BOSTON Public Schools
Focus on Children

ANNUAL REPORT

IMPLEMENTATION OF THE BPS WELLNESS POLICY

School Year 2015-2016

PREPARED BY

The BPS Health and Wellness Department
on behalf of the District Wellness Council
March 2017

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Table of Abbreviations	
BIMAS	Behavior Intervention and Monitoring Assessment System
BMI	Body Mass Index
BPHC	Boston Public Health Commission
BPS	Boston Public Schools
BSAC	Boston Student Advisory Council
CAT	Condom Accessibility Team
CBHM	Comprehensive Behavioral Health Model
CDC	Centers for Disease Control and Prevention
CLSP	Culturally and Linguistically Sustaining Practices
CSH	Coordinated School Health
CSPAP	Comprehensive School Physical Activity Program
DESE	Department of Elementary & Secondary Education
DOE	Department of Education
DWC	District Wellness Council
ETTH	Empowering Teens Through Health
FNS	Food and Nutrition Services
Boston GLASS	Boston Gay & Lesbian Adolescent Social Services
GSA	Gay Straight Alliance
Boston HAPPENS	Boston HIV Adolescent Provider and Peer Education Network for Services
HFFP	Healthy Family Fun Program
HFZ	Healthy Fitness Zone
HPV	Human Papilloma Virus
HS YRBS	High School Youth Risk Behavior Survey
HWD	Health and Wellness Department
IPM	Integrated Pest Management
K/K2	Kindergarten
K1	Pre Kindergarten
LGBTQ	Lesbian, Gay, Bisexual, Transgender and Queer/Questioning
M&E	Monitoring and Evaluation
OOAG	Office of Opportunity and Achievement Gaps
PA	Physical Activity
PD	Profession Development
PE	Physical Education
PREP	Personal Responsibility Education Program
PWTF	Prevention Wellness Trust Fund
QSP	Quality School Plan
RFP	Request for Proposals
SBIRT	Screening Brief Intervention & Referral for Treatment
SLO	Student Learning Outcomes
SRTS	Safe Routes To School
STI	Sexually Transmitted Infection
SY15-16	School Year 2015 to 2016
TA	Technical Assistance
USDA	United States Department of Agriculture
WAP	Wellness Action Plan
WSCC	Whole School, Whole Community, Whole Child Model
WellSAT	Wellness School Assessment Tool

Executive Summary

Research shows that healthy students are better learners.[1] The Boston Public Schools (BPS) understands that physical, social and emotional well-being and positive development are inextricably linked with academic success. BPS strives to be one of the healthiest school districts in the country. Our goal is to actively promote the social, emotional and physical wellness of all students to support their healthy development and readiness to learn. BPS aims to create safe, healthy and welcoming schools environments where the healthy choice is the easy choice. The District Wellness Policy supports these goals.

This report details the results for the metrics for each policy area, highlights key findings and successes, and presents action steps planned or underway to support Wellness Policy implementation, two years after baseline. It is submitted to the Superintendent of Schools and School Committee by the District Wellness Council (DWC) per the annual report requirement of the Massachusetts Standards for School Wellness Councils 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.

Key Findings for SY15-16

Wellness Councils Key Findings

- Sixty percent of schools submitted Wellness Action Plans (WAP) for SY15-16, a notable decrease from SY13-14 (73%). The late notification of the Quality School Plan (QSP) redesign and change in the WAP deadline likely contributed to the decline in completion; communication improvements are underway.
- The range of total wellness council members was 2-18 and the average size was six members. Classroom teachers (80%), nurses (72%) and PE teachers (61%) were the most common members.
- The main areas of focus in SY15-16 WAPs were comprehensive health education (65% of WAPs), comprehensive physical activity and physical education (52%), safe and supportive schools (32%) and health services (31%). Cultural proficiency remains the least addressed topic area (1%).

[1] Basch, C. (2011). Healthier students are better learners: a missing link in school reforms to close the achievement gap. *Journal of School Health,* 81(10), 593-8.

Cultural Proficiency Key Findings

- Twenty-six percent of schools had a parent or family member representative on their wellness council, according to school WAPs.
- The Office of Equity conducted a total of 21 trainings in SY14-15 and 27 trainings in SY15-16 for both school and central office staff.
- Culturally and Linguistically Sustaining Practices have been strongly prioritized through 1) the Superintendent's 2016-2021 Strategic Implementation Plan; 2) the Opportunity and Achievement Gaps Policy and Task Force; and 3) professional development and trainings for school leadership and staff.

Food and Nutrition Key Findings

- The District met the Bronze Alliance for a Healthier Generation Standard for School Meals for 100% of schools.
- The majority of schools report having four of five metrics used to measure competitive food policy compliance "Fully in Place"; only 30% of schools fully comply with the fundraising competitive food policy guidelines.
- More communications and implementation supports are needed to ensure that schools are implementing the competitive foods and beverages policy; tools to track noncompliance are under redevelopment.
- Food and Nutrition Services (FNS) continues to develop district nutritional standards above and beyond state and federal policy in order to make the BPS School Meal Program a leader and innovator in the nation.

Physical Education & Physical Activity Key Findings

- Approximately 50% of schools serving grades K1-8 provided students with opportunities to be physically active during the school day for 150 minutes per week; high schools struggle the most with about a quarter of students in grades 11 and 12 with no in-school physical activity opportunities.
- Nearly all schools offer recess for grades K1-5 while only 56%-67% of schools offer recess to grades 6-8; the percentage of schools offering recess increased in all grades except for grade seven.
- In grades K1-8, nearly all (84-98%) schools are meeting or exceeding the required 45 minutes of Physical Education (PE) per week; there was an increase from SY13-14 in all grades except for fifth and eighth grades. Schools serving grades 6-8 are more likely to offer the recommended 80 minutes of PE (55% of grades 6-7; 50% of grade 8).
- High schools are more likely to offer at least one semester of PE classes in grade 9 (93% of schools) compared to grades 10-12; the percent of schools offering at least one semester of PE in grades 10-12 increased compared to baseline (83% grade 10; 69% grade 11; 71% grade 12).
- 74% of all schools are appropriately staffed to meet the policy requirements for PE (94% of elementary; 96% of K-8; 71% of middle; and 26% of high schools), reflecting a district increase of four percentage points from SY13-14.
- BPS should continue strong district and school-based supports to increase staffing, improve scheduling, and develop implementation strategies to continue improvement trends and overcome barriers to implementation.

Comprehensive Health Education Key Findings

- Eighty-three hours of professional development in comprehensive sexual health education were offered, including 15 hours of training on our *Healthy and Safe Body Unit* for grades 4 and 5; 16 schools participated in the Personal Responsibility Education Program (PREP) and implemented an evidence-based sexual health education curriculum for grade 8; and 13 high schools implemented the *Get Real: Comprehensive Sexuality Education* curriculum.
- Only 48% of schools serving grade 4, 42% of schools serving grades 6-8 and 45% of high schools are meeting the health education course requirements.
- The district is not sufficiently staffed with licensed health education teachers in grades 6-12 or trained elementary school health education teachers to adequately teach health literacy. Efforts to hire more licensed health education teachers for middle and high schools and send more elementary teachers to be trained on health education should be prioritized by the schools.
- A majority of wellness councils are looking to improve health education; 65% of schools included a health education action step in their WAP.

Healthy School Environments Key Findings

- Most schools reviewed their Annual Environmental Audit Reports (89%), have an updated Integrated Pest Management (IPM) Plan (94%), and have identified an IPM Coordinator (93%).
- Fifty-eight percent of all schools have an operations representative on wellness councils, an increase from 42% in SY13-14.
- The BPS Water Policy was passed in June 2016, and BPS continues to work on getting more schools online with plumbed water fountains.
- Over 500 people, including teachers, custodians, and recycling coordinators, were trained on various healthy school environment topics in SY15-16.

Safe & Supportive Schools Key Findings

- Comprehensive Behavioral Health Model (CBHM) training has been provided to 41% of schools.
- Eighty-eight percent of BPS schools are publicizing and disseminating their bullying and sexual harassment policies; 94% have a designated staff member to whom students can confidentially report bullying or sexual harassment.
- Eighty-nine percent of schools have identified "safe spaces" for LGBTQ youth to receive support from school staff; 70% of high schools have student-led Gay Straight Alliance (GSA) clubs, but only 16% K-8 and 33% middle schools have student-led GSA clubs.
- Eight out of nine of the metrics used to measure services, supports and programs to build safe and supportive schools increased from SY13-14 to 15-16.
- The Office of Equity created the "Transgender and Gender Nonconforming Students - Nondiscrimination on the Basis of Gender Identity Policy" and is training schools and district staff on the policy implementation.

Health Services Key Findings

- Ninety-one percent of high schools have a Condom Accessibility Team (CAT), an increase from 83% in SY13-14. Efforts to measure the effectiveness of the CATs are underway.
- Health Services will continue building a mechanism for tracking referrals to community health organizations.

Staff Wellness Key Findings

- Twenty-eight percent of schools WAPs include a goal about staff wellness.
- 150 central office employees attended the first Employee Wellness Day.
- The DWC needs to develop the Staff Wellness Subcommittee and update the policy metrics to track staff wellness efforts.

Student Outcomes Key Findings

- In SY 15-16, there was a large increase (6 percentage points, 14 percentage points, 20 percentage points) in the percentage of K-8, middle and high school students who agreed/strongly agreed that teachers work hard to help them learn and let them know how they are doing.
- Thirty-nine percent of screened students were at an unhealthy weight (BMI overweight or obese) in 2015, a decrease from 2013 (41%), but the same as the 2011 rate. A higher percentage of Black and Latinx students are overweight or obese (43.0% and 44.9%), compared to 28.6% of White and 24.9% of Asian Students.
- The percentage of students with a known asthma diagnosis increased (14% to 20%) from SY 13-14 to SY15-16. A higher percentage of Asian, Black, and Latinx students have a known asthma diagnosis at 21%, 21% and 19% respectively, compared to 14% of White students.
- Significant declines were observed over the past decade for high school students carrying a weapon on school property (4%); being in a physical fight (20%); ever had sex (42%); have been or gotten someone pregnant (5%); and alcohol (25%) and tobacco (≤ 5%) use.
- There have been significant increases in the percentage of high school students reporting that they received sexual health education (81%, 2013 to 2015) and been taught to use a condom (68%, 2009 to 2015).
- There has been a significant increase from 2005 to 2015 in the percentage of high school students reporting not using condoms (39%) and using marijuana (22%).
- High school students that identify as LGB are more likely than their heterosexual peers to engage in many risky health behaviors, suffer from depression, and experience bullying and sexual violence

Recommendations

In order to ensure that all BPS students 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 four action steps:

1. Improve communication of the policy and policy successes to schools, youth and families:

a. Develop an overall communication and branding strategy to disseminate information about the Wellness Policy to increase awareness and knowledge among district leadership, school-based staff, parents/caregivers and students.
   i. Continue to make use of existing communication channels within the district and use new ones, as they are available.
   ii. Develop and provide standardized communications resources for use by central office departments and schools.

b. Outline multiple approaches to engaging parents and caregivers and consistently take their feedback into account to further engage these stakeholders in school-based wellness councils.

2. Develop additional planning and implementation supports for school-based wellness councils and district departments:

a. Conduct a needs assessment among school-based wellness council members to gain a comprehensive understanding of how to improve supports to school-based wellness councils.

b. Continue to hold professional development opportunities designed to support District staff working with schools and school-based wellness councils in implementing the BPS Wellness Policy.
c. Develop a wellness policy dashboard to provide schools with feedback on policy implementation.

3. Strengthen District Wellness Council and Subcommittees:

a. Develop the District Wellness Council Action Plan to ensure consistency across subcommittees.
b. Continue to build the connection between the District Wellness Council and school-based wellness councils.
c. Establish subcommittees for Cultural Proficiency and Staff Wellness.

4. Review and recommend revisions to the current District Wellness Policy:

a. Incorporate emerging policy areas, update BPS policy to incorporate changes in state or federal law and improve policy language.
b. Engage multiple stakeholders in the policy revision process, including parents and caregivers and incorporate their feedback in the District Wellness Policy.
c. Update metrics and evaluation data sources to ensure accurate and appropriate measurement of policy implementation.
d. Improve measures of impact on school- and student-level health and learning outcomes.

Introduction

Research shows that healthy students are better learners.[2] The Boston Public Schools (BPS) understands that physical, social and emotional well-being and positive development are inextricably linked with academic success. BPS strives to be one of the healthiest school districts in the country. Our goal is to actively promote the social, emotional and physical wellness of all students to support their healthy development and readiness to learn. BPS aims to create safe, healthy and welcoming school environments where the healthy choice is the easy choice. The District Wellness Policy supports these goals.

Background

BPS initially approved a District Wellness Policy in 2006. This policy was updated in June of 2013, effective for the school year beginning September 2013. The policy will be updated again in June 2017. This revised Wellness Policy incorporates community input and responds to the Healthy, Hunger-Free Kids Act of 2010 and Massachusetts General Law 111. 223. According to the Massachusetts Standards for School Wellness Advisory Committees[3], "Wellness means a process by which individuals move towards optimal physical and mental health, regardless of their current health status or disability, by practicing healthy choices within an environment which encourages healthy decision making." The 2013 District Wellness Policy incorporates the comprehensive approach outlined in the District's 2010 Strategic Plan for Health and Wellness, *Healthy Connections: Strengthening Coordination and Capacity in the Boston Public Schools to Advance Student Health and Wellness*. Action for Healthy Kids ranked the BPS Wellness Policy second out of ten other urban school districts in strength and comprehensiveness, using the Wellness School Assessment Tool (WellSAT) 2.0.

The District Wellness Policy was created to align with the Centers for Disease Control and Prevention's (CDC) coordinated school health approach, which was expanded into the Whole School, Whole Community, Whole Child (WCSS) model (Appendix A). BPS' whole child approach to education is defined by policies, practices and relationships in school environments that ensure all students, all families and all staff, in all schools are safe, healthy, welcomed, engaged, supported and challenged. The Superintendent's Strategic Implementation Plan, *Stronger Schools Stronger Boston*, connects academic instruction and well-being through one of the five key focus areas: *Implement an inclusive, rigorous and culturally/linguistically sustaining PK-12 instruction program that serves the development of the whole child.* The plan calls for educators to create safe, healthy and welcoming school environments that

Figure 1. District Wellness Policy Diagram

[2] Basch, C. (2011). Healthier students are better learners: a missing link in school reforms to close the achievement gap. Journal of School Health, 81(10), 593-8.
[3] MGL.c.111& 223,105 CMR215.003 DPH Standards for School Wellness Advisory Committees

support learning and student social, emotional and physical well-being.

The Office of Social Emotional Learning and Wellness was created in SY15-16 and leads the district's efforts to address the needs of the whole child through prevention, intervention and intensive response. The vision of this new Office is "for healthy and supportive schools to prepare all students to learn and to thrive." The Office includes the following departments: Athletics, Behavioral Health Services, BPS Cares, Health Services, Guidance Services, Health & Wellness, Safe and Welcoming Schools and Opportunity Youth. The Office also collaborates with multiple Operations departments (Food and Nutrition Services, Facilities, Transportation Services, School Safety) to implement the Wellness Policy.

The eight content areas 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 (Figure 1). The policy requires schools to establish school-based wellness councils, groups that are responsible for assessing the school on health and wellness topics, developing an action plan and implementing the action plan. The policy seeks to actively promote the health and wellness of all students to advance their healthy development and readiness to learn. Student wellness is a core value of the Boston Public Schools district.

The Superintendent-appointed District Wellness Council (DWC; see Member List in Appendix B) submits this report to the Superintendent of Schools 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.

District Wellness Council Action Plan for SY15-16

The BPS DWC Action Plan for SY15-16 (see Appendix C) focused on 1) educating the DWC on new policy areas; 2) supporting communication and implementation of BPS wellness policy in schools; 3) building connections between the DWC and school-based wellness councils; 4) completing and submitting an Annual Report to School Committee; and 5) reviewing and revising components of the District Wellness Policy and/or considering additional policy areas. All action steps were accomplished. The Council will continue to build on these successes in SY16-17.

School- and Student-Level Metrics

This report presents the data for SY15-16, the second quantitative data collection point, related to district-wide implementation of the 2013 comprehensive wellness policy. The data presented here cover both school-level metrics and student-level metrics. From an implementation standpoint, changing the environment of the school by successfully implementing policy components needs to happen before improved student outcomes (measured by student-level metrics) can be observed. School-level outcomes measure policy implementation and compliance, whereas student-level outcomes tell us objectively about students' health status (i.e., Body Mass Index) and about how students themselves gauge their safety, health and behaviors. Figure 2 shows the relationship between the District Wellness Policy, schools and students. This figure depicts the role of BPS departments and how the District Wellness Policy is anticipated to positively affect BPS students' access to programs; knowledge and skills; health behaviors;

and health status. We must understand the steps 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.

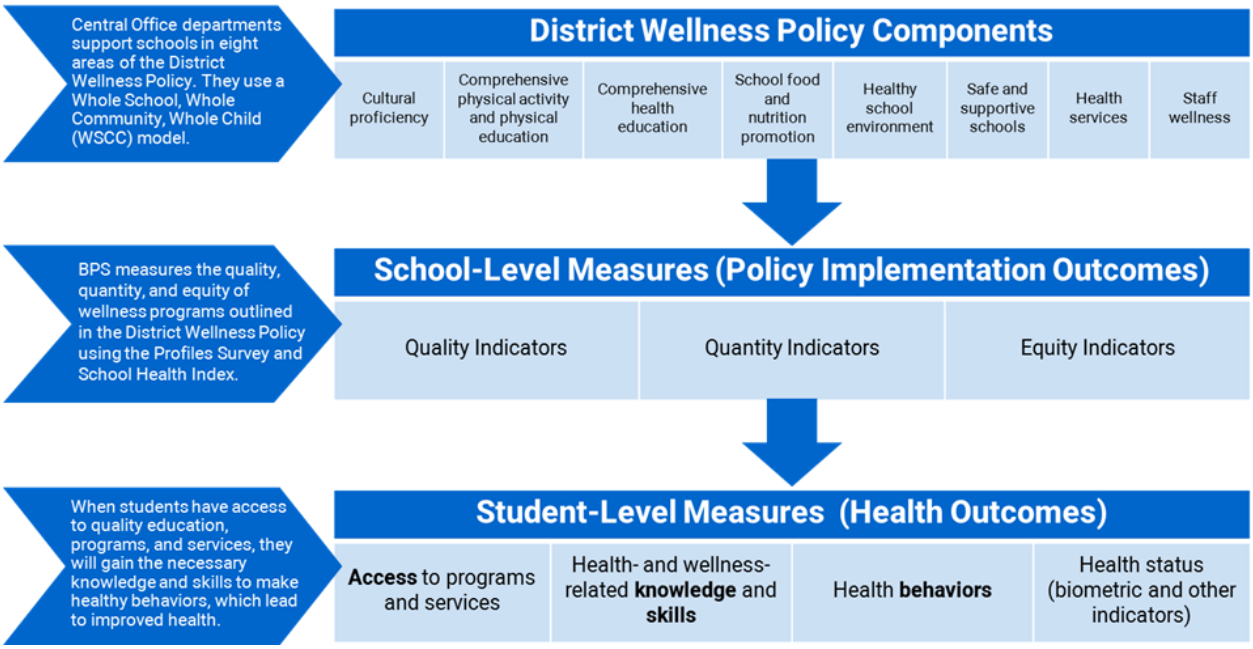


Figure 2. Relationship between district policy, schools and students

Figure 3 below depicts the alignment of school-level and student-level outcomes and how some student-level outcomes cut across more than one school-level policy area. For example, student fitness levels and healthy Body Mass Index (BMI) are both impacted by dietary behaviors and physical activity. Therefore, these two student-level outcomes are considered cross-cutting insofar as they are both related to two separate school-level metrics (Food and Nutrition and Comprehensive Physical Activity).

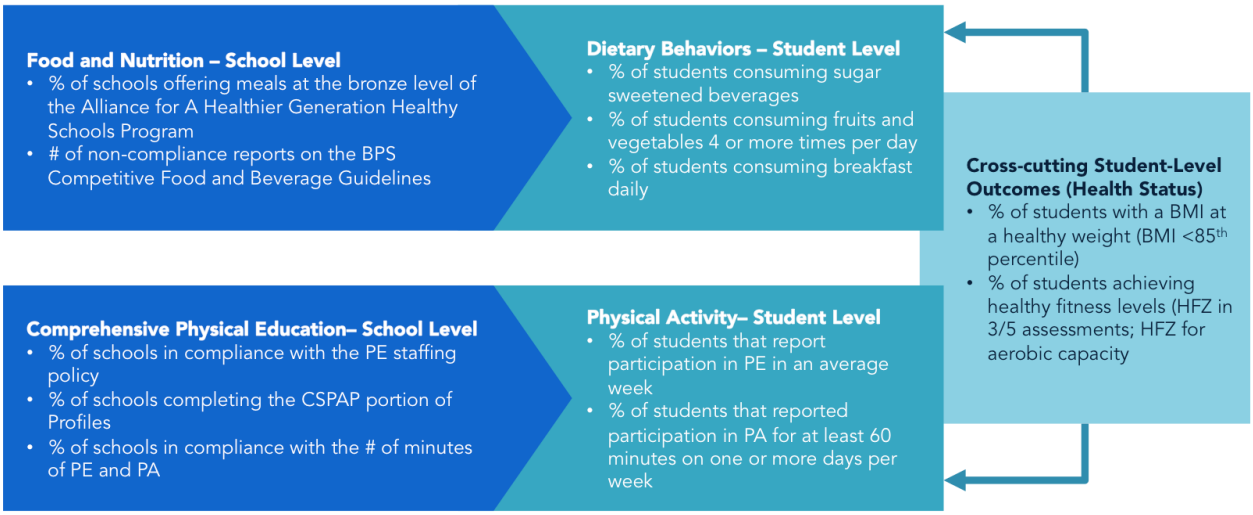


Figure 3. The alignment of school-level, student-level and cross-cutting student-level outcomes

For the purpose of the District Wellness Policy monitoring and evaluation plan, baseline data are from SY13-14. In this report, data from SY15-16 for school-level outcomes will be presented first and organized by the eight areas of the Wellness Policy. Student-level outcomes will be presented next, organized by grouped risk factor areas and will include baseline data for comparison.

Methods

Monitoring and Evaluation Plan Development

The District Wellness Policy Monitoring and Evaluation (M&E) plan was developed by the DWC during SY13-14. The goal of the M&E plan is to assess school-level policy implementation outcomes and student-level health outcomes at baseline (SY13-14), during the first year of policy implementation and over time. Each of the seven DWC subcommittees was charged with identifying school-level policy outcome metrics and student-level health outcome metrics. Subcommittees developed metrics based on policy language. To the extent possible, existing data collection tools and systems were used to identify data sources in order to ensure sustainability and feasibility of the M&E plan. In some cases, questions were added to a survey instrument. Emphasis was placed on aligning metrics with other district and department wellness-related metrics.

Data Collection Methods: School- and Student-Level Metrics

The school-level and student level metrics are drawn from various sources and managed by a number of BPS departments, as illustrated in Tables 1 and 2 below.

Table 1. Data Collection Methods for School Level Metrics

Data Source	Description
Wellness Action Plan (WAP)	WAPs are completed by School Wellness Councils and submitted annually to the Health & Wellness Department. WAPs are a part of each school's Quality School Plan (QSP).
School Health Index (SHI)	The SHI is completed by school Wellness Councils during the fall semester of each year. SHI results generate suggested action steps for school WAPs.
School Health Profiles Survey (Principal)	The Principal Profiles, a school health policies, programs, and practices survey, was completed March – June 2016 by school Principals and will be repeated during spring 2018. There is a separate Principal survey for elementary schools. Surveys are administered electronically via Survey Monkey.
School Health Profiles Questionnaire (Health Education Teacher)	The Health Education Teacher Profiles was completed March – June 2016 and will be repeated during spring 2018. It assesses health education programs, curricula, and supports in each school. This survey is geared towards schools serving grades 6-12. There is no Health Education Teacher Profiles for Elementary schools, instead, questions related to health education are added to the Principal survey for Elementary schools.
Human Resources Staffing and Health & Wellness Dept. Records	For metrics related to staffing, Human Resource staffing records were accessed and cross-referenced with Health & Wellness Dept. records. These data were used to calculate Physical Education staffing ratios to determine if schools are adequately staffed to deliver the required PE minutes and if schools are offering Health Education taught by licensed staff in grades 6-12.
Program/Department Records (various BPS departments)	Departments track programmatic data annually on an ongoing basis.
School Climate Survey	The School Climate Survey is administered by the Office of Data and Accountability. There are three types of School Climate Surveys (Student, Teacher, and Parent/Family). The results shown in this report are from the student survey. It is a paper-based survey for students in grades 3-11 and has been conducted since 2009. Beginning in SY13-14, there were two versions of the student and parent survey (Elementary: for grades 3-5, Secondary: for grades 6-11). Beginning in 2012, seniors complete a separate Senior Exit Survey. Student responses to both surveys are linked to their BPS IDs so that results can be analyzed by demographic characteristics. A factor analysis was run to determine school-level component scores represented in school-level metrics. Individual School Climate Survey reports by school can be found on the Boston Public Schools website (www.bostonpublicschools.org).

Table 2. Data Collection Methods for Student Level Metrics

Data Source	Description	Timetable	Grade levels	BPS Dept.
Youth Risk Behavior Survey (YRBS)	Assesses health-related behaviors associated with the leading causes of premature morbidity & mortality of HS-aged students. This anonymous and confidential paper-pencil survey is taken in class. Trained survey administrators proctor the survey.	Administered every other year in odd numbered years. Results available the following SY	9-12	Health & Wellness
School Climate Survey	Assesses attitudes towards/perceptions of school climate. This is a self-administered paper-pencil survey. There are 3 components: student, staff, parents. However, only the student survey is referenced in this report. Some School Climate Variables include: - Identification w/ & overall school perceptions - Student enthusiasm for learning - Perception of school as a friendly environment - Feelings of Acceptance at School - School Safety - Strong structure and routine for students	Data collection occurs annually in spring Results available the following SY	3-12	Data & Accountability
FitnessGram (FG)	A comprehensive physical fitness assessment covering the five areas of health-related fitness (aerobic capacity, muscle strength, muscle endurance, flexibility, and body composition). PE teachers are provided with professional development and support. FG is conducted in PE class in schools offering PE. Assessment scores are entered on the FG database.	Annually (varies by school)	4-12	Health & Wellness supports PE teachers
Health Services Database (SNAPNurse)	SNAPNurse is the electronic medical records system used by the BPS Health Services Department and school nurses. Body Mass Index (BMI) and asthma data are securely recorded and stored in SNAPNurse.	Annually Ongoing	K-12	Health Services supports school nurses

The data sources for three metrics across three policy areas changed from SY13-14 to SY15-16. There were also three metrics across three policy areas that were not tracked in SY15-16. Details on these changes can be found in Appendix D.

Data Analysis and Reporting

For data analysis and reporting, schools were placed into four categories as shown in Table 3. "Elementary" includes Early Education and Early Learning Centers as well as schools that contain only grades K-5. "K-8" includes schools with grades K-8 or any variation of such, including those with K-6. "Middle" includes schools with grades 6-8 and "High" includes schools with grades 6-12, 7-12, 9-12 and K-12.

Table 3. # of BPS Schools by School Level

School Level	# of Schools
Elementary	48
K-8	34
Middle	6
High	37
District	125

Throughout this report, results are presented in both table and figure formats. Data sources used to inform each metric are denoted in the table header. For each policy metric, results are calculated by dividing number of schools meeting the policy requirement by the number of schools responding to a question. Because response rates differ by data source and individual questions within the same data source, denominators used to calculate percentages may vary. Table 4 shows information on school-level data sources, including response rates, as well as the BPS Department overseeing data collection for each data source. It is important to note that response rates were

substantially lower for FitnessGram (40% less students) and Wellness Action Plan (seven percentage points) and higher for Profiles (15 percentage points) in SY15-16 than in SY13-14.

Table 4. Data Sources and Response Rates for School Level Metrics

Data Source	Response Rates										BPS Dept. overseeing data collection
	Elementary		K-8		Middle		High		District		
	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	
Wellness Action Plan	82% (45/55)	52% (25/48)	81% (21/26)	68% (23/34)	67% (8/12)	50% (3/6)	56% (20/36)	65% (24/37)	73% (94/129)	60% (75/125)	Health & Wellness
School Health Index	89% (49/55)	44% (21/48)	88% (23/26)	44% (15/34)	83% (10/12)	67% (4/6)	81% (29/36)	43% (16/37)	86% (111/129)	45% (56/125)	Health & Wellness
School Health Profiles Questionnaire (Principal)	85% (47/55)	96% (46/48)	85% (22/26)	97% (33/34)	83% (10/12)	100% (6/6)	75% (27/36)	92% (34/37)	82% (106/129)	95% (119/125)	Health & Wellness
School Health Profiles Questionnaire (Health Ed. Teacher)	–	–	65% (17/26)	94% (30/32)	67% (8/12)	83% (5/6)	78% (28/36)	89% (33/37)	72% (53/74)	91% (68/75)	Health & Wellness
Human Resources Staffing and Health & Wellness Dept. Records	–	–	–	–	–	–	–	–	–	–	Human Capital Health & Wellness
Program/Department Records (various BPS departments)	–	–	–	–	–	–	–	–	–	–	Equity; Healthy Schools Taskforce; Safe and Welcoming Schools; Behavioral Health Services; Health Services
School Climate Survey	100% (55/55)	96% (47/49)*	100% (26/26)	96% (26/27)	100% (12/12)	86% (6/7)	100% (36/36)	97% (35/36)	100% (129/129)	96% (114/119)	Data & Accountability

*Does not include Early Education Centers or Early Learning Centers as the Student School Climate Survey only surveys students in grades 3+.

School-Level Outcomes

School-level outcomes provide information regarding policy implementation and compliance at the school level. Each school-level outcomes section includes the following components:

- Policy component requirements
- Metrics
- Data Overview
- Implementation Successes in SY14-15 and SY15-16
- Action steps Planned or Underway

There are eight areas of the District Wellness Policy. All sections are reported on in this Annual Report. However, while many schools and central departments have launched or participated in staff wellness initiatives developed by the Health and Wellness Department and community partners, we do not currently have a tool to collect information on these efforts. The Health and Wellness Department hopes to bring cohesion to this work in the future through identifying additional resources and leveraging existing work, including City of Boston initiatives.

General Compliance with District Wellness Policy

General compliance with the District Wellness Policy is measured through the completion of the Wellness Action Plan (WAP). Wellness Action Plans (WAPs) are the tool that guides the school-level work of BPS School Wellness Councils. It is a requirement of the BPS Wellness Policy that every school completes a WAP for each school year and includes the WAP in the Quality School Plan (QSP). WAPs are two-year plans that are updated mid-cycle. SY15-16 was a year where new WAPs were developed. WAPs are inserted into the QSP and submitted to Teaching and Learning Team Superintendents.

Wellness Councils Key Findings

- Sixty percent of schools submitted WAPs for SY15-16, a notable decrease from SY13-14 (73%).
- The range of total wellness council members was 2-18 and the average size was six members. Classroom teachers (80%), nurses (72%), and PE teachers (61%) were the most common members.
- The main areas of focus in SY15-16 WAPs were comprehensive health education (65% of WAPs), comprehensive physical activity and physical education (52%), safe and supportive schools (32%) and health services (31%). Cultural proficiency remains the least addressed topic area (1%).

Metric

An overarching general metric for compliance with the District Wellness Policy is the percent of schools completing a WAP as a part of their QSP.

Data Overview

As seen in Table 5, 60% of schools submitted WAPs for SY15-16; this is a notable decrease from 73% in SY13-14. The District redesigned the QSP in SY15-16 and shifted the deadline for the WAP component from June to early December 2016. This shift and late notification of the change likely contributed to the decline in completion. One positive trend shows a greater percentage of high schools submitted their WAP in SY15-16 (65%) than SY 13-14. This increase may be due to the 20 high schools participating in the CDC-funded Empowering Teens through Health (ETTH) grant program, a sexual health education grant, which supports development of wellness councils and WAPs in these 20 high schools.

Table 5. % of schools completing Wellness Action Plans		
	SY13-14	SY15-16
Elementary	82% (45/55)	52% (25/48)
K-8	81% (21/26)	68% (23/34)
Middle	67% (8/12)	50% (3/6)
High	56% (20/36)	65% (24/37)
District	73% (94/129)	60% (75/125)

The most common Wellness Policy areas included in the SY15-16 WAPs are comprehensive health education (65% of WAPs), comprehensive physical activity and physical education (52%), safe and supportive schools (32%) and health services (31%). Cultural Proficiency remains the least addressed topic area in the WAPs with only one school including a related goal. Out of the 75 WAPs, 69 included a wellness council roster. The range of total members was 2-18 and the average size was six members. For council composition, classroom teachers (80%), nurses (72%) and PE teachers (61%) were the most common members. See Appendix E for further detail.

Implementation Successes for SY14-15 & SY15-16

In SY14-15, the Wellness Policy and Promotions Manager worked with the DWC subcommittees to expand the BPS Wellness Policy Implementation Toolkit to cover all eight areas of the policy. The toolkit includes overviews of the policy topic area and how to get started, school success stories and implementation resources. The Health and Wellness Department (HWD) led sessions at the New Teachers Institute and the August Leadership Institute to give an overview of the Wellness Policy, share the Toolkit and highlight how teachers and principals can be involved. Throughout SY15-16, the HWD led 10 professional development trainings on the policy and wellness councils to improve the development and effectiveness of the school-based wellness councils.

Action Steps Planned or Underway

The Health and Wellness Department will continue to communicate to schools that they must complete their WAPs and insert a link to their WAP in their school's QSP. Starting in SY 16-17, deadlines for the WAPs will be coordinated with the Instructional and Operational Superintendents to increase the emphasis on submitting WAPs through the QSP. The HWD will provide professional development and technical assistance in developing next year's plans. In SY16-17, the Health and Wellness Department hired a Wellness Council Support Coordinator to help support school-level wellness councils with completing the WAP and implementing the plan. The Toolkit will be updated in 2017 with new resources and policy updates.

Cultural Proficiency

The cultural proficiency section of the District Wellness Policy states that school-based wellness councils shall examine their school's learning environment and organizational traditions to identify inclusive practices and opportunities to celebrate diverse cultures and identities, including the physical environment, the academic environment, classroom curriculum and promotional materials. Cultural Proficiency-related policies include those regarding race, ethnicity, gender, sexual orientation, gender identity, disabilities and policies that promote family and student engagement.

Cultural Proficiency Key Findings

- Twenty-six percent of schools had a parent or family member representative on their wellness council.
- The Office of Equity conducted a total of 21 trainings in SY14-15, and 27 trainings in SY15-16 for both school and central office staff.
- Culturally and Linguistically Sustaining Practices have been strongly prioritized through 1) the Superintendent's 2016-2021 Strategic Implementation Plan; 2) the Opportunity and Achievement Gaps Policy and Task Force; and 3) professional development and trainings for school leadership and staff.

Metrics

The metrics selected by the DWC for cultural proficiency include measures of student/family involvement in school-based wellness councils and cultural proficiency trainings offered by district departments.

Data Overview

Table 6 shows 26% of schools had a parent or family member representative on their wellness council in SY15-16, not much change from baseline. Only 3% percent of schools had a student body member representative on the wellness council in SY15-16, a large decrease from 28% in SY13-14. It is important to note that principals report higher rates of parents (61%) and students (33%) on the Principal Profiles SY15-16 Survey, another and new data source for this same question. Please see Appendix E for comparison.

Table 6. % of schools with a student body member or a parent/family member on the Wellness Council. Source: WAPs

	Schools with a student on the Wellness Council		Schools with a parent representative on the Wellness Council	
	SY13-14	SY15-16	SY13-14	SY15-16
Elementary	23% (7/30)	0% (0/24)	33% (10/30)	50% (12/24)
K-8	14% (2/14)	0% (0/22)	36% (5/14)	18% (4/22)
Middle	29% (2/7)	0% (0/3)	14% (1/7)	0% (0/3)
High	54% (7/13)	10% (2/20)	8% (1/13)	10% (2/20)
District	28% (18/64)	3% (2/69)	27% (17/64)	26% (18/69)

As seen in Table 7, trainings conducted by the Office of Equity were offered to both School and Central office staff. A total of 21 trainings were conducted in SY14-15 and 27 trainings in SY15-16.

Implementation Successes for SY14-15 & SY15-16

In 2016, Superintendent Tommy Chang published the Strategic Implementation Plan for 2016-2021. The plan contains three focus areas that target improvements in culturally and linguistically sustaining practices (CLSP). Superintendent Chang and Mayor Marty Walsh's strategic efforts are aimed at closing achievement and opportunity gaps.

Table 7. Professional Development conducted by the Office of Equity from SY14-15 to SY15-16		
Title of Training	# of Trainings SY14-15	# of Trainings SY15-16
Gender Identity and Expression – Creating Safe Schools for Students (EQT-7 Training)	4	5
Welcoming Schools: Embracing Family Diversity	–	3
Welcoming Schools: Laws and Policies	–	2
Welcoming Schools: Creating Gender Expansive Schools	–	1
Preventing Harassment, Discrimination, and Retaliation Staff Training	17	8
Equity Protocols Training for Supervisors	–	8

Acting on these priorities, the Office of Opportunity and Achievement Gaps (OOAG) embarked on many exciting projects in SY15-16. School Committee approved the Opportunity and Achievement Gaps Policy in July 2016. This policy gives recommendations to BPS for the key areas of focus aimed at the elimination of opportunity and achievement gaps for students of color, economically disadvantaged students, English Language Learners and students with disabilities in BPS. OOAG has begun the process of creating an implementation plan for the policy, partnering with all offices within BPS, as well as the Opportunity and Achievement Gaps Task Force, to create SMART goals based on the objectives of the policy.

OOAG has also been influential in promoting CLSP as a focal point of the district, with an emphasis on creating environments that help sustain the cultural assets that students, families and communities bring to BPS. Professional development across all leadership positions has been hosted across the district in SY16-17, centering on the awareness of bias and bias-based practices. This foundational work with leadership will then be disseminated to schools and offices in the district starting next school year. The OOAG has already supported multiple schools and individuals to begin to dig deeper into CLSP. They partnered with Wheelock College and their Culture, Self and Teaching Course, which ran in both the spring and fall of 2016 for teachers in BPS. OOAG also supported multiple customized school-based staff professional development and created a mini-grant program that allows schools to start or continue targeted initiatives around CLSP. This program has supported work ranging from race dialogues within school communities to culturally responsive curriculum development. Furthermore, cross-departmental efforts have begun to align priority standards from the teacher and principal evaluation rubric to reflect CLSP.

Finally, the OOAG created and expanded programming targeted towards marginalized populations. Success Mentor, a program that creates one-on-one mentoring relationships for chronically absent students, started with three schools in Spring 2017: Burke High School, English High School and Perkins Elementary School.

Action Steps Planned or Underway

Given the low percentage of school-based wellness councils with representation from students, the Health and Wellness Department will continue to emphasize the importance of student voice through wellness council PDs. Student engagement is also supported through the ETTH grant through improving the quantity and quality of student-led GSA clubs. Similarly, family and parent involvement will be emphasized in trainings held by the new Wellness Council Support Coordinator on wellness council development. The Health and Wellness Department also supports family engagement through the Healthy Family Fun program, which provides funding to schools to host family engagement events emphasizing health and wellness.

The OOAG has restarted the 10-Boys program, which focuses on academic rigor, physical challenges, tutoring, real-talk spaces and community service learning for boys and young men of color. The program has been bolstered by the creation of standards-aligned curriculum (both common core and social emotional learning) and professional development focused on rights of passage. The office has also partnered with practitioners to initiate the creation of a 10-Girls program with curriculum support coming in the near future. Additionally, the Success Mentor program will expand to 5 more schools in fall 2017 with the support of Johns Hopkins University and Mass Mentors.

School Food and Nutrition Promotion

The Boston Public Schools supports lifelong healthy eating habits for students and staff. BPS shall promote healthy lifestyles and appropriate nutritional practices for all students. For school meals, competitive foods & beverages and all foods sold or provided outside of the school meals program, schools shall follow standards outlined in federal, state and local policies; and at a minimum follow Bronze status standards for the Alliance for a Healthier Generation, work toward Bronze status standards for the Healthier US School Challenge and meet the Food and Beverage Guidelines outlined in the BPS Nutrition Policy. All Boston Public Schools shall follow school food and nutrition promotion-related policies.

Food and Nutrition Key Findings

- The District met the Bronze Alliance for a Healthier Generation Standard for School Meals for 100% of schools and is approaching the Silver Standard.
- The majority of schools report having four of five metrics used to measure competitive food policy compliance "Fully in Place"; only 30% of schools fully comply with the fundraising competitive food policy guidelines.
- More communications and implementation supports are needed to ensure that schools are implementing the competitive foods and beverages policy; tools to track noncompliance are under redevelopment.
- Food and Nutrition Services (FNS) continues to develop district nutritional standards above and beyond state and federal policy in order to make the BPS School Meal Program a leader and innovator in the nation.

Metrics

The metrics selected by the DWC for school food and nutrition promotion include measures of compliance with the competitive food and beverage policy and school meals compliance with Bronze standards from the Alliance for a Healthier Generation.

Data Overview

Competitive foods and beverages: Guidelines for competitive foods and beverages comes from the FNS-3 Nutrition Policy Circular. The Health and Wellness Department receives reports of non-compliance (anonymous or not) via website, phone and email. During SY15-16, this system was under redevelopment, so no reports of non-compliance were recorded. However, based on school self-assessment data collected from the School Health Index, Table 8 shows that the majority of schools reported having four of five metrics used to measure competitive food policy compliance "Fully in Place." "Fundraising efforts during and outside school hours meet standards" showed the least compliance with only 30% of schools reporting the policy "Fully in Place."

Table 8. School Health Index responses regarding compliance with Competitive Food & Beverage guidelines for SY15-16					
(Fully in place = 3, Partially in Place = 2, Underdevelopment = 1, Not in Place = 0)	Mean	Fully in Place	Partially in Place	Under-development	Not in Place
All foods sold during the school day meet standards*	2.43	68% (38/56)	14% (8/56)	11% (6/56)	7% (4/56)
All beverages sold during the school day meet standards*	2.70	82% (46/56)	9% (5/56)	5% (3/56)	4% (2/56)
All foods and beverages served and offered during the school day meet standards*	2.45	64% (36/56)	18% (10/56)	16% (9/56)	2% (1/56)
All foods and beverages served and offered during the extended school day meet standards*	2.64	79% (44/56)	9% (5/56)	11% (6/56)	2% (1/56)
Fundraising efforts during and outside school hours meet standards*	1.80	30% (17/56)	30% (17/56)	29% (16/56)	11% (6/56)
*Standards refer to USDA's Smart Snacks in School nutrition standards					

Schools meals: All BPS schools meet the Bronze requirements outlined by the Alliance for a Healthier Generation. Schools serve salads at least twice a week and school meals are completely juice free. All schools, including satellite schools, serve fresh fruits daily. BPS schools are still 6-Cent Certified by the United States Department of Agriculture (USDA). This certification demonstrates that all Healthy Hunger-Free Kids Act meal requirements are being met, including adequate daily servings of both fruits and vegetables.

Implementation Successes for SY14-15 & SY15-16

In SY14-15, FNS made advances by getting more nutrient dense items on the menu and by incorporating more scratch cooking. FNS is now able to consistently provide satellite schools with fresh fruit daily; packaging any fruits with edible skins to ensure food safety. FNS is utilizing USDA commodities, which help to lower food costs. In collaboration with Project Bread's Chefs in Schools Initiative, FNS is exploring recipes that are culturally influenced and reflect the population of BPS students. FNS is working on defining a list of ingredients to avoid and have eliminated foods with trans fats, MSG, high fructose corn syrup, azodicarbonamide, artificial colors and sweeteners and preservatives such as BHA, BHT and THBQ. Cured meats were eliminated and with FNS efforts to reduce sugar exposure to students, juice and high sugar breakfast items were eliminated and chocolate milk is only available at lunch. The competitive food and beverage implementation guidelines have been revised to reflect updated nutrient guidelines and to clarify language on fundraising and food provided in classroom and all school events.

Action Steps Planned or Underway

Food and Nutrition Services is looking to be an innovator for school food. FNS wants to create a nutrition policy and standards that commit to clean labels, minimally processed foods and will emphasize procuring more local products. Additionally, FNS is working towards meal equity so that packaged meals sent to the satellite schools match the quality and ingredients served at the schools with full kitchens. A RFP (request for proposals) for vended meals will be released so that vendors will follow the new nutrition standards.

FNS will also be developing a communication mechanism to best reach parents and students to both let them know of the advancements with the menu and to collect feedback. To ensure alignment with BPS safe, healthy and welcoming schools, meal times and length of meals will be evaluated to make sure they are properly spaced throughout the day and leave enough time to eat and have recess. Additionally, FNS is working to make more culturally influenced meals to serve a student population that represents over 132 different countries of origin.

Efforts are underway to improve procedures for reporting and addressing violations of competitive food sales and inappropriate foods served at schools. A healthy food and beverage focus area will be developed for the Wellness Champion program to help train individuals at schools to address competitive food and beverage issues at their school.

Comprehensive Physical Activity and Physical Education

The Boston Public Schools is committed to a district-wide, strategic effort to increase all students' physical activity and fitness by bringing more physical education and physical activity to schools, improving the quality of physical education and recess and increasing the equity of physical activity programs and resources across our schools. In accordance with state law, all schools must provide all students in all grades with opportunities for physical activity. Schools should aim to offer at least 150 minutes of in-school physical activity weekly in grades K1-8, including required physical education, movement breaks, recess, or lessons involving movement. Students in K1-8 are expected to have daily recess. All schools must offer standards-based physical education (PE) for all students in all grades. Schools are required to offer at least 45 minutes of weekly PE in grades K1-8 and at least one semester of PE per grade in grades 9-12. The policy recommends that schools provide at least 80 minutes of weekly PE in grades K1-8.

Physical Education & Physical Activity Key Findings

- Approximately 50% of schools serving grades K1-8 provided students with opportunities to be physically active during the school day for 150 minutes per week; high schools struggle the most with about a quarter of students in grades 11 and 12 with no in-school physical activity opportunities.
- Nearly all schools offer recess for grades K1-5 while only 56%-67% of schools offer recess to grades 6-8; percent of schools offering recess increased in all grades but grade seven.
- In grades K1-8, nearly all schools are meeting or exceeding the required 45 minutes of PE per week; there was an increase from SY13-14 in all grades except for fifth and eighth grades. Schools serving grades 6-8 are more likely to offer the recommended 80.
- High schools are more likely to offer at least one semester of PE classes in grade 9 (93% of schools) compared to grades 10-12; the percent of schools offering at least one semester of PE in grades 10-12 increased compared to baseline.
- 74% of all schools are appropriately staffed to meet the policy requirements for PE, a district increase of four percentage points.
- BPS Should continue strong district and school-based supports to increase staffing, improve scheduling, and develop implementation strategies to continue improvement trends and overcome barriers to implementation.

Metrics

The metrics selected by the DWC for comprehensive physical activity and physical education includes measures of school compliance with the physical education (staffing and program weekly duration) and physical activity (weekly duration and program components of a Comprehensive School Physical Activity Program (CSPAP)) policy.

Data Overview

The tool for collecting CSPAP data changed in SY15-16. Physical education minutes and in-school physical activity for each grade level were reported as a part of the Principal and PE Teacher Profiles Survey, rather than via a planning chart attached to the WAP as was the approach in SY13-14.

Table 9 shows that 88% of BPS schools reported on the CSPAP in SY15-16, an increase from 67% overall in SY 13-14. Middle schools had the lowest rate of return, with only 83% of schools responding. The increase in response rate from SY13-14 to SY15-16 is due to improvements in the data collection method and provides a more complete and accurate assessment of policy implementation.

Table 9: % of schools reporting on PA		
	CSPAP SY13-14	Profiles SY15-16
Elementary	76% (42/55)	94% (45/48)
K-8	69% (18/26)	94% (32/34)
Middle	92% (11/12)	83% (5/6)
High	44% (16/36)	86% (32/37)
District	67% (87/129)	91% (114/125)

According to the data in Figure 4, approximately 50% of schools provide students with opportunities to be physically active during the school day for 150 minutes per week. Students in grades K1 and K2 are closest to receiving these minutes with about 60% of schools providing 150 minutes of physical activity per week. Only 36%-50% of schools provide students in grades 10,11 and 12 with 150 minutes per week. Overall, the average minutes of PA per week decreased in SY15-16 when compared to SY13-14. Because almost double the number of schools responded to these questions in SY15-16, the data are a more complete and accurate assessment of policy implementation than was reported at baseline.

Recess data, shown in Figure 5, shows that for elementary and K-8 schools nearly all schools offer recess for grades K1-5 while 56-67% of schools offer recess to grades 6-8. Overall, the percentage of schools offering recess increased in SY15-16 compared to SY13-14 for all grades except for 7th grade where it decreased by 2 percentage points. Again, these results reflect a more complete and accurate assessment of policy implementation given the higher response rates.

As seen in Figure 6, based on staffing data for SY15-16, 74% of all schools are appropriately staffed to meet the policy requirements for PE. Broken down by grade level, this equates to the following proportions of schools being staffed appropriately: 94% of elementary; 96% of K-8; 71% of middle; and 26% of high schools. This is a District level increase (70% to 74%) from SY13-14 in the percentage of schools that are meeting policy's staffing requirements. District data includes K-12 schools, but they are not broken out as their own category.

As Figure 7 shows, nearly all schools (84%-98%) are meeting or exceeding the required 45 minutes of PE per week in grades K1-8. This is an increase from SY13-14 for almost all grades; grades 5 and 8 showed a slight decrease. Schools are more likely to offer middle grades (6-8) the recommended 80 minutes of PE per week (50% - 55%) than elementary grades (20%-31%). However, even with higher response rates, the percentage of schools meeting or exceeding 80 minutes increased in SY15-16 compared to SY13-14.

Between SY13-14 and SY15-16, there was an increase in PE being offered for at least 1 semester in each grade (Figure 8), but the average minutes of PE per week decreased between SY13-14 and SY15-16 for grades 11 and 12. The higher survey response rates may account for some of the differences, but increases in staffing suggest high schools are doing a better job of policy implementation in SY15-16. Overall, PE is more likely to be offered in Grade 9.

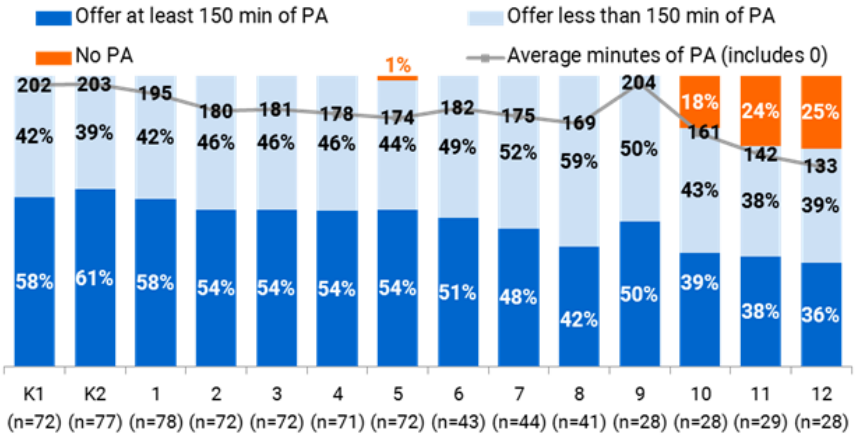


Figure 4. Percent of schools that offer opportunities for at least 150 min of PA. Source: CSPAP

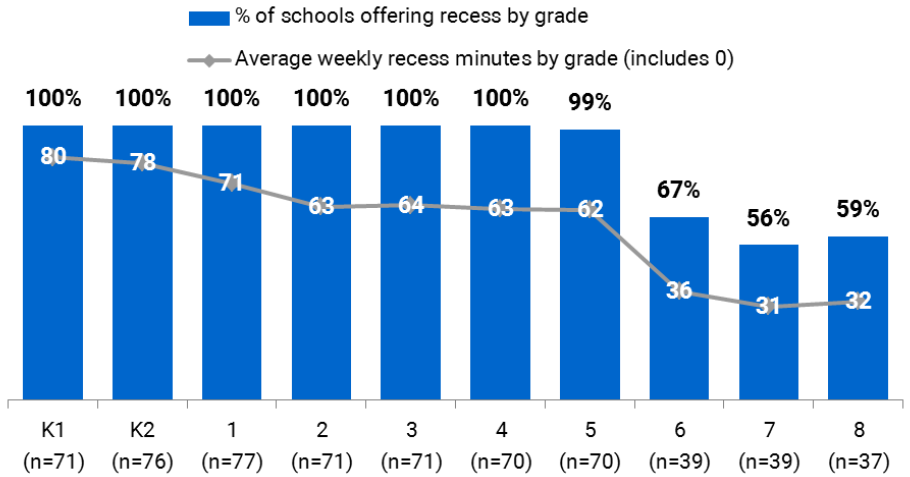


Figure 5. Percent of schools to offer recess by grade. Source: CSPAP

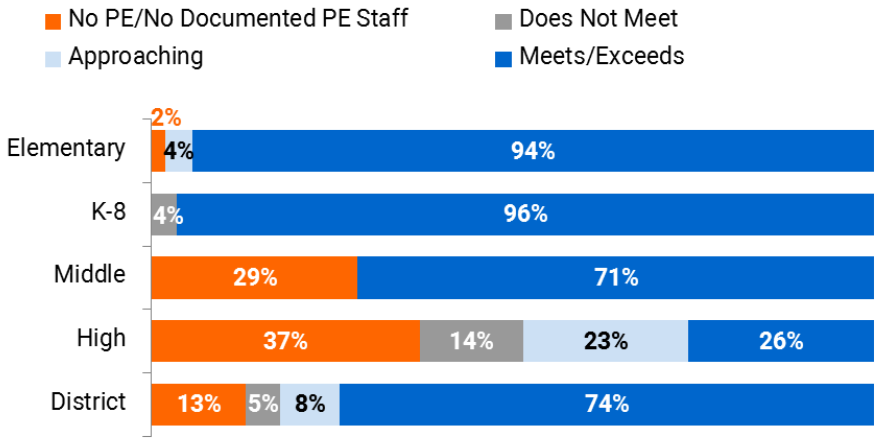


Figure 6. Percent of schools with PE staff FTE to meet the PE policy requirements. Source: CSPAP

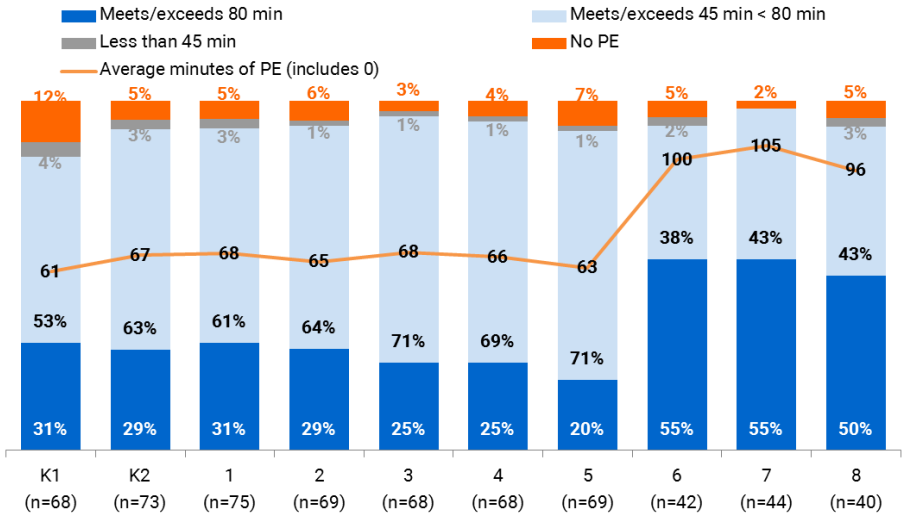


Figure 7. Percent of schools that meet or exceed the required 45 min of PE by grade. Source: CSPAP

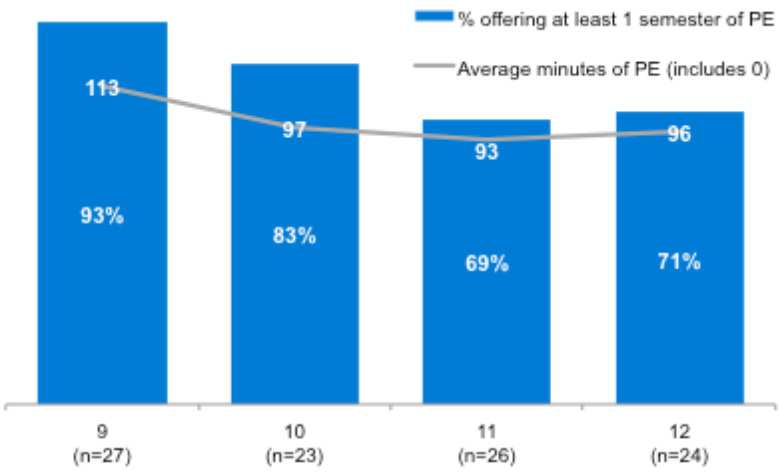


Figure 5. % of high schools offering at least one semester of PE by grade. Source: CSPAP

Implementation Successes for SY14-15 & SY15-16

Since SY10-11, the percent of schools staffed to offer PE has increased by over 20%. Seventy-four percent of schools are currently staffed to *meet* or *exceed* the PE policy. This significant increase can be in part contributed to several effective school-based supports including high quality professional development (PD), one-on-one PE instructional coaching, technical assistance (TA) for all schools and dissemination of standards-based PE curriculum and equipment. In SY14-15, PE teachers were provided with 18 PD opportunities. In SY15-16, this number increased to 23 opportunities. PDs have included *Innovations in PE*; *Social Emotional Learning through PE*; and *Inclusive Practices in PE*. In SY14-15, schools were supported with a combined total of 267 PE instructional coaching sessions and TA sessions; PE instructional coaching supported 24 schools. In SY15-16, the number of PE instructional coaching and TA sessions increased to 282; PE instructional coaching supported 18 schools. Within each of the past two years, at least 80% of PE teachers were supported through PD and/or PE instructional coaching. Each year, TA is provided to schools through PE staffing recommendations, PE program planning and PE position pairings.

PE student learning outcomes (SLOs), what students need to know and be able to do at grade level, are updated annually. SLOs are posted on the Health and Wellness Department website and are referenced at all PD opportunities. SLOs are aligned with the BPS PE Framework and organized by unit to provide schools with a standards-based scope and sequence that spirals to best support student achievement. Schools are provided with standards-based PE curricula, aligned with the SLO's, to support successful implementation.

Since 2012, the PE Lending Library, an innovative system of sharing high quality units of instruction among PE teachers, has grown to incorporate 15 innovative PE units that rotate among 56 schools. Schools are provided with PD, PE instructional coaching, TA and curriculum to support the implementation of these units. PE Lending Library units are designed to build student competence and confidence in lifelong physical activities such as Fitness Circuit Training, Rollerblading, Tennis and Snowshoeing.

In SY15-16, a Wellness Course was developed and implemented in the BPS Rising Scholars summer enrichment program for 8th grade students transitioning into 9th grade. The Wellness Course was designed to be an innovative, engaging hybrid of PE and health education, overlaying the eight essential health education skills over the BPS PE Standards. The course was successfully piloted in Summer 2016

providing students at three school sites (Brighton High School; Burke High School; Charlestown High School) with an opportunity to enter high school with PE and health education course credit.

Schools are also increasing the quality and quantity of comprehensive PA opportunities for students including recess; Safe Routes to Schools; before and after school programs; movement breaks in the classroom and whole-school family; and staff PA promotions. In SY15-16, the BPS Physical Activity Partners Collaborative was formed. This group represents collaboration between BPS and ten PA focused community partner organizations. The mission of this Collaborative is to provide all BPS students with the opportunity to be physically active for 60 minutes each day.

Recess opportunities have increased in both quantity and quality due to support for recess programs. Between SY13-14 and SY14-15, the district staffed a Recess Coordinator who supported 22 schools in implementing a high quality recess program. Support included PD, TA and recess coaching. Outdoor recess PDs were supported by Playworks. In SY14-15, a Recess Toolkit was developed to support high quality recess implementation at schools district-wide. Also in SY14-15, a PD was held for 24 PE teachers, providing them with tools and resources to support recess at their schools.

Let's Move More in the Common Core is a series of lessons designed for K-3 classrooms to integrate kinesthetic learning strategies into Math and English Language Arts instruction. Since 2014, over 70 teachers have been trained or introduced to this program via the *Wellness Champion: Movement in the Classroom* program and PD offered through the New Teacher Institute, Annual English Language Learners Institute and MyLearningPlan reached over 28 different Elementary or K-8 schools. Trained Wellness Champions are expected to share the movement-based lessons with other teachers, thus increasing exposure to individual teachers and classrooms.

Safe Routes to School Boston (SRTS) is a citywide effort to make walking to school safe, popular and fun. It is a great way to get daily physical activity that enhances student's health and their academic performance. In SY15-16, the program has reached 32% of BPS K-8 schools. Through PD, the district has trained 30 PE teachers on a pedestrian safety curriculum to implement with their students; to date 2,642 students have received Pedestrian Safety in PE. The program has offered 12 hours of training to SRTS Wellness Champions who facilitated the program at 17 schools in SY15-16. In SY15-16, two Walk to School Day events (WTSD) were held in which 13 schools participated and were attended by City Officials. Schools have completed Walk Audits to create Preferred Walking Route Maps. In SY15-16, 11 schools completed maps, which will be shared with parents to highlight safe routes to their school. District-wide 21% of students in grades K-8 reported walking or biking to and from school each day, according to a two-day Hand Tally Survey with students. In spring 2016, we collected data from 79% of K-8 schools and an average of 60% of classrooms turned in the tallies.

In SY13-14, with grant funding from Boston Children's Hospital and Kohl's Foundation, the district began supporting schools in hosting the *Healthy Family Fun Program (HFFP)*. This grant has allowed for the hiring of a HFFP Coordinator, as well as funds for schools to plan and execute the Healthy Family Fun events. All events have included physical activities, such as yoga and Zumba. Since SY13-14, schools have hosted 137 HFFP events.

In SY15-16, BPS Athletics began work on a strategic plan to integrate social emotional learning into students' athletics experience. The strategic plan is a collaborative effort between BPS and several community partner organizations. The mission of this group is to give all students (grades 6 - 12) the

opportunity to participate in an innovative athletic experience that intentionally develops the social-emotional skills and physical well-being of all athletes in a student-centric, culturally responsive environment that emphasizes the positive nature of competition.

Action Steps Planned or Underway

For SY16-17, the initiatives of the BPS PE Program are 1) maximize movement for ALL students and 2) maximize learning for ALL students. The ultimate goal is to implement PE that is safe, supportive, engaging and meaningful for every BPS student. These two initiatives are communicated to schools through PE professional development and PE Instructional Coaching.

For SY16-17, the district allotted funding to hire a second PE instructional coach, allowing for 17 additional schools to be supported on a more in-depth basis. Thirty-five schools will be supported with year-long PE instructional coaching. One PE instructional coach supports new teachers and teachers in transition (i.e. teaching at a new school or teaching a new grade level). The second PE instructional coaching supports veteran teachers through a program called the PE Learning Community, where they work together to develop and implement new, high-quality units of instruction. Exemplary units developed through the PE Learning Community will be shared district-wide through an online PE Unit Library. On-going PD opportunities continue with 22 PD opportunities planned for SY16-17.

In SY16-17, the objective of the district's PE/PA subcommittee is to develop a shared resource map of all BPS PE/PA programs by school and by grade level. This map will help the district and our PA community partners strategically target schools and grade levels where there are programmatic opportunity gaps. This will allow for more intentional supports and programming at certain schools and help to improve the equity of access to PE and PA across BPS. The BPS PA Partners Collaborative will also support this objective.

During SY16-17, *Movement in the Classroom* will again be offered as a focus for Wellness Champions and it is anticipated that another 10 schools will participate. The program continues to look for ways to expand the reach within school buildings in order to increase the consistency of teachers who utilize movement as a means to teach academic subjects.

During SY16-17, the *SRTS program* has offered 12 hours of training to SRTS Wellness Champions who facilitated the program at 13 schools. SRTS plans on engaging additional schools by rolling out a district-wide communication strategy to have more schools and parents join the movement to safely walk to school. SRTS Boston will pilot up to six easy, inexpensive and temporary pop-up traffic calming projects at participating SRTS schools to raise safety awareness and engage their immediate school and surrounding community on this issue. Mayor Marty Walsh and Police Commissioner William Evans were in attendance at the fall Walk to School Day in which 11 schools participated. Another Walk to School Day is scheduled for spring 2017.

For SY16-17, the HFFP is set to support 30 schools in implementing events that include physical activity. The district will continue to seek grant funding and other opportunities to increase the quality, quantity and equity of PE and PA programs for all of BPS.

Comprehensive Health Education

The Boston Public Schools requires Comprehensive pre-K through grade 12 Health Education that is medically-accurate, age and developmentally appropriate, culturally inclusive and implemented in safe and supportive learning environments where all students feel valued. All schools will follow relevant promotion and graduation requirements that include: Health education, inclusive of HIV education, in grade 4; two semesters of health education in grades 6 to 8 taught by a certified health teacher; and one semester course of health education in total in grades 9 to 12 taught by a certified health teacher. Health education will be integrated into the Common Core curricula where possible.

Comprehensive Health Education Key Findings

- Eighty-three hours of professional development in comprehensive sexual health education were offered, including 15 hours of training on our *Healthy and Safe Body Unit* for grades 4 and 5; 16 schools took part in the Personal Responsibility Education Program (PREP) and implemented an evidence-based sexual health education curriculum for grade 8; and 13 high schools implemented the *Get Real* curriculum.
- Only 48% of schools serving grade 4, 42% of schools serving grades 6-8 and 45% of high schools are meeting the health education course requirements.
- The district is not sufficiently staffed with licensed health education teachers in grades 6-12 or trained elementary school health education teachers to adequately teach health literacy. Efforts to hire more licensed health education teachers for middle and high schools and send more elementary teachers to be trained on health education should be prioritized by the schools.
- A majority of wellness councils are looking to improve health education; 65% of schools included a health education action step in their WAP.

Metrics

The metrics selected by the DWC for comprehensive health education include measures of: health education curriculum, teacher licensure and health education graduation requirements.

Data Overview

Survey response rates markedly increased in SY15-16, improving the policy compliance assessment in health education. Table 10 indicates that 55% of K-12 schools across the District are using written health education curriculum, with goals, objectives and expected learning outcomes. This is an increase from 51% in SY13-14. Elementary schools are the least likely to comply with the policy and provide the curriculum supports necessary for implementing quality health education programs.

Table 10. Comprehensive Health Education Curriculum: % of schools delivering a district-approved health education curriculum that meets standards outlined in the Wellness Policy (Profiles)

% of schools that provide those who teach health education with each of the following materials	Elementary		K-8		Middle		High		District	
	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16
Goals, objectives, and expected outcomes for health education	42% (18/43)	45% (19/42)	65% (11/17)	74% (23/31)	75% (6/8)	50% (2/4)	75% (21/28)	71% (22/31)	58% (56/96)	61% (66/108)
A chart describing the annual scope and sequence of instruction for health education	26% (11/43)	31% (13/42)	53% (9/17)	71% (22/31)	25% (2/8)	50% (2/4)	57% (16/28)	53% (16/30)	40% (38/96)	50% (53/107)
Plans for how to assess student performance in health education	30% (13/43)	36% (15/42)	53% (9/17)	55% (17/31)	63% (5/8)	50% (2/4)	57% (16/28)	65% (20/31)	45% (43/96)	50% (54/108)
A written health education curriculum	31% (13/42)	41% (17/42)	63% (10/16)	68% (21/31)	50% (4/8)	50% (2/4)	75% (21/28)	61% (19/31)	51% (58/94)	55% (59/108)
% of schools that address each of the following skills in its health education curriculum	**Elementary**		**K-8**		**Middle**		**High**		**District**	
	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16
Comprehending concepts related to health promotion and disease prevention to enhance health	29% (12/41)	28% (12/43)	63% (10/16)	66% (21/32)	63% (5/8)	75% (3/4)	79% (22/28)	74% (23/31)	53% (49/93)	54% (59/110)
Analyzing the influence of family, peers, culture, media, technology, and other factors on health behaviors	27% (11/41)	21% (9/43)	73% (11/15)	63% (20/32)	63% (5/8)	50% (2/4)	81% (21/26)	77% (24/31)	53% (48/90)	50% (55/110)
Accessing valid information, products and services to enhance health	24% (10/41)	14% (6/43)	53% (8/15)	50% (16/32)	63% (5/8)	75% (3/4)	78% (21/27)	74% (23/31)	48% (44/91)	44% (48/110)
Using interpersonal communication skills to enhance health and avoid or reduce health risks	29% (12/41)	26% (11/42)	73% (11/15)	75% (24/32)	75% (6/8)	75% (3/4)	79% (22/28)	71% (22/31)	55% (51/92)	55% (60/109)
Using decision-making skills to enhance health	29% (12/41)	30% (13/43)	69% (11/16)	75% (24/32)	75% (6/8)	75% (3/4)	79% (22/28)	77% (23/30)	55% (51/93)	58% (63/109)
Using goal-setting skills to enhance health	20% (8/41)	23% (10/43)	67% (10/15)	63% (20/32)	75% (6/8)	75% (3/4)	75% (21/28)	68% (21/31)	49% (45/92)	49% (54/110)
Practicing health-enhancing behaviors to avoid or reduce risks	27% (11/41)	33% (14/43)	75% (12/16)	72% (23/32)	75% (6/8)	75% (3/4)	75% (21/28)	74% (23/31)	54% (50/93)	57% (63/110)
Advocating for personal, family, and community health	20% (8/41)	16% (7/43)	67% (10/14)	59% (19/32)	63% (5/8)	75% (3/4)	67% (18/27)	74% (23/31)	45% (41/91)	47% (52/110)

As seen in Table 11, 42% of schools that teach grades 6-8 comply with the policy requirement of a minimum of two semesters of health education in grades 6-8. Compliance with one semester of health education in grades 9-12 increased in high schools from 35% to 45% between SY13-14 and SY15-16. The percentage of schools teaching health education in grade 4 was 48%, a decrease from 53% in SY13-14. The percent of schools that contain middle and high school grades with licensed health education teachers that are currently teaching slightly increased from 12% to 14% between SY13-14 and SY15-16. A higher percentage (32%) of schools have a trained health education teacher at the elementary level, a decrease from 42% in SY13-14. For SY15-16, 65% of schools included a health education action step on the WAP, an increase from 8% at baseline.

Table 11. % of schools with trained Health Education teachers, % of schools teaching Health Education, & % of schools with a Health Education action step (HWD records, Profiles, WAP)

Comprehensive Health Education is taught by trained teachers:	Elementary		K-8		Middle		High	
	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16
% of schools with trained health education teacher in elementary	49% (24/49)	25% (12/48)	35% (8/23)	41% (14/34)	–	–	–	–
% of schools with certified health education teachers in middle and high (certified - licensed to teach HE in MA and who were teaching HE)	–	–	12% (3/26)	12% (4/34)	17% (2/12)	17% (1/6)	11% (4/36)	16% (6/37)
Comprehensive Health Education is taught to students:	**Elementary**		**K-8**		**Middle**		**High**	
	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16
% of schools teaching HE in grade 4	51% (20/39)	54% (20/37)	44% (7/16)	35% (9/26)	–	–	–	100% (2/2)
% of schools teaching HIV prevention (elementary)	7% (3/43)	7% (3/44)	–	–	–	–	–	–
% of schools teaching a minimum of two semesters of comprehensive health education in grades 6-8	–	–	50% (4/8)	48% (14/29)	100% (4/4)	20% (1/5)	–	33% (3/9)
% of schools teaching a minimum of one semester of comprehensive health education in grades 9-12	–	–	–	–	–	–	35% (6/17)	45% (15/33)
Health Education Action Step	**Elementary**		**K-8**		**Middle**		**High**	
	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16
% of schools with an action step regarding health education on their Wellness Action Plans	4% (2/49)	56% (14/25)	13% (3/23)	48% (11/23)	30% (3/10)	100% (3/3)	4% (1/28)	88% (21/24)

Implementation Successes for SY14-15 & SY15-16

Student learning outcomes (SLOs), what students need to know and be able to do at grade level, are updated annually. SLOs are posted on the Health and Wellness Department website and are referenced at all professional development opportunities. In SY15-16, a total of 142 hours of professional development in health education were offered, including 59 hours in comprehensive health education and 83 hours in sexual health education. This includes 15 hours of training on our *Healthy and Safe Body Unit*, a health education curriculum that is inclusive of HIV education for Grades 4 and 5. Thirty-nine teachers & staff were trained on this curriculum, reaching 34 schools. According to SY15-16 Qualtrics survey results, 21 of these schools taught this unit. At the K-8/Middle schools levels, 16 schools participated in the Personal Responsibility Education Program (PREP) and implemented an evidenced-based sexual health education curriculum to 8th graders. The curriculum was taught by trained teachers/staff and supported by the HWD and community partners. The HWD received funding from the Department of Elementary and Secondary Education through the Teen Pregnancy Prevention grant to fund this program. This funding ended in August 2016. At high school grade levels, 7 teachers/staff were trained in the *Get Real* curriculum in SY15-16 as part of the ETTH program. Thirteen schools are currently implementing this curriculum. The Wellness Champion program included a Health Education focus option in SY15-16. Seven schools participated in this program completing all requirements including: attending training, delivering a unit of instruction and hosting a Healthy Family Fun event.

Action Steps Planned or Underway

Building on the work to improve the quality, increase the quantity and ensure the equity of comprehensive health education across the District, the Health and Wellness Department advocated and received district funds to hire a 1.0 FTE Health Education Instructional Coach. This position will directly support school-based teachers/staff to implement high-quality programming, including supporting those who have been a part of the PREP program at the middle school grade level. The Health and Wellness Department will continue to host professional development on Comprehensive Health Education, as well as training specifically geared to supporting sexual health education. The department is working closely with Advocates for Youth to bring their comprehensive sexuality education curriculum, *Rights, Respect, Responsibility* to BPS. They will expand the professional development offerings and target the lower middle school grades (Grades 6 & 7) with this curriculum, allowing for more seamless programming as they bridge Grade 4 & 5 programming to Grade 8. The department will also target Grade 9 so that they are better able to serve all high schools, expanding beyond those currently served by the ETTH program, which supports 20 of our 34 high schools.

The Health and Wellness Department acknowledges and values the community partners and they will continue to work closely with them to enhance and support school programming. In an effort to better address particularly challenging school-based issues and concerns and to reach a broader audience, the department has modified the monthly series of PD - health education workshops featuring BPS departments and key community partners, to a Health Education PD Series that will be offered quarterly. This series of workshops will allow community partners to use their knowledge and expertise to help build staff capacity, helping to increase the quality of school programming and ensure the equity of resources and support across schools.

The Health and Wellness Department provides evidenced-based curricula to those teachers/staff who attend training and offers support to schools on curriculum implementation. As more teachers and staff attend professional development training and implement high-quality curriculum, the department expects to see some of those staff and teachers becoming licensed health education teachers as they gain in confidence and competence and witness the impact of programming on their students. As the Health and Wellness Department expands programming and continues to offer Health Education as a focus option as part of the Wellness Champion program, they are likely to increase the number of schools that include a health education action step on their WAP. Lastly, the District Wellness Policy requirement for licensed health education teachers at the middle and high school levels is expected to lead to larger numbers of licensed health education teachers over time. Improvements in these areas continue to be observed in SY16-17.

Healthy School Environments

The Boston Public Schools is committed to providing high-performing school buildings and grounds that are in good repair, have superior indoor air quality, are clean, use resources efficiently, provide opportunities for physical activity and provide accessible and culturally-inclusive learning environments that positively impact the productivity, health and wellness of all students and staff. To meet these standards, the Boston Public Schools shall maintain a Healthy Schools Taskforce (HSTF) 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, through an Environmental Committee or school-based wellness council, shall comply with existing city ordinances and District policies related to promoting and managing healthy school environments, including but not limited to Green Cleaners, Integrated Pest Management (IPM), Recycling, Infection Prevention & Control, Tobacco Free Environmental Policy, Environmental Inspection/Audit, Student Safety/Health in School Shops, Water Policy and Laboratories and Chemical Inventory "Right to Know" Law.

Healthy School Environments Key Findings

- Most schools reviewed their Annual Environmental Audit Reports (89%), have an updated IPM Plan (94%), and have identified an IPM Coordinator (93%).
- Fifty-eight percent of all schools have an operations representative on school wellness councils, an increase from 42% in SY13-14.
- The BPS Water Policy was passed in June 2016, and BPS continues to work on getting more schools online with plumbed water fountains.
- Over 500 people, including teachers, custodians, and recycling coordinators, were trained on various healthy school environment topics in SY15-16

Metrics

The metrics selected by the DWC for healthy school environments include measures of: operations representation on wellness councils, use of healthy school environment tools at the school level and staff training on healthy school environment topics.

Data Overview

As seen in Table 12 below, 58% of all schools have an Operations representative (custodian or administrator) included on the wellness Council. At the district level, 89% of schools report reviewing the school building environmental audit - an important first step in addressing school-level healthy environment issues. Ninety-four percent have an updated IPM Plan and 93% of schools have identified an IPM Coordinator. These are all indicators that schools are working to address healthy school environment policies.

Table 12. Healthy School Environments (WAPs & Profiles)

	Elementary		K-8		Middle		High		District	
	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16
% of schools with an operations representative on the Wellness Council (either custodian or administrator in charge of school building operations) (Source: WAPs)	47% (14/30)	63% (15/24)	36% (5/14)	64% (14/22)	29% (2/7)	33% (1/3)	46% (6/13)	50% (10/20)	42% (27/64)	58% (40/69)
% of schools where annual BPS/BPHC Environmental Audit results are reviewed annually	90% (37/41)	93% (42/45)	82% (18/22)	85% (28/33)	75% (6/8)	83% (5/6)	77% (17/22)	88% (29/33)	84% (78/93)	89% (104/117)
% of schools that have an updated Integrated Pest Management (IPM) plan	93% (38/41)	89% (40/45)	95% (21/22)	100% (33/33)	88% (7/8)	83% (5/6)	91% (20/22)	97% (32/33)	92% (86/93)	94% (110/117)
% of schools that have identified an IPM Coordinator	83% (33/40)	89% (40/45)	95% (21/22)	97% (32/33)	75% (6/8)	83% (5/6)	95% (18/19)	97% (32/33)	88% (78/89)	93% (109/117)

Over 500 people (Table 13), including teachers, custodians and recycling coordinators, were trained on various healthy school environment topics in SY15-16.

Table 13. Professional Development on Healthy School Environments (Food & Nutrition Services & Facilities Department Records)

	Number of staff and teachers who received professional development about healthy school environment topics
Cafeteria Managers	140
Custodians	337
Nurses	15
School Administrators	1
Teachers	24
Total	517

Implementation Successes in SY14-15 & SY15-16

In SY15-16, a new Water Policy was passed in June 2016 to help ensure reliable access to safe drinking water in all BPS schools. In accordance with the policy, BPS hired an engineering consulting firm to retest the drinking water in the 30 school buildings that had active water fountains. BPS also conducted testing of sinks in all school nurses' offices and all food-preparation areas. Principals and cafeteria staff received training on the policy and protocols in August of 2016.

The HSTF is a group that meets quarterly and oversees policies to improve school health conditions. They raise awareness and educate various stakeholders such as teachers, custodians and nurses, about BPS green cleaning and environmental policies. In SY15-16, they worked on the Safer Sanitizer Project and began to pilot the use of OxivarTB Ready-to-Use sanitizer. The goal of this pilot program was to reduce exposure in the classrooms to bleach – a sanitizing and disinfecting product that can be an asthma trigger.

As a part of the Wellness Champion program, 14 individuals from 12 schools received training and technical assistance in the Healthy Environments topic area. The Champions used the Asthma Friendly Checklist, conducting a building walk through environmental audit with the help of school district and city and community partners. They also worked with their wellness council to review building environmental health audit(s); identified areas for reducing asthma and allergen triggers in the school; and took action on at least one environmental health area such as: eliminating pests, reducing clutter, using

green cleaners in classrooms, managing good recycling practices, controlling outdoor air pollution, promoting water consumption.

Action Steps Planned or Underway

At the beginning of SY16-17, 24 school buildings receive drinking water from active water fountains and 108 school buildings receiving bottled water. Efforts will continue around implementing the Water Policy and ensuring that all students have access to clean water throughout the school day. The district's intent has been and will continue to be, to take steps to ensure that all of our schools are "online" (receiving drinking water from active water fountains connected to the public water system) as soon as possible. The district is now taking an additional step of installing filters in food-service equipment, where applicable. BPS will continue to consult with health and water experts to develop a long-term solution that will ensure predictable and consistently low, or non-detectable, lead levels. We will work to further explore the use of filtering mechanisms, advance our knowledge of water system flushing protocols and adopt best practices that could serve as a national model. The Health and Wellness Department is developing and disseminating health education lessons on the importance, benefits and access to safe drinking water. Harvard School of Public Health will begin research on perceptions of drinking water and current drinking patterns in a subset of schools. These findings will inform future educational and promotional campaigns.

The piloting of OxivarTB will continue through January of SY16-17 in 10 schools with early education classrooms. During this pilot period, the HSTF will continue to research and discuss the best way to roll out the new "safer sanitizer" policy for all early education and afterschool programs. Further research on whether classroom tables need a "food contact" sanitizer will be performed. Lastly, the Wellness Champion program will continue to offer individuals in about 10 schools the opportunity for training and technical assistance on creating healthy school environments.

Safe and Supportive Schools

The Boston Public Schools shall 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 provides access to support services. Prevention and intervention-based work will address and integrate social health, emotional health, mental health, behavioral health, physical health, suicide prevention, safe inclusive climates for LGBTQ students, violence prevention, including intimate partner violence, sexual harassment & assault prevention, bullying and cyberbullying prevention, emergency preparedness, school safety, substance use and pregnant and parenting students. Schools shall implement the Comprehensive Behavioral Health Model (CBHM) to equip all students with the skills and provide supports and services, needed to address the multitude of challenges they face in our schools and communities. CBHM incorporates the six elements of the Safe and Supportive Schools Framework, including: leadership, professional development, academic and non-academic strategies, access to resources and services, policies and protocols and collaborations with families. In addition, schools shall follow the code of conduct and related policies. Schools shall also promote healthy relationships and follow the Sexual Misconduct policy.

Safe & Supportive Schools Key Findings

- Comprehensive Behavioral Health Model (CBHM) training has been provided to 41% of schools.
- Eighty-eight percent of BPS schools are publicizing and disseminating their bullying and sexual harassment policies; 94% have a designated staff member to whom students can confidentially report bullying or sexual harassment.
- Eighty-nine percent of schools have identified "safe spaces" for LGBTQ youth to receive support from school staff; 70% of high schools have student-led Gay Straight Alliance (GSA) clubs, but only 16% K-8 and 33% middle schools have student-led GSA clubs.
- Eight out of nine of the metrics used to measure services, supports and programs to build safe and supportive schools increased from SY13-14 to 15-16.
- The Office of Equity created the "Transgender and Gender Nonconforming Students - Nondiscrimination on the Basis of Gender Identity Policy" and is training schools and district staff on the policy implementation.

Metrics

The metrics selected by the District Wellness Council for safe and supportive schools included measures of: school climate, bullying, the CBHM described above and safe and supportive environments for LGBTQ youth.

Data Overview

Table 14 shows information on bullying efforts and the CBHM, a multi-tiered system of supports designed to ensure that all Boston Public School students have access to high quality and coordinated behavioral and mental health supports. In SY15-16, approximately 70 Bullying Prevention Specialists were trained, about a third of the number that were trained in SY13-14. Between SY12-23 and SY15-16, 51 schools (41%) have been trained on CBHM.

Table 14. Safe & Supportive Schools (BHS & SAWS Department Records)		
	SY13-14	SY15-16
# of Bullying Prevention Specialists trained	210	70
% of schools with a student-led bullying prevention group	Data N/A	Data N/A
% of bullying cases closed	89% (275/310)	Data N/A
% of schools trained in CBHM	23% (30/128)	41% (51/125)
# of staff trained in CBHM interventions	600	1,877
# of students screened during universal behavioral health screening	13,661	12,165

As seen in Table 15, a greater percentage of schools in SY15-16 have a perception of school component score of three or greater out of a total of four on the School Climate Survey. This is a two-percentage point increase from SY13-14. There is also a six percentage point increase from SY13-14 in the percentage of schools with a school safety component score of 3 or greater.

Table 16 highlights the proportion of schools that provide services, supports and programs to build safe and supportive schools. A large proportion of BPS schools are publicizing and disseminating their bullying and sexual harassment policies (88%) and many (94%) also have a designated staff member to whom students can confidentially report bullying and sexual harassment. A large proportion of our schools (89%) have identified "safe spaces" where LGBTQ youth can receive support from school staff. Many high schools (70%) have student-led GSA clubs. However, only 16% K-8s and 33% middle schools have a student-led GSA. Overall, eight out of nine of the metrics used to measure services, supports and programs to build safe and supportive schools increased from SY 13-14 to 15-16.

Table 15. % of schools creating a safe and supportive school climate as measured by the results of the BPS School Climate Survey										
	Elementary		K-8		Middle		High		District	
Perceptions of School Component	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16
% of schools with a component score of 3+	57% (31/55)	64% (30/47)	71% (20/28)	77% (20/26)	60% (6/10)	0% (0/6)	34% (12/35)	40% (14/35)	54% (69/127)	56% (64/114)
% of schools with a component score above the district mean (3.04 for SY13-14 & SY15-16)	46% (25/54)	57% (27/47)	68% (19/28)	62% (16/26)	30% (3/10)	0% (0/6)	26% (9/35)	31% (11/35)	44% (56/127)	49% (56/114)
	Elementary		K-8		Middle		High		District	
School Safety Component	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16
% of schools with a component score of 3+	72% (39/54)	77% (36/47)	93% (26/28)	100% (26/26)	90% (9/10)	100% (6/6)	91% (32/35)	100% (35/35)	84% (106/127)	90% (103/114)
% of schools with a component score above the district mean (3.34 for SY13-14 & 3.35 for SY15-16)	11% (6/54)	9% (4/47)	44% (11/28)	27% (7/26)	30% (3/10)	17% (1/6)	74% (26/35)	86% (30/35)	36% (46/127)	37% (42/114)

Table 16. % of schools that indicate a positive (yes) response to the following questions on the 2014 & 2016 School Health Profiles Questionnaires

	Elementary		K-8		Middle		High		District	
Does your school…	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16
Have a student-led club that aims to create a safe, welcoming, and accepting school environment for all youth, inclusive of sexual orientation or gender identity? These clubs sometimes are called gay/straight alliances	--	--	5% (1/21)	16% (5/31)	13% (1/8)	33% (2/6)	70% (16/23)	70% (23/33)	35% (18/52)	43% (30/70)
Identify "safe spaces" where LGBTQ youth can receive support from administrators, teachers, or other school staff	--	--	68% (15/22)	87% (27/31)	63% (5/8)	67% (4/6)	79% (19/24)	94% (31/33)	72% (39/54)	89% (62/70)
Prohibit harassment based on a student's perceived or actual sexual orientation or gender identity	--	--	95% (21/22)	100% (31/31)	100% (8/8)	100% (6/6)	100% (24/24)	100% (33/33)	98% (53/54)	100% (70/70)
Encourage staff to attend professional development on safe and supportive school environments for all students, inclusive of sexual orientation or gender identity	--	--	68% (15/22)	90% (28/31)	75% (6/8)	50% (3/6)	88% (21/24)	97% (32/33)	78% (42/54)	90% (63/70)
Facilitate access to providers not on school property who have experience in providing health services, including HIV/STD testing and counseling to LGBTQ youth	--	--	64% (14/22)	42% (13/31)	50% (4/8)	50% (3/6)	75% (18/24)	85% (28/33)	67% (36/54)	63% (44/70)
Facilitate access to providers not on school property who have experience in providing social and psychological services to LGBTQ youth	--	--	55% (12/22)	71% (22/31)	75% (6/8)	50% (3/6)	79% (19/24)	85% (28/33)	69% (37/54)	76% (53/70)
Provide PD on preventing, identifying, and responding to student bullying and sexual harassment, including electronic aggression, to all staff	64% (28/44)	76% (35/46)	64% (14/22)	76% (25/33)	75% (6/8)	67% (4/6)	75% (18/24)	73% (24/33)	67% (66/98)	75% (88/118)
Have a designated staff member to whom students can confidentially report student bullying and sexual harassment, including electronic aggression	84% (37/44)	89% (41/46)	95% (21/22)	97% (32/33)	100% (8/8)	100% (6/6)	100% (23/23)	97% (33/34)	92% (89/97)	94% (112/119)
Use electronic, paper, or oral communication to publicize and disseminate policies, rules, or regulations on bullying and sexual harassment, including electronic aggression	82% (36/44)	80% (37/46)	86% (19/22)	94% (31/33)	88% (7/8)	100% (6/6)	92% (22/24)	91% (31/34)	86% (84/96)	88% (105/119)

Implementation Successes for SY14-15 & SY15-16

Implementation of CBHM began during SY12-13 and is now in 51 schools (SY15-16) serving over 22,000 students. A new cohort of schools is added each year. CBHM has shown demonstrated benefits for:

- Students: improved academic performance and increased prosocial behaviors
- Schools: improved school climate and student engagement; increased staff skills to address students' needs
- District: Increased capacity to provide coaching and services to schools; improved access to and coordination of mental health partners

CBHM schools outperformed students in non-CBHM schools on standardized tests. CBHM schools have demonstrated an increase in positive behaviors, as measured using BIMAS (Behavior Intervention and Monitoring Assessment System), between SY12-13 and SY15-16 and a decrease in problem behaviors between SY13-14 and SY15-16.

In SY14-15, 97% of schools identified a liaison as required by the Expectant and Parenting Student Policy to communicate and implement the newly updated 13-14 policy. Of those schools required to identify a liaison, 81% attended a training. In SY15-16, the Office of Equity created the Transgender and Gender Nonconforming Students - Nondiscrimination on the Basis of Gender Identity Policy. This policy

sets out guidelines for schools and district staff to create a culture where transgender and gender nonconforming students feel safe, supported and fully included and to meet each school's obligation to provide educational opportunities for all students. BPS aims to achieve inclusion of transgender and gender nonconforming students, while maintaining students' right to privacy.

Action Steps Planned or Underway

In SY16-17, an additional 10 schools will be trained in CBHM. The Safe and Welcoming Schools (SAWS) Department was launched and includes four SAWS Specialists that offer PD and TA to student support staff across the district. All of BPS will be working together to support and implement the Transgender and Gender Nonconforming Student Policy.

The Safe and Supportive Schools Subcommittee will focus on raising awareness about the behavioral health needs of students as well as existing BPS and community resources available to help students, schools and families. The Subcommittee will develop and disseminate a series of behavioral health fact sheets designed for school staff, parents and community partners.

As part of the ETTH grant program, an Out for Safe Schools Badge Campaign will be launched in high schools to support an inclusive environment for LGBTQ students. The ETTH grant program seeks to address bullying and create safe spaces for all youth in the 20 priority high schools, including LGBTQ students. The following grant activities will continue for school years SY16-17 and SY17-18:

- Ensure that all schools have a trained bullying prevention specialist;
- Ensure that all staff at these schools receive LGBTQ inclusive bullying prevention;
- Conduct a Safe and Supportive Environment Assessment and Action Plan to improve supports for all students;
- Start and support student-led GSA clubs;
- Encourage family engagement by holding Healthy Family Fun events;
- Ensure that all students sign the BPS Computer Acceptable Use Policy, which is targeted at improving cyber safety and preventing cyber bullying.

Health Services

School-based health care removes the health obstacles to learning by ensuring access and/or referral to primary health care services; managing chronic disease conditions during school hours; providing emergency care for illness or injury; identifying communicable diseases; and enacting practices and systems to ensure that all students have access to key resources and services that are developmentally appropriate and support sexual and reproductive health in a safe and supportive environment. BPS High Schools shall provide access to condoms, with appropriate health education and counseling services, for students.

Health Services Key Findings

- Ninety-one percent of high schools have a Condom Accessibility Team (CAT), an increase from 83% in SY13-14. Efforts to measure the effectiveness of the CATs are underway.
- Health Services will continue building a mechanism for tracking referrals to community health organizations.

Metrics

The metrics selected by the DWC for health services include measures of monthly nurse activity report requests and condom access. For SY15-16, the number of principals requesting a monthly activity report was not tracked as a metric.

Data Overview

Data from responses to the 2016 School Health Profiles Principal Survey shows an increase of eight percentage points in the percentage of schools where condom provision is available (Table 17). This suggests an increase in compliance with the Condom Accessibility Team (CAT) policy in SY15-16. However, there was a slight decrease in the percentage of schools that offer sexual health counseling in order for students to receive condoms (Table 17).

Table 17. Condom Provision in High Schools (Profiles)

	SY13-14	SY15-16
% of schools where condom provision is available	83% (19/23)	91% (30/33)
% of schools that offer sexual health counseling in order for students to receive condoms	64% (14/22)	60% (18/30)
% of schools that offer student referrals to any organizations/health care professionals not on school property for condom provision	77% (17/22)	79% (26/33)

Implementation Successes in SY14-15 & SY15-16

In collaboration with the Health & Wellness Department and the ETTH Program, Health Services created sexual health videos featuring five youth- and LGBTQ-friendly medical providers. These videos will be integrated into the sexual health education curriculum and shared with students during class time. CATs now also include sexual health education teachers. Two sexual health liaison nurses are tasked with assisting with CAT development, marketing and assessment. SY15-16 showed an improvement in the collaboration between School Based Health Centers and school nurses. Health Services supported the Boston Public Health Commission (BPHC) HPV campaign to increase the number of youth receiving the

HPV vaccine at two pilot high schools, New Mission and Boston Community Leadership Academy. This HPV vaccination program continued in SY16-17 with Boston Latin Academy and Madison Park.

In spring of SY15-16, Health Services focused on training high school nurses on the "Get Yourself Tested" Sexually Transmitted Infections (STI) Campaign. In addition to supporting sexual health, Health Services provides supports and best practices to schools around diabetes and asthma via nurse liaisons.

Action Steps Planned or Underway

At the back-to-school training in September, nurses were provided with CAT materials to promote CAT and extra materials regarding the "Get Yourself Tested" Campaign. The BPHC HPV campaign this year will focus on two different schools, Madison Park and Boston Latin Academy. Boston HAPPENS, a program of Children's Hospital, and Boston GLASS will start STI testing in two pilot high schools.

In Spring 2017, representatives from Health Services and the Health and Wellness Department plan to hold a focus group with the Boston Student Advisory Council (BSAC). This focus group will look at sexual health policies and in school and community resources as they relate to comprehensive sexual health education and condom availability. In addition, BSAC created a "Know Your Rights" student phone application, which this school year will be updated to include sexual health information, resources and the condom accessibility policy.

The Prevention Wellness Trust Fund (PWTF) asthma initiative has laid the groundwork for bridging the case management chasm between the medical home and schools in the management of asthma for the past three years. In SY16-17, seven neighborhood health centers (Dimock, Bowdoin, Codman Square, Harvard St, Harbor Health, Whittier, Dorchester House) will have meetings with the five asthma liaison nurses and 27 schools targeted for the intervention to build the working relationships required to manage asthma from home to clinic to school and back.

The groundwork for Screening Brief Intervention & Referral for Treatment (SBIRT) for substance use will begin with staff trainings and the tools developed for data collection in SY16-17. Screenings will begin in February 2017.

In efforts to better evaluate the development of the CATs, sexual health nurse liaisons will assess all CATs using the "Emerging/Proficient/Exemplar" rating. The Health Services subcommittee will also be reviewing the policy metrics to better capture the implementation of all aspects of the health services policy.

Staff Wellness

The Boston Public Schools care about the well-being of staff members and understand 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.

Staff Wellness Key Findings

- Twenty-eight percent of schools WAPs include a goal about staff wellness.
- 150 central office employees attended the first Employee Wellness Day.
- The DWC needs to develop the Staff Wellness Subcommittee and update the policy metrics to track staff wellness efforts.

Metrics

Currently, there are no metrics to track Staff Wellness. Metrics will be developed by the Staff Wellness Subcommittee by June 2017.

Data Overview

In spring 2016, the City of Boston sent out a Wellness Survey for City Employees (only school-based staff were included from Boston Public Schools; central office staff were not asked to complete the survey). Results from this survey show that being healthy is important to almost every respondent (97%); however, only about one-third (36%) believe that the City of Boston cares about their health. About a third of respondents find that their leaders model good health practices and another third feel that their work environment contains a health-minded culture.

According to WAPs, 28% of schools have included a goal about Staff Wellness into their Plan. Out of the 56 schools that completed the School Health Index, 21% of schools offer staff members accessible and free or low-cost health assessments at least once a year; 27% offer accessible and free or low-cost physical activity/fitness programs; 13% offer healthy eating/weight management programs that are accessible and free or low-cost; 46% responded that food and beverages served and sold at staff meetings, school-sponsored staff events and in the staff lounge meet USDA's Smart Snacks in School nutrition standards; and 43% use three or more methods to promote and encourage staff member participation in its health promotion programs.

Implementation Successes in SY14-15 & SY15-16

In February 2016, the Health & Wellness Department, in collaboration with other Office of Social Emotional Learning & Wellness departments, came together to put on the first Employee Wellness Day for central office staff at the Bruce C. Bolling Building. Approximately 150 staff members attended the event, with 66 completing the Exit Survey. Results from the Exit Survey showed that on a scale from 1-5, where 1 equals "Not at All Enjoyed" and 5 is "Completely Enjoyed", attendees responded with an average score of 4.7. In response to the enthusiasm generated by the Employee Wellness Day, central staff launched *BPS on the Move*, a weekly walking and running club.

Action Steps Planned or Underway

During SY16-17, a Staff Wellness Center opened in the basement of the Bolling Building. This Wellness Center offers fitness equipment and classes for a small monthly fee. Currently underway, the DWC is searching for co-chairs for the staff wellness subcommittee.

Student-Level Outcomes

When students have access to an environment providing quality education, programs and services, they will gain the knowledge and skills to make healthy choices, leading to improved health. To understand the extent to which the District Wellness Policy impacts student health over time, the DWC selected key student outcome indicators aligned with each component of the policy. Student-level outcomes provide information on student access to health promoting resources in school (i.e., to sexual health education and physical education); student knowledge, skills and attitudes/perceptions; student behaviors; and student health status.

Youth Risk Behavior Survey (YRBS) - High School

The following tables present data from the Boston Youth Risk Behavior Survey (YRBS), a part of the Centers for Disease Control and Prevention national surveillance system, conducted with BPS high school students by the Health and Wellness Department (HWD), every other year since 1993.

The high school student-level data presented below are shown in table format with percentages and, where applicable, the years for which there was a decrease or increase in the behaviors/health status item. Health topics and risk behaviors have been grouped into the following tables:

- Alcohol, Other drugs and Tobacco
- Mental Health; Safety, Violence and Unintentional Injury; and Bullying
- Dietary behaviors, Weight Management and Physical Activity and Access to Physical Education
- Sexual Health Education and Risky Sexual Behaviors.

As the tables below illustrate, most of the risk behavior rates presented have not changed significantly over the past 10 years. Changes observed from 2013 to 2015 do not necessarily reflect significant shifts in trends[4]. For each of the four health topics highlighted *significant declines were observed over the past decade* in the following: carrying a weapon on school property and being in a physical fight; ever had sex; and have been or gotten someone pregnant. There have been *significant increases* in the percentage of students reporting that they received sexual health education (2013 to 2015) and been taught to use a condom (2009 to 2015); however, there has also been a *significant increase* in the number of students reporting not using condoms (2005 to 2015). Alcohol and tobacco use have *decreased* in the past decade, while marijuana use among students has *increased*.

For questions that have only two years of data, we see *significant declines* in the percentage of students using blunt wrapper or cigar wrappers to smoke marijuana; smoking Black and Mild, Swisher Sweets, or Dutch Masters cigarillos; and experiencing physical dating violence. (2013-2015).

[4] The CDC calculates significant trends for risk behaviors with three or more data points. If a risk behavior has only been measured twice, then they will calculate a statistical difference between the two years.

A summary chart of student-level outcomes by select demographic factors is provided in Appendix F. The demographic factors are: sexual orientation (lesbian, gay, bisexual); race/ethnicity; sex (male or female); and pregnant or have gotten someone pregnant. The HWD is working with community partners and the CDC to find an accurate way to collect data on transgender and gender-nonconforming students. We hope to include this data in the 2017 YRBS reports.

Table 18. Alcohol, Other drugs, and Tobacco. Source: HS YRBS

Alcohol Use	2013	2015	Trend Data
Ever had at least one drink of alcohol	61%	55%	↓ (2005-2015)
Currently drink alcohol	32%	25%	↓ (2005-2015)
Had 5+ drinks in a row in last 30 days	15%	11%	↓ (2005-2015)
Drug Use	**2013**	**2015**	**Trend Data**
Currently use marijuana	26%	22%	↑ (2005-2015)
Currently use a blunt wrap or cigar wrapper to smoke marijuana	25%	18%	↓ (2013-2015)
Tobacco Use	**2013**	**2015**	**Trend Data**
Currently smoke cigarettes	8%	5%	↓ (2005-2015)
Currently use smokeless tobacco	3%	2%	– (2005-2015)
Currently use cigars, cigarillos, or little cigars	9%	5%	– (2005-2015)
Smoking Black and Mild, Swisher Sweets, or Dutch Masters cigarillos in past 30 days	7%	5%	↓ (2013-2015)

↑ Signifies a statistically significant increase, p<0.05
↓ Signifies a statistically significant decrease, p<0.05
– Signifies no statistically significant change

Table 19. Mental Health; Safety, Violence, and Unintentional Injury; and Bullying. Source: HS YRBS

Mental health	2013	2015	Trend Data
Experienced depression (sad and hopeless almost every day for 2+ weeks in a row)	30%	27%	– (2005-2015)
Seriously considered attempting suicide	13%	11%	– (2005-2015)
Made a plan about how they would attempt suicide	12%	10%	– (2005-2015)
Attempted suicide one or more times	9%	8%	– (2005-2015)
Safety, Violence, and Unintentional Injury	**2013**	**2015**	**Trend Data**
Carried a weapon on school property	5%	4%	↓ (2005-2015)
Were in a physical fight during the past 12 months	21%	20%	↓ (2005-2015)
Were ever physically forced to have sexual intercourse when didn't want to	10%	8%	↓ (2009-2015)
Experienced physical dating violence	9%	6%	↓ (2013-2015)
Bullying	**2013**	**2015**	**Trend Data**
Bullied on school property in last 12 months	13%	12%	– (2009-2015)
Electronically bullied in last 12 months (email, chat rooms, instant messaging, website, texting)	9%	8%	↓ (2011-2015)
Victim of teasing or name calling because someone thought they were gay, lesbian, bisexual in last 12 months	8%	7%	↓ (2011-2015)

↑ Signifies a statistically significant increase, p<0.05
↓ Signifies a statistically significant decrease, p<0.05
– Signifies no statistically significant change

Table 20. Dietary Behaviors, Weight Management, and Physical Activity and Access to Physical Education. Source: HS YRBS

Dietary Behaviors	2013	2015	Trend Data
Drank soda one or more times daily	17%	17%	↓ (2007-2015)
Percent of students consuming breakfast daily	33%	31%	– (2009-2015)
Weight Management	**2013**	**2015**	**Trend Data**
Vomited or took laxatives in last 30 days to lose/keep from gaining weight	6%	6%	– (2005-2015)
Physical Activity/Physical Education Access and Participation	**2013**	**2015**	**Trend Data**
Attended PE classes on one or more days in an average school week	42%	37%	– (2005-2015)
Attended PE classes on all five days in an average school week	9%	9%	– (2005-2015)
Physically active for at least 60 minutes per day over the last 7 days	15%	16%	– (2011-2015)

↑ Signifies a statistically significant increase, p<0.05
↓ Signifies a statistically significant decrease, p<0.05
– Signifies no statistically significant change

Table 21. Sexual Health Education and Risky Sexual Behaviors. Source: HS YRBS

Sexual Health Education in School	2013	2015	Trend Data
Ever had sexual education in school	76%	81%	↑ (2013-2015)
Taught in school how to use a condom	60%	68%	↑ (2009-2015)
Taught about AIDS or HIV in school	78%	78%	– (2005-2015)
Ever taught in school about STDs (not including AIDS or HIV), such as genital herpes, chlamydia, syphilis, or genital warts	74%	78%	– (2013-2015)
Risky Sexual Behaviors	**2013**	**2015**	**Trend Data**
Ever had sexual intercourse	47%	42%	↓ (2005-2015)
Had sexual intercourse with 4+ persons during their life	18%	12%	↓ (2005-2015)
Drank alcohol or used drugs before had sexual intercourse the last time	24%	18%	– (2005-2015)
Do not use a condom (among those currently sexually active)	37%	39%	↑ (2005-2015)
Did not use any method to prevent pregnancy (among those currently sexually active)	18%	11%	– (2009-2015)
Have been pregnant or have gotten someone pregnant	6%	5%	↓ (2005-2015)

↑ Signifies a statistically significant increase, p<0.05
↓ Signifies a statistically significant decrease, p<0.05
– Signifies no statistically significant change

Table 22. % of students achieving healthy fitness levels. Source: FitnessGram

	SY13-14	SY15-16
HFZ in 3/5 assessments	63% (2580/4069)	49% (1260/2546)
HFZ for aerobic capacity	53% (2295/4304)	33% (829/2525)

Note: Only 2546 students were assessed in five FitnessGram components. In addition, 2525 students were assessed in the Aerobic Capacity component.

Additional student-level outcomes

Additional metrics were selected by the DWC to measure the percent of students with healthy fitness levels, with a healthy Body Mass Index (BMI) and percent of students diagnosed with asthma. We also measure school climate metrics related to students' perception of their school and teachers.

Physical Fitness

FitnessGram is the national health-related fitness assessment adopted by the Presidential Youth Fitness Program. It serves as a student-centered assessment, reporting and educational tool used to promote children's health-related fitness and activity levels. Each year, physical education teachers measure their students' fitness such as aerobic capacity, muscular strength, muscular endurance and flexibility, using a series of tests.

Each of the test items was selected to assess important aspects of a student's health-related fitness, not skill or agility. Students are not compared to each other, but rather to criterion-based Healthy Fitness Zone (HFZ) standards, carefully established for each age and gender, that indicate good health.

Table 22 shows that in SY15-16, results from five assessments were entered for 2,546 students which is much lower compared to SY13-14, where data was entered for 4,069 students. Only 49% of students met the HFZ in three out of five components, a decrease of fourteen percentage points. Only 33% of students met the HFZ for aerobic capacity, a decrease of twenty percentage points from SY13-14.

Body Mass Index

Body Mass Index, or BMI, is measured in 1st, 4th, 7th and 10th grade students each year. Weight categories are determined by the Centers for Disease as follows:

- Underweight - Less than the 5th percentile
- Healthy Weight - 5th percentile to less than the 85th percentile
- Overweight - 85th to less than the 95th percentile
- Obese - Equal to or greater than the 95th percentile

As seen in Table 23, in 2015, 2.6% of students screened were underweight, 58.1% of students screened were at a healthy weight, 15.5% of students screened were overweight and 23.7% of students screened were obese. Overall, 39.1% of screened students were at an unhealthy weight (overweight or obese) in 2015, a slight decrease from 2013 (40.6%), but the same as the 2011 rate.

Table 23. Body Mass Index. Source: SNAPNurse

	Underweight		Normal Weight		Overweight		Obese		Total Students Screened	
	2013 %	2015 %	2013 %	2015 %	2013 %	2015 %	2013 %	2015 %	2013 #	2015 #
District Total	2.6	2.6	56.7	58.1	17.3	15.5	23.3	23.7	20,415	16,317
Race										
Asian/Pacific Islander	1.3	6.3	68.3	68.8	15.4	12.3	14.8	12.6	1044	1120
Black	0.8	2.3	56.0	54.7	17.7	16.3	25.5	26.7	4436	4980
Latino/Hispanic	0.6	2.0	53.7	53.1	18.3	16.5	27.4	28.4	5253	5708
Native American	0.0	5.0	56.7	57.5	23.3	12.5	20.0	25.0	30	40
White	1.6	3.2	64.0	68.2	17.0	12.8	17.4	15.8	1706	2222
Unknown	5.2	2.8	56.1	62.8	16.9	15.6	22.0	18.8	7946	2247
Grade										
1st	1.2	3.8	60.6	63.3	16.7	13.7	21.5	19.2	3844	3303
4th	0.4	2.4	54.7	56.4	18.1	16.9	26.8	24.4	3374	2804
7th	1.1	1.5	54.1	52.8	19.0	18.0	25.8	27.7	2890	2021
10th	0.9	1.9	58.6	58.7	16.9	15.7	23.6	23.7	2361	1706
Unknown	5.2	2.7	56.0	57.7	16.8	15.1	22.0	24.6	7946	6483

A higher percentage of Black and Latinx students are overweight or obese (43.0% and 44.9%), compared to 28.6% of White and 24.9% of Asian Students. The percentage of obese Black and Latinx students increased in 2015, while the percentage of overweight students decreased.

Known Asthma Diagnosis

As seen in Table 24, across the district, 20% of students have a known asthma diagnosis, as reported by the student's doctor and recorded in SNAPNurse. This is an increase of 6 percentage points from SY13-14. Asian, Black and Latinx students have the highest percentage of students with a known asthma diagnosis at 21%, 21% and 19% respectively, compared to 14% of White students. Males also have a much higher asthma diagnosis than females, 23% vs. 16%.

Table 24. % of Students Diagnosed with Asthma. Source: SNAPNurse

	SY13-14	SY15-16
District Total	14%	20%
Race		
Asian	17%	21%
Black	16%	21%
Hispanic/Latino	16%	19%
Native American	17%	14%
White	10%	14%
Sex		
Male	14%	23%
Female	13%	16%

School Climate – Student Survey

As seen in Table 25, the School Climate Survey results (student-level), students' feelings about school and perceptions of adult support were highest in elementary school and declined in middle and high school. However, even at high school more than 70% agreed or strongly agreed that their school is getting them ready for the next grade or college; what they are learning is valuable; their classes will be useful in the future; recommend this school to their friends; their teacher works hard to help them learn; and their teacher does a good job letting them know how they are doing in class. There was a slight decrease (1-2 percentage points) in the percentage of students in Elementary, K-8 and Middle schools that agreed or strongly agreed that their school is getting them ready for the next grade or college.

In SY 15-16 there was a large increase in the percentage of K-8, middle and high school students (6 percentage points, 14 percentage points, 20 percentage points) who agreed/strongly agreed that teachers work hard to help them learn and let them know how they are doing. The 2015 HS YRBS results show that 65% of BPS high school students felt there is an adult they can talk to at school; this is a decrease from 2013, where 70% of BPS high school students felt there was an adult they could talk to at school.

Table 25. School Climate Survey – Student Level Results

% of students who agree/strongly agree	Elementary		K-8		Middle		High		District	
	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16	SY13-14	SY15-16
I enjoy going to school everyday	76% (4,876/ 6,527)	75% (4,482/ 5,982)	69% (4,944/ 7,166)	71% (5,279/ 7,441)	59% (1,899/ 3,201)	60% (953/ 1,600)	58% (4,974/ 8,560)	59% (6,057/ 10,194)	66% (16,806/ 25,554)	67% (16,771/ 25,217)
My school is getting me ready for the next grade or college	95% (6,121/ 6,469)	93% (5,632/ 6,029)	93% (6,676/ 7,191)	92% (6,922/ 7,487)	91% (2,950/ 3,240)	89% (1,438/ 1,619)	91% (7,830/ 8,633)	92% (9,428/ 10,288)	92% (23,767/ 25,737)	92% (23,420/ 25,423)
The things I learn are valuable to me	93% (6,003/ 6,442)	93% (5,573/ 6,012)	90% (6,472/ 7,174)	91% (6,818/ 7,473)	88% (2,835/ 3,232)	88% (1,416/ 1,612)	84% (7,193/ 8,590)	84% (8,614/ 10,247)	88% (22,626/ 25,643)	88% (22,421/ 25,344)
The classes I am taking will be useful in the future	92% (5,881/ 6,387)	92% (5,458/ 5,963)	91% (6,451/ 7,127)	90% (6,688/ 7,432)	88% (2,827/ 3,207)	88% (1,407/ 1,597)	78% (6,691/ 8,562)	80% (8,164/ 10,205)	86% (22,019/ 25,486)	86% (21,717/ 25,197)
I brag about my school to my friends who do not attend this school	40% (2,553/ 6,407)	38% (2,280/ 5,956)	39% (2,749/ 7,126)	37% (2,745/ 7,409)	43% (1,386/ 3,209)	41% (655/ 1,602)	47% (4,022/ 8,521)	46% (4,726/ 10,180)	43% (10,811/ 25,462)	41% (10,406/ 25,147)
I would recommend this school to my friends	76% (4,890/ 6,426)	78% (4,638/ 5,981)	74% (5,255/ 7,145)	75% (5,613/ 7,436)	64% (2,036/ 3,202)	65% (1,030/ 1,594)	71% (6,078/ 8,547)	74% (7,500/ 10,188)	72% (18,403/ 25,502)	75% (18,781/ 25,199)
My teacher(s) works hard to help me learn	98% (6,326/ 6,468)	98% (5,926/ 6,076)	90% (6,424/ 7,132)	96% (7,284/ 7,587)	77% (2,270/ 2,945)	91% (1,580/ 1,734)	73% (5,742/ 7,859)	93% (9,926/ 10,723)	85% (20,898/ 24,612)	95% (24,716/ 26,120)
My teacher(s) does a good job letting me know how I am doing in class	92% (5,983/ 6,487)	91% (5,562/ 6,099)	79% (5,613/ 7,127)	90% (6,827/ 7,595)	61% (1,805/ 2,944)	87% (1,513/ 1,731)	54% (4,244/ 7,842)	85% (9,124/ 10,722)	72% (17,731/ 24,607)	88% (23,026/ 26,147)

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 (WCSS) model. The WSCC model is an ecological approach that is directed at the whole school, with the school in turn drawing its resources and influences from the whole community and serving to address the cognitive and health needs of the whole child (Appendix A). School-level efforts change the context and improve the environment in which students spend so much time, making the healthy choice the easy choice. For this reason, we placed a focus on the school-level data in this report. The changes in BPS health-related policies in the past 10 years are creating safe, healthy and welcoming school environments and that 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

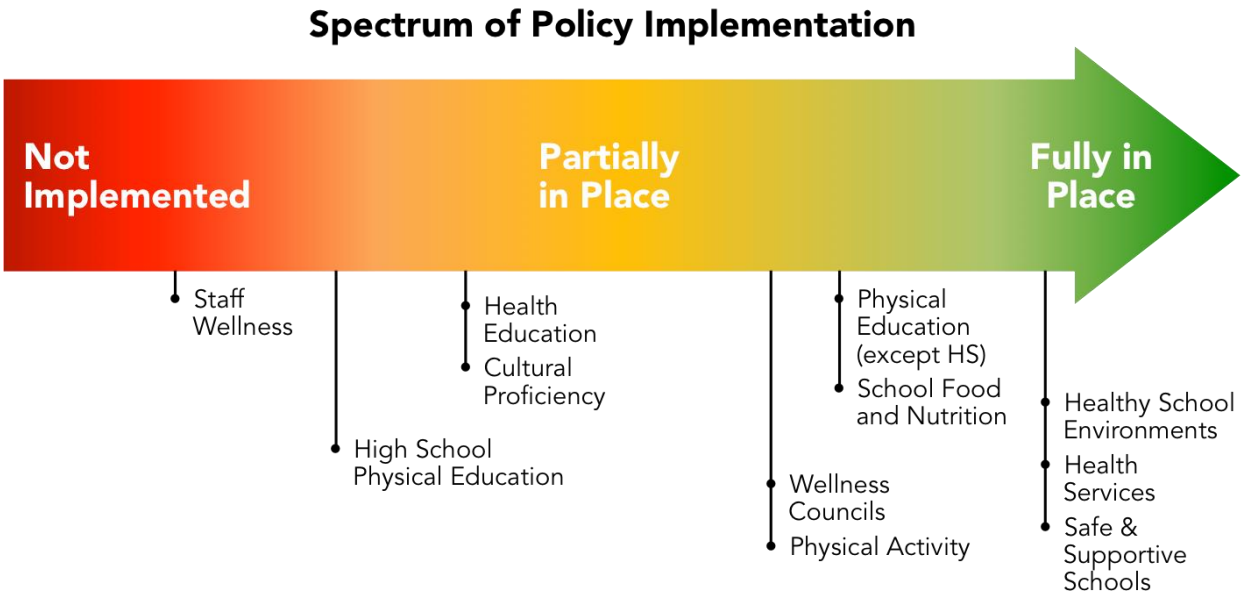
Collectively, the key findings for the school-level metrics indicate that in five of the eight policy areas progress has been made on implementing school level policy requirements; this is summarized in Table 26. Additionally, there was a decrease in implementation in one policy area (wellness councils), little change in another (health education) and mixed results in comprehensive physical activity. Metrics have not been established for staff wellness.

Table 26. Policy implementation changes between SY13-14 and SY15-16.

Policy Area	Change SY13-14 to SY15-16	Observations
Wellness Councils	↓ Decrease	• # of wellness councils completing a WAP decreased
Cultural Proficiency	↑ Improved	• Increased number of trainings and policies • Parent membership on wellness councils did not change
Food and Nutrition Promotion	↑ Improved	• Approaching silver rating for school meals • Developed stronger competitive food & beverage standards
Physical Education/Physical Activity	PE: ↑ Improved PA: ↓ Decrease	• Increased in all grades, but more than 25% high schools not providing PE in grades 11 and 12 and 74% not staffed to provide PE to all students • Average PA minutes provided declined, as did the % of schools providing 150 min/week • Recess increased
Comprehensive Health Education	No Change ↔	• Overall not much change and low rates of compliance • Slight increase in % of high schools and middle schools offering one semester of HE • Slight increase in % of high schools staffed with licensed HE teacher
Healthy School Environment	↑ Improved	• % of schools with an an operations representative on the wellness council increased • Most schools have met policy metrics • Water policy passed
Safe and Supportive Schools	↑ Improved	• 8 out of 9 metrics increased
Health Services	↑ Improved	• Increase in the number of schools with CATs

Staff Wellness	N/A	• No metrics established for measuring policy implementation • District and school level initiatives are underway, but there is no strategic approach to address implementation

Overall, Figure 9 below shows that five of the policy issues are partially in place, four policy issues are under development and health education, staff wellness and high school PE policies are being poorly implemented.



Policy Impact on Student Health Outcomes

Research indicates that educationally relevant health issues disproportionately impact urban minority youth and that these health disparities play a role in the achievement gap. By systematically addressing educationally relevant health inequities, BPS strives to reduce 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 obesity
- Improving mental and behavioral health
- Decreasing asthma
- Improving sexual health and decreasing teen pregnancy

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

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). BPS passed its first Wellness Policy targeted at reducing obesity in 2006, which included nutrition guidelines for competitive food and beverages and requirements for physical education. 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 Alliance for a Healthier Generation and CDC launched a district-wide effort to start wellness councils at every BPS school.

We have seen a leveling off of obesity rates since 2011. According to data collected by school nurse screenings, 39% of students who were screened had a Body Mass Index (BMI) in the overweight or obese category. Despite the progress we have made to address childhood obesity, there is a large disparity in rates of unhealthy weight among Black (43%) and Latinx (45%) students compared to their White (29%) and Asian (25%) peers. We have seen progress in some health behaviors among high school students. The YRBS found that the percent of high school students drinking soda every day has continued to decrease since 2007. However, only about 20% are eating their recommended daily amount of fruits and vegetables and about a third are still not eating breakfast every day. Additionally, only 16% of high school students reported getting at least 60 minutes of physical activity every day and only 37% attend PE classes on one or more school days.

BPS has made great strides in eliminating sugar-sweetened beverages from schools. FNS continue to improve district nutritional guidelines for the school meal program and to ensure meal equity between schools with full kitchens and schools without full kitchens. School-based staff and administration are being trained on competitive food guidelines, but there is still a lot of work to be done to change the culture around food-based rewards and classroom parties. Schools are still struggling to implement the competitive food guidelines for school fundraisers. More work is needed to support schools in implementing these guidelines and holding them accountable for compliance.

Staffing and class offerings for physical education are improving across the district and continue to be most strong in grades K1-8. The percent of schools offering recess has improved in grades K1-8, with room for improvement in the middle grades. While PE and recess have increased the amount of in-school daily physical activity for students, only about 50% of schools are offering students opportunities to be physically activity for 150 minutes per week. The disparity in opportunities for physical activity for high school students remains high, especially for grades 10-12. 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. High school students should be taking at least one semester of PE every year and not only in 9th grade.

Comprehensive health education continues to be stymied by infrastructure barriers similar to physical education and this has an impact on all of the educationally relevant health issues discussed here. The BPS District Wellness Policy supports health education and the Health and Wellness Department provides comprehensive curriculum and trainings. Also, there is interest from the schools to offer health education and a large number of wellness councils are tackling the issue in their WAPs. However, schools still lack the trained (for grades K1-5) or licensed (for middle and high school) staff and the space for health education classes in the master schedule. There is no legislative support of health education at the state level and it is not included in the MCAS (Massachusetts Comprehensive Assessment System) and

therefore health education courses remain a low priority despite the interest from schools and the efforts from wellness councils.

Sexual Behavior

In June 2013, the District Wellness Policy was updated to include condom access at all BPS high schools, as well as comprehensive pre-K through grade 12 health education that is medically-accurate, age and developmentally appropriate, culturally inclusive and implemented in safe and supportive learning environments where all students feel valued. In addition to providing resources and services to support sexual and reproductive health among students, comprehensive health education promotes healthy lifestyle habits, healthy relationships and health literacy to reduce risky sexual behaviors and sexual violence. CATs exist in 91% of high schools and the ETTH grant is working with specific high schools to improve the quality and increase the quantity of sexual health education. Yet only 12% of sexually active students have asked an adult at their school for a condom (YRBS) and only 60% of schools offer sexual health counseling in connection to the CAT condom provision.

YRBS data show that the percent of high school students that engaged in sexual intercourse has decreased since 1993 and the percent of students who have been pregnant or gotten someone pregnant has decreased in the last decade. However, the number of sexually active students using a condom has significantly decreased over the last decade and there has been no change in the percent sexually active students that drank alcohol or used drugs before their last sexual intercourse. There has been an increase in high schools students reporting having had sex education, but licensed health education teachers are staffed at only 16% of high schools and only 45% are meeting the health education course requirements (minimum of one semester in grades 9-12). Therefore, most high school students are not receiving comprehensive health education from a licensed teacher.

The YRBS found that high students who reported being physically forced to have sexual intercourse or experienced physical dating violence have decreased. However, the percentage of BPS high school students that report having been physically forced to have intercourse is higher than the state average. Additionally, females are more likely to have been physically forced to have intercourse than male students and those students who identify as lesbian, gay and bisexual are more likely than their heterosexual counterparts (Appendix F).

As was stated earlier in this report, more needs to be done to address the infrastructure barriers to providing comprehensive health education. Also, an assessment of the CATs needs to be done to evaluate the effectiveness of providing condom access through these teams.

Asthma

Asthma is the leading cause of school absenteeism nationally and Boston Public Schools have asthma rates over two times the national average (MA Asthma Advocacy Partnership). 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. BPS 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. BPS and BPHC have been conducting annual environmental audits and safety checks for the past 15 years. The BPS HSTF has worked to promote healthy school environments and train wellness councils to access their school

environment and implement action steps to address and prevent environmental asthma triggers. Thanks to these efforts, schools have done an excellent job on all metrics, focused particularly on education and awareness. However, school nurse data (SNAPNurse) shows an increase in the percent of students diagnosed with asthma (20%), with higher rate among Asian (21%), Black (21%) and Latinx (19%) students compared to White students (14%).

BPS needs to continue to work with BPHC and the other partners on the HSTF to improve learning environments that impact the productivity, health and wellness of students and staff within our school buildings. While the HSTF has helped wellness councils evaluate their building and make action steps to address eliminating pests, reducing clutter, using green cleaners in classrooms and managing good recycling practices, schools struggle to deal with the major repairs and aging infrastructure that can impact the school environment. During SY15-16, Boston Mayor Martin J. Walsh, the Boston School Committee and BPS Superintendent Dr. Tommy Chang launched BuildBPS, a process to develop a 10-Year Educational and Facilities Master Plan. BuildBPS conducted assessments on all BPS buildings in order to take inventory of the building layout and condition and to determine the adequacy of spaces for the educational programs offered in each building. The Build BPS report sets new standards for our buildings and provides helpful pieces of information that BPS will examine as it prioritizes facility improvements, such as building ventilation systems, with the goal of enhancing student learning. The DWC should select existing environmental metrics to assess the management of the healthy school environment at each school in order to measure the success of these efforts. Additionally, BPS and BPHC need to continue to build the working relationships required to better manage asthma from home to health clinic to school and back.

Behavioral and Mental Health

A safe and supportive school environment is important for academic success and can reduce or prevent health risk behaviors. The Safe and Supportive Schools component of the policy ensures a positive school climate that actively teaches positive behaviors and engage in prevention activities to promote feelings of security and connectedness for students and adults. New policies for expectant and parenting students and transgender and gender nonconforming students have been published to continue to ensure support of all students. The BPS Bullying Prevention and Intervention Plan has been in place since 2010 and schools have seen a decrease in the incidents of bullying. Many staff have been trained as Bullying Prevention Specialists and the BPS Counseling and Intervention Center participated in a pilot project to provide intensive counseling services for students who have violated the code of conduct, praised by President Obama as a national model. The ETTH grant has helped 20 high schools focus on bullying prevention, especially for LGBTQ students. Efforts to expand CBHM in the district have reached 41% of schools and have helped to coordinate behavioral and mental health supports for all students.

Progress has been made in students' perception of their school and teachers. According to the School Climate Survey, the vast majority of students agreed or strongly agreed that:

- Their school is getting them ready for the next grade or college
- What they are learning is valuable
- Their classes will be useful in the future
- Their teacher works hard to help them learn
- Their teacher does a good job letting them know how they are doing in class.

Sixty-five percent of high school students felt there is an adult they can talk to at school (a five percentage point decrease from 2013; YRBS). Unfortunately, we have not seen a change in mental health metrics for high school students (Table 19). Additionally, there is a higher rate of certain negative mental health behaviors among LGB, Hispanic/Latinx students and female students (Appendix F).

With regard to violence and school safety, there has been a decrease in students carrying a weapon on school property and students being in a physical fight. The School Climate Survey shows that the vast majority of students feel safe at their school. However, LGB and Latinx students were more likely to be in a fight than their heterosexual and White peers respectively (Appendix F). Also male students were more likely than female students to carry a weapon or be in a physical fight. As mentioned previously, sexual violence has decreased, but there are disparities in the populations that experience sexual violence. The YRBS found that student reports of bullying on school property have not changed, but electronic bullying and sexual orientation-based bullying has decreased since 2011. And yet, LGB students are more likely to be bullied based on their perceived sexual orientation and female students are more likely to be bullied both electronically and on school property.

Challenges

Data collection: The data sources for three metrics across three policy areas changed from SY13-14 to SY15-16. Additionally, response rates substantially varied between data collection periods on three data sources. There were also three metrics across three policy areas that were not tracked in SY15-16. This variability in data collection limits the ability to assess policy implementation and impact. To ensure accurate and appropriate measurement of policy implementation, DWC subcommittees need to update metrics and data sources to align with availability of District and department data collection and improve measures of impact on school- and student-level health and learning outcomes. Furthermore, efforts should be made to maintain high response rates and increase those that declined.

Policy Awareness: As reported in the SY14-15 Wellness Policy Annual Report, there is significant work to be done around increasing awareness of the Wellness Policy among students, parents and families. Awareness- raising efforts will empower families and students to be advocates for policy implementation at their own schools and through leadership channels within the District, such as the City-wide Parent Council and BSAC and School Committee. Efforts to brand and package the BPS Wellness Policy will be helpful in communicating a consistent message that the Wellness Policy is the big picture and showing how the different components are connected. Rather than focus on the Policy itself, the focus groups with parents and families revealed that branding efforts should focus on the *benefits* of the policy, strategies and activities for families and children. In addition, a communications strategy for reaching parents, families and students should highlight activities of the policy and ways that families and students can engage with it and be active participants in the process. Students also may be aware of specific components of the Wellness Policy but not necessarily know how it fits into the overall Wellness Policy. Raising awareness of the policy as a whole, as well as the components of the policy, is an essential area of future work to ensure that students know what the Wellness Policy includes and how it supports their education.

By systematically addressing educationally relevant health inequities, BPS can reduce educational achievement gaps and improve health. Our efforts need to continue to focus on the prevention of Boston priority health issues and promotion of overall well-being. High quality, strategically planned and

effectively coordinated programs and policies are the key.[5] Implementing the Wellness Policy, using a Whole School Whole Community Whole Child approach, as is called for in the Superintendent's Strategic Plan, will create safe, healthy and welcoming school environments that support learning and student social, emotional and physical well-being.

Recommendations

In order to ensure equity for all BPS students 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 four action steps:

1. Improve communication of the policy and policy successes to schools, youth and families:

a. Develop an overall communication and branding strategy to disseminate information about the Wellness Policy to increase awareness and knowledge among district leadership, school-based staff, parents/caregivers and students.
   iii. Continue to make use of existing communication channels within the district and use new ones as they are available.
   iv. Develop and provide standardized communications resources for use by central office departments and schools.
b. Outline multiple approaches to engaging parents and caregivers and consistently take their feedback into account to further engage these stakeholders in the school-based wellness councils.

2. Develop additional planning and implementation supports for school-based wellness councils and district departments

a. Conduct a needs assessment among school-based wellness council members to gain a comprehensive understanding of how to improve supports to school-based wellness councils.
b. Continue to hold professional development opportunities designed to support District staff working with schools and School-based wellness councils in implementing the BPS Wellness Policy.
c. Develop a wellness policy dashboard to provide schools with feedback on policy implementation.

3. Strengthen District Wellness Council and Subcommittees:

a. Develop the District Wellness Council Action Plan to ensure consistency across subcommittees.
b. Continue to build the connection between the District Wellness Council and school-based wellness councils.
c. Establish subcommittees for Cultural Proficiency and Staff Wellness.

4. Review and recommend revisions to the current Wellness Policy

a. Incorporate emerging policy areas, updates to align BPS policy with changes in state or federal law and updates to improve policy language to benefit the health of BPS students.
b. Engage multiple stakeholders in the policy revision process, including parents and caregivers and incorporating their feedback in the Wellness Policy.
c. Update metrics and evaluation data sources to ensure accurate and appropriate measurement of policy implementation.
d. Improve measures of impact on school- and student-level health and learning outcomes.

[5] Basch, C. (2011). Healthier students are better learners: a missing link in school reforms to close the achievement gap. Journal of School Health, 81(10), 593-8.

Conclusion

Boston Public Schools takes seriously the health and wellness needs of students and staff. Important steps have already been taken by adopting a comprehensive district wellness policy. BPS Departments have had significant accomplishments to date. And schools have worked through their wellness councils to make the district policy come alive at their school buildings. It's clear that much has been accomplished already, but there is still much more work to do. The DWC continues to be an active group in SY16-17 and the District Wellness Action Plan (Appendix G) focuses on (1) reviewing and revising components of the District Wellness Policy and/or consider additional policy areas by June 30, 2017; (2) communicating and advocating for implementation of the District Wellness Policy; (3) considering and responding to requests for new policies or other community inquiries of the DWC; and (4) completing and submitting an Annual Report to School Committee. The DWC SY16-17 Annual Report will report on the policy update process and detail the feedback from stakeholders in BPS and the Boston community.

Appendix A

The Whole School, Whole Community, Whole Child Model

From the CDC: "The Whole School, Whole Community, Whole Child (WSCC) model is an expansion and update of the Coordinated School Health (CSH) approach. The WSCC incorporates the components of CSH and the tenets of the ASCD's whole child approach to strengthen a unified and collaborative approach to learning and health. The WSCC model focuses its attention on the child, emphasizes a school-wide approach and acknowledges learning, health and the school as being a part and reflection of the local community."[6]

[6] https://www.cdc.gov/healthyyouth/wscc/pdf/wscc_fact_sheet_508c.pdf

Appendix B

SY15-16 District Wellness Council Member List

Name	Organization
Boston Public Schools Appointed Members	
Andria Amador	Behavioral Health Services
Jill Carter	Health and Wellness
Steven Chen*	Equity Office
Avery Esdaile	Athletics
Ana Impellizeri	BPS Parent
Carleton Jones	Facilities
Kim Rice*	Assistant Superintendent of Operations
Monica Roberts	Office of Engagement
Jon Sproul	School-Community Partnerships
Maureen Starck	Health Services
Deb Ventricelli	Food and Nutrition Services
Caren Walker-Gregory	Principal (HS)
Tommy Welch*	Principal Leader
Amalio Nieves (Co-Chair)*	Assistant Superintendent of Social Emotional Learning and Wellness
Harry Gilliam*	Health Education teacher
Charles Lucas*	Physical Education teacher
Jason Gallagher*	Principal (elementary)
Cathy Couture*	School Nurse
Regina Robinson*	School Committee Member
Community Partner Appointed Members	
Allison Bauer	The Boston Foundation
Angie Cradock	Harvard School of Public Health
Tolle Graham	MassCOSH
Sheri Kasper	Action for Healthy Kids/New England Dairy and Food Council
Michelle Keenan	Brigham and Women's – Community Health
Anne McHugh	Boston Public Health Commission
Huy Nguyen (Co-Chair)	Boston Public Health Commission
Alex Oliver-Davila	Sociedad Latina
Liz Peck*	Massachusetts Alliance on Teen Pregnancy
John Riordan	Boston Children's Hospital
Liz Salomon	Fenway Health Center
Steph Trilling	Boston Area Rape Crisis Center

* Indicates new member for SY15-16

Appendix C

BPS District Wellness Council SY15-16 Action Plan

Goal	Action Steps	Lead	By When?
Educate Council on new policy topics	1. Have at least two presentations in 15-16 on topics ranked highly by subcommittee co-chairs	1. Health and Wellness Department	1. June 2016
Support communication and implementation of BPS wellness policy in schools	1. Disseminate Policy Implementation Toolkit to schools	1. Health and Wellness Department with support from Principal Leaders	1. Jan 2016
	2. Inventory BPS Department supports for implementing the BPS wellness policy and create communication products on what the Departments are doing to support schools	2. Health and Wellness Department with BPS departments	2. Mar 2016
	3. Get input from subcommittees on strategies and tactics for raising awareness and engagement in the wellness policy among students and parents	3. Subcommittees	3. June 2016
	4. Develop messaging and implement communication strategies to raise awareness of the wellness policy and supports to schools, parents and students	4. Health and Wellness Department with BPS Departments and Subcommittees	4. Sept 2016
Build connections between District Wellness Council and school-based wellness councils	1. Bring at least one school-based wellness council presentation to the District Wellness Council	1. Health and Wellness Department	1. June 2016

Goal	Action Steps	Lead	By When?
Complete and submit an Annual Report to School Committee by April 2016	1. Develop draft of second Annual Report (qualitative) on wellness policy	1. Health and Wellness Department	1. Feb 2016
	2. Finalize second Annual Report (qualitative) on wellness policy implementation	2. Health and Wellness Department, with subcommittee co-chairs	2. April 2016
	3. Collect data for third Annual Report	3. Health and Wellness Department and BPS Departments, with support from subcommittees	3. June 2016
	4. Draft third Annual Report (quantitative)	4. Health and Wellness Department with support subcommittee co-chairs	5. Sept 2016
	5. Finalize Annual Report	5. Health and Wellness Department with subcommittee co-chairs	6. Jan 2017
Review and revise components of the District Wellness Policy and/or consider additional policy areas for consideration by June 2016	1. Consider updates to and revisions of existing policies based on available data	1. District Wellness Council with Subcommittees	1. June 2016
	2. Identify any new areas of policy work to address through District Wellness Council	2. District Wellness Council with Subcommittees	2. June 2016

Appendix D

Table of School-level Metrics and Data Sources by Policy Topic Area

Policy Area	Metric	Source	Changes
General	1. % schools completing a Wellness Action Plan as a part of their Quality School Plan	Wellness Action Plan	N/A
Cultural Proficiency	1. % schools with a parent or family on wellness council	Wellness Action Plan	N/A
	2. % schools with a member of the student body on wellness council	Wellness Action Plan	N/A
	3. # staff/teachers who have participated in a cultural proficiency training or workshop.	Office of Equity	Data was captured by the Office of Equity instead of the Office of the Achievement Gap
	4. % schools using the teacher evaluation rubric, which includes cultural proficiency indicators: Respects differences (Standards IIC-1), Maintains respectful environment (Standards IIC-2), Culturally proficient communication (Standards IIIC-2)	Office of the Achievement Gap	These data were not captured in SY15-16
School Food & Nutrition Promotion	1. % schools who offer meals at the Bronze level of the Alliance for a Healthier Generation Healthy Schools Program	School Health Index (Measured by Food and Nutrition Services Menu Assessment)	Name changed from Healthy Schools Program Inventory to School Health Index
	2. % schools in compliance with the Food and Beverage Guidelines	School Health Index and district monthly compliance checks	Name changed from Healthy Schools Program Inventory to School Health Index. Compliance data were not captured in SY15-16.
Comprehensive PA & PE	1. % schools in compliance with the PE staffing policy	HR Staffing + H&W Records	N/A
	2. % schools completing the CSPAP portion of the WAP	CSPAP Improvement Plan, part of the Profiles Survey	In SY13-14, CSPAP used to be part of the Wellness Action Plan
	3. % schools in compliance with the % minutes of PE and PA	CSPAP Improvement Plan, part of the Profiles Survey	In SY13-14, CSPAP used to be part of the Wellness Action Plan

Policy Area	Metric	Source	Changes
Comprehensive Health Ed.	1. % schools delivering a district-approved health education curriculum that meets standards outlined in the Wellness Policy	School Health Profiles (Health Ed. Survey)	N/A
	2a. Health education is taught by trained teachers: % schools with trained health education teachers in elementary	H&W Records	Data source changed to H&W Records from Healthy Schools Program Inventory (School Health Index)
	2b. Health education is taught by trained teachers: % schools with a certified health education teacher in middle and high	HR Staffing + H&W Records	N/A
	3a. Comprehensive Health education is taught to students: % schools teaching HIV in grade 4	School Health Profiles (Health Ed. Survey)	N/A
	3b. Comprehensive Health education is taught to students: % schools teaching a minimum of two semesters of comprehensive health education in grades 6-8	School Health Profiles (Health Ed. Survey)	N/A
	3c. Comprehensive Health education is taught to students: % schools teaching a minimum of one semester of comprehensive health education in grades 9-12	School Health Profiles (Health Ed. Survey)	N/A
	4. % schools with an action step regarding health education on their Wellness Action Plans	Wellness Action Plan	N/A
Healthy School Environment	1. % schools with a wellness council with a representative from operations, either a custodian or administrator in charge school building operations.	Wellness Action Plan	N/A
	2. % schools where annual BPS/BPHC Environmental Audit results are reviewed annually	School Health Profiles (Principal Survey)	N/A
	3. % schools that have an updated Integrated Pest Management (IPM) plan and have identified an IPM Coordinator in the school.	School Health Profiles (Principal Survey)	N/A
	4. # staff (custodians, nurses, secretaries, school administrators) and teachers at the district level who received professional development about healthy school environment topics.	Healthy Schools Task Force	N/A
Safe & Supportive Schools	1. % schools creating a safe and supportive school climate as measured by the results of the BPS School Climate survey	School Climate Survey	N/A

Policy Area	Metric	Source	Changes
	2. % schools that indicate a positive (yes) response to the following questions on the 2014 School Health Profiles School Principal Questionnaire. (# 11, #12, #13, #14, #15, #41)	School Health Profiles (Principal Survey)	N/A
	3. % schools with Gay Straight Alliances	School Health Profiles (Principal Survey)	N/A
	4. % bullying prevention specialists trained	Safe & Welcoming Schools Dept. Records	Name of dept. changed from Counseling & Intervention Center to Safe & Welcoming Schools
	5. % schools with student led Bullying prevention groups	Safe & Welcoming Schools Dept. Records	Name of dept. changed from Counseling & Intervention Center to Safe & Welcoming Schools
	6. % bullying cases that have been closed	Safe & Welcoming Schools Dept. Records	Name of dept. changed from Counseling & Intervention Center to Safe & Welcoming Schools. These data were not captured in SY15-16.
	7. % schools trained in CBHM	Behavioral Health Services Dept. Records	N/A
	8. # staff trained in CBHM interventions	Behavioral Health Services Dept. Records	N/A
	9. # students screened during universal behavioral health screening	Behavioral Health Services Dept. Records	N/A
Health Services	1. % high schools where the nurse provides access to condoms	School Health Profiles (Principal Survey)	N/A
	2. % high schools where student receive counseling with condom access (question must be same for nurses, SBHC's and HRCs)	School Health Profiles (Principal Survey)	Data source changed from Health Services Dept. Records to Profiles.
	3. % schools where principals use the Health Services monthly toolkit (monthly check list)	Health Services Site Visit Records	These data were not captured in SY15-16.

Table of Student-level Metrics and Data Sources by Topic Area

Topic Area	Metric	Source
Alcohol, Other Drugs, and Tobacco	1. % of students (ab)using alcohol • Ever had at least one drink of alcohol • At least one drink of alcohol in last 30 days (current drinker) • Had 5+ drinks in a row in last 30 days	High School Youth Risk Behavior Survey
	2. % of students (ab)using other drugs • Ever used marijuana • Currently use marijuana • Currently use a blunt wrap or cigar wrapper to smoke marijuana	High School Youth Risk Behavior Survey
	3. % of students (ab)using tobacco products • Currently smoke cigarettes • Currently use smokeless tobacco • Currently use cigars, cigarillos, or little cigars • Smoked Black and Mild, Swisher Sweets, or Dutch masters cigarillos in past 30 days	High School Youth Risk Behavior Survey
Mental Health, Safety, Violence, and Unintentional Injury, and Bullying	1. Mental Health • % experienced depression (sad and hopeless almost every day for two weeks or more in a row) • % seriously considered attempting suicide • % made a plan about how would attempt suicide • % attempted suicide one or more times	High School Youth Risk Behavior Survey
	2. Safety, Violence, and Unintentional Injury • % carried a weapon on school property • % were in a physical fight during the past 12 months • % were ever physically forced to have sexual intercourse when didn't want to • % experienced physical dating violence	High School Youth Risk Behavior Survey
	3. Bullying • % bullied on school property in last 12 months • % electronically bullied in last 12 months (email, chat rooms, instant messaging, website, texting) • % victims of teasing or name calling because someone thought they were gay, lesbian, bisexual in last 12 months	High School Youth Risk Behavior Survey

Topic Area	Metric	Source
Dietary Behaviors, Weight Management, and Physical Activity and Access to Physical Education	1. Dietary Behaviors • % drank soda one more times daily • % ate 5 or more servings of fruit and vegetables daily during past seven days • % consuming breakfast daily	High School Youth Risk Behavior Survey
	2. Weight Management • % went 24 hours without eating to lose/not gain weight • % vomited or took laxatives in last 30 days to lose/keep from gaining weight	High School Youth Risk Behavior Survey
	3. Physical Activity/Physical Education Access and Participation • % attended PE classes on one or more days in an average school week • % attended PE classes on all five days in an average school week • % physically active for at least 60 minutes per day over the last 7 days	High School Youth Risk Behavior Survey
	4. % of students achieving health fitness levels • HFZ in 3/5 assessments • HFZ for aerobic capacity	FitnessGram
Sexual Health Education and Risky Sexual Behaviors	1. Sexual Health Education in School • % ever had sexual education in school • % taught in school how to use a condom • % taught about AIDS or HIV in school • % ever taught in school about STDs (not including AIDS or HIV), such as genital herpes, chlamydia, syphilis, or genital warts	High School Youth Risk Behavior Survey
	2. Risky Sexual Behaviors • % ever had sexual intercourse • % had sexual intercourse with 4+ persons during their life • % rank alcohol or used drugs before had sexual intercourse the last time • % do not use a condom (among those currently sexually active • % did not use any method to prevent pregnancy (among those currently sexually active)	High School Youth Risk Behavior Survey

Topic Area	Metric	Source
	• % have been pregnant or have gotten someone pregnant	
Body Mass Index	1. % of students with a BMI at a healthy weight (BMI <85th percentile)	SNAPNurse
Known Asthma Diagnosis	1. % of students with a known asthma diagnosis	SNAPNurse

Appendix E

SY15-16 Wellness Action Plan Topics and Member Type

Wellness policy area included in WAP goals. Source: WAP	
	District (n=75)
Comprehensive Health Education	65% (49/75)
Comprehensive Physical Activity and Physical Education	52% (39/75)
Safe and Supportive Schools	32% (24/75)
Health Services	31% (23/75)
Staff Wellness	28% (21/75)
School Food and Nutrition Promotion	21% (16/75)
Healthy School Environment	17% (13/75)
Cultural Proficiency	1% (1/75)

Percent of types of school-based wellness council members by data source. Sources: WAP & Profiles			
WAP Member Type	WAP	Profiles	Profiles Member Type
Classroom Teacher	80% (55/69)	92% (77/84)	Other classroom teacher (not including Health Education teachers)
Nurse	72% (50/69)	84% (68/81)	Health services staff (e.g., school nurses)
PE teacher	61% (42/69)	87% (72/83)	Physical Education Teacher
Principal/Headmaster	57% (39/69)	95% (81/85)	School Administrators
Social Workers/Guidance Counselor	33% (23/69)	83% (67/81)	Mental health or social services staff (e.g., school counselors)
Parent	26% (18/69)	61% (50/82)	Parents or families of students
Community Partner	23% (16/69)	40% (31/78)	Includes: Local health departments, agencies, or organizations; Faith-based organizations; Businesses; Local government agencies
Student	3% (2/69)	33% (26/79)	Student body
Custodian	1% (1/69)	16% (12/77)	Maintenance and transportation staff
--	--	60% (49/82)	Health Education Teacher
--	--	48% (38/79)	Community Members
--	--	28% (22/79)	Nutrition or Food Staff
--	--	18% (14/78)	Technology Staff
--	--	16% (12/77)	Library/Media Center Staff

*There were 32 schools that stated that they do not have a group at their school that offers guidance on the development of policies or coordinates activities on health topics and thus skipped this question.

Appendix F

YRBS Student-Level Outcomes by Select Demographic Factors

	Lesbian, Gay, Bisexual	Race/ Ethnicity	Sex	Academic Grades
Alcohol/Other drug abuse	**(1)** More LGB students currently use marijuana compared to hetero sexual peers **(2)** More LGB students currently drink alcohol compared to heterosexual peers	**(1)** Fewer Black and Asian students drink alcohol in comparison to White students. **(2)** Fewer Asian students currently use marijuana compared to White students.	Female students more likely than male students to currently drink alcohol	Fewer students who get mostly A's drink alcohol, or use marijuana compared to students who mostly get D's/F's
Bullying	**(1)** More LGB students have been victim of teasing or name calling because someone thought they were gay, lesbian or bisexual **(2)** No association between sexual orientation and being bullied on school property or electronically bullied	Black and Asian students were less likely to be electronically bullied compared to White students.	Female students were more likely than male students to be electronically bullied or bullied on school property	Overall, no association between academic grades and bullying.
Dietary Behaviors	Overall, no differences in dietary behaviors between students who identify as heterosexual and those who identify as LGB.	**(1)** Fewer Black and Hispanic/ Latinx students ate veggies 2+ times a day compared to White students. **(2)** More Hispanic/Latinx student drank 1+ servings of soda per day compared to White students. **(3)** Fewer Black and Hispanic/Latinx students drank 1+ glasses of milk per day compared to White students **(4)** Black and Hispanic/Latinx students were more likely to NOT eat breakfast daily than White students.	**(1)** Female students were more likely to NOT eat breakfast all 7 days before survey **(2)** Female students were less likely to drink 1+ servings of soda per day **(3)** Male students were less likely to drink 1+ glasses of water per day **(4)** Female students were less likely to rink 1+ glasses of milk per day	**(1)** Students who got poor grades were more likely to not eat vegetables than students who got better grades. **(2)** Students with better grades were more likely to NOT drink a can, bottle, or glass of soda pop than students who got poor grades. **(3)** Students who got poor grades were less likely to eat breakfast on all 7 days before the survey than students who got better grades.
Unintentional Injury, Safety and Violence	**(1)** More LGB students were in a physical fight in the past year **(2)** More gay, lesbian or bisexual students were forced to have sexual intercourse when they did not want to	**(1)** Black, Asian and Hispanic/Latinx students were more likely to rarely or never wear a seat belt as a passenger compared to White students. **(2)** Fewer Asian students reported fighting compared to their peers. **(3)** Hispanic/Latinx students were more likely to be in a physical fight on school property in the past year	**(1)** Male students were more likely than female students to carry a weapon and to be in a physical fight in the last 12 months **(2)** Female students were more likely than male students to be physically forced to have sexual intercourse when they didn't want to.	**(1)** Students who get mostly D's/F's were more likely to carry a weapon such as a gun, knife, or club than students who got mostly A's. **(2)** Students who get mostly D's/F's were more likely to not go to school because they felt unsafe at school or on their way to or from school than students who got mostly A's. **(3)** Students who get mostly D's/F's were more likely to be in a physical fight than students who got mostly A's.

	Lesbian, Gay, Bisexual	Race/ Ethnicity	Sex	Academic Grades
Mental Health	More students who identify as LGB: (1) Experienced depression compared to their heterosexual peers (2) Did something to purposely hurt themselves without wanting to die in the past year (3) Seriously considered attempting suicide and (4) Attempted suicide	**(1)** More Hispanic/ Latinx students did something to purposely hurt themselves without wanting to die compared to White students **(2)** More Hispanic/ Latinx students seriously considered attempting suicide in the past year compared to White students	**(1)** Female students were more likely than male students to feel sad or hopeless **(2)** Female students were more likely than male students to purposely hurt themselves without wanting to die **(3)** Female students were more likely than male students to seriously consider attempting suicide	Students with poor grades were more likely to feel sad or hopeless or attempt suicide that resulted in an injury, poisoning, or overdose that had to be treated by a doctor or nurse than students with better grades.
Physical Activity	Students who identified as LGB were more likely to play video or computer games or use a computer 3+ hours on an average school day compared to Heterosexual students.	**(1)** More Black students and Hispanic/Latinx students watched 3+ hours of TV on an average school day compared to Asian and White students. **(2)** More Asian students played video/ computer games or used a computer for 3+ hours on an average school day compared to White students.	**(1)** Female students more likely that male students to not participate in at least 60 minutes of physical activity on at least 1 day of 7 days before survey. **(2)** Female students were also less likely than male students to attend physical education classes on 1+ school days	Students with poor grades were more likely to play video or computer games or use a computer 3+ hours per day than students who got better grades.
Tobacco Use	More LGB students currently smoke, currently use tobacco products and currently use electronic products compared to Heterosexual students.	**(1)** Hispanic/Latinx students were more likely than White students to currently use tobacco products. **(2)** Asian students were less likely than White students to currently use tobacco products.	Female students were less likely than male students to currently smoke cigarettes.	Fewer students who get mostly A's currently smoke cigarettes or cigars, cigarillos or little cigars, compared to students who mostly get D's/F's
Sexual Behavior	More LGB students have ever had sexual intercourse and are currently sexually active compared to Heterosexual students.	Black and Hispanic/Latinx students were more likely to have ever had sexual intercourse, to have had sexual intercourse with 4+ persons during their life and to be currently sexually active compared to Asian and White students.	**(1)** Male students were more likely to have ever had sexual intercourse, to have had sexual intercourse before age 13 and to have had sexual intercourse with 4+ persons compared to female students. **(2)** Female students were more likely to have NOT used a condom during last sexual intercourse.	Students were poor grades were more likely to be currently sexually active and to have had sexual intercourse with 4+ persons than students with better grades.

	Lesbian, Gay, Bisexual	Race/ Ethnicity	Sex	Academic Grades
Weight Management	No differences in weight management behaviors were observed between populations.	No differences in weight management behaviors were observed between racial/ethnic groups.	**(1)** Female students were more likely than male students to describe themselves as slightly or very overweight. **(2)** Female students were also more likely than male students to be trying to lose weight. **(3)** No different between male and female students for who vomited or took laxatives to lose weight or to keep from gaining weight	Students who got mostly D's/F's were more likely to describe themselves as slightly or very overweight than students who got mostly A's.

Note: *Data represented in this table are from the HS YRBS survey (grades 9-12). Only statistically significant trends are reported. By "more" or "fewer," we mean proportions (% of students) and not counts (# of students).*

Appendix H

BPS District Wellness Council SY16-17 Action Plan

District Wellness Council Goals	Action Steps	Lead	Deadline
1. Review and revise components of the District Wellness Policy and/or consider additional policy areas.	• Consider updates to and revisions of existing policies based on available data • Identify any new areas of policy work to address through District Wellness Council	Subcommittees	January 2017
2. Communicate and advocate for implementation of the Wellness Policy.	• Develop and propose communication strategies and approaches about the Wellness Policy	Co-Chairs and Subcommittees	June 2017
3. Consider and respond to requests for new policies or other community inquiries of the District Wellness Council.	• Apply decision making process and criteria according to updated Council Bylaws	Co-Chairs and Subcommittees	June 2017
4. Complete and submit an Annual Report to School Committee.	• Collect data for third Annual Report	Subcommittees	April 2017
	• Develop draft of third Annual Report (qualitative) on Wellness Policy implementation	HWD with support from Subcommittee Co-chairs	
	• Finalize third Annual Report (quantitative) on Wellness Policy implementation	HWD with support from Subcommittees	
Standard Subcommittee Objectives:			
1. Review and revise wellness-related policies as applicable.		Subcommittees	June 2017
2. Advise on and assist with communicating about the Wellness Policy to all stakeholders (parents, students, community partners, and district staff and leadership).		Co-Chairs and Subcommittees	Ongoing in 2016-17 SY
3. Apply decision-making process to new policy areas, new work of the subcommittees, new work of the District Wellness Council, etc.		Co-Chairs and Subcommittees	Ongoing in 2016-17
4. Provide relevant data and stories for the Annual Report on Implementation of the Wellness Policy.		Subcommittees; HWD with support from Co-Chairs and Subcommittees	June 2017

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