</td>
<td>21.2</td>
<td>W&gt;A; W&gt;B; W&gt;L</td>
</tr>
<tr>
<td>Currently were binge drinking</td>
<td>10.5</td>
<td>9.8</td>
<td>W&gt;A; W&gt;B</td>
</tr>
<tr>
<td>Currently used marijuana</td>
<td>24.4</td>
<td>22.6</td>
<td>L&gt;A; W&gt;A</td>
</tr>
<tr>
<td>Ever took prescription pain medication without a doctor’s prescription or differently from how a doctor told them to use it</td>
<td>8.9</td>
<td>11.3</td>
<td>B&gt;L; B=W; LGB&gt;Straight</td>
</tr>
</tbody>
</table>

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*Indicates data not available; * Indicates a significant difference as compared to 2015 based on t-test analyses, p<.05

Table 11.2. High School YRBS Results: Prevalence of risk behaviors related to substance use. The orange data points indicate an adverse change. Reported 2017-2019 changes and subgroup analysis were completed by Westat on behalf of the CDC (Source: YRBS)

Most substance use among students in Boston is lower when compared to state and national data. Students in Boston are statistically more likely than their peers across the state and the nation to not smoke cigarettes, use electronic vapor products (EVP), drink alcohol, binge drink, or misuse prescription pain medication (see Appendix F). There have been significant decreases in students who currently smoked cigarettes (20.9% in 1993 to 2.8%) and drank alcohol (40.1% in 1993 to 21.2%). The exception is current marijuana use: There has been a statistically significant increase since 1993 (17.8% to 22.6%); there is no significant difference in current marijuana use between students in BPS, MA, and the nation. It is important that we keep an eye on the emerging trend of vaping tobacco products; there was a significant increase in vaping prevalence, doubling from 2017 to 2019 (Table 11.2). However, vaping prevalence among BPS students is 20 percentage points less than MA and nationally. Figure 1 shows the differences in substance use or misuse by race and ethnicity; Table 11.2 delineates where the significant differences between subgroups exist. White students are more likely to currently drink alcohol than Black, Latinx, and Asian students, and more likely to binge drink than Asian and Black

---

*The question changed from asking had they ever been tested for STDs other than HIV to asking had they been tested for STDs other than HIV in the past 12 months.*
students. Latinx and White students were more likely than Black students to vape nicotine products and more likely than Asian students to use marijuana. There is no significant difference between Black students and their peers in current cigarette and marijuana use; Black student were more likely to misuse prescription pain meds than their Latinx and White peers.

**Figure 11.1** Percentage of BPS high school students that currently used (at least once in the past 30 days before the survey) tobacco, nicotine, alcohol, or marijuana or ever misused prescription pain medication by race/ethnicity (Source: 2019 YRBS).

**Middle School YRBS Data:** 1.4% of BPS middle school student currently smoked cigarettes; 7.6% currently used EVP; 5.4% currently drank alcohol; 5.9% currently used marijuana; and 12.2% ever misused prescription pain medication (significant increase from 2017, 7%). Current cigarette use, alcohol drinking, and marijuana use have all significantly decreased since 2013 (3%, 11%, and 10%, respectively).

**Unintentional Injury & Violence**

There were no significant changes between 2017-2019 for violence victimization, injury, and bullying (Table 11.3). BPS has seen significant long-term decreases since 1993 among students who did not go to school because they felt unsafe at school or on their way to or from school (14.4% to 7.5%); students who carried a weapon on school property (15.8% to 3.6%); students who were threatened or injured with a weapon on school property (12% to 5.3%); and students who were in a physical fight on school property (15.2% to 8.1%). There have been no significant changes in the percent of students bullied on school property since 2011 (11.2%) or electronically bullied since 2009 (9.1%); MA shows significantly higher rates than Boston in both forms of bullying (16.3% and 13.9%; Appendix F). Looking at the trend data for sexual and dating violence victimization, there has been no significant change in the prevalence of students who experienced physical and sexual dating violence since we started collecting
the data in 2013 or the percent of students who were ever physically forced to have sexual intercourse when they did not want to since 2009. Students who identify as gay, lesbian, or bisexual are more likely than students who identify as heterosexual to experience sexual violence victimization, injury, and bullying (see Appendix G).

<table>
<thead>
<tr>
<th>Intended Outcome: Decrease Violence Victimization, Injury &amp; Bullying</th>
<th>2017 %</th>
<th>2019 %</th>
<th>2019 Significant Subgroup Differences (more likely than)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not go to school because they felt unsafe at school or on their way to or from school (on at least 1 day in the last 30 days)</td>
<td>5.9</td>
<td>7.5</td>
<td>LGB&gt;Straight</td>
</tr>
<tr>
<td>Carried a weapon on school property (in the last 30 days)</td>
<td>3.5</td>
<td>3.6</td>
<td>B&gt;A; B&gt;W; L&gt;A; L&gt;W</td>
</tr>
<tr>
<td>Were threatened or injured with a weapon on school property (in the last year)</td>
<td>5.7</td>
<td>5.3</td>
<td>None</td>
</tr>
<tr>
<td>Were in a physical fight on school property (in the last year)</td>
<td>7.2</td>
<td>8.1</td>
<td>B&gt;A</td>
</tr>
<tr>
<td>Were bullied on school property (in the last year)</td>
<td>10.6</td>
<td>11.2</td>
<td>F&gt;M</td>
</tr>
<tr>
<td>Were electronically bullied (in the last year)</td>
<td>9.2</td>
<td>9.1</td>
<td>LGB&gt;Straight</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Intended Outcome: Decrease Sexual &amp; Dating Violence Victimization</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced physical dating violence (in the last year)</td>
<td>7.5</td>
<td>6.3</td>
<td>None</td>
</tr>
<tr>
<td>Experienced sexual dating violence (in the last year)</td>
<td>10.3</td>
<td>11.5</td>
<td>F&gt;M</td>
</tr>
<tr>
<td>Were ever physically forced to have sexual intercourse (when they did not want to)</td>
<td>8.2</td>
<td>9.2</td>
<td>F&gt;M; B&gt;W; L&gt;W</td>
</tr>
</tbody>
</table>

-- Indicates data not available; * Indicates a significant difference as compared to 2015 based on t-test analyses, p<.05

Table 11.3. High School YRBS results: Prevalence of risk behaviors related to violence victimization, injury and bullying. There were no significant changes in prevalence. Reported 2017-2019 changes and subgroup analysis were completed by Westat on behalf of the CDC (Source: YRBS)

Middle School YRBS Data: 40% of students reported having ever been bullied on school property, 20.5% were ever electronically bullied (Significant increase from 2013, 16%); 11.6% experienced physical dating violence in the past year; 3.5% were ever forced to have sexual intercourse when they did not want to. 52% of students were ever in a physical fight and 16.5% had ever carried a weapon.

Social Emotional & Mental Health

The percentage of students who felt persistent sadness has increased significantly since 2015 (26.7% to 35%), reversing a decreasing trend from 1999 (32.2%) to 2015. The percentage of students who have seriously considered suicide and attempted suicide has significantly decreased since 1993 (23.7% to 15.6% and 13.5% to 9.3% respectively) though there have been significant increases in both since 2017 (Table 11.4). There has been no significant trend in the percentage of students who did something to purposely hurt themselves without wanting to die. Related to school connectedness, 58.2% of students agree or strongly agree that they feel close to people at their school (a new question asked in 2019); White students are more likely than Black, Latinx, or Asian students to report feeling close to people at school (see Appendix G). There are disparities among female students and students that identify as
lesbian, gay, or bisexual; they are more likely to experience persistent sadness, suicidality, and self-harm, compared to their male and straight counterparts respectively (Appendix G).

<table>
<thead>
<tr>
<th>Intended Outcome: Increase school connectedness</th>
<th>2017 %</th>
<th>2019 %</th>
<th>2019 Significant Subgroup Differences (more likely than)</th>
</tr>
</thead>
</table>
| Agreed or strongly agreed that they felt close to people at school | -- | 58.2 | M>F  
W>L; W>A; W>B |

<table>
<thead>
<tr>
<th>Intended Outcome: Decrease Sexual &amp; Dating Violence Victimization</th>
<th>2019 Significant Subgroup Differences (more likely than)</th>
</tr>
</thead>
</table>
| Felt depressed (sad or hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities) | 33.4 | 35.0 | F>M  
L>A; L>B  
LGB>Straight |
| Did something to purposely hurt themselves without wanting to die | 16.3 | 15.4 | F>M  
LGB>Straight |
| Seriously considered attempting suicide | 11.9 | 15.6* | F>M  
LGB>Straight |
| Attempted suicide | 5.6 | 9.3* | LGB>Straight |

-- Indicates data not available; * Indicates a significant difference as compared to 2015 based on available t-test analyses, p<.05  
1 During the 12 months before the survey

**Table 11.4.** High School YRBS results: Prevalence of risk behaviors related to school connectedness, suicidality, and self-harm. The orange data points indicate an adverse change. Reported 2017-2019 changes and subgroup analysis were completed by Westat on behalf of the CDC (Source: YRBS)

**Middle School YRBS Data:** 26.5% of BPS middle school students felt persistent sadness that impacted their day-to-day activities; 29% felt stressed most of the time or always (significant increase from 2013, 22%); 22.8% had ever seriously considered attempting suicide; and 11.2% had ever attempted suicide (significant increase from 2013, 8%). 45% of students rarely or never got the kind of help they needed when they felt sad, empty, hopeless, angry, or anxious.

**Physical Activity & Nutrition**

Lastly, healthy eating and physical activity behaviors have remained mostly stagnant (Table 11.5). We continue to see no significant change since 2011 in the percentage of students getting the recommended amount of physical activity (60 min per day) or students who have not been active for 60 minutes or more on any day in the past week (14.8%). BPS students were significantly less likely to get the recommended daily physical activity compared to MA and nationally (21.7% and 23.2%). There has been a significant positive trend in percentage of students who are not watching three or more hours of TV on an average school day since 1999 (49.1% to 79.3%), but student reporting three or more hours of screen time for video games or computer use has simultaneously significantly increased since 2007 (26.3% to 45.3%).

For healthy eating behaviors, there was a significant decrease in the number of students eating breakfast daily from 2017, continuing a negative trend since 2013 (33.3% to 24.7%); there has been no change in the percent of students not eating breakfast on all 7 days since 2009 (15.7% to 17.5%). BPS
students are significantly less likely to eat breakfast daily compared to students in MA (30.8%) and nationally (33.1%). There has been a decrease in daily fruit consumption (57.1% in 2009 to 26.8%), no change in daily vegetable consumption, and a significant decrease in drinking one or more glasses of milk (32.9% in 2009 to 22.6%). On the plus side, we have seen significant increase since 2007 in the percentage of students who do not drink soda (17.1% to 29.4%) and no change in the 87% of students who do not drink sugar-sweetened beverages (not counting soda).

<table>
<thead>
<tr>
<th>Percentage of students who…</th>
<th>2017 %</th>
<th>2019 %</th>
<th>2019 Significant Subgroup Differences (more likely than)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intended Outcome: Increase in Physical Activity &amp; Decrease Sedentary Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were physically active at least 60 minutes per day on all 7 days</td>
<td>15.5</td>
<td>14.8</td>
<td>M&gt;F W&gt;A; W&gt;B</td>
</tr>
<tr>
<td>Did not participate in at least 60 min of physical activity on any day</td>
<td>27.5</td>
<td>25.6</td>
<td>F&gt;M A&gt;W; B&gt;W; L&gt;W</td>
</tr>
<tr>
<td>Did not watch 3+ hours of TV (on an average school day)</td>
<td>76.3</td>
<td>79.3</td>
<td>B&lt;A; L&lt;A; L&lt;W</td>
</tr>
<tr>
<td>Did not play video or computer games or used a computer 3+ hours per day (for something that was not schoolwork, on an average school day)</td>
<td>55.9</td>
<td>54.7</td>
<td>None</td>
</tr>
<tr>
<td><strong>Intended Outcome: Increase Positive Dietary Choices</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ate breakfast daily (in the past week)</td>
<td>29.4</td>
<td>24.7*</td>
<td>M&gt;F W&gt;B; W&gt;L Straight&gt;GLB</td>
</tr>
<tr>
<td>Ate fruit or drank 100% fruit juices 2+ times per day (in the past week)</td>
<td>28.2</td>
<td>26.8</td>
<td>W&gt;A; W&gt;B; W&gt;L</td>
</tr>
<tr>
<td>Ate vegetables 2+ times daily (in the past week)</td>
<td>19.7</td>
<td>20.4</td>
<td>A&gt;L; W&gt;A; W&gt;B; W&gt;L</td>
</tr>
<tr>
<td>Drank 3+ glasses of water daily (in the past week)</td>
<td>46.3</td>
<td>49.5</td>
<td>L&gt;B; W&gt;B</td>
</tr>
<tr>
<td>Drank 1+ glasses of milk daily (in the past week)</td>
<td>24.9</td>
<td>22.6</td>
<td>M&gt;F W&gt;B; W&gt;L</td>
</tr>
<tr>
<td>Did not drink a soda (in the past week)</td>
<td>30.1</td>
<td>29.4</td>
<td>F&gt;M A&gt;B; A&gt;L; W&gt;L</td>
</tr>
<tr>
<td>Did not drink a sugar-sweetened beverage† (in the past week)</td>
<td>86.2</td>
<td>87</td>
<td>L&lt;A</td>
</tr>
</tbody>
</table>

-- Indicates data not available; * Indicates a significant difference as compared to 2015 based on available t-test analyses, p<.05; † Sugar-sweetened beverages do not include soda or 100% fruit juice

Table 11.5. High school YRBS results: Prevalence of protective health behaviors related to physical activity and dietary behaviors. The orange data points indicate an adverse change. Reported 2017-2019 changes and subgroup analysis were completed by Westat on behalf of the CDC (Source: YRBS)
Asthma

19.8% of students screened in Grades 1, 4, 7, and 10 have asthma (SNAPNurse). The percent of students with asthma increases at each grade level (Table 11.6). Of the students that have asthma, 44.4% are Hispanic/Latinx, 33.4% are Black, 10% are White, 8.4% are Asian, 3.5% are Multiracial, and 0.4% are Native American or Pacific Islander.

Figure 4 compares the percent of students with asthma by race/ethnicity. Among students enrolled in grades 1, 4, 7, and 10, 22% of multiracial students, 21% of Black students, 20% of Asian students, and 20% of Hispanic/Latinx students have asthma. Fourteen percent of White students and 15% of Native American and Pacific Islander students in those grades have asthma, suggesting they are less likely than the other student groups to have asthma. No statistical analysis was conducted on this data to compare differences among subgroups.

Body Mass Index

Body Mass Index (BMI) is used here as a public health surveillance measure. BMI is calculated by dividing a person's weight in kilograms by the square of height in meters. For children and teens, BMI is age- and sex-specific. The CDC states, “A child’s weight status is determined using an age- and sex-specific percentile for BMI rather than the BMI categories used for adults. This is because children’s body composition varies as they age and varies between boys and girls. Therefore, BMI levels among children and teens need to be expressed relative to other children of the same age and sex.” Obesity is defined as a BMI at or above the 95th percentile for children and teens of the same age and sex.; overweight is defined as a BMI at or above the 85th percentile and below the 95th percentile; underweight is defined as a BMI less than the 5th percentile; and healthy weight is defined as a BMI at the 5th percentile to less than the 85th percentile (CDC).

Table 11.6. Percent of students with asthma by grade. Students are screened for asthma by nurses in Grades 1, 4, 7, and 10 (Source: SNAPNurse)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade 1</td>
<td>15.3%</td>
</tr>
<tr>
<td>Grade 4</td>
<td>20.1%</td>
</tr>
<tr>
<td>Grade 7</td>
<td>21.5%</td>
</tr>
<tr>
<td>Grade 10</td>
<td>22.5%</td>
</tr>
<tr>
<td>All Grades</td>
<td>19.8%</td>
</tr>
</tbody>
</table>

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5 Division of Nutrition, Physical Activity, and Obesity, National Center for Chronic Disease Prevention and Health Promotion, [https://www.cdc.gov/obesity/childhood/defining.html](https://www.cdc.gov/obesity/childhood/defining.html)
BPS School nurses measure BMI in grades 1, 4, 7, and 10 each year. In SY17-18, 70% of Grade 1, 68% of Grade 4, 57% of Grade 7, and 49% of Grade 10 students were screened for BMI, similar to SY15-16. In SY19-20, 66.5% of Grade 1, 66.7% of Grade 4, 61.2% of Grade 7, and 36.9% of Grade 10 were screened for BMI, 57.9% of all students in those grades (SNAPNurse). No statistical analysis was conducted on this data to compare changes over time or differences among subgroups.

In SY19-20, 2.0% of student were considered underweight, 57.4% healthy weight, 16.9% overweight, and 23.7% obese (SNAPNurse). Overall, 41% of students in the district were either overweight or obese. These percentages have neither increased nor decreased drastically since 2013 (Figure 5).

When the percent of students in each weight category is compared by gender and by grade (Figure 6, next page), the data show some differences across the grade levels. There are more students in the healthy weight category in Grade 10 and fewer in the overweight or obese categories compared to all other grades. There are higher percentages of students, both male and female, in the overweight and obese categories in Grades 4 and 7. There are differences between male and female students in Grades 4 and 10. In Grade 4, there are fewer male students in the healthy weight range (50.9%), and more were in the obese category (29.9%) compared to the female students (57.2% and 23.1% respectively). In Grade 10, there are slightly more male students in the healthy weight range (68.1%), fewer in the overweight category (11.5%), and more in the underweight category (3.6%) compared to female students (66.7%, 14.5%, and 1.9% respectively). When comparing all male students screened to all female students screens, there are not major differences in the percentages in each weight status category (Figure 6, next page).

On the following page, Figure 7 illustrates the differences in percent of BPS students in Grades 1, 4, 7, and 10 screened for BMI within the four weight status categories by race/ethnicity (SNAPNurse). Native American and Pacific Islander student have the greatest percent of students within the healthy weight range (70.7%), followed by White students (69.2%), multiracial students (69.7%), and Asian students (64.8%); Black students and Hispanic/Latinx students have the lowest percent of students within the healthy weight category (53.6% and 54.2% respectively). 44.4% of Black students and 44.2% of Hispanic/Latinx students fall within the overweight or obese categories, a greater percentage than multiracial students (30.7%), Asian students (29.8%), White students (29.4%), and Native American and Pacific Islander students (29.3%; SNAPNurse). White students have the lowest percent of students within the obese category (13.2%), and Native American and Pacific Islander students have the lowest
percent of students within the overweight category (9.8%). Lastly, Asian students have the greatest percent of students within the underweight category (5.4%), followed by Black students (2.1%), Hispanic/Latinx students (1.6%), White students (1.4%), and multiracial students (0.6%); no Native American or Pacific Islander students screened were considered underweight (Figure 7). Statistical analysis is needed to determine the statistical significance of these differences.

Figure 11.4 Percent of BPS students (Grades 1, 4, 7, and 10) screened for BMI within the four weight status categories by grade and by sex. (Source: SNAPNurse)

Figure 11.5 Percent of BPS students (Grades 1, 4, 7, and 10) screened for BMI within the four weight status categories by race/ethnicity. (Source: SNAPNurse)
Culture & Climate Survey

The MCIEA Culture & Climate Survey and the Student Feedback Survey administrations were interrupted by school closures in March 2020. As a result, the program ended earlier than planned and results are incomplete. To promote the voice of students who did complete the survey, results are available for schools who had at least 7 responses and a response rate of at least 10%. Additionally, the data were compiled differently from the SY17-18 Annual Report. For each question, students were asked to respond using a 5-point scale where responses 1-3 of the scale were considered least favorable (e.g., 1= “not at all important”, 2= “slightly important”, and 3= “somewhat important”) and responses 4 and 5 were considered “favorable” (e.g., 4= “quite important” and 5= “extremely important”). The table below represents district-level favorable results for each category and question (n=5,406).

<table>
<thead>
<tr>
<th>Student Value of Learning in School</th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Valuing of Learning</strong></td>
<td></td>
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<tr>
<td>59% favorable average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall, how important is school to you?</td>
<td>71% quite or extremely important</td>
<td></td>
</tr>
<tr>
<td>How curious are you to learn more about things you talked about in school?</td>
<td>50% quite or extremely curious</td>
<td></td>
</tr>
<tr>
<td>How much do you enjoy learning in school?</td>
<td>51% quite a bit or tremendous amount</td>
<td></td>
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<tr>
<td>How much do you see yourself as a learner?</td>
<td>64% some extent or completely</td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Social Emotional Health</th>
<th></th>
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<tbody>
<tr>
<td><strong>Academic Stress</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26% favorable average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much does your schoolwork make you feel stressed?</td>
<td>47% quite or extremely stressed</td>
<td></td>
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<tr>
<td>When you take a test, how nervous do you feel about doing well</td>
<td>50% quite or extremely nervous</td>
<td></td>
</tr>
<tr>
<td>Typically, how anxious do you feel about your grades?</td>
<td>55% quite or extremely anxious</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Positive Affect</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>39% favorable average</td>
<td></td>
<td></td>
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<tr>
<td>On a regular day at school, how often do you feel relaxed?</td>
<td>29% often or very often</td>
<td></td>
</tr>
<tr>
<td>How often are you enthusiastic at school?</td>
<td>35% often or almost always enthusiastic</td>
<td></td>
</tr>
<tr>
<td>On a normal day in school, how confident do you feel?</td>
<td>44% significantly or very confident</td>
<td></td>
</tr>
<tr>
<td>On a normal day in school, how much are you able to concentrate?</td>
<td>48% well or extremely well</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Student Community Engagement</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Social Perspective</strong></td>
<td></td>
<td></td>
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<tr>
<td>45% favorable average</td>
<td></td>
<td></td>
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<tr>
<td>How often do you try to think of more than one explanation for why someone else acted as they did?</td>
<td>39% often or very frequently</td>
<td></td>
</tr>
<tr>
<td>Overall, how often do you try to understand the point of view of other people?</td>
<td>55% often or very frequently</td>
<td></td>
</tr>
<tr>
<td>How often do you try to figure out what motivates others to behave as they do?</td>
<td>40% often or very frequently</td>
<td></td>
</tr>
<tr>
<td>In general, how often do you try to understand how other people see things?</td>
<td>47% often or very frequently</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Civic Participation</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>52% favorable average</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How much do you believe that being concerned with national, state, and local issues is everyone’s responsibility?</td>
<td>44% quite a bit or a great deal</td>
<td></td>
</tr>
<tr>
<td>How important is it to you to get involved in improving your community?</td>
<td>57% quite or extremely important</td>
<td></td>
</tr>
<tr>
<td>How important is it to you to actively challenge inequalities in society?</td>
<td>53% quite or extremely important</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How important is it to you to take action when something in society needs changing?</td>
<td>54% quite or extremely important</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td><strong>Student Work Ethic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grit</td>
<td>If you face a problem while working towards an important goal, how well can you keep working?</td>
<td>58% quite or extremely well</td>
</tr>
<tr>
<td></td>
<td>How important is it to you to finish things you start?</td>
<td>71% quite or extremely important</td>
</tr>
<tr>
<td></td>
<td>How confident are you that you can remain focused on what you are doing, even when there are distractions?</td>
<td>41% quite or extremely confident</td>
</tr>
<tr>
<td></td>
<td>If you fail to reach an important goal, how likely are you to try again?</td>
<td>58% quite or extremely likely</td>
</tr>
<tr>
<td>Growth Mindset</td>
<td>How much do you think you can change your own intelligence?</td>
<td>61% significantly or tremendously</td>
</tr>
<tr>
<td></td>
<td>How much do you think that being bad at math is something someone can change?</td>
<td>66% significantly or tremendously</td>
</tr>
<tr>
<td></td>
<td>How much do you think that struggling as a writer is something someone can change?</td>
<td>64% significantly or tremendously</td>
</tr>
<tr>
<td></td>
<td>How much do you think that trying hard to learn something means you’re bad at it?</td>
<td>64% significantly or tremendously</td>
</tr>
</tbody>
</table>

† Shows percentage of students choosing the two least favorable results

Table 11.7. District-level results from the 2019-2020 MCIEA Culture and Climate Survey organized by the academic learning and community well-being outcomes listed in the 17-18 School Quality Measures Framework (n=5,406 student responses; Source: ODA)
Discussion

The District Wellness Policy aligns with the Centers for Disease Control and Prevention’s (CDC) and ASCD’s Whole School, Whole Community, Whole Child (WSCC) model (Appendix A). The district’s wellness policy builds on this ecological, multilevel approach, aligning our eight policy areas to their 10 components, and calling out the links between cultural proficiency and these components. Michael et al. (2015) wrote:

“...WSCC provides school leaders with a new comprehensive approach for addressing the health-related barriers to learning. WSCC also provides the opportunity for health and education professionals to leverage their limited resources and work together to provide more effective and efficient programs and services to students.”

This report illustrates how the health of BPS students and schools drives the work of various departments and offices to coordinate across all policy areas to provide support to schools and direct support to students. This model and the focus on the physical, social, and emotional health of students, staff, and families provide a foundation for our response to the COVID-19 pandemic. School districts across the country have been severely challenged by the COVID-19 pandemic. BPS and other large urban districts faced significant challenges to adjust to remote learning practices and respond to health and safety concerns, social and emotional struggles, and the economic impact of the pandemic. Coordination through a WSCC approach is our guide to return, recover and reimagine our education system.

The changes in BPS health-related policies in the past 12-plus years are creating safer, healthier, and more welcoming school environments and this will impact student health over time. Student health behaviors are also impacted by access to resources and services in their homes and community. Therefore, where BPS policies and initiatives are aligned with larger city- and state- wide efforts, we would expect even larger impacts on student health. The data presented in this report provide evidence that this approach is already having the intended impact at the school level and, in some health areas, at the student level.

Progress on Policy Implementation at the School Level

In Figure 1, we provide an overview of how fully the policy areas are being implemented. The figure shows that almost all policy areas improved implementation between SY17-18 and SY19-20. Only three areas did not show any improvement: comprehensive health education, high school physical education, and wellness council; though wellness councils policy remains mostly implemented and health education and high school physical education are minimally implemented.
Because the metrics for each policy area have changed, it is not possible to measure the change of all the metrics. Throughout the report we have identified changes where possible. In the table below, we have attempted to provide some insight into the overall change in the policy areas since the last report.

**Overall policy implementation changes between SY17-18 and SY19-20**

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Overall Change</th>
<th>Observations for SY19-20</th>
</tr>
</thead>
</table>
| Wellness Councils      | No Change      | • Efforts to communicate the policy and support SWCs has increased and as a result we have maintained submission of higher quality WAPs  
                         |                | • Very few schools are engaging students and families in SWC                                                                                                                                 |
| Cultural Proficiency   | ↑ Improved     | • Increased training and resources at the central office and at schools  
                         |                | • The Racial Equity Planning Tool was rolled out and central office departments and school leaders have developed strategic goals for how to address opportunity gaps  
                         |                | • Continued lack of student and family engagement on SWCs                                                                                                                                 |
| School Food & Nutrition Promotion | ↑ Improved | • Competitive Food and Beverage Policy adherence continues to be an issue at many schools, particularly for vending machines and food sales, as well as fundraisers |
### Overall policy implementation changes between SY17-18 and SY19-20

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Overall Change</th>
<th>Observations for SY19-20</th>
</tr>
</thead>
</table>
| **Comprehensive Physical Activity & Physical Education** | Improved (No change in High School PE) | • Community eligibility provision continues to allow BPS to provide school meals free for all students  
• Continued improvements to kitchen infrastructure at three schools  
• FNS was able to quickly pivot to continue providing meals to students and families as soon as schools closed and throughout the summer. |
| **Comprehensive Health Education**         | No Change      | • Nearly all schools serving PreK-8 meet PE requirements; however, high schools continue to struggle to meet the PE policy  
• There were improvements in providing some recess for middle grades, however, 58% of schools with grades 6-8 do not provide at least 20 mins of daily recess for those grades  
• 80% of schools report that all or many of their teachers implement movement breaks or classroom lessons that involve movement and 69% of schools provide grades PreK-8 with at least 150 min of physical activity weekly.  
• The OHW PE-PA team worked with PE teachers to provide at-home lessons and activities to keep students and families moving during the remote learning. |
| **Healthy School Environment**             | Improved       | • Insufficiently staffed to provide Comprehensive Health Ed with licensed HE teachers in grades 6-12  
• It is estimated that under 16% of BPS students received health education based on course enrollment data; 42% of school serving middle and high school grades did not require a health education course and 39% of all BPS schools with grades PreK-5 did not offer any health instruction to students.  
• The OHW HE Team provided virtual lessons and resources for teachers and students to support caring for their physical, social, and emotional health during remote learning. |
| **Safe & Supportive Schools**              | Improved       | • Big investments in water infrastructure will allow BPS to continue to bring schools online for drinking water and testing protocol continues to function smoothly to identify issues so they are addressed swiftly without major interruptions  
• Custodians trained and supporting with integrated pest management, use of green cleaners and safer sanitizers, zero waste efforts, drinking water maintenance, and reducing energy use, as well as cleaning and maintenance of the buildings  
• BPS Sustainability continues to build programing and supports for schools and the district to move toward greater environmental sustainability  
• Most schools take a MTSS approach and have a student support team, and the district is investing in important mental health support services staff at the schools |
Overall policy implementation changes between SY17-18 and SY19-20

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Overall Change</th>
<th>Observations for SY19-20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• BPS K-12 Transformative SEL standards are being rolled out through the district and embedded in health ed, PE, and the arts to ensure instruction that is culturally responsive and supports positive social emotional development</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• BPS Homeless Education Resource Network continues to improve on systems to identify and support student experiencing homelessness and housing insecurity</td>
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<tr>
<td></td>
<td></td>
<td>• Behavioral Health Services provided remote services and connected students and families to mental health supports after schools closed in March; Opportunity Youth mobilized outreach and support services for homeless students and families experiencing house instability during the pandemic.</td>
</tr>
<tr>
<td>Health Services</td>
<td>↑ Improved</td>
<td>• 99% of schools are appropriately staffed with a full-time school nurse and screenings have increased.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• All high schools report having a Condom Accessibility Team</td>
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<tr>
<td></td>
<td></td>
<td>• BPS launched the Menstrual Access Pilot Program</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• BPS Health Service and school nurses held virtual office hours and created Virtual Health Offices to elevate important information and resources to students and families; Several BPS school nurses also worked with BPHC Infectious Disease Bureau to support contact tracing efforts. This work began during the school year and carried on throughout the summer.</td>
</tr>
<tr>
<td>Staff Wellness</td>
<td>↑ Improved</td>
<td>• 53% of schools report implementing staff wellness programs or initiative</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Central office departments are supporting dimensions of staff well-being; the Recruitment, Cultivation &amp; Diversity Team in OHC is specifically focusing on supports to retain and develop educators and staff of color.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Many schools and central office departments created remote systems to connect colleagues and support one another through the challenges of the pandemic and remote learning; the City of Boston increased communications to staff about staff wellness and resources and benefits to support staff throughout the city.</td>
</tr>
</tbody>
</table>

Policy Impact on Student Health Outcomes

Research indicates that health-related barriers to learning disproportionately impact youth of color, particularly in urban school districts, and that these health disparities play a role in the opportunity and achievement gaps. By systematically addressing educationally relevant health inequities, BPS strives to reduce opportunity gaps, educational achievement gaps, and improve health. Our efforts have focused on the prevention of four priority health issues:

- Increasing physical activity and healthy eating to reduce childhood obesity
• Improving sexual health and decreasing teen pregnancy
• Improving mental and behavioral health
• Decreasing asthma

In this section, we will review the impact of district and school level policy implementation efforts on student level outcomes in these four priority health areas.

**Obesity**

Healthy eating and physical activity are key behaviors for healthy development and lifelong wellness for children and adolescents, as well as developing a healthy self-image and relationship to your body. Nationally, there has been a rise in childhood obesity since the 1970s. Obesity is associated with serious health risks, and obesity in childhood “can harm nearly every system in a child’s body—heart and lungs, muscles and bones, kidneys and digestive tract, as well as the hormones that control blood sugar and puberty.”  

The latest data from the National Center for Health Statistics (2017-2018) shows that the prevalence of obesity was 19.3% and affected about 14.4 million children and adolescents.  

Nationally, obesity prevalence was 20.3% among 6- to 11-year-olds and 21.2% among 12- to 19-year-olds.  

Nationally, obesity prevalence was 25.6% among Hispanic children, 24.2% among non-Hispanic Black children, 16.1% among non-Hispanic White children, and 8.7% among non-Hispanic Asian children.  

Since children spend most of their time in schools, schools play an essential role in addressing childhood obesity. A comprehensive approach—addressing nutrition and physical activity in schools and involving parents, caregivers, and other community members—is the most effective way to address obesity through school-based interventions. This kind of approach aims to support the health and well-being of all students and does not single out students according to their weight status, reducing stigma and avoiding exacerbating risks for disordered eating.  

We must also recognize and address the impact of income and experiences of racism have on weight status and health complications and ensure our efforts are culturally responsive and seek to change systems and environments to improve the health of communities.

Federal, state, and citywide policy, systems, and environmental change efforts to improve nutrition and physical activity over the past 10 years likely contributed to the 2009-2011 reductions in childhood obesity (BMI ≥95%) in BPS. The School Food and Nutrition, Comprehensive Physical Activity and Physical Education, Comprehensive Health Education, and the Healthy School Environment areas of the wellness policy work to contribute to a physical environment and educational instruction that promote healthy eating and physical activity. Safe and Supportive Schools and Cultural Proficiency policy areas also establish the district’s commitment to safe and support environments for culturally and linguistically diverse students and students of all sizes. Subsequently, millions of dollars of grants from the CDC, US Department of Education (DOE), hospitals and local and national foundations have supported the implementation of quality education, programs and services needed to support schools in implementing this policy. Much of this work was done in collaboration with BPHC. Funding from the


8 [https://www.cdc.gov/healthyschools/obesity/index.htm](https://www.cdc.gov/healthyschools/obesity/index.htm)
Alliance for a Healthier Generation and CDC launched a district-wide effort to start wellness councils at every BPS school. More recently, we have seen a shift in funding priorities and there is less funding for obesity prevention.

BPS has seen a leveling-off with obesity rates since 2011, hovering between 23% and 26%. According to data collected by school nurse screenings, 41% of students who were screened in SY19-20 had a Body Mass Index (BMI) in the overweight (above 85% and 95%) or obese category. When the prevalence of obesity is disaggregated by race, we see similar disparities compared to national data: 27.5% among Hispanic/Latinx students, 25.9% among non-Hispanic Black students, 13.1% among non-Hispanic White students, and 15.5% among non-Hispanic Asian students (6.8 percentage points higher than the national prevalence). This surveillance data tells us that Boston has seen a halt in the rise in the prevalence of childhood obesity and must continue to improve the implementation of a comprehensive approach and reduce weight bias and stigma to promote health at any size.

We have seen progress in some healthy eating behaviors among high school students. According to the 2019 High School YRBS, the percent of high school students drinking soda every day has continued to decrease since 2007. However, there has been no significant increase since 2009 in the percentage of students who consume the recommended servings of fruits (26.8%) and vegetables (20.4%), and drink three or more glasses of water daily (49.5%). There was a significant decrease of high school students who ate breakfast daily (24.7%) and 45% of middle school students reported eating breakfast daily (YRBS). Data from FNS shows that for all students the participation rate in the School Breakfast Program increased from 39% to 45% and now all schools offer a Breakfast After the Bell model. Additionally, only 14.8% of high school students and 19.5% of middle school students reported getting at least 60 minutes of physical activity every day.

BPS has made great strides in eliminating sugar-sweetened beverages from schools. Additionally, FNS continues to improve the appeal and cultural responsiveness of their meals and to ensure meal equity between schools with full kitchens and schools without full kitchens. In collaboration with the BPS Food and Nutrition Services department (FNS), the Shah Family Foundation, and the City of Boston Public Facilities Department, the BPS Facilities Management renovated 92 school kitchens within a three-year period for the My Way Cafe School Meals Program. Of the 92 kitchens, 54 have been rolled out to support cooking and prepping fresh meals onsite. Due to the pandemic, 12 schools from phase two and 28 schools from phase three are on hold to rollout in the 2021-22 school year. It is anticipated that 20 additional cafeteria construction projects to be completed in Summer 2021 to complete phase four of the cafeteria renovations. FNS will add these schools to the rollout schedule, a total of 60 schools. These are huge strides for our school food program. There is still a lot of work to be done to change the culture around fundraisers, food-based rewards, and classroom parties. More work is needed to support schools in implementing these guidelines and holding them accountable for compliance.

Opportunities for physical activity before, during, and after school are hugely important to ensuring students get the recommended amount of physical activity during the day, especially for students that have limited access to recreational spaces where they live. For the first time, starting in SY19-20, all BPS students in grades 7-12 received free “M7” MBTA passes to ride the subways, buses, and certain Commuter Rail lines, increasing opportunities for active transportation on their way to school. Staffing
and class offerings for physical education are improving across the district and continue to be most strong in grades K-8. 75% of schools containing any grades PreK-5 have at least 20 min of recess daily of all those grades in the school, though 100% of those schools offer some amount of recess weekly. There have been improvements in schools offering some weekly recess for grades 6-8, however, only 42% of schools with those grades provide the minimum of 20 minutes of daily recess. While PE and recess have increased the amount of in-school daily physical activity for students, there remains around 30% of schools not offering all students in all grades PreK-8 opportunities to be physically active for 150 minutes per week. The disparity in opportunities for physical activity for high school students remains high. Only 58% of high schools offer PE each year in grades 9-12, same as SY17-18. The district needs to continue to work with high schools to improve the infrastructure (i.e., PE staffing and course scheduling) to support the implementation of the PE policy. Partnerships with community organizations have been key to providing before and after school opportunities at all grade levels; both non-competitive (K-12) and competitive (middle school and high school grades) opportunities have expanded because of these partnerships.

Comprehensive health education, which includes nutrition and health management topics, continues to be stymied by infrastructure barriers similar to physical education: staffing and course schedules. Thirty-nine percent of schools with grades K-5 did not offer any health instruction and only 33% of those school followed the minimum requirements for Health Ed. Forty-two percent of schools with grades 6-12 do not have required Health Education courses; 12% of schools serving grades 6-8 required two semesters taught by a licensed health educator and 8% of schools serving grades 9-12 required 1 semester taught by a licensed health educator as required by the policy. Forty-four percent of schools did report having a school food or vegetable garden, and BPS Sustainability has partnered with CitySprouts and Green City Growers to support outdoor education in these spaces. The Central Office's Health and Wellness Department provides comprehensive curriculum and trainings, however, there has been little recent training that has focused on the topic of nutrition and healthy eating. Plans for the coming school year involved a renewed effort to support nutrition education. Ultimately, schools still lack the qualified teachers and the space in the master schedule for health education classes. When compiling enrollment course enrollment records for SY19-20, under 16% of all BPS students received health education. This disservice to our students’ education must be addressed and the district should commit to investing improving health education district wide.

**Sexual Health**

Human sexuality is a natural part of human development. Schools play a vital role in guiding young people through important physical, social, and emotional changes related to their sexuality, not least because sexuality-related issues—such as unintended pregnancy, sexually transmitted infections, sexual harassment, and bias-based bullying, and sexual and dating violence—can greatly impact student academic performance. The World Health Organization defines sexual health as, “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality
and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.”

Unfortunately, half of new STD cases reported in 2019 were among young people, between the ages of 15 to 24. Also, young people (aged 13-24) accounted for an estimated 21% of all new HIV diagnoses in the United States in 2018; 88% were young men and 12% were young women. In order to achieve sexual health for BPS students, the wellness policy requires Sexual Health Education (part of Prek-12 Comprehensive Health Education) that is medically-accurate, age and developmentally appropriate, culturally and linguistically relevant, LGBTQ+ inclusive, and implemented in safe and supportive learning environments where all students feel valued. In addition, students must have access to sexual health services where students feel safe and supported. It is the goal of the BPS Wellness Policy to give students the knowledge and skills to adopt healthy sexual behaviors, including delaying sexual initiation. Research shows this comprehensive approach is particularly important to students with disabilities and students that identify as LGBTQ+ as they are at higher risk for negative health outcomes.

The Empowering Teens Through Health (ETTH) Program began in 2013 with a grant from the CDC. The current program began as a collaboration between the Office of Health & Wellness (OHW), Health Services, and Office of Equity to support 20 high schools to improve the quality and increase the quantity of sexual health education and sexual health services and create safe and welcoming school environments for LGBTQ+ students. Currently, the grant is in its second iteration. The program continues to support 18 priority schools serving both middle and high school grades and places an emphasis on diffusion of activities to schools to increase district-wide access to sexual health education, sexual health services, and safe and support school environments. Additionally, OHW was able to hire an instructional coach in SY19-20 to help improve comprehensive health education for students with disabilities by coaching school staff in health ed implementation, developing and delivering professional development, and partnering closely with the Special Education Department. In SY17-18, Thirty out of 35 high schools (86%) were implementing Sexual Health Education programming. In SY19-20, unfortunately, we saw a significant decrease in schools providing sexual health education due to school closure since sexual health education is most often delivered in the spring. It was not recommended by content experts that sexual health education be delivered remotely at that time. High school programming has been delivered by BPS trained teachers/staff and city agencies/community partners: BPHC Health Resource Center and Start Strong Initiative staff, Harbor Health Services staff, and Peer Health Exchange trained college volunteers. As was stated earlier in this report, more needs to be done to address the infrastructure barriers to providing comprehensive health education, inclusive of sexual health education.

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10 CDC: STDs in Adolescents and Young adults, https://www.cdc.gov/std/stats18/adolescents.htm


YRBS data show that the percentages of high school students who have ever had sex (37.6%); were currently sexually active (26.4%); have had four or more sexual partners in their life (11%); and have ever been pregnant or gotten someone else pregnant (5.7%) have significantly decreased since 1993. However, the number of sexually active high school students using a condom (52%) has also significantly decreased between 2005-2017. Despite an increase in effective hormonal birth control use, only 28.36% of currently sexually active students used effective hormonal birth control to prevent pregnancy during last sexual intercourse and only 6% used both a condom and hormonal birth control. In middle school, about 8% of students have ever had sexual intercourse, 3.2% before the age of 11 years and 2.3% ever had sexual intercourse with three or more persons (significant increase from 2017, 1.2%).

As a result of the ETTH program, there has been an improvement in the quality and quantity of Condom Accessibility Teams (CATs) at high schools; 100% of schools report having at CAT and 95% were trained before the close of schools in March (online training was develop over the summer and implemented in SY20-21). CAT promotion at high schools remains a key priority for implementing this part of the wellness policy. School-based Health Centers (SBHC) and Health Resource Centers (HRC) have improved access to sexual health services and sexual health counseling and referrals to community health care resources for some schools. However, except for the provision of condoms, less than 20% of schools with grades 6-12 reported providing sexual health services, and sexual health referrals to clinics not on school property were provided by 43% to 56% of schools depending on the service. In high schools (Grades 9-12) these referrals were provided by around 90% of schools on average. According to the 2019 YRBS, 23.5% of students had ever been tested for HIV (a significant increase from 16.4% in 2017) and 20.1% had been tested for STDs other than HIV in the past 12 months.

Sexual Health Education is also key to preventing sexual and dating violence, building the knowledge and skills to develop healthy relationships and social development from an early age, contributing to the reduction of violence perpetration and victimization. The YRBS found that the percentage of high school students who were physically forced to have sexual intercourse when they did not want to (9.2%) has not changed since 2009. There has also been no change in the percentages of high school students who experienced physical dating violence (6.3%) or sexual dating violence (11.5%) since 2013. Middle School YRBS shows 11.6% of students experienced physical dating violence in the past year and 3.5% were ever forced to have sexual intercourse when they did not want to. Additionally, students who identify as lesbian, gay, and bisexual were more likely than their straight counterparts to have been physically forced to have intercourse (13.9% vs. 7.1% respectively) and more likely to have experienced sexual dating violence (17.1% vs. 9.3%). National studies of YRBS data have also found a strong correlation between substance use and risky sexual behaviors\textsuperscript{13}, highlighting the need for comprehensive health ed that addresses substance use as well.

LGBTQ+ inclusive curricula and a welcoming school environment is fundamental to address health disparity among LGBTQ+ youth and ensure they are flourishing. Equity policies and training, as well as ETTH programming has helped to create better environments for LGBTQ+ students. Sixty-eight

\textsuperscript{13} CDC, https://www.cdc.gov/healthyyouth/substance-use/dash-substance-use-fact-sheet.htm
percent of schools reported that some of or all their staff have received training in the past two-years on creating safe and welcoming learning environments for LGBTQ+ students and 51% of schools with grades 6-12 have GSA clubs (up from 43% in SY17-18). In SY19-20, an LGBTQ+ Student Support Manager position was created in collaboration between the Office of Equity and OHW and the position was filled in July 2020. The role leads the district’s efforts to meet the needs of BPS students who identify as lesbian, gay, bisexual, transgender, queer, gender non-conforming, or who are questioning their gender and/or sexual orientation. The manager also serves as lead of the Safe and Supportive Environment strategy on the Empowering Teens Through Health Grant.

**Asthma**

Asthma is the leading cause of school absenteeism nationally and low-income populations, children of color, and children living in urban areas experience more emergency department visits, hospitalizations, and deaths due to asthma than the general population. Childhood asthma is a complex condition that can be exasperated by indoor environmental triggers, like mold, pests, dust, and fumes from cleaning products, and outdoor air quality, which can be an issue in urban areas due to traffic congestion and idling vehicles. Proper asthma management includes the prevention and management of environmental triggers and adherence to medication. BPS Health Services and the Boston Public Health Commission (BPHC) have a long history of partnering to control and prevent pediatric asthma by offering services to promote effective medication management and healthy indoor and outdoor environments through the Prevention Wellness Trust Fund. BPS Environmental Division and BPHC collaborate to complete the annual School Environmental Audit Inspections. Detailed reports are sent to school leaders and summary reports are available on the BPS website. MassCOSH and Facilities Management have been partnering with the Health and Wellness Department to provide stipends and training to Wellness Champions at schools who can assess their school environment and implement action steps to address and prevent environmental asthma triggers. BPS Sustainability maintains several sustainability and environmental, health and safety resources for the BPS community, including the BPS Integrated Pest Management Guide, the BPS Declutter Guide, the Healthy School Environment Toolkit, and the BPS Zero Waste Guide. This work is vital since SNAPNurse records show 19.8% of BPS students screened have a diagnosis of asthma and the 2019 YRBS found 26.2% high school students were ever told by a doctor or nurse that they have asthma.

BPS Health Services manages the Asthma in School Policy for the District (Superintendent Circular SHS-20). Schools are required to have protocols and procedures in place for students with asthma. A comprehensive plan includes management and support systems, appropriate health and mental health services, educational programs for staff and students, appropriate and reasonable environmental remediation and communication systems with home and child clinicians. The SHS-20 policy follows national best practices and outlines the roles for families, students, school administrators, school nurses, teachers, and other school staff (e.g., coaches). This includes implementing key parts of the wellness policy’s Healthy School Environment section: maintaining an active Integrated Pest Management Program; reviewing and acting on annual school inspections; using green cleaners and

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14 CDC, https://www.cdc.gov/healthyschools/asthma/index.htm
safer sanitizers; enforcing the tobacco policy; and reducing the idling of buses and other motor vehicles on school property. Data were not available for the percent of students with asthma that have Individual Health Care Plans; tracking this metric will help us better understand the implementation of SHS-20.

BPS has launched an ongoing BuildBPS educational and facilities master plan—a 10-year, $1 billion vision for transforming all school buildings into learning environments where students access the teaching and support services, they need to be successful. A timeline and plan for continued maintenance and upgrades of all school buildings has been established. Renovations and capital repairs will take place across the district, including upgrades to electrical and lighting, exterior refurbishment, repairs to roofs and boilers, updates to HVAC systems, and continued repairs to windows. There needs to be a renewed effort in communicating the Tobacco Free Policy and the bus and vehicle idling laws to see them fully implemented at the schools. We need to continue to make sure that classroom teachers are aware of the policy requiring the use of green cleaners and safer sanitizers in their classrooms. Zero Waste efforts have been launched across the district and BPS Sustainability have worked with the Science Dept, student groups, school leaders, and teachers to embed environmental sustainability lessons into student instruction. 57% of BPS’ active bus fleet runs on propane and BPS Transportation is only purchasing propane-fueled buses when buying new buses, instead of diesel, to address the carbon emissions and health impacts of diesel. The transportation team also started working with the city on ways to add electric vehicles to the transportation fleet. We hope that major efforts by BPS Facilities over SY20-21 and the significant investments from the city and grant funds awarded will improve the physical learning environment for our students.

**Behavioral and Mental Health**

Behavioral and mental health issues can cause major disruptions to a student’s education and to social development within the school community. Addressing behavioral health in schools through a safe and supportive schools approach helps to improve positive health outcomes for students. A safe and supportive school environment is important for academic success and can reduce or prevent health risk behaviors related to violence victimization, substance use, and social, emotional, and mental health. The Massachusetts Safe & Supportive Framework Law (M.G.L. c. 69, § 1P) defines safe and supportive schools as:

“Schools that foster a safe, positive, healthy & inclusive whole-school learning environment that: (1) enables students to develop positive relationships with adults and peers, regulate their emotions and behavior, achieve academic and non-academic success in school and maintain physical and psychological health and well-being; and (2) integrates services and aligns initiatives that promote students' behavioral health, including social and emotional learning, bullying prevention, trauma sensitivity, dropout prevention, truancy reduction, children's mental health, foster care and homeless youth education, inclusion of students with disabilities, positive behavioral approaches that reduce suspensions and expulsions and other similar initiatives.

The Safe and Supportive Schools component of the wellness policy ensures the implementation of each of the elements in the Massachusetts Safe & Supportive Framework. The policy requires that BPS
schools implement social-emotional learning standards in K-12 and ensures a multi-tiered system of supports for mental health, including tier 2 and 3 services for groups of students and individuals that need additional mental and behavioral supports. It recognizes that students need learning environments that are safe, supportive, inclusive, and culturally and linguistically sustaining to succeed academically. This policy area must also be considered in tandem with the Cultural Proficiency section. BPS must implement culturally responsive systems of support that help all students experience success and growth; that value the social and cultural experiences of all students and families; and that actively address bias related to race, color, sex, gender identity, religion, national origin, and sexual orientation.

The YRBS data shows 58.2% of high school students agreed or strongly agreed that they felt close to people at their school (YRBS). However, Black (56.9%), Asian (60.6%), and Latinx (55.2%) students were statistically less likely to report that school connectedness compared to their white peers (74.7%; Appendix G). There has been a significant increase (2001-2017) in the percentage of students who felt persistently sad or hopeless (35.0%) and there has been no change (2009-2017) in the percentage of students who did something to purposely hurt themselves without wanting to die (16%). Fortunately, the percentage of students who have seriously considered suicide and attempted suicide has significantly decreased since 1993 (11.9% and 5.6% respectively). High school students who identify as LGB and female students are statistically more likely to engage in these suicidal behaviors (Appendix I). In middle school, 26.5% of students felt persistent sadness that impacted their day-to-day activities; 29% felt stressed most of the time or always (significant increase from 2013, 22%); 22.8% had ever seriously considered attempting suicide; and 11.2% had ever attempted suicide (significant increase from 2013, 8%). When it came to school connectedness and support, 56% of middle school students said there was at least one adult in their school they could talk to if they had a problem, but 45% of students rarely or never got the kind of help they needed when they felt sad, empty, hopeless, angry, or anxious. Considering this the baseline for our high school and middle school students prior the collective trauma of the pandemic and challenges to building school connectedness during remote learning, addressing these social, emotional, and mental health issues across the district is a key first step to recovery.

Efforts to implement the Safe and Supportive component of the policy have included an increased advocacy, funding and hiring of mental health professionals in the schools and an increased focus on social emotional learning instruction, school climate and related programs, work that originated through several grants over the past 10 years. BPS has focused our efforts on strengthening Social Emotional Learning, through a whole child approach, where SEL is a lever for equity, and should be part of teaching practices in all our classrooms. By strengthening adult and youth social and emotional skills and competencies, we enhance our abilities to connect and relate to others across differences. BPS SEL competencies were developed in SY17-18 and updated in 2019 to reflect a Transformative SEL approach, an equity-based approach that is better align with culturally and linguistically sustaining practices (CLSP) in our district. Transformative SEL is a process whereby young people and adults build strong, respectfulful relationships that facilitate co-learning to critically examine root causes of inequity and to develop collaborative solutions that lead to personal, community, and societal well-being. Boston Public Schools is leading the nation with SEL Competencies inclusive of equity. Through a four-year research grant, Partnership in SEL Initiative, we are learning more about the implementation of
SEL in service of equity. Early findings suggest that our SEL coaching model is having an impact, increasing ratings of climate, SEL instruction, SEL integration and student collaboration in the research schools. To deepen implementation of this part of the policy, the district will need to invest in select SEL professional development and instructional coaches to increase supports for Adult SEL and integration of SEL into academics. The district will also need to broaden our efforts to align SEL with CLSP and focus on social emotional development that supports academics and physical and mental health.

Behavioral Health Services, social workers, and other mental health professionals play an important role in providing social-emotional supports and mental health services, as does Health Services through school nurses. In SY19-20, BPS hired more nurses, ensuring at least one FTE per school building. In SY20-21 more social workers and family liaisons were hired and next year, SY21-22, BPS will hire 95 social workers and 58 family liaisons, so that every school will have nurses, social workers, and family liaisons. Behavioral Health Services continues to advance implementation of a multi-tiered approach to social-emotional development and mental health. The Comprehensive Behavioral Health Model (CBHM) was developed in collaboration between BPS Behavioral Health, the Boston Children’s Hospital, and the UMass Boston School Psychology Department. Beginning in SY12-13, the Comprehensive Behavioral Health Model has been expanded in the district, reaching 74 schools in SY19-20 and helping to coordinate behavioral and mental health support for students. Most schools report using a Multi-Tiered Systems of Support (MTSS) to provide universal, targeted, and intensive behavioral support to students. In SY20-21, Behavioral Health Services developed its use of telehealth tools and use of the Panorama platform to track student success. To fully implement MTSS, the district will need to deepen the resources and capacity building for MTSS in tier 2 and 3.

Student outcomes related to violence and school safety have seen significant long-term decreases. Between 1993-2017, there have been decreases in the percentages of high school students who did not go to school because they felt unsafe at school or on their way to or from school (14.4% to 7.5%); students who carried a weapon on school property (15.8% to 3.6%); students who were threatened or injured with a weapon on school property (12% to 5.3%); and students who were in a physical fight on school property (15.2% to 8.1%). In middle school, 52% of students had ever been in a fight and 16.5% had ever carried a weapon. As mentioned previously, sexual violence has not significantly changed over the long term and there are disparities in the populations that experience violence victimization (Appendix G).

The BPS Bullying Prevention and Intervention Plan has been in place since 2010. The 2019 YRBS data show that the percentages of middle school students who were ever bullied on school property (40%) and were ever electronically bullied (20.5%) was high. The prevalence of bullying behaviors high school in the past 12 months before the survey was 11.2% and 9.1%, respectively and there has been no change since 2009. However, both high school data points are significantly lower than state percentages (Appendix F).

BPS continues to be committed to restorative justice (RJ) work. Restorative Justice brings people together to reconcile and build relationships when harm has been done. Restorative Justice aims to build understanding, explore how the wrongdoing has impacted those involved, and to develop
agreements that increase trust, safety and understanding so that things are better in the future. BPS Office of Student and Community Engagement and Succeed Boston train and support schools to implement RJ. Succeed Boston, through funding from the American Institute for Research and Center for Restorative Justice at Suffolk University, provides RJ services to 30 BPS schools. Additionally, The Boston Teachers’ Union (BTU) maintains the Restorative Justice Learning Community (RJLC).

BPS has put policies and practices in place to create safe and supportive environments for LGBTQ+ students. In SY20-21, the new LGBTQ+ Student Support Manager provided individual support to LGBTQ+ students, assisted schools with administering and supporting transgender and gender non-conforming students’ transition planning and implementation, and delivered LGBTQ+-related professional development. They developed and sustained external partnerships, such as GLSEN, Boston GLASS, Boston Alliance of LGBTQ+ Youth (BAGLY), Fenway Health, and the Theater Offensive and coordinated support for LGBTQ+ parents/guardians in BPS and parents/guardians of LGBTQ+ students through 1-on-1 consultations, support groups, and relationship building. Lastly, they supervised the Gender and Sexuality Alliances (GSAs) Support Specialist in partnership with the OHW to support school-based GSAs and other similar organizations. This work is essential to ensuring LGBTQ+ students thrive and that the district addresses the systems that produce disparities in substance use, violence victimization, and social, emotional, and mental health risk behaviors for these students.

The Office of Opportunity Gaps (OG) is also training central office staff and working with school leadership to improve Cultural Proficiency and increase culturally and linguistically sustaining practices throughout the district. In SY19-20, OG Office trained staff, school leaders, and central office departments in using the Racial Equity Planning Tool and CLSP Continuum to improve the district’s collective approach to cultural proficiency. The office also identified and began training on the CRIOP (Culturally Responsive Instruction Observation Protocol) as tool to guide CLSP in the classroom. Racial equity and authentic community participation were central to the development of the BPS Strategic Vision 2020-2025, and all schools and central departments have worked to set specific goals related to their work and advancing education equity. For wellness councils, engagement of students and family members in this shared-leadership team is still lacking. District and school-based Community Equity Roundtables began in the summer and were further developed throughout the SY20-21. The district and the schools should look for opportunities to work in tandem with the roundtables and the wellness councils to achieve health equity goals for students. The work of reimagining BPS as an actively antiracist institution is difficult and continuous work. The feedback from our students, families, staff, and community partners tells us that our efforts have only just begun to germinate. If we keep pushing forward in this work and continually reflect and evaluate our approach in authentic partnership with the members of the BPS community, we can make real growth and see real change.

Challenges

Using a collective impact approach—an intentional way of working together and sharing information—to improve wellness requires five conditions be in place: a common agenda, a shared measurement system, mutually reinforcing activities, continuous communications, and a backbone structure. Through the BPS Wellness Policy, we have established a common understanding of the impact of wellness on learning, a shared vision for change and a commitment to coordinate across the district to improve wellness. The policy recognizes the need for differentiated approaches to implement each policy area. These mutually reinforcing activities must be coordinated through a joint plan of action. The District Wellness Council and its eight subcommittees, coordinated and convened by the Office of Health and Wellness, serve as the backbone structure. Though the DWC has established an evaluation plan with agreed upon metrics to measure improvement on policy implementation, there remain challenges to data collection. We must also continue to improve communications at every level in the district and build an internal system to break through siloed work.

Data collection: The expanded Evaluation and Monitoring Plan has increased the amount data gathering and coordination across multiple departments in the district that is needed. While subcommittees tried to identify existing data collection tools and systems aligned with other district indicators, coordination, collaboration, and consistency with data collection have been a challenge. There needs to be repeated communication and coordination with the departments linked to this plan to improve the efficiency of gathering the data for this report. There also needs to be a reinforcement of the alignment of the District Wellness Policy implementation goals and the individual department and central office goals, so that health and wellness are a part of each department’s strategic plan and benchmarks are set to improve policy implementation. We want to ensure the sustainability and feasibility of monitoring and evaluating policy implementation by improving the information and data sharing between departments.

Policy Awareness: It is an on-going goal of the District Wellness Council to increase awareness of the Wellness Policy among central office leaders, school leaders, school staff, students, and families. Awareness-raising efforts will empower families and students to be advocates for policy implementation and improvement at their own schools and through leadership channels within the district, such as the district parent councils, Boston Student Advisory Council, and School Committee. Changes in district and school leadership and staff also means that wellness policy awareness can also decrease at the administrative level, and the policy must always be re-communicated to those tasked with its implementation. Communication efforts to the various stakeholders remains a challenge.

Recommendations

To ensure equity for all BPS students, they must have access to an environment that provides quality health and wellness education, programs, and services, we must continue to implement the policy across the district’s diverse schools. We suggest the following action steps:
1. **Improve communication of the policy to district leaders, schools, youth, and families:**
   a. Develop an overall communication plan to disseminate information about the Wellness Policy to increase awareness and knowledge among district leadership, school leaders, school-based staff, students, and families
      i. Continue to make use of existing communication channels within the district and use new ones as they are available.
      ii. With changing leadership in the district, ensure understanding and adoption of the policy at all levels of BPS.
   b. Outline multiple approaches to engaging parents and caregivers and consistently take their feedback into account to further engage these stakeholders in SWCs

2. **Strengthen District Wellness Council and subcommittees:**
   a. Maintain diverse representation of stakeholders as DWC members, as defined in the policy.
   b. Improve the functionality of the subcommittees for Cultural Proficiency, Health School Environment, Health Services, and Staff Wellness.
      i. Continue to improve the information and data sharing between the Office of Opportunity Gap and the DWC to better align the work of the Opportunity and Achievement Gap Policy and the District Wellness Policy.
      ii. Strengthen collaboration between the District Wellness Council and efforts to improve staff well-being and organizational health.
   c. Improve data systems for evaluating the implementation of the Wellness Policy.
      i. To improve sustainability of the evaluation process and improve collective impact, systems for collaboration and data sharing must be improved.

3. **All departments and offices responsible for the implementation of areas of the policy should include wellness policy implementation strategies and benchmarks into their work plans and strategic plans to improve alignment with department and district wellness goals:**
   a. Convene an internal committee with department and office heads to meet quarterly to discuss strategic plans and benchmarks to implement the BPS District Wellness Policy.

4. **All department responsible for the implementation of areas of the policy should address the following key implementation issues to improve district and school-level implementation of the wellness policy:**
   a. **Cultural Proficiency:**
      i. Increase the representation of students and families on DWC and school-based wellness councils and work in tandem with the district and school-based Equity Roundtables and the wellness councils to achieve health equity goals for students.
      ii. Improve schools’ abilities to collectively assess their organizational structure, policies, and school-wide practices for bias(es) as well as examine their physical environment, classroom curricula, instructional materials, and wellness promotions.
   b. **School Food & Nutrition Promotion:**
      i. Increase culinary processes to include more culturally relevant meals and implement a process for a continuous feedback from students
      ii. Increase opportunities for nutrition education training through OHW Health Ed Team
      iii. FNS should return to managing the contracts for vending machines in the schools to ensure that the food and beverages in the vending machines meets district guidelines.
iv. Improve communication and reinforcement healthy food environment practices outlined in the policy for schools and central office.

c. **Comprehensive Physical Activity & Physical Education:**
   i. Increasing time in the schedule for recess for middle grades, as well as training, equipment, and resources to support schools in managing recess for these grades.
   ii. Improve PE offerings for high schools by funding additional PE staff, space improvements, additional equipment, curriculum, and professional learning.
   iii. Improve communication of the benefits of PA on student behavior and attention and reduce the number of schools withholding or using PA as a punishment.
   iv. Improve funding and centralized coordination in the Transportation Dept for Safe Routes to School Boston to better promote and support active transportation for BPS.

d. **Comprehensive Health Education:**
   i. Increase the number of licensed Health Education teachers teaching CHE in grades 6-12 and the number of trained teachers teaching CHE in grades PreK-5.
   ii. Improve schools’ master schedule planning to include time for Health Education.

e. **Healthy School Environment:**
   i. Improve communication of HSE policies to school leaders and provide more opportunities for training and information sharing between facilities and school leaders.
   ii. Increase school engagement in sustainability efforts across the district.

f. **Safe & Supportive Schools:**
   i. Increase awareness and understanding of Expectant & Parenting Student (EPS) Policy through EPS liaison trainings and easy access to resources and information.
   ii. Continue to build on and improve support for LGBTQ+ students and students experiencing homelessness.
   iii. Strengthen tier 1 social-emotional supports through investments in Transformative SEL professional development and instructional coaches to increase supports for adult SEL and integration of SEL into academics.
   iv. Provide intensive training and development support to new mental health support staff and family liaisons in the schools to strengthen the multi-tiered systems of support approach.
   v. Improve coordination and alignment across central office divisions to strengthen tier I MTSS approach through a district strategic plan for SEL, including learnings from the Boston Hub School roll out.

g. **Health Services:**
   i. Continue to increase the capacity of school nurses to provide health services to students and the capacity of the Health Services Department to support data collection and professional development of nurses.
   ii. Increased focus on improving existing immunization compliance in schools.
   iii. Increase trainings, resources, and supports to school nurses to provide sexual health services and referrals to middle and high school students.

h. **Staff Wellness:**
   i. Establish a district-level lead for staff wellness to coordinate a plan for sustainable staff wellness promotion and a menu of district supports.
**Conclusion**

Boston Public Schools takes seriously the health and wellness of students and staff. Important steps have already been taken by adopting our comprehensive district wellness policy. BPS Departments have had significant accomplishments to date in all policy areas, and schools have worked through their wellness councils to make the district policy come alive at their school buildings. There have been investments in improving infrastructure and increasing staff to provide support services; now is the time for the district to invest in whole child instruction. We must improve our district’s delivery of standards aligned, skills-based health education and increase SEL delivery through health education, physical education, the arts, and embedded into other academic areas. This report illustrates how the health of BPS students and schools drives the work of various departments and offices to coordinate across all policy areas to provide support to schools and direct supports to students. This coordination pushes the health & wellness mission of BPS forward: to actively promote the social, emotional, and physical wellness of all students to support both their healthy development and readiness to learn. We must ensure that the district continues to address the non-academic health barriers to learning through an equity-based Whole School, Whole Community, Whole Child approach.
Appendix A: Whole School, Whole Child, Whole Community (WSCC) Model

The Whole School, Whole Community, Whole Child (WSCC) Model, is a student-centered framework that emphasizes the connections between health and education, the contributions of the community in supporting the school, and the importance of evidence-based school policies and practices.¹ This framework combines and expands on the Coordinated School Health approach and tenants of ASCD’s whole child framework and is supported by evidence showing that healthy students are better learners.² The WSCC Model highlights the school health components that every school needs to ensure the health, safety, and well-being of their students, staff, and environment.²

¹ [https://www.cdc.gov/healthyschools/wssc/index.htm](https://www.cdc.gov/healthyschools/wssc/index.htm)
Appendix B: SY19-20 DWC Membership List

Council Co-Chairs:
Jill Carter, Assistant Superintendent, BPS Office of Social Emotional Learning and Wellness
Jennifer Jose Lo, MD, Medical Director, Boston Public Health Commission

Appointed Members:
Andria Amador, Senior Director of Behavioral Health Services, BPS Behavioral Health Services
Laura Benavidez, Executive Director, BPS Food and Nutrition Services
Casey Corcoran, Youth Sexual Violence Prevention Education Director, BARCC (Boston Area Rape Crisis Center)
Angie Cradock, Senior Research Scientist, Harvard TH Chan School of Public Health
Tony DaRocha, Physical Education Teacher, Higginson-Lewis K-8, BPS
Jon Gay, Executive Director, Playworks
Marianna Gil, Director of Health Benefits, City of Boston
Irvinne Goldson, Deputy Director, Health Services Department, Boston ABCD
Jessica Greene, Director of Physical Education, BPS Health & Wellness Dept
Faye Holder-Niles, MD, MPH, Medical Director of Community Primary Care, Boston Children's Hospital
Michelle Keenan, Director, Brigham and Women's Hospital
Tiffany Luo, BSAC Representative, Boston Latin School
Brian Marques, Senior Director, BPS Opportunity Youth Dept
Anne McHugh, Director of Child, Adolescent and Family Health Bureau, Boston Public Health Commission
Ilyitch Nahiely Tábor, Executive Director, Immigrant & Targeted Populations, BPS Office of Opportunity Gaps
Phebean Ogunsanwo, BSAC Representative, Brighton High School
Myrian Ortiz, Director of Community Engagement, BPS Office of Engagement
Jeri Robinson, School Committee Member, Boston School Committee
Zack Scott, Deputy Chief Operating Officer, BPS Operations
Jack Sinnott, SPedPac Parent Rep
Cheryl Todisco, Director of Health Education, BPS Health & Wellness Dept
Margaret VanCleve-Rocchio, Senior Director Health Services, BPS Health Services
Dr. Caren Walker Gregory, School Leader, EMK Academy for Health Careers
Ann Wei, BSAC Representative, Community Academy of Science & Health
Erin Wholey, RD, LDN, Director of Youth Wellness, New England Dairy Council
Tanya Woodard, Interim Principal, James W. Hennigan K-8, BPS
## SY19-20 Subcommittee Co-Chairs

<table>
<thead>
<tr>
<th>Category</th>
<th>Co-Chairs</th>
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<tr>
<td>Cultural Proficiency</td>
<td>Ilyitch Nahiley Tábora (BPS, Opportunity Gaps)</td>
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<td></td>
<td>Bethany Allen (Peer Health Exchange)</td>
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<td>Food and Nutrition Services</td>
<td>Kelly Thompson (BPS, FNS)</td>
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<td>Sonia Carter (BPHC, Food &amp; Nutrition)</td>
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<td>Health Education</td>
<td>Cheryl Todisco (BPS, HWD Health Ed)</td>
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<td>Maria Melchondia (MA-HPRED)</td>
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<td>Health Services</td>
<td>Margaret VanCleve-Rocchio (BPS, Health Services)</td>
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<td>Sonya Purvis (BPHC, School Based Health Centers)</td>
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<td>Health School Environment</td>
<td>Katherine Walsh (BPS, Facilities)</td>
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<td>Al Vega (MassCosh)</td>
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<td>Physical Education and Physical Activity</td>
<td>Jessica Greene (BPS, HWD)</td>
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<td>Angie Cradock (Harvard Prevention Research Center)</td>
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<td>Safe and Supportive Schools</td>
<td>Andria Amador (BPS, BHS)</td>
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<td></td>
<td>John Riordan (Children’s Hospital)</td>
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<tr>
<td>Staff Wellness</td>
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Appendix C: SY19-20 DWC Action Plan

**GOAL 1:** Improve effectiveness of communication of the BPS District Wellness Policy, District Wellness Council activities and the annual report of the wellness policy implementation in order to increase knowledge and buy-in of stakeholders.

- **OBJECTIVE B:** Communicate findings of the SY17-18 Annual Report
- **OBJECTIVE A:** (Re)establish communication channels to key stakeholders in the district

**GOAL 2:** Improve the functionality of the District Wellness Council and the subcommittees to execute the responsibilities of the council in all areas of the policy.

- **OBJECTIVE B:** Establish Staff Wellness subcommittee
- **OBJECTIVE A:** Establish Cultural Proficiency subcommittee
- **OBJECTIVE C:** Support departments to develop strategic benchmarks for implementing policy

**GOAL 3:** Improve the ability of the District Wellness Council to measure implementation of the wellness policy at the school level and the policy’s impact on student-level outcomes.

- **OBJECTIVE B:** Subcommittee must review evaluation plan metrics and verify data collection
- **OBJECTIVE A:** Complete the SY18-19 Annual Report (Qualitative)
Appendix D: Policy Monitoring & Evaluation Plan

Table Abbreviations:
PO = Process Outcome; STO = Short-term Outcome IMO = Intermediate Outcome

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<tr>
<th>General Policy/Council (GEN) Metrics</th>
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**GEN Process Outcomes (PO)**

**PO1: DWC and Subcommittee Meetings [DWC Records]**
- PO1.1: # of Meetings (DWC & by subcommittee)
- PO1.2: # of attendees
- PO1.3: Action Plan completion (yes/no)
- PO1.4: Review Policy (yes/no)
- PO1.5: Hear Stakeholder Feedback through public comment (yes/no)
- PO1.6: Update policy (yes/no/not applicable)

**PO2: Policy Communication/Public Notification (yes/no) [DWC Records]**
- PO2.1: Policy Translation
- PO2.2: Post to BPS website: Policy, meeting times, action plan, membership, contact information
- PO2.3: Policy in Parent Guidebook
- PO2.4: Policy update presentations to School Committee
- PO2.5: Policy update presentations to: BSAC, CPC, DELAC, SPEDPAC

**PO3: Policy Evaluation [DWC Records/Profiles]**
- PO3.1: Evaluation Plan (in place)
- PO3.2: Annual Report (yes/no)
  - PO3.2.1: Alternating Qualitative & Quantitative Reports
  - PO3.2.2: Post to website
  - PO3.2.3: Share with Superintendent, School Committee, DESE
  - PO3.2.4: Sent to parent councils
  - PO3.3: Biennial School Wellness Reports [Profiles]

**PO4: Policy Trainings**
- PO4.1: PDs for school wellness council and teachers [OHW Records]
- PO4.2: Training materials for Principals, Superintendents, Central Office Leaders
- **NEW** PO4.3: (#) of schools receiving policy implementation training

**PO5: School-based Wellness Councils**
- PO5.1: % of schools submitting WAPs [OHW Records]

**GEN STO 1: Increase awareness and knowledge of the District Wellness Policy among BPS families, District staff, and school leadership and staff**

- **X** STO1.1: % of schools that post WAP, council members, and council chair(s) contact information to their website [Profiles SY19-20]
- STO1.2: % of schools that send a communication about the policy home to parents [Profiles]
- STO1.3: % of schools that communicate policy to school staff [Profiles]
- **NEW** # of schools that connect their WAP goals to their school’s instructional focus

**GEN STO 2: Improve diverse stakeholder involvement on the District Wellness Council, the DWC subcommittees & school-based wellness councils**
Appendix D: Policy Monitoring & Evaluation Plan

STO2.1: DWC membership includes representatives from families, students, school and district instructional and operational administrators, relevant central department heads, school food and nutrition services staff, physical education and health education teachers, school nurses and other school health professionals (e.g. psychologists, guidance counselors, social workers) a school committee member, community youth serving agencies, Boston Public Health Commission representatives, healthcare providers and the general public [DWC Records]

STO2.2: # of public comments made during DWC meetings [DWC Records]
STO2.2: #(%): of school wellness councils with 2 or more family reps on the wellness council [WAPs]
STO2.3: #(%): of school wellness councils with 2 or more students on the wellness council [WAPs]

NEW STO2.4: #(%): of school wellness councils with at least one student represented
NEW STO2.5: Community partners listed as school wellness council members
NEW STO2.6: #(%): of schools demonstrating shared leadership with delegating action steps towards WAP goals

GEN STO 3: Improve policy to align with model school wellness policies and best practices, annual report findings and recommendations, input from schools and the community, research evidence, and government regulations. [DWC records]

STO3.1: Policy updates by area

GEN STO 4: Increase the number of schools with quality wellness councils [OHW Records]

STO4.1: #(%): of schools with wellness councils that meet quarterly
STO4.2: #(%): of schools with identified wellness council chair(s)

GEN IMO 1: Improve the functionality of the school-based wellness councils [WAPs]

IMO1.1: % of WAPs with SMART Goals
IMO1.2: % of WAPs goals in each policy area
NEW IMO1.3: #(%): of schools with at least two goals listed in their WAP
NEW IMO1.4: #(%): of schools with WAP goals in each policy area
IMO1.5: % of wellness council with (previously IMO1.3)
IMO1.5.1: Minimum representation of member roles
IMO1.5.2: Addition representation of member roles
IMO1.6: #(%): of schools with trained wellness council co-chairs (previously IMO1.4)

Cultural Proficiency (CP) Metrics

CP Process Outcomes:

PO1: # of trainings on Equity policy and practices [Equity Office]
PO2: #(%): of schools that have staff trained on CLSP
PO3: #(%): of central office departments that have at least 70% staff trained on CLSP
PO4: #(%): of staff by school trained on CLSP
### Appendix D: Policy Monitoring & Evaluation Plan

#### CP STO 1: Increased # of schools assessing organizational structure, policies, and school-wide practices for cultural proficiency

- **STO1.1:** # (%) of schools with CLSP goal on their WAP
- **NEW** **STO1.2:** # (%) of schools in which staff have received training
  - **STO1.2.1:** addressing equity in education outcomes for students of color
  - **STO1.2.2:** implementing service-learning (SL), a teaching and learning methodology that integrates community service with academic study to enrich learning, teach civic responsibility, and strengthen communities
  - **STO1.2.3:** creating a supportive learning environment for lesbian, gay, bisexual, transgender, or questioning (LGBTQ) students
- **NEW** **STO1.3:** # (%) of school leaders that agree teachers at their school implement SEL approaches that are culturally responsive

#### CP STO 2: Increased # of schools engaging families, students, and community members in decision-making

- **IMO1.1:** District score on Community Involvement Scale [Climate Survey/ODA]
- **IMO1.2:** District score on Appreciation for Diversity Scale [Climate Survey/ODA]
- **IMO1.3:** District score on Family/School Relationship Scale [Climate Survey/ODA]
- **IMO1.4:** District score on Cultural Responsiveness Scale [Climate Survey/ODA]
- **IMO1.5:** District score on Student/Teacher Relationships Scale [Climate Survey/ODA]
- **IMO1.6:** Parent perception of school climate as safe and welcoming [Climate Survey/ODA]

#### School Food & Nutrition Promotion (SFNP) Metrics

##### SFNP Process Outcomes (PO)

- **PO1:** # (%) of schools participating in the School Breakfast Program [FNS Records]
  - **PO1.1:** # (%) of schools using different models of the School Breakfast program
- **PO2:** % (#) of schools participating in School Lunch Program [FNS Records]
  - **PO2.1:** % (#) of school using different models of the School Lunch Program
- **PO3:** # (%) of schools with cafeteria staff trained on food safety [FNS Records]
- **PO4:** # (%) of schools with completed kitchen inspection [FNS records]
- **PO5:** # of Healthy Food Environment Wellness Champions [OHW records]
- **PO6:** # of nutrition education PDs [OHW Records] (previously PO7)
- **PO7:** # of staff trained at nutrition education PDs [OHW Records] (previously PO8)

#### SFNP STO 1: Increase variety of foods that are local, culturally influenced, and clean label [FNS Records]

- **STO1.1:** % of food items procured by the district that are local
- **STO1.2:** % of menu items that are culturally influenced to reflect the student population

#### SFNP STO 2: Increase support of BIC from school administration

- **STO2.1:** # (%) of schools implementing BIC [FNS Records]
Appendix D: Policy Monitoring & Evaluation Plan

SFNP STO 3: Increase communication of the competitive food & beverage policy

NEW STO3.1: % (#) of schools in which school leaders communicate that all foods sold, provided, or served within school buildings or on school grounds outside of the school meals program must follow the BPS nutrition guidelines

STO3.2: % (#) of schools in which school leaders communicate that food sold in competition with school meals, including food-based fundraisers and vending machines, during school meal times is prohibited (previously STO3.1)

NEW STO3.3: % (#) of schools in which school leaders communicate that the use of food alternatives for school fundraisers, school parties, and classroom celebrations is encouraged

NEW STO3.4: % (#) of schools in which school leaders communicate that the use of food or beverage as a reward or means of discipline is prohibited

SFNP STO 4: Maintain 100% of schools with cafeteria staff with all required certifications, inspected kitchen, and a Hazard Analysis and Control Points plan

STO4.1: % of schools with cafeteria staff with all required certifications, compliant kitchen, and a Hazard Analysis and Control Points plan [FNS Records]

SFNP STO 5: Increase in schools teaching healthy eating habits in health education, physical education, and other subjects

SFNP STO5. 1: % (#) of schools teaching nutrition education through Comprehensive Health Education

SFNP STO6: Increase in the number of satellite schools able to provide bulk, freshly-prepared, on-site meal service

STO6.1: % of schools receiving vended meals

STO6.2: % of satellite schools that are converted to be able to provide bulk, freshly-prepared, on-site meal service (In three years, all schools implementing My Way Cafe model)

SFNP STO7: Increase in schools with policies and practices to promote healthy eating and discourage unhealthy eating habits in students [Profiles] (previously IMO 3)

STO7.1: #(% of schools that sell food and/or beverages from school vending machines or at a school store, fundraisers, canteen, or snack bar that met BPS nutritional guidelines

NEW STO7.2: # (%) of schools that offer fruits and non-fried vegetables when food or beverages are offered at school celebrations

NEW STO7.3: # (%) of schools that collected suggestions from students, families, and school staff on nutritious food preferences and strategies to promote healthy eating

NEW STO7.4: # (%) of schools that conducted taste tests to determine food preferences for nutritious items

NEW STO7.5: # (%) of schools that planted a school food or vegetable garden

NEW STO7.6: # (%) of schools that offered a self-serve salad bar to students

NEW STO7.7: # (%) of schools that encouraged students to drink plain water

NEW STO7.8: # (%) of schools that prohibited less nutritious foods and beverages (e.g., candy, baked goods) from being sold for fundraising purposes

NEW STO7.9: # (%) of schools that prohibit advertisements for candy, fast food restaurants, or soft drinks in various physical and digital school locations

NEW STO7.10: # (%) of schools that permit students to have a drinking water bottle with them during the school day: a. in all locations; b. in some locations

NEW STO7.11: # (%) of schools that offer a free source of drinking water in the cafeteria
Appendix D: Policy Monitoring & Evaluation Plan

IMO1.1: Number or percent of schools with at least XX% of students participating in SBP, NSLP, CACFP, and Summer meals program [FNS Records]

SFNP IMO 2: Reduced food waste

* IMO2.1: Difference in weight between food served and food uneaten (thrown away) [BOSfoodlove]

SFNP IMO 3: Increase in student practicing healthy eating habits [FNS Records] (previously IMO 4)

IMO3.1: # of breakfast provided
IMO3.2: # of milk provided
IMO3.3: # of students choosing/served a fruit
IMO3.4: # of students choosing/served a vegetable

Physical Activity & Physical Education (PE/PA) Metrics

PE/PA Process Outcomes [OHW Records]

PO1: # of PD opportunities for PE, PA and SRTS
PO2: # of teachers in attendance at PDs
PO3: # of IC sessions for PE, PA and SRTS
PO4: Tools developed for school-based staff (Qual)
PO5: # of TA sessions
PO6: # of active PA community partnerships
PO7: # of PE curricula distributed
PO8: # of PE equipment distributed
PO9: # of MS Athletic programs
PO10: # of HS Athletic programs

PE/PA STO1: Improve the staffing capacity of schools to provide PE according to Policy

STO1.1: #(%) of schools with PE staff FTE to provide PE according to policy.

PE/PA STO 2: Increase capacity of school-based staff to deliver high quality PE/PA programs

School day: PE, Recess, Before/After school programming (including sports), SRTS [OHW Records]

STO2.1: #(%) of schools with PE teachers completed IC during last 2 years
STO2.2: #(%) of schools implementing standards-based PE curricula
STO2.3: #(%) of schools with PE teachers that have completed PD for PE
STO2.4: #(%) of schools with teachers that have completed PD for PA
STO2.5: #(%) of schools with teachers that have completed PD for SRTS
STO2.6: #(%) of schools receiving training on active recess

PE/PA STO 3: Increase % of schools offering any PE

STO3.1: # (%) of schools offering any amount of PE classes [Profiles]

PE/PA STO 4: Increase % of schools offering recess to grades PreK-8 [Profiles]

STO4.1: # (%) of schools offering at least 20 min of recess for grades PreK-5
STO4.2: # (%) of schools offering at least 20 min of recess for grades 6-8

NEW STO4.3 mean number of minutes of recess offered per grade K-8
## Appendix D: Policy Monitoring & Evaluation Plan

**PE/PA STO 5:** Increase % of schools offering before- and after-school physical activity opportunities

- **STO5.1:** #(%)(s) of schools in SRTS program [OHW Records]
- **STO5.2:** #(%)(s) of schools with MS Athletic programs [Athletics Dept]
- **STO5.3:** #(%)(s) of schools with HS Athletic programs [Athletics Dept]
- **STO5.4:** #(%)(s) of schools with students participating in HS Athletic programs
- **STO5.5:** #(%)(s) of schools offering opportunities for students to participate in intramural sports programs or physical activity clubs [Profiles]

**PE/PA STO 6:** Increase % of schools not withholding physical activity as punishment

- **STO6.1:** # (%)(s) of schools not withholding physical activity as punishment [Profiles]

**PE/PA STO 7:** Increase number of schools that access resources, partnerships and supports

- **STO7.1:** #(%)(s) of schools with partnerships by PA/PE type [Partnership Portal]
- **STO7.2:** #(%)(s) of schools with resources/supports by PA/PE type [OHW Records]

**PE/PA STO 8:** Improve collaborations between the district, city agencies, schools, families and schools around safe, active transportation

- **STO8.1:** # (%)(s) of schools with identified priority walking routes [OHW records]
- **STO8.2:** # (%)(s) of schools participating in Walk to School Day [OHW Records]
- **STO8.3:** # (%)(s) of schools that provide pedestrian safety education programming [OHW Records]
- **STO8.4:** # (%)(s) of schools represented in requested transportation surveys (previously STO8.5)

**PE/PA IMO 1:** Increase % of students receiving PE

- **IMO1.1:** # of students who receive PE classes (PE course enrollment) (previously IMO1.2)

**PE/PA IMO 2:** Increase % of schools providing PE according to BPS policy [Profiles]

- **IMO2.1:** # (%)(s) of schools (which contain grades PreK-8) that are providing 45 minutes of weekly PE for students in grades PreK-8 (subdivided by grade level)
- **IMO2.2:** # (%)(s) of schools (which contain grades PreK-8) that are providing recommended 80 min of weekly PE for students in grades PreK-8
- **IMO2.3:** # (%)(s) of schools (which contain grades 9-12) that are providing 1 semester of PE each year for students grades 9-12 (subdivided by grade level)

**PE/PA IMO 3:** Increase % of students reporting active transportation to and from school

- **IMO3.1:** % of students that report walking or biking to school [YRBS]

**PE/PA IMO 4:** Increase % of schools with grades PreK-8 meeting policy for 150 minutes of weekly PA

- **IMO4.1:** # (%)(s) of schools providing students (PreK-8) with 150 minutes of physical activity, including at least 45 minutes of PE per week and 20 minutes of recess daily [Profiles]

**PE/PA IMO 5:** Improve the equity of access to athletic programming [Athletics]

- **IMO5.1:** #(%)(s) students participating in a school sports program
- **IMO5.2:** #(%)(s) of schools offering access to Athletics Programs according to the BPS Athletics Criteria for Equity
- **IMO5.3:** # (%)(s) of schools with equal number of boys’ and girls’ athletic teams
- **NEW IMO5.4:** Participation in MS and HS athletics programs by sex
Appendix D: Policy Monitoring & Evaluation Plan

Comprehensive Health Education (CHE) Metrics

CHE Process Outcomes: [OHW records]

PO1: # of HE PD opportunities
PO2: # of teachers/staff in attendance at PDs
PO3: Tools developed for school-based staff (Qual)
PO4: # of technical assistance sessions ( # schools reached, # of hours, and # sessions)
NEW PO5: # of instructional coaching sessions ( # schools reached, # of hours, and # sessions)
PO6: # of HE related community partnerships

CHE STO 1: Increase number of qualified and trained teachers in elementary school and licensed health education teachers in middle and high schools (previously STO 2)

STO1.1: # of qualified and trained teachers delivering health education in elementary schools [Profiles]
NEW STO1.2: Breakdown of staff roles delivering health education in elementary schools [Profiles]
STO1.3: # of Licensed health education teachers delivering health education in middle and high schools [OHC]
NEW STO1.4: % of middle and high schools with a leader health education teacher certified, licensed, or endorsed by the state to teach health education [Profiles]
NEW STO1.5: Breakdown of professional preparation of staff delivering health education in middle and high schools [Profiles]

CHE STO 2: Increase the number of schools providing Health Education [Profiles] (previously STO 4)

STO2.1: % of schools with health instruction in elementary grades (by grade level and by # of grades taught)
NEW STO2.2: % of schools with required health instruction for grades 6-12 (by school configuration)
NEW STO2.3: % of schools with required health education courses for grades 6-12 (by number of required courses and by grade level)
STO2.4: # (%) of schools offering 2 semesters of HE in MS (previously STO4.2)
STO2.5: # (%) of schools offering 1 semester of HE in HS (previously STO4.3)
NEW STO2.6: Median hours of health instruction by grade level

CHE STO 3: Increased number of schools implementing comprehensive health education curricula for all grades [OHW Records/Profiles]

STO3.1: # (%) of schools with PreK-3 grades that use approved curriculum
STO3.2: # (%) of schools with 4-5 grades that use Healthy & Safe Body Unit
STO3.3: # (%) of schools with 6-8 grades that use approved curriculum
STO3.4: # (%) of schools with 9-12 grades that use approved curriculum

CHE STO 5: Increase number of schools that leverage resources, partnerships and supports to improve the quality of HE [Profiles/OHW]

STO5.1: # (%) of schools with partnerships to support HE teaching [Profiles]
STO5.2: # (%) of schools that use a written health education curriculum to guide health education
STO5.3: # (%) of schools that use a district-endorsed health education curriculum to guide health education

CHE IMO 1: Increased number of students who receive health education (previously IMO 2)

IMO1.1: # of students who received dedicated health education time (end of year course grades) [ODA]
Appendix D: Policy Monitoring & Evaluation Plan

CHE IMO 2: Increase in number of schools providing HE according to BPS policy [Profiles, OHW, OHC]

IMO2.1: # (%) of schools with trained BPS teachers teaching grades 4-5 Healthy and Safe Body Unit in all classes
IMO2.2: # (%) of schools with grades 6-8 offering at least two semesters of skills-based health education for all students taught by a licensed health education teacher
IMO2.3: # (%) of schools with grades 9-12 offering at least one semester of skills-based health education for all students taught by a licensed health education teacher

Healthy School Environment (HSE) Metrics

HSE Process Outcomes:

PO1: School Environmental Audits [Environmental Division/BPHC records]
  PO1.1: #(%)(% of schools with SEA
PO2: Green Cleaner Policy
  × PO2.1: # of safer sanitizer bottles distributed [Facilities Mgmt]
  PO2.2: #(%)(% of programs trained to properly use Oxivir
  NEW PO2.3: #(%)(% of schools with custodians using green cleaners in classroom and offices
PO3: Rapid Response [Facilities Mgmt]
  PO3.1: # of custodians trained to properly clean/treat outbreaks
  PO3.2: Updated/Improved system for tracking illness/outbreak responses
PO4: Integrated Pest Management Program [Facilities Mgmt/IPM contractors’ records]
  PO4.1: #(%)(% of Schools with IPM Coordinators
  PO4.2: #(%)(% of Schools with IPM Plans
  NEW PO4.3 % of full-time custodians trained on IPM
PO5: Water Policy [Facilities Mgmt] (previously PO6)
  PO5.1: # (%)(% online and offline schools
  PO5.2: # of drinking water units by type
PO6: Decluttering and Zero Waste Policy [Facilities Mgmt] (previously PO7)
  PO6.2: #(%)(% of schools with zero waste equipment/bins present
  PO6.3: #(%)(% of schools with book recycling bins
  PO6.4: #(%)(% of schools with textile recycling bins
  NEW PO6.5: # of new operational equipment and signage by type
PO7: Water Policy
  PO7.1 % online and offline schools
  PO7.2 # of school drinking water units by type
PO8: Communication of HSE Policies [Facilities Mgmt/OHW/MassCOSH records]
  PO8.1: #(%)(% of school leaders trained on the Healthy School Environment-related policies
  PO8.2: # of schools participating in the HSE Wellness Champions Program (previously PO9.2)
  PO8.3: # of HSE Wellness Champion Program training sessions (previously PO9.1)

HSE STO 1: Increase in use of SEAs to identify and address HSE improvements

STO1.1: #(%)(% of repair requested as a result of SEA [Facilities Mgmt]
STO1.2: #(%)(% of repair requests completed as a result of SEA [Facilities Mgmt]
NEW STO1.3: # of Principals reported reviewing results of SEA [Profiles]
NEW STO1.4: # schools with HSE WAP goals
NEW STO1.5: % of principals coordinating with their wellness council to address issues identified in their SEA
Appendix D: Policy Monitoring & Evaluation Plan

HSE STO 2: Increase in the schools with staff using green cleaners in classrooms and offices

STO2.1: #(% of schools with staff aware of green cleaning policy [Profiles]
STO2.2: #(% of BPS Early Ed Programs, after-school programs that serve food, and YMCA school-based programs receiving and using Oxivir [Facilities] (previously STO2.3)
NEW STO2.3: #(% of schools that reported all cleaning supplies complied with the Green Cleaning Policy [Profiles]

HSE STO 3: Increase school capacity to address IPM incidents [Profiles]

STO3.1: #(% of schools with staff that know how to use IPM log (previously STO3.1)

HSE STO 4: Increase schools implementing systems to reduce, reuse, and recycle to decrease waste and clutter [Facilities Mgmt]

STO4.1: # of schools who complete declutter initiatives
NEW STO4.2: #(% of schools with active recycling programs

HSE STO5: Improve drinking water infrastructure and maintenance of water coolers at offline schools [Facilities Mgmt]

STO5.1: #(% of schools that reviewed water policy with staff

HSE STO 6: Decrease in causes of poor outdoor air quality around school buildings

STO6.1: #(% of schools where staff are aware/promote Tobacco Free Policy [Profiles]
STO6.2: #(% of elementary schools that limit busing idling to no more than 5 minutes [Profiles]

HSE STO 7: Improved building infrastructure to support active transportation and active play

STO7.1: #(% of playground assessment issues addressed [Profiles]
STO7.2: #(% of schools that have bike racks or other storage systems for students and staff [Facilities Mgmt]

HSE IMO 1: Decrease in infection and illness outbreaks [Facilities Mgmt/Health Services]

IMO1.1: # of infection and illness outbreaks

HSE IMO 2: Decrease in pest-related incidents

IMO2.1: #(% of pest incidents logged, reported, and treated [Facilities Mgmt/IPM contractors’ records]

HSE IMO 3: Decrease clutter, decrease waste and increase recycling and proper disposal of waste such as office supplies, textiles, books, electronics, batteries, ink/toner

NEW IMO3.1 # of tons recycled
STO3.2: # of OIIT e-waste requests submitted in one year (previously STO4.1.3)
STO3.3: # of universal and hazardous waste pick-ups in one year
NEW IMO3.4: Amount of waste recycled at each school per week

HSE IMO 4: Decrease bottled water needs and ensure water quality and maintenance (previously IMO 3)

IMO4.1: #(% of schools getting annual water system testing
IMO4.2: #(% schools with coolers cleaned
IMO4.3: #(% of schools undergoing water infrastructure improvements
## Appendix D: Policy Monitoring & Evaluation Plan

**HSE LTO 1:** Increase the number of high-performing school buildings with grounds that are clean and in good repair

- **LTO1.1:** SEA Trends [Facilities Mgmt]

### Safe & Supportive Schools (SSS) Metrics

**SSS Process Outcomes:**

- **PO1:** # of Behavioral Health community partnerships [BPS Partnership Portal]
- **PO2:** #%(%) of schools using universal screening for mental health [BHS Records]
- **PO3:** # of PDs / # of attendees
  - **PO3.1:** Bullying/Violence Prevention [Succeed Boston]
  - **PO3.2:** Restorative Justice [Succeed Boston]
  - **PO3.3:** Social emotional learning and instruction [SEL-I & SAWS Records]
  - **PO3.4:** Targeted interventions for vulnerable populations [BHS/Succeed Boston/Opportunity Youth Records]
  - **PO3.5:** MTSS/CBHM [BHS Records]
- **PO4:** #%(%) of schools with Student Support Team [Profiles]
- **PO5:** #%(%) of middle and high schools with EPS liaisons [Profiles]
- **PO6:** #%(%) of schools with a Homelessness Liaison [Opportunity Youth]
- **PO7:** #%(%) of schools with trained Bullying Prevention Liaisons [Profiles]

### SSS STO 1: Increased social emotional learning and instruction in schools [Profiles]

- **STO1.1:** #%(%) of schools with adequate training SEL standards
- **NEW** **STO1.2:** #%(%) of schools leaders committed to supportive students social emotional learning and development
- **NEW** **STO1.3:** #%(%) of schools with explicit systems in place to develop students SEL competencies
- **NEW** **STO1.4:** #%(%) of schools with teachers that use explicit SEL instruction
- **NEW** **STO1.5:** #%(%) of schools with teachers that implement SEL approaches that are culturally responsive
- **NEW** **STO1.6:** #%(%) of schools with teachers that are proficient in providing explicit SEL instruction

### SSS STO 2: Increased implementation of Multi-tiered System of Supports (MTSS-B) to improve school and classroom climate [Profiles]

- **STO2.1:** %(#) of schools that offer tier 1 supports
- **STO2.2:** %(#) of schools that offer tier 2 supports
- **STO2.3:** %(#) of schools that offer tier 3 supports

### SSS STO 3: Increase in schools appropriately staffed to meet the mental, emotional, and behavioral health needs of students as determined by the BPS staffing criteria for school psychologists, social workers, and guidance counselors (previously STO 7)

- **NEW** **STO3.1:** Total FTE student social, emotional, and mental health support staff positions by position type
- **STO3.2:** #%(%) school appropriately staffed according to BPS criteria [BHS/OHC Records]

### SSS STO 4: Increased quality of Student Support Teams (previously STO 8)

- **STO4.1:** % of schools indicating a “yes” on the following Profiles question: “Include the following positions on their SST: school psychologists, social workers, guidance counselors (for only HS), school nurses, community partners and trained classroom teachers” [Profiles]
Appendix D: Policy Monitoring & Evaluation Plan

SSS STO 5: Increased CBHM implementation fidelity [BHS Records] (previously STO 4)
STO5.1: Tiered fidelity inventory (measure normed) schools in CBHM model use
STO5.2: # of students screened in CBHM schools, fall and spring screening

SSS STO 6: Increase in the number of schools with behavioral health partner supports
NEW STO6.1: % of schools that collaborated with a Behavioral Health community partner
x STO6.2: #(% of schools with a minimum of 3 behavioral supports partners [BHS Records]

SSS STO 7: Increased targeted interventions for vulnerable populations [Profiles]
STO7.1: #(% of schools with gay straight alliances (previously STO3.1)
STO7.2 # (% of schools with EPS liaisons using/communicating liaison supports [Profiles] (previously IMO7.1)
STO7.3: #(% of schools providing additional supports to vulnerable populations (previously STO3.3)

SSS STO 5: Increased # of schools with all staff trained on bullying prevention
STO5.1: #(% of schools with staff trained on bullying prevention [Profiles]

SSS IMO 1: Increased # schools with all teachers implementing explicit SEL instruction (previously IMO 2)
IMO1.1: # (% of CBHM schools with all teachers teaching explicit SEL instruction. [BHS Records]
IMO1.2: # (% of CBHM schools with all teachers teaching explicit SEL instruction [Profiles]

SSS IMO 2: Improve systems for identifying and decreasing incidents of violence at schools [Succeed Boston]
IMO2.1: # of bullying incidents reported/closed (previously IMO1.3)
IMO2.2: # of students referred to Succeed Boston by Code of Conduct Violations (violence/suspensions)
(previously IMO3.1)

NEW IMO 3: Improve systems for identifying and supporting youth experiencing homelessness
IMO3.1: # of students experiencing homelessness identified
IMO3.2: # of unaccompanied youth identified
IMO3.3: # families receiving housing vouchers
IMO3.4: # families housed
IMO3.5: # students experiencing homelessness participating in summer learning programs

SSS IMO 4: Increase number of schools with safe school climate [School Climate Survey/ODA]
IMO4.1: District score on Sense of Belonging Scale
IMO4.2: District score on Student Emotional Safety Scale
IMO4.3: District score on Staff Support Scale
IMO4.4: District score on Student Physical Safety Scale

SSS IMO 5: Decrease in crisis/behavioral response requests from schools [Health Services/BHS]
IMO5.1: # of incidents where ambulance or police has been called for behavioral health needs

SSS IMO 6: Increase SEL Skills in students
IMO6.1: BIMAS adaptive scales (CBHM schools)
IMO6.2: TBD-district-wide
Appendix D: Policy Monitoring & Evaluation Plan

Health Services Metrics

HS Process Outcomes:

PO1: Quality Improvement [HS Records]
   PO1.1: Electronic Medical Record Protocols written
   PO1.2: Formula for staffing school nurses developed

PO2: Professional Development for Nurses [HS Records]
   PO2.1: #(% of nurses trained
   PO2.3: #(% of schools with nurses trained
   PO2.4: # of Nursing PD opportunities by type

NEW
PO3: Care Coordination Support Nurses Technical Assistance [HS records]
   PO3.1: # of TA sessions
   PO3.2: # of schools receiving TA

PO4: School Nurse Direct Services [SNAPNurse]
   PO4.1: # of injury visits
   PO4.2: # of acute disease management visits
   PO4.3: # of chronic disease management visits
   PO4.4: # of visit for treatments and medications
   PO4.5: Case management (school nurse/PCP/parent)
   PO4.6: # of screenings/referral/completed referrals
   PO4.7: School Nurse Referrals
      x PO4.7.1: # of referrals to HRCs
   PO4.7.2: # of referrals to SBHCs
   PO4.7.3: # of referrals for acute medical management
   PO4.7.4: # of referrals for chronic disease management

   x PO5: # of nurse-led school staff training sessions

PO6: # of Individual and group sessions with students

PO7: Health Promotions

PO8: Community partner services
   PO8.1: # of schools with access to Health Resource Centers (HRCs)
   NEW PO8.1.1 HRC services and students reached
   PO8.2: # of schools with access to School Based Health Centers (SBHCs)
   NEW PO8.2.1 SBHC services and utilization
   PO8.3: # of schools receiving community partnerships by type

PO9: Condom Accessibility [OHW records]
   PO9.1: % of high schools with CATs
   PO9.2: % of CAT members trained on how to make referrals and provide condoms

HS STO 1: Increase schools appropriately staffed to meet the medical needs of students as determined by the BPS Health Services staffing criteria

STO1.1: # (% school appropriately staffed according to BPS criteria [OHC]
   NEW STO1.2 # (total FTE) school-based nurses
   NEW STO1.3 Nurse to student ratio

HS STO 2: Increase capacity of school-based staff to deliver high quality nursing services

STO2.1: #(% of schools with nurses receiving required Health Service Professional Develop (18 hour and/or monthly exemplar practice)
STO2.2: # of nurses receiving National Asthma Certification (previously 2.7)
Appendix D: Policy Monitoring & Evaluation Plan

HS STO 3: Increase compliance with the district records and immunization and physical exam policies
STO3.1: # of schools with 90% or greater of immunization compliance (previously STO2.3)
STO3.2: % of schools with 90% or greater compliance with district physical exam policy (previously STO2.5)
STO3.3: % of Individual Health Care Plans (IHCP) (previously STO2.4)

TBD – HS STO 4: Improve school-wide awareness for students with chronic disease

HS STO 5: Increase the % of students receiving state-mandated screenings [SNAPNurse] (previously STO 4)
STO5.1: # (%) of schools with XX% of students screened: Hearing screening
STO5.2: # (%) of schools with XX% of students screened: Vision screening
STO5.3: # (%) of schools with XX% of students screened: SBIRT screening
STO5.4: # (%) of schools with XX% of students screened: Height & Weight (Body Mass Index)
STO5.6: # (%) of students with referrals for failed screening
STO5.7: # (%) of students with completed referrals for failed screenings

HS STO 6: Increase % of students visiting the nurse that return to the classroom for continued learning (previously STO 5)
STO6.1: % of students returning to their classroom [SNAPNurse]

HS STO 7: Increase the schools with nurse-lead health promotions campaigns (previously STO 6)

X STO7.1: #%(%) schools conducting nurse-lead health promotions campaigns [OHW]

HS STO 8: Increase in the % of CATs making referrals and providing condoms [OHW] (previously STO 7)
STO8.1: # of condoms distributed
STO8.2: # of sexual health referrals
STO8.3: % of schools with functioning CATs

NEW STO 9: Increase access of menstrual products to menstruating students
STO9.1: % of schools with a menstrual access program team
STO9.2: # of school nurse visits for menstrual products
STO9.3: # of menstrual products distributed

HS STO 10: Increase the provision of sexual health referrals and services [Profiles] (previously STO 8)
STO10.1: % of middle and high schools with nurses providing sexual health referrals to students
STO10.2: % of middle and high schools with nurses providing sexual health services to students

TBD - HS IMO 1: Improved school-wide management for students with chronic disease
# Appendix D: Policy Monitoring & Evaluation Plan

## Staff Wellness (SW) Metrics

**SW Process Outcomes:**

- **NEW** PO1 Centralized training opportunities to support school-based staff wellness [OHW records]

**SW STO 1: Increased % of schools with staff wellness activities and initiatives [Profiles] (previously STO 3)**

  STO1.1: % of schools with staff wellness as a goal on their Wellness Action Plan
  
  STO1.2: % of schools that answered yes to “In the past school year, did your school offer any staff wellness initiatives?”

**SW STO 2: Increase in teachers’ physical health**

- STO2.1 % of schools reporting 3+ (out of 5) on physical health

**SW IMO 1: Increase in teachers’ school climate**

- IMO1.1: Improve professional community
  
  IMO1.2: Improve support for teacher development and growth

**SW IMO 2: Increased % of schools with an institutionalized Staff Wellness Program**

- IMO2.1: % of schools with a staff wellness promotion or program that took place for an extended duration across the year. [Profiles/WAP]
## WELLNESS POLICY LONG-TERM STUDENT IMPACTS

1. **Improve student physical fitness**
   1. % of students achieving health fitness levels (Source: Fitnessgram)
      1. Health Fitness Zone in % assessments
      2. Health Fitness Zone for aerobic capacity

2. **Reduce prevalence of health-risk behaviors among students** (Source: YRBS)
   1. % of students who have ever had sexual intercourse
   2. % of students who had sexual intercourse in the last 3 months (i.e. sexually active)
   3. % of students who had sexual intercourse with four or more persons during their life
   4. % of students who have ever been pregnant or gotten someone pregnant
   5. % of students who did not go to school because they felt unsafe at school or on their way to or from school (in the last 30 days)
   6. % of students who carried a weapon on school property (in the last 30 days)
   7. % of students who were threatened or injured with a weapon on school property (in the past 12 months)
   8. % of students who were in a physical fight on school property (in the past 12 months)
   9. % of students who were bullied on school property (in the past 12 months)
   10. % of students who experienced physical dating violence (in the past 12 months)
   11. % of students who experienced sexual dating violence (in the past 12 months)
   12. % of students who were ever physically forced to have sexual intercourse (when they did not want to)

3. **Increase in protective health behaviors among students** (Source: YRBS)
   1. % of students who used a condom during last sexual intercourse (among students who were currently sexually active)
   2. % of students who used effective hormonal birth control† to prevent pregnancy (during last sexual intercourse among students who were currently sexually active)
   3. % of students who used a condom and effective hormonal birth control during last sexual intercourse (among students who were currently sexually active)
   4. % of students who were ever tested for HIV (not including tests done when donating blood)
   5. % of students who were physically active at least 60 minutes per day on all 7 days
   6. % of students who did not watch 3+ hours of TV (on an average school day)
   7. % of students who did not play video or computer games or used a computer for 3+ hours per day (for something that was not school work, on an average school day)
   8. % of students who ate breakfast daily (in the past week)
   9. % of students who ate fruit or drank 100% fruit juices 2+ times per day (in the past week)
   10. % of students who ate vegetables 2+ times daily (in the past week)
   11. % of students who drank 3+ glasses of water daily (in the past week)
   12. % of students who drank 1+ glasses of milk daily (in the past week)
   13. % of students who did not drink a soda (in the past week)
   14. % of students who did not drink a sugar-sweetened beverage† (in the past week)
Appendix D: Policy Monitoring & Evaluation Plan

4. Improve feeling of school connectedness among students (Source: YRBS & Climate Survey)
   1. % of students who have at least one teacher or other adult in their school that they can talk to if they have a problem
   2. District score on student engagement in school scale
   3. District score on appreciation for diversity scale
   4. District score on student civic participation scale

5. Improve student social-emotional wellbeing
   1. District score on student social emotional health scale
   2. District score on student growth mindset scale
   3. District score on student perseverance and determination scale

6. Improve student mental health outcomes (Source: YRBS)
   1. % of students who felt depressed (sad or hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities)
   2. % of students who did something to purposely hurt themselves without wanting to die
   3. % of students who seriously considered attempting suicide
   4. % of students who attempted suicide

7. Reduce prevalence of substance use among students
   1. % of students who currently used tobacco products (cigarettes, cigars, smokeless tobacco, electronic vapor products)
   2. % of students who currently smoked cigarettes or cigars
   3. % of students who currently used electronic vapor products
   4. % of students who currently drank alcohol
   5. % of students who currently binge drank (males 5+ drinks; females 4+ drinks in a row)
   6. % of students who currently used marijuana
   7. % of students who ever took prescription pain medication without a doctor’s prescription or differently from how a doctor told them to use it

8. Increase prevalence of students with health weight status
   1. % of students with health MI status (Source: SNAPNurse)

9. Reduce in prevalence of asthma among students
   1. % of students with asthma diagnosis (Source: SNAPNurse)

10. Reduce the prevalence of sexually transmitted diseases, HIV, and adolescent pregnancy among students (Source: BPHC)
    1. Incidence rate for chlamydia among Boston youth
    2. Incidence rate for gonorrhea among Boston youth
    3. Incidence rate for Incidence rate for gonorrhea among Boston youth among Boston youth
    4. Prevalence of Boston youth living with HIV
    5. Birth rate among adolescent females

11. Decrease number of medically-related absences among students (Source: ODA)
    1. # of medically-related absences among students

12. Improve school climate for staff (Source: School Climate Survey)
## Appendix E: MCIEA Culture & Climate Survey – Safe & Supportive Metrics

The MCIEA Culture & Climate Survey and the Student Feedback Survey administrations were interrupted by school closures in March 2020. As a result, the program ended earlier than planned and results are incomplete. To promote the voice of students who did complete the survey, results are available for schools who had at least 7 responses and a response rate of at least 10%. For each question, students were asked to respond using a 5-point scale where responses 1-3 of the scale were considered least favorable (e.g., 1 = “not at all important”, 2 = “slightly important”, and 3 = “somewhat important”) and responses 4 and 5 were considered “favorable” (e.g., 4 = “quite important” and 5 = “extremely important”). The table below represents district-level favorable results for each category and the individual questions (n=5,406).

### Sense of Belonging: 54% favorable

- 58% Feel like they belong almost totally or quite a bit at school
- 62% Feel extremely or quite accepted by the other students at their school
- 50% Understood by people at school extremely well or quite a bit
- 55% Shown a great deal or quite a bit of respect by students at their school
- 45% Feel extremely well or quite connected to the adults at their school

### Student perception of Student Emotional Safety: 48% favorable

- 30% Think students at their school are almost never or rarely unkind to each other
- 52% Think student at their school are almost never or rarely unkind to each other online
- 63% Think almost none or only a little bit of bullying occurs at their school

### Student perception of Student Physical Safety: 70% favorable

- 64% Think students almost never or rarely get into physical fights at their school
- 72% Almost never or rarely worry about violence at their school
- 64% Feel extremely or quite safe at school
- 80% Almost never or rarely feel like they might be harmed by someone at school

### Student perception of Support Staff: 49% favorable

- 45% When they are hurt, sad, or just need to talk to someone, is there an adult at school other than their teacher they can go to almost all the time or often
- 52% When they need help learning something, is there an adult at school other than their teacher who can work with them almost all the time or often
## Comparison of Boston, MA, and United States 2019 YRBS Results

<table>
<thead>
<tr>
<th>Percentage of students who…</th>
<th>Boston Middle</th>
<th>Boston High</th>
<th>MA High</th>
<th>USA High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decrease Risky Sexual Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever had sexual intercourse</td>
<td>7.9</td>
<td>37.6</td>
<td>36.9</td>
<td>38.4</td>
</tr>
<tr>
<td>Were currently sexually active (at least once in previous 3 months)</td>
<td>--</td>
<td>26.4</td>
<td>26.9</td>
<td>27.4</td>
</tr>
<tr>
<td>Had intercourse with 4+ persons during their life <em>(for middle school: 3+ persons)</em></td>
<td>2.3</td>
<td>11.0</td>
<td>7.8</td>
<td>8.6</td>
</tr>
<tr>
<td>Had been pregnant or gotten someone pregnant</td>
<td>--</td>
<td>5.7</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Increase Protective Sexual Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used a condom during last sexual intercourse (among students who were currently sexually active)</td>
<td>--</td>
<td>52.0</td>
<td>51.4</td>
<td>54.3</td>
</tr>
<tr>
<td>Used effective hormonal birth control to prevent pregnancy during last sexual intercourse (among students who were currently sexually active)</td>
<td>--</td>
<td>28.3</td>
<td>45.5*</td>
<td>30.9</td>
</tr>
<tr>
<td>Used a condom and effective hormonal birth control during last sexual intercourse (among students who were currently sexually active)</td>
<td>--</td>
<td>6.0</td>
<td>16.2*</td>
<td>9.1</td>
</tr>
<tr>
<td>Were ever tested for HIV (not including tests done when donating blood)</td>
<td>--</td>
<td>23.5</td>
<td>12.6*</td>
<td>9.4*</td>
</tr>
<tr>
<td>Were tested for a STD other than HIV (in the past 12 months)</td>
<td>--</td>
<td>20.1</td>
<td>12.7*</td>
<td>8.6*</td>
</tr>
<tr>
<td><strong>Decrease Substance Use</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently smoked cigarettes</td>
<td>1.4</td>
<td>2.8</td>
<td>5.0*</td>
<td>6.0*</td>
</tr>
<tr>
<td>Currently used electronic vapor products (Nicotine)</td>
<td>7.6</td>
<td>12.2</td>
<td>32.2*</td>
<td>32.7*</td>
</tr>
<tr>
<td>Currently drank alcohol</td>
<td>5.4</td>
<td>21.2</td>
<td>29.8*</td>
<td>29.2*</td>
</tr>
<tr>
<td>Currently were binge drinking</td>
<td>--</td>
<td>9.8</td>
<td>15.0*</td>
<td>13.7*</td>
</tr>
<tr>
<td>Currently used marijuana</td>
<td>5.9</td>
<td>22.6</td>
<td>26</td>
<td>21.7</td>
</tr>
<tr>
<td>Ever misused prescription pain medication</td>
<td>12.2</td>
<td>11.3</td>
<td>--</td>
<td>14.3*</td>
</tr>
<tr>
<td><strong>Decrease Violence Victimization, Injury, and Bullying</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not go to school because they felt unsafe at school or on their way to or from school (on at least once in the past 30 days)</td>
<td>--</td>
<td>7.5</td>
<td>6.4</td>
<td>8.7</td>
</tr>
<tr>
<td>Carried a weapon on school property (in the past 12 months)</td>
<td>--</td>
<td>3.6</td>
<td>1.8*</td>
<td>2.8</td>
</tr>
<tr>
<td>Were threatened or injured with a weapon on school property (in the past 12 months)</td>
<td>--</td>
<td>5.3</td>
<td>4.5</td>
<td>7.4*</td>
</tr>
<tr>
<td>Were in a physical fight on school property (in the past 12 months)</td>
<td>--</td>
<td>8.1</td>
<td>6.4</td>
<td>8</td>
</tr>
<tr>
<td>Were bullied on school property (in the past 12 months)</td>
<td>40.0*</td>
<td>11.2</td>
<td>16.3*</td>
<td>15.7</td>
</tr>
<tr>
<td>Were electronically bullied (in the past 12 months)</td>
<td>20.5*</td>
<td>9.7</td>
<td>13.9*</td>
<td>19.5</td>
</tr>
<tr>
<td>Experienced physical dating violence (of students who had dated in past year)</td>
<td>11.6</td>
<td>6.3</td>
<td>6.9</td>
<td>8.2</td>
</tr>
<tr>
<td>Experienced sexual dating violence (of students who had dated in past year)</td>
<td>--</td>
<td>11.5</td>
<td>6.0*</td>
<td>8.2</td>
</tr>
<tr>
<td>Were ever physically forced to have sexual intercourse (when they did not want to)</td>
<td>3.5</td>
<td>9.2</td>
<td>10</td>
<td>7.3</td>
</tr>
<tr>
<td><strong>Increase School Connectedness</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agreed or strongly agreed they feel close to people at their school</td>
<td>--</td>
<td>58.2</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Decrease Suicidality and Self-harm</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt sad or hopeless almost every day for 2+ weeks in a row (in the past 12 months)</td>
<td>26.5</td>
<td>35</td>
<td>33.8</td>
<td>36.7</td>
</tr>
<tr>
<td>Did something to purposely hurt themselves without wanting to die (in the past 12 months)</td>
<td>--</td>
<td>15.4</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Seriously considered attempting suicide (in the past 12 months)</td>
<td>22.8*</td>
<td>15.6</td>
<td>17.5</td>
<td>18.8*</td>
</tr>
<tr>
<td>Attempted suicide (in the past 12 months)</td>
<td>11.2*</td>
<td>9.3</td>
<td>7.3</td>
<td>8.9</td>
</tr>
</tbody>
</table>
## Appendix F: 2019 YRBS - Boston, State, and National Comparisons

### Comparison of Boston, MA, and United States 2019 YRBS Results (cont.)

<table>
<thead>
<tr>
<th>Percentage of students who…</th>
<th>Boston Middle</th>
<th>Boston High</th>
<th>MA High</th>
<th>USA High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Increase Physical Activity and Decrease Sedentary Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were physically active at least 60 minutes per day, all 7 days</td>
<td>19.5</td>
<td>14.8</td>
<td>21.7*</td>
<td>23.2*</td>
</tr>
<tr>
<td>Did not participate in at least 60 min of physical activity on any day in the past week</td>
<td>18.2</td>
<td>25.6</td>
<td>15.7*</td>
<td>17.0*</td>
</tr>
<tr>
<td>Did not watch television 3+ hours per day</td>
<td>74.6</td>
<td>79.3</td>
<td>--</td>
<td>80.2</td>
</tr>
<tr>
<td>Did not play video or use a computer (other than schoolwork) 3+ hours per day</td>
<td>49.4</td>
<td>54.7</td>
<td>51.2</td>
<td>53.9</td>
</tr>
<tr>
<td><strong>Increase Positive Dietary Choices</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ate breakfast daily (during 7 days before survey)</td>
<td>44.7</td>
<td>24.7</td>
<td>30.8*</td>
<td>33.1*</td>
</tr>
<tr>
<td>Ate fruit or drank 100% fruit juice 2+ times per day (during 7 days before survey)</td>
<td>--</td>
<td>26.8</td>
<td>25.9</td>
<td>28.9</td>
</tr>
<tr>
<td>Ate vegetables 2+ times per day (during 7 days before survey)</td>
<td>--</td>
<td>20.4</td>
<td>24.7</td>
<td>26.1*</td>
</tr>
<tr>
<td>Drank 3+ glasses of water daily (during 7 days before survey)</td>
<td>64.0†</td>
<td>49.5</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Drank 1+ glasses of milk daily (during 7 days before survey)</td>
<td>--</td>
<td>22.6</td>
<td>27.1*</td>
<td>28.6*</td>
</tr>
<tr>
<td>Did not drink soda (during 7 days before survey)</td>
<td>58.0†</td>
<td>29.4</td>
<td>34.7</td>
<td>31.7</td>
</tr>
<tr>
<td>Did not drink sugar-sweetened beverages not including soda (during 7 days before survey)</td>
<td>--</td>
<td>87</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

† There are no state or national data to which to compare the Boston Middle School YRBS data set; -- indicates data not available; † Indicates difference in the way the question was asked: In their lifetime rather than in the past 12 months before the survey; * Indicates a significant difference compared to Boston High School based on t-test analyses, p<.05
## Appendix G: 2019 High School YRBS – Subgroup Comparisons

### 2019 HS YRBS Significant Subgroup Differences by Sex, Race/Ethnicity, and Sexual Identity

<table>
<thead>
<tr>
<th>Health Behavior</th>
<th>Total %</th>
<th>Male (Ref)</th>
<th>Female</th>
<th>White NH (Ref)</th>
<th>Black NH</th>
<th>Asian NH</th>
<th>Hispanic/Latinx</th>
<th>Hetero (Ref)</th>
<th>LGB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decrease Risky Sexual Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ever had sexual intercourse</td>
<td>37.6</td>
<td>38.9</td>
<td>36.1</td>
<td>24.9</td>
<td>37.5</td>
<td>22.5</td>
<td>44.6</td>
<td>36.0</td>
<td>51.8*</td>
</tr>
<tr>
<td>Were currently sexually active</td>
<td>26.4</td>
<td>25.1</td>
<td>27.8</td>
<td>19.0</td>
<td>25.5</td>
<td>14.1</td>
<td>32.4*</td>
<td>25.6</td>
<td>36.7*</td>
</tr>
<tr>
<td>Had intercourse with 4+ persons during their life</td>
<td>11.0</td>
<td>13.7</td>
<td>8.5</td>
<td>6.5</td>
<td>13.7</td>
<td>2.5</td>
<td>12.2*</td>
<td>9.8</td>
<td>18.3*</td>
</tr>
<tr>
<td>Have been pregnant or gotten someone pregnant</td>
<td>5.7</td>
<td>4.3</td>
<td>7.1</td>
<td>0.8</td>
<td>8.8*</td>
<td>1.1</td>
<td>6.0*</td>
<td>5.0</td>
<td>8.7*</td>
</tr>
<tr>
<td><strong>Increase Protective Sexual Health Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used a condom during last sexual intercourse</td>
<td>52.0</td>
<td>--</td>
<td>35.4</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>45.5</td>
<td>56.9</td>
<td>36.1*</td>
</tr>
<tr>
<td>Used effective hormonal birth control to prevent pregnancy</td>
<td>28.3</td>
<td>--</td>
<td>42.9</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>33.7</td>
<td>28.0</td>
<td>25.6</td>
</tr>
<tr>
<td>Used both a condom and effective hormonal birth control during last sexual intercourse</td>
<td>6.0</td>
<td>--</td>
<td>6.9</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>3.8</td>
<td>6.2</td>
<td>6.0</td>
</tr>
<tr>
<td>Were ever tested for HIV</td>
<td>23.5</td>
<td>19.1</td>
<td>27.4</td>
<td>13.1</td>
<td>25.2*</td>
<td>13.5</td>
<td>27.8*</td>
<td>22.5</td>
<td>28.9</td>
</tr>
<tr>
<td>Were tested for a STD other than HIV in the past 12 months</td>
<td>20.1</td>
<td>15.7</td>
<td>23.5</td>
<td>8.9</td>
<td>24.1*</td>
<td>11.7</td>
<td>23.3*</td>
<td>19.0</td>
<td>24.3</td>
</tr>
<tr>
<td><strong>Decrease Substance Use</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently smoked cigarettes</td>
<td>2.8</td>
<td>3.2</td>
<td>2.3</td>
<td>0.7</td>
<td>3.1</td>
<td>2.1</td>
<td>3.2*</td>
<td>2.5</td>
<td>5.0</td>
</tr>
<tr>
<td>Currently used electronic vapor products</td>
<td>12.2</td>
<td>10.9</td>
<td>13.4</td>
<td>21.0</td>
<td>7.4*</td>
<td>13.0</td>
<td>13.1</td>
<td>12.1</td>
<td>15.9</td>
</tr>
<tr>
<td>Currently drank alcohol</td>
<td>21.2</td>
<td>18.9</td>
<td>23.8</td>
<td>35.7</td>
<td>16.8*</td>
<td>14.5*</td>
<td>22.6*</td>
<td>20.5</td>
<td>27.8</td>
</tr>
<tr>
<td>Currently were binge drinking</td>
<td>9.8</td>
<td>9.7</td>
<td>10.0</td>
<td>20.1</td>
<td>6.9*</td>
<td>7.4*</td>
<td>10.4</td>
<td>10.0</td>
<td>10.2</td>
</tr>
<tr>
<td>Currently used marijuana</td>
<td>22.6</td>
<td>20.2</td>
<td>24.9</td>
<td>29.0</td>
<td>19.2</td>
<td>12.3*</td>
<td>25.9</td>
<td>22.0</td>
<td>28.8</td>
</tr>
<tr>
<td>Ever misused prescription pain medication</td>
<td>11.3</td>
<td>9.2</td>
<td>12.5</td>
<td>6.2</td>
<td>15.5*</td>
<td>9.0</td>
<td>9.0</td>
<td>9.1</td>
<td>17.4*</td>
</tr>
<tr>
<td><strong>Decrease Violence Victimization, Injury, and Bullying</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did not go to school because they felt unsafe at school or on their way to or from school</td>
<td>7.5</td>
<td>7.4</td>
<td>7.1</td>
<td>6.8</td>
<td>5.4</td>
<td>10.8</td>
<td>7.7</td>
<td>6.2</td>
<td>14.0*</td>
</tr>
<tr>
<td>Carried a weapon on school property</td>
<td>3.6</td>
<td>4.3</td>
<td>2.7</td>
<td>0.0</td>
<td>4.7*</td>
<td>0.0</td>
<td>4.5*</td>
<td>2.7</td>
<td>7.4</td>
</tr>
<tr>
<td>Were threatened or injured with a weapon on school property</td>
<td>5.3</td>
<td>5.9</td>
<td>4.0</td>
<td>4.1</td>
<td>5.8</td>
<td>4.7</td>
<td>4.5</td>
<td>4.2</td>
<td>10.0</td>
</tr>
<tr>
<td>Were in a physical fight on school property</td>
<td>8.1</td>
<td>9.6</td>
<td>6.4</td>
<td>6.2</td>
<td>10.6</td>
<td>3.3</td>
<td>7.2</td>
<td>6.5</td>
<td>10.6</td>
</tr>
<tr>
<td>Were bullied on school property</td>
<td>11.2</td>
<td>7.3</td>
<td>15.1*</td>
<td>17.3</td>
<td>8.3</td>
<td>10.6</td>
<td>11.7</td>
<td>9.9</td>
<td>15.6</td>
</tr>
<tr>
<td>Were electronically bullied</td>
<td>9.7</td>
<td>7.8</td>
<td>10.4</td>
<td>10.9</td>
<td>7.6</td>
<td>10.6</td>
<td>9.3</td>
<td>7.8</td>
<td>16.7*</td>
</tr>
<tr>
<td>Experienced physical dating violence</td>
<td>6.3</td>
<td>4.2</td>
<td>7.6</td>
<td>--</td>
<td>5.7</td>
<td>--</td>
<td>5.9</td>
<td>5.2</td>
<td>10.2</td>
</tr>
</tbody>
</table>

-- Indicates too few responses (insufficient power to compare); * Indicates a significant difference compared to reference group (ref) based on t-test analyses, p<.05; NH=Non-Hispanic
## Appendix G: 2019 High School YRBS – Subgroup Comparisons

### 2019 HS YRBS Significant Subgroup Differences by Sex, Race/Ethnicity, and Sexual Identity (cont.)

<table>
<thead>
<tr>
<th>Health Behavior</th>
<th>Sex %</th>
<th>Race / Ethnicity %</th>
<th>Sexual Identity %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total %</td>
<td>Male (Ref)</td>
<td>Female</td>
</tr>
<tr>
<td><strong>Decrease Violence Victimization, Injury, and Bullying (cont.)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experienced sexual dating violence</td>
<td>11.5</td>
<td>5.0</td>
<td>17.3*</td>
</tr>
<tr>
<td>Were physically forced to have sexual intercourse</td>
<td>8.2</td>
<td>5.3</td>
<td>12.7</td>
</tr>
<tr>
<td><strong>Increase School Connectedness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agreed or strongly agreed that they feel close to people at their school</td>
<td>58.2</td>
<td>6.2</td>
<td>54.5*</td>
</tr>
<tr>
<td><strong>Decrease Suicidality and Self-harm</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt sad or hopeless almost every day for 2+ weeks in a row</td>
<td>35.0</td>
<td>25.1</td>
<td>44.8*</td>
</tr>
<tr>
<td>Did something to purposely hurt themselves without wanting to die</td>
<td>15.4</td>
<td>9.7</td>
<td>20.1*</td>
</tr>
<tr>
<td>Seriously considered attempting suicide</td>
<td>15.6</td>
<td>9.0</td>
<td>21.6*</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>9.3</td>
<td>6.7</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Increase Physical Activity and Decrease Sedentary Behaviors</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were physically active at least 60 minutes per day, all 7 days</td>
<td>14.8</td>
<td>20.0</td>
<td>10.0*</td>
</tr>
<tr>
<td>Did not participate in at least 60 min of physical activity on at least 1 day</td>
<td>25.6</td>
<td>18.5</td>
<td>32.0*</td>
</tr>
<tr>
<td>Watched television 3+ hours per school day</td>
<td>20.7</td>
<td>18.0</td>
<td>23.3</td>
</tr>
<tr>
<td>Played video or use a computer 3+ hours per school day</td>
<td>45.3</td>
<td>46.8</td>
<td>44.1</td>
</tr>
<tr>
<td><strong>Increase Positive Dietary Choices</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ate breakfast daily (during 7 days before survey)</td>
<td>24.7</td>
<td>28.7</td>
<td>21.1*</td>
</tr>
<tr>
<td>Ate fruit or drank 100% fruit juice 3+ times per day (during 7 days before survey)</td>
<td>26.8</td>
<td>29.4</td>
<td>24.6</td>
</tr>
<tr>
<td>Ate vegetables 2+ times per day (during 7 days before survey)</td>
<td>20.4</td>
<td>19.4</td>
<td>20.9</td>
</tr>
<tr>
<td>Drank 3+ glasses of water daily (during 7 days before survey)</td>
<td>49.5</td>
<td>49.0</td>
<td>50.2</td>
</tr>
<tr>
<td>Drank 1+ glasses of milk daily (during 7 days before survey)</td>
<td>22.6</td>
<td>30.8</td>
<td>15.0*</td>
</tr>
<tr>
<td>Drank no soda (during 7 days before survey)</td>
<td>29.4</td>
<td>25.6</td>
<td>33.1*</td>
</tr>
<tr>
<td>Drank no sugar-sweetened beverages not including soda (during 7 days before survey)</td>
<td>87.0</td>
<td>85.4</td>
<td>88.3</td>
</tr>
</tbody>
</table>

* Indicates too few responses (insufficient power to compare); * Indicates a significant difference compared to reference group (ref) based on t-test analyses, p<.05; NH = Non-Hispanic

---