Health Education Curriculum Review Report

INTRODUCTION

During the fall of 2014 the Cambridge Public Schools contracted an outside consultant to assist in facilitation of the Health Education Curriculum Review. Various meetings and interviews were conducted with Kim DeAndrade, Health/Social Emotional Learning Program Leader, Principals and Assistant Superintendents. Other key stakeholders submitted survey data, including classroom teachers, health and physical education teachers, special education teachers, nurses and principals.

The survey data and interviews focused on the following key areas: knowledge and alignment of curriculum to the Massachusetts Comprehensive Health Curriculum Framework and the National Health Standards, lesson content, frequency of instruction, and health concerns staff have for students.

This report is organized into five major components:

- Executive Summary
- Current Research on Comprehensive Health Education and Academics
- Assess Current Program Practices
- Assess Current Resources
- Strengths and Recommendations Summary

This document represents a compilation of the data collected by the consultant. Unlike other Curriculum Reviews conducted for the CPS, a team of teachers and administrators was not formed because of the diversity of implementation and the unmandated structure, especially at the elementary level. Strengths and Recommendations are included throughout the document to direct the work for Phase II, III, and IV.

Ms. Kim DeAndrade, Health Education and Social Emotional Learning Program Leader, is to be commended for the strides made in promoting a comprehensive health education program (as defined in the MA Comprehensive Health Curriculum Framework). The Cambridge Public School District is like most high performing districts, managing an environment where various local and state initiatives hold a priority in competing for student time. Teachers often report not having enough time to accomplish all that is needed for student's physical, social, emotional and intellectual growth. Ms. DeAndrade's efforts in advocating for health education, at every level are unwavering when one considers the roadblocks that exist for implementation of the health education curriculum framework.

This report was authorized by Jessica Huizenga, Assistant Superintendent. Questions can be directed to Kim DeAndrade at kdeandrade@cpsd.us, 617-349-6851.

Respectfully submitted by Patricia Degon, Health and Wellness Associates

EXECUTIVE SUMMARY

The historical pathway in the commonwealth reaches back to the *Education Reform Act of 1993* and *the Massachusetts Common Core of Learning, when* both identified health content as critical to the development and academic achievement of students. However, health education is currently not considered a core academic subject and not part of the Massachusetts or national assessment requirements. The significance of this situation is that educators and administrators are constantly struggling to justify the existence and implementation of health content in the academic community. Health education should be considered a critical component for any school system as it provides students with real-life application of critical skills while learning health-related content, which promotes academic success.

The Guiding Principles in the MA Comprehensive Health Curriculum Framework are as follows:

- Comprehensive Health education teaches students fundamental health concepts and skills that foster healthy habits and behaviors for the individual and others through **sequential and coordinated teaching** of health education, physical education and family and consumer sciences education at each grade level, prekindergarten through grade 12.

- Comprehensive Health education teaches students to use fundamental health concepts to **assess risks,** to consider potential consequences, and to make health-enhancing decisions.

- Comprehensive Health education teaches skills that assist students to understand and **communicate** health information clearly for self-management and health promotion.

- Comprehensive Health education contributes to the capacity of students to work in a positive manner with families, school staff, peers and community members to enhance personal health and create **a safe and supportive environment** where individual similarities and differences are acknowledged.

- Comprehensive Health Education is strengthened through **collaboration** and partnerships among all components of the coordinated school health program and other subjects

The Cambridge Public Schools currently struggle with complying with these guiding principles consistently for all students across the district.

Health education in the elementary grades is expected by some but not all, to be delivered by the classroom teacher during at least one lesson per week. At the elementary level health curricula and training are available for classroom teachers but implementation is not mandatory and is inconsistent in delivery and best practices. The curricula selected by the district, The Great Body Shop, would align with the MA Comprehensive Health

Curriculum Framework and National Standards if delivered with fidelity and in a sequential manner.

Though there is an expectation by some that classroom teachers teach one health lesson per week, there is no requirement to implement health instruction for students in grades PreK through 5, and there is no consistent mechanism to monitor the expectation. Thus, there is no evidence to support sequential K-12 curricula with clear performance standards and no process to assess what students should know or be able to do at the elementary level.

This prevents the students from being able to consistently progress through the elementary grades and master the foundation knowledge to prepare for age appropriate content/concepts at the middle level and then on to the high school. Some formative assessments may be conducted depending on the individual teacher's planning. Summative assessment is not conducted in any standardized manner and no performance reports are given to students, parents or guardians

At the middle and high school levels there are specific licensed health and/or physical education teachers that take ownership of the curricula and it's delivery to students. The content is matched to the MA Comprehensive Health Curriculum Framework and National Standards. The curricula selected by the district for the secondary grade include Health Smart, Get Real and Second Step.

Many of the content topics must be introduced to the students for the first time in middle school rather than expanding or reinforcing information and skill development that should have been introduced in elementary school. There are a variety of frequency schedules for health instruction for grades 6, 7, and 8. The range of time for learning in grade 6 averages approximately one class per week all year long. However, most schools are able to offer 36 classes and one school can only offer 30. There is even more discrepancy for grades 7 and 8. In 7th grade one school is offering only 18 classes per year, one school offering 30 classes per year, and three schools offering 36 classes per year. In 8th grade the difference in time on learning is most diverse with one school offering 30 classes per year, three schools offering 36 classes per year and one school having the benefit of 72 classes per year for comprehensive instruction. Students are only assessed and graded in the upper schools and at the high school. Formalizing the instruction, developing common assessments, and recording and reporting the level of understanding should be considered for elementary students as well.

The high school health curriculum is scheduled for health being delivered every other day, alternating with physical education, for one semester totaling approximately 45 classes. All 9th graders must take this course. It is commendable that CPS has recognized the value of this content and made this a course that students must take and pass to graduate. Additionally, the high school is preparing to offer a new elective course for students in grades 10 called Wellness 2. This course will be an elective next year, but will hopefully be required for 10th graders in the future. There is also an elective for students in grades 11through 12 titled Young Adult Wellness. It is commendable to offer additional

instruction tailored to the needs of older students who are preparing to transition to college or the world of work. This course will also be an appealing choice for any student that has a personal interest in learning more about health promotion. For most students, unless they are pursuing some training associated with the health care field, this is the last opportunity they will have for formal health education addressing the adult world, adult challenges, and practices to promote lifelong wellness.

All students in the Cambridge Public School District are entitled to have full access to the curriculum and that includes health education. Students that qualify for special instruction or academic support are those children with learning disabilities and students that English is not their first language.

It is the expectation by some at the elementary level that SEI and SPED classroom teachers teach one health education lesson per week. Just as is the case with the general education classroom teachers this expectation is inconsistent, not mandated and often omitted due to other competing factors.

At the Upper Schools, SEI students are mainstreamed into health class with a certified health teacher. Students in self contained special education programs have different methods of instruction and participation in health education including being mainstreamed into health class with a certified instructor, some taught by classroom teacher, and some have a separate health class taught by a certified health teacher allowing adaptive instruction.

At the Extension School students participate in wellness mini courses organized by school staff once a week. There is little evidence or insurance that the topics presented in the mini courses match the high school curriculum or are aligned with the state and national standards.

SEI students at the high school are mainstreamed into the general health education classes when it will fit into their schedule and when they have sufficient English to participate. If a 9th grader does not participate in the course due to other instructional conflicts, the student is only sometimes placed into a health elective at a later year. Monitoring and managing this important content opportunity for these students should be ensured before graduation.

SPED students that attend and learn in a self-contained classroom setting can be considered for mainstreamed health instruction if it suits the students learning needs. Although most are placed into the 9th grade course, they are often unsuccessful due to the class not meeting their learning needs. For students that will be in a new class based on their diagnosis of being on the autism spectrum, the plan for their health instruction is to be determined.

Both SEI and SPED students have the same basic health needs as all students do and many have greater needs based on their personal circumstances. Due to interrupted schooling, physical or emotional health needs, social and cultural challenges many of these students

are not succeeding in the general health education classes. Their academic challenges or behaviors may impede their access to the curriculum and their ability to master the content within a large group setting.

When their academic level puts them significantly behind other students, either due to knowledge, processing or mastering English, even with modified work, they are unable to achieve. In many cases their physical needs are different than the general school population. These challenging conditions include hygiene, safety, caring for self, eating choices, and risk behavior patterns all cause additional barriers for learning in the mainstreamed setting.

The Cambridge Public Schools have begun an exciting new initiative to incorporate Social Emotional Learning. According to the interview conducted with the three Assistant Superintendents, Jessica Huizenga, Mary Ann MacDonald, and Victoria Greer, this initiative is a full framework including curriculum and services for students and families. Principals have endorsed prioritizing this initiative due to the frequency of school incidents they deal with on a regular basis and the attention and energy these situations take from an administrator and staff to avoid episodes escalation to crisis status. Because the initiative is addressing social and emotional needs there is a natural parallel to the fifth standard in the MA Comprehensive Health Curriculum Framework – Mental Health. As this initiative progresses it will be an efficient use of time and resources to explore the existing health standards, existing research based health curricula, determine the method to ensure social/emotional content delivery and determine the most appropriate staff qualifications to teach the social/emotional content. In recognition of the inconsistent nature that health education is currently being delivered at the elementary level it will be critical for the Cambridge Public Schools to create a plan that is adopted and monitored across the district.

Strengths:
Health instruction utilizes research-based curricula.

Health instruction is facilitated at the Upper Schools by certified health teachers. Certified health teachers and/or certified physical education teachers teach the curriculum at the High School.

Successfully passing the 9th grade health course is a graduation requirement.

Offering a new course, as an elective for older students in grades 10 – 12, at the high school will address mature students' needs and appeal to students that have a personal interest in learning about lifelong wellness.

Recommendations:
Increase the awareness and understanding of the MA Comprehensive Health Curriculum Framework among administrators, principals, classroom teachers and all other school faculty.

Develop a sequential curricula implementation plan beginning at the elementary level reflecting the performance standards in the MA Comprehensive Health Curriculum Framework and clarifying what content and skills will be taught in each grade and who will be responsible for the instruction

Develop a curriculum implementation plan that emphasizes the teaching objectives, activities and assessment strategies, required for each elementary grade, matched to the performance standards, resulting in consistency and comprehensive health instruction.

Utilize all principals to ensure that health is taught according to the implementation plan.

Review the middle grade health schedules to create more consistent time for health instruction for all students.

Determine an assessment plan to track students' learning of knowledge and skill at the elementary level and examine consistent authentic assessment practices at the middle and high school levels.

Health teachers should complete the 15-hour WIDA course to better meet the needs of the SEI students. Health teachers should work with SEI core subject teaches to suggest appropriate health content and skills to be incorporated into their teaching to reinforce learning.

Health teachers should complete the 15-hour required Special Education course to be able to better meet the needs of the mainstreamed SPED students. Health teachers should also work with SPED core subject teaches to suggest developmentally appropriate health content and skills to be incorporated into their teaching to reinforce learning.

A certified health teacher should be assigned to coordinate instruction at the Extension School and ensure the curricula activities parallel what is taught at the High School.

A certified health teacher should be hired or assigned to teach adaptive classes to K – 12 students that cannot have full access to the curriculum or succeed in the mainstreamed health classes.

Create a Social Emotional Learning plan that is adopted and monitored consistently across the district.

Greater alignment among the 10 components of a Whole School, Whole Community, Whole Child approach will lead to more support for and will lead to more support for and more effective implementation of health education in schools.*
CDC

** Whole School, Whole Community, Whole Child approach developed by ASCD and the CDC&P includes: Health Education, Physical Education and Activity, Nutrition Environment and Services, Health Services, Counseling, Psychological and Social Services, Social and Emotional Climate, Physical Environment, Employee Wellness, Family Engagement and Community Involvement.*

CURRENT RESEARCH ON COMPREHENSIVE HEALTH EDUCATION AND ACADEMICS

Eva Marx, Susan Wooley, and Daphne Northrop published a critical publication, Health Is Academic. In it they state, *"We must connect the dots between health and learning" and that "limited resources and a shared commitment to children's well-being make a coordinated approach not only practical but preferable" (p. 9).*

And

"As the authors of this volume assert, educational reforms will be effective only if students' health and well-being are identified as contributors to academic success and are at the heart of decision and policy making. Schools, in concert with students, their families, and communities, must consider how well schools are accomplishing their missions and how they can best help students realize their full potential" (p. 293).
—Eva Marx, Susan Frelick Wooley, and Daphne Northrop, 1998

Even though the above passage was published more than decade ago the conditions still exist and little progress has been made. Additionally, in a more recent document, Charles E. Basch stated in his 2010 research review, Healthier Students Are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap, *"Though rhetorical support is increasing, school health is currently not a central part of the fundamental mission of schools in America nor has it been well integrated into the broader national strategy to reduce the gaps in educational opportunity and outcomes" (p. 9).*

When health education has been required to be an integral part of the curriculum, the results have been educationally productive for all subjects. Schools that work purposefully toward enhancing the mental, social, emotional, and physical health of both their staff and students frequently report the results that principals and administrators want to hear:

- higher academic achievement from students
  (Basch, 2010; Case & Paxson, 2006; Crosnoe, 2006; Haas & Fosse, 2008; Hass, 2006; Heckman, 2008; Koivusilta, Arja, & Andres, 2003; Palloni, 2006),
- increased staff satisfaction and decreased staff turnover
  (Byrne, 1994; Dorman, 2003; Grayson & Alvarez, 2008),
- greater efficiency
  (Bergeson, Heuschel, Hall, & Willhoft, 2005; Harris, Cohen, & Flaherty, 2008;Lezotte & Jacoby, 1990),
- the development of a positive school climate
  (Basch, 2010; Benard, 2004), and ultimately
- the development of a school-community culture to promote and enhance student growth
  (Battin-Pearson et al., 2000; Bond & Carmola Hauf, 2007; Fleming et al., 2005; Klem & Connell, 2004; Ladd, Birch, & Buhs, 1999; Nelson, 2004; Rosenfeld, Richman, & Bowen, 1998).

Health-related factors that are out of the control of young learners such as hunger, abuse, and chronic illness have been shown to lead to poor school performance.[1]

Health-risk behaviors may be experienced by older students, such as early sexual initiation, violence, unhealthy eating, and physical inactivity are consistently linked to poor grades, poor test scores, and lower educational attainment.[2-5] This report hopes to endorse the close relationship between health and education, as well as the need to promote health and well-being within the educational environment for all students.[6-9]

Various scientific reviews have documented that school health programs can have positive effects on academic outcomes, as well as health-risk behaviors and health outcomes.[10-11] Schools can play a critical role in promoting the health and safety of young people and helping them establish lifelong healthy behaviors. Research also has shown that school health programs can reduce the prevalence of health-risk behaviors among young people and have a positive effect on academic achievement. Schools can and must play a critical role in promoting the health and safety of young people and helping them establish lifelong healthy behaviors.

To capitalize on the far reaching benefits for academic achievement for all students, it is vital that the health curricula is supported by research and proven to be effective, must teach functional health information, shape personal values and beliefs supporting health behaviors, shape group norms that value healthy lifestyles, and develop essential health skills necessary to adopt, practice and maintain health-enhancing behaviors. Curricula that overemphasize teaching just scientific facts and just assessing student knowledge have been proven to be less effective in influencing life long wellness.

Effective Curriculum

An effective health education curriculum has the following characteristics, according to reviews of effective programs and curricula and experts in the field of health education: [1-14]

1. **Focuses on clear health goals and related behavioral outcomes**. An effective curriculum has clear health-related goals and behavioral outcomes that are directly related to these goals. Instructional strategies and learning experiences are directly related to the behavioral outcomes.

2. **Is research-based and theory-driven**. An effective curriculum has instructional strategies and learning experiences built on theoretical approaches (for example, social cognitive theory and social inoculation theory) that have effectively influenced health-related behaviors among youth. The most promising curriculum goes beyond the cognitive level and addresses health determinants, social factors, attitudes, values, norms, and skills that influence specific health-related behaviors.

3. **Addresses individual values, attitudes, and beliefs**. An effective curriculum fosters attitudes, values, and beliefs that support positive health behaviors. It provides instructional strategies and learning experiences that motivate students to critically examine personal perspectives, thoughtfully consider new arguments that support health-promoting attitudes and values, and generate positive perceptions about protective behaviors and negative perceptions about risk behaviors.

4. **Addresses individual and group norms that support health-enhancing behaviors**. An effective curriculum provides instructional strategies and learning experiences to help students accurately assess the level of risk-taking behavior among their peers (for example, how many of their peers use illegal drugs), correct misperceptions of peer and social norms, emphasizes the value of good health, and reinforces health-enhancing attitudes and beliefs.

5. **Focuses on reinforcing protective factors and increasing perceptions of personal risk and harmfulness of engaging in specific unhealthy practices and behaviors**. An effective curriculum provides opportunities for students to validate positive health-promoting beliefs, intentions, and behaviors. It provides opportunities for students to assess their vulnerability to health problems, actual risk of engaging in harmful health behaviors, and exposure to unhealthy situations.

6. **Addresses social pressures and influences**. An effective curriculum provides opportunities for students to analyze personal and social pressures to engage in risky behaviors, such as media influence, peer pressure, and social barriers.

7. **Builds personal competence, social competence, and self-efficacy by addressing skills**. An effective curriculum builds essential skills — including communication, refusal, assessing accuracy of information, decision-making, planning and goal-setting, self-control, and self-management — that enable students to build their personal confidence, deal with social pressures, and avoid or reduce risk behaviors.
   For each skill, students are guided through a series of developmental steps:
   a. Discussing the importance of the skill, its relevance, and relationship to other learned skills.
   b. Presenting steps for developing the skill.
   c. Modeling the skill.
   d. Practicing and rehearsing the skill using real–life scenarios.
   e. Providing feedback and reinforcement.

7. **Provides functional health knowledge that is basic, accurate, and directly contributes to health-promoting decisions and behaviors**. An effective curriculum provides accurate, reliable, and credible information for usable purposes so students can assess risk, clarify attitudes and beliefs, correct misperceptions about social norms, identify ways to avoid or minimize risky situations, examine internal and external influences, make behaviorally relevant decisions, and build personal and social competence. A curriculum that provides information for the sole purpose of improving knowledge of factual information will not change behavior.

8. **Uses strategies designed to personalize information and engage students.** An effective curriculum includes instructional strategies and learning experiences that are student-centered, interactive, and experiential (for example, group discussions, cooperative learning, problem solving, role playing, and peer-led activities). Learning experiences correspond with students' cognitive and emotional development, help them personalize information, and maintain their interest and motivation while

accommodating diverse capabilities and learning styles. Instructional strategies and learning experiences include methods for

a. Addressing key health-related concepts.
b. Encouraging creative expression.
c. Sharing personal thoughts, feelings, and opinions.
d. Thoughtfully considering new arguments.
e. Developing critical thinking skills.

9. **Provides age-appropriate and developmentally appropriate information, learning strategies, teaching methods, and materials**. An effective curriculum addresses students' needs, interests, concerns, developmental and emotional maturity levels, experiences, and current knowledge and skill levels. Learning is relevant and applicable to students' daily lives. Concepts and skills are covered in a logical sequence.

10. **Incorporates learning strategies, teaching methods, and materials that are culturally inclusive**. An effective curriculum has materials that are free of culturally biased information but includes information, activities, and examples that are inclusive of diverse cultures and lifestyles (such as gender, race, ethnicity, religion, age, physical/mental ability, appearance, and sexual orientation). Strategies promote values, attitudes, and behaviors that acknowledge the cultural diversity of students; optimize relevance to students from multiple cultures in the school community; strengthen students' skills necessary to engage in intercultural interactions; and build on the cultural resources of families and communities.

11. **Provides adequate time for instruction and learning**. An effective curriculum provides enough time to promote understanding of key health concepts and practice skills. Behavior change requires an intensive and sustained effort. A short-term or "one shot" curriculum, delivered for a few hours at one grade level, is generally insufficient to support the adoption and maintenance of healthy behaviors.

12. **Provides opportunities to reinforce skills and positive health behaviors**. An effective curriculum builds on previously learned concepts and skills and provides opportunities to reinforce health-promoting skills across health topics and grade levels. This can include incorporating more than one practice application of a skill, adding "skill booster" sessions at subsequent grade levels, or integrating skill application opportunities in other academic areas. A curriculum that addresses age-appropriate determinants of behavior across grade levels and reinforces and builds on learning is more likely to achieve longer-lasting results.

13. **Provides opportunities to make positive connections with influential others**. An effective curriculum links students to other influential persons who affirm and reinforce health–promoting norms, attitudes, values, beliefs, and behaviors. Instructional strategies build on protective factors that promote healthy behaviors and enable students to avoid or reduce health risk behaviors by engaging peers, parents, families, and other positive adult role models in student learning.

14. **Includes teacher information and plans for professional development and training that enhance effectiveness of instruction and student learning**. An effective curriculum is implemented by teachers who have a personal interest in promoting positive health behaviors, believe in what they are teaching, are knowledgeable about the curriculum content, and are comfortable and skilled in implementing expected instructional strategies. Ongoing professional development and training is critical for helping teachers implement a new curriculum or implement strategies that require new skills in teaching or assessment.

PRE K-12 STANDARDS
GROWTH & DEVELOPMENT Students will learn the basic characteristics of physical growth and development, including body functions and systems throughout the life cycle, and will acquire skills to promote and maintain positive growth and development. (p.12)
PHYSICAL ACTIVITY & FITNESS Students will, by repeated practice, acquire and refine a variety of manipulative, locomotor, and non-locomotor movement skills, and will utilize principles of training and conditioning, will learn biomechanics and exercise physiology, and will apply the concept of wellness to their lives. (p. 14)
NUTRITION Students will gain the knowledge and skills to select a diet that supports health and reduces The risk of illness and future chronic diseases. (p. 18)
REPRODUCTION/SEXUALITY Students will acquire the knowledge and skills necessary to make effective personal decisions that promote their emotional, sexual, and reproductive health. (p. 21)
MENTAL HEALTH Students will acquire knowledge about emotions and physical health, the management of emotions, personality and character development, and social awareness; and will learn skills to promote self-acceptance, make decisions, and cope with stress, including suicide prevention. (p. 26)
FAMILY LIFE Students will gain knowledge about the significance of the family on individuals and society, and will learn skills to support the family, balance work and family life, be an effective parent, and nurture the development of children. (p. 29)
INTERPERSONAL RELATIONSHIPS Students will learn that relationships with others are an integral part of the human life experience and the factors that contribute to healthy interpersonal relationships, and will acquire skills to enhance and make many of these relationships more fulfilling through commitment and communication. (p. 32)
DISEASE PREVENTION & CONTROL Students will learn the signs, symptoms, and treatment of chronic and communicable diseases, and will gain skills related to health promotion, disease prevention, and health maintenance. (p. 37)
SAFETY & INJURY PREVENTION Students will gain the knowledge and skills to administer first aid and carry out emergency procedures, including cardiopulmonary resuscitation, avoid, recognize, and report verbal, physical, and emotional abuse situations, and will assess the factors that contribute to intentional and unintentional injury, including motor vehicle accidents, fire safety, and weapons safety (p. 40)
TOBACCO, ALCOHOL, & OTHER SUBSTANCES USE/ABUSE PREVENTION Students will acquire knowledge and skills to be competent in making health-enhancing decisions regarding the use of medications and avoidance of substances, and in communicating about substance use/abuse prevention for healthier homes, schools, and communities. (p. 43)
VIOLENCE PREVENTION Students will learn how their actions affect others, will understand the power that positive character traits can have in violence prevention, will gain skills to report incidents of violence and hurtful behavior to adults in the school and community, will avoid engaging in violence, and identify constructive alternatives to violence, including how to discourage others from engaging in violence. (p. 46)
CONSUMER HEALTH & RESOURCE MANAGEMENT Students will acquire the knowledge and skills necessary to obtain, manage, and evaluate resources to maintain physical and mental health and well being for themselves, their family, and the community. (p. 51)
ECOLOGICAL HEALTH Students will gain knowledge of the interdependence between the environment and physical health, and will acquire skills to care for the environment. (p. 54)
COMMUNITY & PUBLIC HEALTH Students will learn the influence of social factors on health and contribution of public health, and will gain skills to promote health and to collaborate with others to facilitate healthy, safe, and supportive communities. (p. 56)

EXISTING PROGRAM ASSESSMENT

Electronic surveys were developed and distributed to the following key stakeholders: Elementary Classroom Teachers, Elementary Special Education (SPED) Teachers, elementary Sheltered English Immersion (SEI) Teachers, elementary and upper school Physical Education (PE) Teachers, district wide Nurses, and elementary Principals

Health Education Pre K-5
Program Assessment

43 Elementary Classroom Teachers responded to the elementary survey.

90.7% Classroom teacher – general education
2.3% Self contained classroom teacher – OSS
4.7% SEI teacher
2.3% Other

62.8% **have** a *Great Body Shop* Teachers Guide
23.3% do **not** have a *Great Body Shop* Teachers Guide
1.4% report **don't know**

34.9% **attended** the 10-week health education workshop
55.8% did **not** attend the 10-week health education workshop
9.3% **don't remember**

34.9% need **additional** training to teach health education effectively
65.1% **no** need for additional training to teach health education effectively

41.9% **do not teach any** health education
21% teach health education **less** than once per week
7% teach health education **once** per week
2.3% teach health education **more** than once per week

25.6 do **teach** health
27.9% report **no time** to teach health
4.7% **someone else** teaches it for my students
14% didn't **know** I was supposed to
14% other

72.1% **teach** health in other ways besides teaching the health curriculum
23.3% do **not** teach health in other ways

41.9% do **not use** the *Great Body Shop* curriculum to teach health education
48.8% use the *Great Body Shop* curriculum to teach health **less** than once per week
7% use the *Great Body Shop* curriculum to teach health education **once** per week

2.3% use the *Great Body Shop* curriculum to teach health **more** than once per week
18.6% **only** use the *Great Body Shop*
27.9% use the *Great Body Shop* and **other** materials
25.6% teach health with **other** materials but **not** with the *Great Body Shop*
27.9% do **not** teach health education

48.8% send home the ***Great Body Shop*** **magazines**
4.7% send home **the *Great Body Shop* Parent Bulletins**
18.6% would send home the parent bulletin if had access to the **electronic version**
25.6% do **not** teach health education
11.6% **other**

90.7% **teach** a social emotional learning curriculum
7% do **not** teach a social emotional learning curriculum

25.6% use ***Second Step***
16.3% *use* ***Social Thinking***
2.3% use ***Open Circle***
2.3% do **not** teach a social emotional curriculum

95.3% teach Social Emotional Health (mental health, family life, getting along with others)
62.8% teach Physical Health (growth/development, fitness, nutrition, reproduction-sexuality)
60.5% teach Safety and Prevention (disease prevention, safety and injury prevention, bullying and violence prevention, and substance abuse prevention)
58.1% teach Personal and Community health
2.3% do not teach any health content

9.5% **administer** health assessments to determine the level of understanding students have for health content
88.4% do **not** administer health assessments to determine the level of understanding students have for health content

<u>Health concerns teachers have for their students:</u>
74.4% Social skills
69.8% Anger management, Self regulation
62.8% Lack of sleep
53.5% Poor eating habits, hunger, hydration
53.5% Changes in family life- births, deaths, moving, divorce
51.2% Mental health issues of student or family, depression, anxiety
41.9% Poor personal hygiene
39.5% Family conflict
27.9% Bullying- target or aggressor
23.3% Frequent illness, dental problems
14% Substance abuse in family
4.7% Other

14 Elementary Physical Education Teachers responded to the survey

Health concerns Physical Education Teachers have for their students:
100% Poor eating habits, hunger, hydration
75.6% Anger management, Self-regulation
71.4% Bullying- target or aggressor
57.1% Social skills
50.0% Mental health issues of student or family, depression, anxiety
35.7% Poor personal hygiene
28.6% Lack of sleep
28.6% Changes in family life- births, deaths, moving, divorce
28.6% Substance abuse in family
21.4% Family conflict
7% Other
0% Frequent illness, dental problems

85.7% **incorporate** health content lesson objectives in physical education classes
14.3% do **not** incorporate health content lesson objectives in physical education classes

35.7% teach Social Emotional Health (mental health, family life, getting along with others)
88.1% teach Physical Health (growth and development, nutrition)
100% teach Physical Health (fitness)
37.5% teach Safety and Prevention (disease prevention, safety and injury prevention, bullying and violence prevention, substance abuse prevention)
21.4% teach Personal and Community health
7% do not teach any health content
0% teach lessons addressing Reproduction/Sexuality, and Consumer Health and Resource Management.

50% teach health **specific** content lesson objectives
35.6% **informally** include some health topics but do not include objectives or assess outcomes
7% **not trained** to teach health education

42.8% recommend including health content in **every** physical education lesson
50% recommend including health content in physical education lessons **once** per week
7% recommend including health content in physical education lessons **less** than once per week
7% do **not** recommend including health content in physical education lessons
7% **other** – where it can be fit in and informally at the elementary level

85.7% recommend certified **health education teachers** contribute to the deliver health education
64.3% recommend **classroom teachers** contribute to the deliver health education
100% recommend **physical education teachers** contribute to the delivery of health education

85.7% recommend **nurses** contribute to the delivery of health education
64.2% recommend **school counselors** contribute to the delivery of health education
21.4 % recommend **classroom teachers** NOT contribute to the delivery of health education
14.2% recommend **physical education teachers** NOT contribute to the delivery of health education
21.4 % recommend **school nurses NOT** contribute to the delivery of health education
35.7% recommend **school counselors NOT** contribute to the delivery of health education

85.7% have **attended** health education professional development
28.6% have **not** attended health education professional development

85.7% would a**ttend** training to teach health education effectively
28.6% would **not** attend training to teach health education effectively

18 School Nurses responded to the survey

<u>Health concerns School Nurses have for their students:</u>
81.8% Mental health issues of student or family, depression, anxiety
63.6% Poor eating habits, hunger, hydration
63.6% Bullying- target or aggressor
63.6% Lack of sleep
54.5% Poor personal hygiene
54.5% Anger management, Self regulation
54.5% Family conflict
54.5% Substance abuse in family
54.5% Social skills
45.5% Frequent illness, dental problems
45.6% Changes in family life- births, deaths, moving, divorce27.3% Other
27.3% Other

Every nurse reported seldom being able to get into classrooms to discuss any health topics.

81.8% recommend certified **health education teachers** contribute to the deliver health education
72.7% recommend **classroom teachers** contribute to the deliver health education
72.7% recommend **physical education teachers** contribute to the delivery of health education
72.7% recommend **nurses** contribute to the delivery of health education
72.7% recommend **school counselors** contribute to the delivery of health education
18.2% do **not** recommend teaching health education at their level

54.5% have **attended** health education professional development
36.4% have **not** attended health education professional development

4 Elementary Principals responded to the Survey*

Health concerns Principals prioritized for their students include anger management, self-regulation, social skills and mental health issues.

The MA Comprehensive Health Curriculum Frameworks organizes health content into four Strands and fourteen Content Standards. The strands and standards most recommended to be included in the curriculum for elementary students are Physical Activity & Fitness, Bullying and Violence Prevention, Safety and Injury Prevention, and Mental Health

Including health instruction in elementary schools will ensure a comprehensive education that addresses physical, social and emotional needs. The principals recommended a minimum of once per week for the amount of time that should be provided for health instruction.

Principals recommended health education be taught in PreK/K, First Grade, Second Grade, Third Grade, Fourth Grade and Fifth Grade.

When asked what obstacles or barriers exist that impede the implementation of health education at the elementary level, the most frequent challenge reported was limited time and schedule conflicts, inconsistency in delivery, and classroom teacher confidence with sensitive subjects.

Principal recommendations to overcome the obstacles and barriers to implement health education include:

- infuse into the existing curriculum
- formalizing a combination of deliver with physical education, classroom teachers, and possibly health education teachers.
- consider collaboration within science and other core subjects.

Based on the principal responses Bullying, Mental Health, Nutrition, and Physical Activity and Fitness were the most commonly recommended content standards that should be taught to elementary students.

*Multiple attempts to get input from the other elementary principals were unsuccessful.

State of Health Education Survey-2004

Previous information collected to support the district's efforts include a State of Health Education survey conducted in 2004. Teachers from nine schools participated with a return rate of 47%.

The expectation for K to 6 was questioned regarding the effectiveness of elementary teachers teaching health once per week using the Great Body Shop. The findings are as follows:

63% reported teaching health education **less** than once per week
29% reported teaching health education **once** per week

7% reported teaching health education **more** than once per week

Teachers reported relying on a monthly magazine and not using the teachers' guide for participatory activities:
45% **never** sent home the parent bulletin
41% **sometimes** sent home the parent bulletin
14% **always** sent home the parent bulletin
71% reported **no** parent involvement planned and executed to reinforce the curriculum

70% did not teach critical thinking objectives embedded in health education
72% do not use the resources, such as charts/graphic organizers provided in the teacher's guide
79% do not use the Substance Abuse/Violence Prevention Portfolios in the teacher's guide
87% did not administer the pre-test
79% did not plan on administering the post-test

At the time 29% of teachers in grades K – 8 had not attended the health curriculum training.

The 2004 survey results related to grades 7 and 8 are as follows:

- The average number of health lessons taught within a year was 15.
- The following materials were used; Life Skills Training, Great Body Shop, Self created lessons, and Peace Games.
- Interpersonal Relationships, Violence Prevention, and Tobacco/Alcohol/Other Substance Use/Prevention, were the topics most frequently reported as taught by the teacher.
- Some teachers reported teaching lessons addressing Growth and Development, Nutrition, Mental Health, Family Life, Disease Prevention.
- Few teachers reported teaching lessons addressing Safety and Injury Prevention, Community and Public Health, Ecological Health, Physical Activity and Fitness.
- No teachers reported teaching lessons addressing Reproduction/Sexuality, and Consumer Health and Resource Management.

Health Education Pre K-5
Strengths and Recommendations

Strengths

Principals, teachers, and nurses have all reported parent conversations and personal concerns about health content topics and the health issues that are barriers to learning. The faculty, administration and support staff clearly recognize the challenges that schools face to provide care, support and structure to enable students to learn.

Some teachers are using the resources provided and sending home parent bulletins and monthly magazines to reinforce the instruction going on in the classroom.

A significant majority of teachers recognize and address the social/emotional needs of the students.

Physical Education Teachers recognize the contributions they can make to effective health education. A significant majority of physical education teachers incorporate health content lesson objectives in physical education classes either formally or informally.

10 Session Know Your Body class for fifth graders is taught consistently throughout the district due to a contract with an outside agency

Recommendations

Develop clear expectations for all elementary teachers defining the number of lessons, content and frequency of health education because the percentage of teachers reporting that they are planning and implementing health lessons once a week has declined from 29% in 2004 to only 7% in 2015.

Ensure that a curriculum will infuse the MA Comprehensive Health Curriculum Framework and National Standards for Health objectives in a sequential manner at all three levels.

Ensure that the staff responsible for health education instruction have the health education training needed to teach effectively

Health Education 6-8
Program Assessment

Students receive health education instruction in each of the three grades at the Upper Schools. Time for health varies greatly with a minimum of 18 classes per year to a maximum of 72 class periods. The discrepancy is minimal for grade 6 with a range from 30 to 36. The gap is greater for grade 7 with the contact hours ranging from 18 lessons to 36. Grade 8 also offers a significant disparity with a low of 30 lessons and a high of 72 class segments.

Certified health educators are in place to deliver the content. The health department has used the National Standards for Health and MA Comprehensive Health Curriculum Framework as their outline but is unable to address all standards due to scheduling restrictions. The content standards are delivered in the following sequence:

Grade 6:
Conflicts, Bullies and Bystanders, Mental and Emotional Health, Nutrition and Personal Hygiene

Grade 7:
Social and Emotional Health, Resolving Conflicts, Bullying Prevention, Understanding Substances, and Nutrition

Grade 8:
Media and Health, Sexuality, Healthy Relationships, Substance Abuse Prevention and Transitioning to High School

The curricula selected by the district, *Health Smart, Get Real, Second Step*, and *Safe Dates* are evidence based and proven effective if delivered with fidelity. However, because of the inconsistent instruction at the elementary level the instruction for grades 6. 7, and 8 must be flexible to address the student needs due to gaps in knowledge for some and repetition for others that have benefitted from more lessons.

Students receive grades on their report card to inform them and their parents/guardians of their progress. The overwhelming majority of students are successful in these courses. Assessment data is included later in this report.

Health Education 6-8
Strengths and Recommendations

Strengths

Certified health and/or physical educators deliver the instruction and are trained and skilled to address sensitive subjects with age appropriate delivery.

Resources have been provided for staff teaching health. District developed content has also been implemented to fill the need.

The district uses risk behavior data to identify and prioritize content. This results in customized instruction, matched to the MA Comprehensive Health Curriculum Framework and National Standards for Health to best meet the community needs.

Recommendations

Review the scheduling options by grade level, to bring the content hours closer for students in all Upper Schools.

Because the class composition is heterogeneous and students often have a wide range of academic and behavioral needs, health teachers should be provided the professional development needed to meet the needs of their diverse student population.

Explore assessment practices at each school and offer professional development to create common assessments and assessment practice to ensure inter rater reliability.

Facilitate collaboration with Special Education staff and Sheltered English Immersion staff to best deliver and reinforce the content.

Health Education 9-12
Program Assessment

Certified health and/or physical educators are in place to deliver the content. The health department has utilized the National Standards for Health and MA Comprehensive Health Curriculum Framework. The content standards are delivered in a sequential manner utilizing the 9th grade health course as prioritized reinforcement to instruction at the lower levels but enhanced to be age appropriate for high school students. The content standards addressed in this course includes; Mental/Emotional Health, and Sexuality. The topics have been selected based on the risk behavior data collected and analyzed by the district.

The elective courses offer instruction to students genuinely interested in enhancing and preserving their own wellness. It is anticipated that the new course offered for 10th graders could evolve into a required course but currently offers a more matched option for students to complete their graduation requirement if unsuccessful during 9th grade, without waiting till their junior or senior year.

The high school has also reported the same challenge the upper schools face when students arrive from the elementary level. Because of the inconsistent instruction at the upper schools the high school instruction must be flexible to address the student needs due to gaps in knowledge for some and repetition for others that have benefitted from more lessons.

Students receive grades on their report card to inform them and their parents/guardians of their progress. The overwhelming majority of students are successful in these courses. Assessment data is included later in this report.

At the Extension School students participate in wellness mini courses organized by school staff once a week. There is little evidence or insurance that the topics presented in the mini courses match the high school curriculum or are aligned with the state and national standards.

Health Education 9-12
Strengths and Recommendations

Strengths

Certified health and/or physical educators deliver the instruction and are trained and skilled to address sensitive subjects with age appropriate delivery.

The district has implemented a required 9th grade course and elective options to prepare students to maintain their own health and safety.

Including the 9th grade course as a graduation requirement reinforces the value students must put on completing and passing the course.

Recommendations

Because the class composition is heterogeneous and students often have a wide range of academic and behavioral needs, health teachers should be provided the professional development needed to meet the needs of their diverse student population.

Explore assessment practices of teachers and offer professional development to create common assessments and assessment practice to ensure inter rater reliability.

Facilitate collaboration with Special Education staff and Sheltered English Immersion staff to best deliver and reinforce the content.

Consider including the new 10th grade course as a graduation requirement in the future.

A certified health teacher should be assigned to coordinate instruction at the Extension School and ensure the curricula activities parallel what is taught at the High School.

Assessment Practices for the Middle and High School Health Education

Health education teachers at the Upper Schools and High School use formative and summative assessments to track student learning. Common assessments, contained in the district-approved curriculum, are implemented at the conclusion of each unit. A common summative capstone assessment is used at the high school. Teachers meet as often as they can to review student performance data. Because there is only one teacher assigned to health classes in each of the upper schools their opportunity to collaborate is highly valued. The high school staff also values and benefits from collaboration that occurs during professional development hours and informally when common preparation time is available.

Teachers have developed the best practice of administering pre-tests to determine the levels of prior knowledge student have mastered. Due to the discrepancy in amount of health education students have in the elementary grades, the information collected from the pre-tests influence the upper school health education teacher's lesson planning. A similar challenge exists for the high school health education teachers due to the discrepancy in the schedules and the range of class time student's experience.

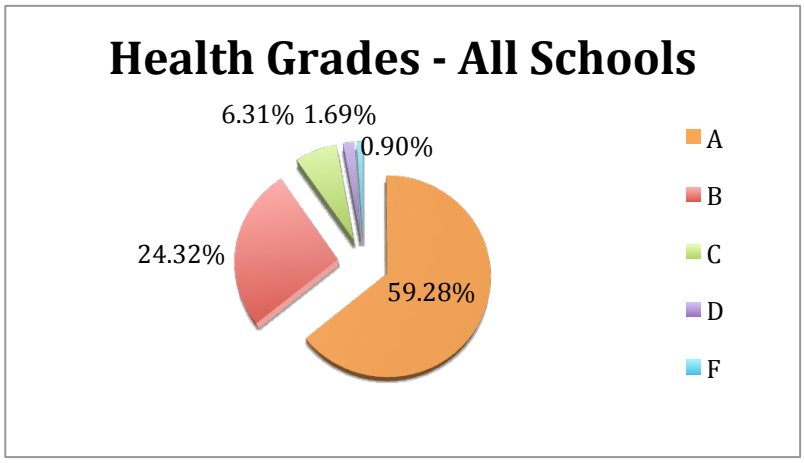
The instruction is planned and assessed to address the content standards in the MA Comprehensive Health Curriculum Framework. The National Standards for Health focus on the skills of analyzing influences, access valid information, interpersonal communication, decision-making, goal setting, personal safety and advocacy. The National Standards skill cues are embedded in the health content units to enhance and reinforce what students know and are able to do.

The table below represents the grading data reported and recorded by school, for the 2014 and 2015 school years combined. To calculate the percentages the letter grades were standardized with the following benchmarks: A=90 to 100, B- 80 to 89, C = 70 to 79, D = 60 to 69, F = 59 and below. The + and – grades were encumbered to ensure consistency among the schools reporting.

The percentage of students receiving a passing grade of C (scoring 70 or better) or P for passing is significant. It is clear that Cambridge students are successful in demonstrating the knowledge and skills contained in the instruction and very few student, less than 1%, have earned a failing grade.

School	A	B	C	D	F	P	C (70) or better - including P	D (60) or better - including P
Amigos School	81.82%	14.55%	3.64%	0.00%	0.00%	0.00%	100.00%	100.00%
Cambridge Rindge and Latin School	55.34%	20.61%	8.97%	5.92%	4.58%	4.58%	89.50%	95.42%
Cambridge Street Upper School	47.68%	26.16%	6.33%	0.63%	0.00%	19.20%	99.37%	100.00%
Putnam Avenue Upper School	53.57%	33.19%	10.08%	2.73%	0.21%	0.21%	97.06%	99.79%
Rindge Avenue Upper School	66.11%	14.73%	2.21%	0.00%	0.00%	16.94%	100.00%	100.00%
Vassal Lane Upper School	64.08%	30.52%	5.40%	0.00%	0.00%	0.00%	100.00%	100.00%
All Schools	59.28%	24.32%	6.31%	1.69%	0.90%	7.50%	97.41%	99.10%

The pie chart below represents the total grades reported for all students from all schools combined.



<u>Strengths</u>
Pre-tests are implemented to determine the levels of knowledge students have and the course content is planned based on the needs the students have.

Teachers collaborate whenever possible to review student outcomes and share best practices.

All use common assessments from research-based curricula for the units that are taught be all.

Embedding the National Standard for Health skills in the health units promotes real application of the health content.

Grading indicates the vast majority of students master the understanding contained in the health courses.

<u>Recommendations</u>
Review formative assessment practices to ensure consistency

Continue to enable teachers to collaborate to share best practices and analyze student performance data

EXISTING PROGRAM RESOURCES

The district has invested in time and resources to offer training to staff and acquire the materials needed to teach health education. The curricula selected at each level are research based and proven effective if taught with fidelity.

Health education is taught at the elementary level in the following high performing districts: Arlington, Newton, Peabody, Shrewsbury, Everett, Lexington and Brookline. The method of delivery varies from a shared responsibility with classroom teachers, physical education teachers, nurses, and certified health educators. The most consistent and structure health programs offer the instruction via one class per week.

In all interviews conducted, it was acknowledged that classroom teachers have significant time constraints due to many district and state initiatives and program responsibilities. Everyone described health topics as being beneficial for students but believe they do not have time in the current schedule or schedule structure to incorporate additional required health instruction. Currently there are only certified health educators employed at the middle and high school levels.

The resources and materials selected by the district are aligned to the MA Comprehensive Health Curriculum Framework and National Standards for Health but are not required, monitored or assessed at the elementary level. The middle and high school level resources are aligned to MA Comprehensive Health Curriculum Framework and National Standards for Health.

Additional professional development will be needed to help staff understand their responsibilities to implement Common Core components matched to health content. The current program does adhere to CPS district wide goals but only at the middle and high school level.

Due to the inconsistency and unclear expectation for health education at the elementary level the curriculum is not sequenced K-12. Grade level outcomes are not clearly identified. There is no requirement to assess what students know and do and makes the transition to the upper schools that much more challenging.

Grade level content and outcomes are identified for grades 6, 7, and 8 but are not consistent at all Upper Schools related the time scheduled to teach health. Thus, due to the inconsistency in scheduling at the upper schools the high school received students with wide gaps of health education backgrounds and experiences. The outcomes are assessed and reported to students and parent/guardians on report cards.

EXISTING PROGRAM RESOURCES
Strengths and Recommendations

Strengths

Health education is included for students in grades 6, 7, 8, and 9 as required. Elective options for students in grades 10, 11, and 12 contribute to a comprehensive educational program for all students

Recommendations

Developing a plan to incorporate sequential, comprehensive health education for all students, in every grade, will likely require funds for staff training and instructional materials.

Health instruction at the elementary level can be a shared responsible among existing staff including classroom teachers, physical education teachers and other appropriate educators. However, hiring certified health educators is the best option to address the sensitive subjects they are trained to teach in an age appropriate manner and to ensure consistent instruction.

STRENGTHS AND RECOMMENDATIONS
EXECUTIVE SUMMARY

Strengths:
Health instruction utilizes research-based curricula.

Health instruction is facilitated at the Upper Schools by certified health teachers. Certified health teachers and/or certified physical education teachers teach the curriculum at the High School.

Successfully passing the 9th grade health course is a graduation requirement.

Offering a new course for grade 10 and an elective for grades 11, 12, for older students at the high school will address mature students' needs and appeal to students that have a personal interest in learning about lifelong wellness.

Dedicated teacher leader who has functioned as a Curriculum Coordinator and directed curriculum development and implementation, professional development, community and parent engagement in health education and social emotional learning across the district.

Recommendations:
Increase the awareness and understanding of the MA Comprehensive Health Curriculum Framework among administrators, principals, classroom teachers and all other school faculty.

Develop a sequential curricula implementation plan beginning at the elementary level reflecting the performance standards in the MA Comprehensive Health Curriculum Framework and clarifying what content and skills will be taught in each grade and who will be responsible for the instruction

Develop a curriculum implementation plan that emphasizes the teaching objectives, activities and assessment strategies, required for each elementary grade, matched to the performance standards, resulting in consistency and comprehensive health instruction.

Utilize elementary principals to ensure that health is taught according to the implementation plan.

Review the middle grade health schedules to create more consistent time for health instruction for all students.

Determine an assessment plan to track students' learning of knowledge and skill at the elementary level and examine consistent authentic assessment practices at the middle and high school levels.

Health teachers should complete the 15 hour WIDA course to be able to better meet the needs of the SEI students. Health teachers should also work with SEI core subject teaches to suggest appropriate health content and skills to be incorporated into their teaching to reinforce learning.

Health teachers should complete the 15 hour required Special Education course to be able to better meet the needs of the mainstreamed SPED students. Health teachers should also work with SPED core subject teaches to suggest developmentally appropriate health content and skills to be incorporated into their teaching to reinforce learning.

A certified health teacher should be assigned to coordinate instruction at the Extension School and ensure the curricula activities parallel what is taught at the High School.

A certified health teacher should be hired or assigned to teach adaptive classes to K-12 students that cannot have full access to the curriculum or succeed in the mainstreamed health classes.

Create a Social Emotional Learning plan that is adopted and monitored consistently across the district.

Greater alignment among the 10 components of a Whole School, Whole Community, Whole Child approach will lead to more support for and more effective implementation of health education in schools.*

Strengths and Recommendations Summary
PK-5

Strengths

Principals, teachers, and nurses have all reported parent conversations and personal concerns about health content topics and the health issues that are barriers to learning. The faculty, administration and support staff clearly recognize the challenges that schools face to provide care, support and structure to enable students to learn.

Some teachers are using the resource provided and sending home parent bulletins and monthly magazines to reinforce the instruction going on in the classroom.

The provided Health instruction materials include research based curricula.

A significant majority of teachers recognize and address the social/emotional needs of the students.

Physical Education Teachers recognize the contributions they can make to effective health education. A significant majority of physical education teachers incorporate health content lesson objectives in physical education classes either formally or informally.

The 10 Session ***Know Your Body*** *sexuality education class for fifth graders is taught consistently throughout the district due to a contract with an outside agency.*

Recommendations

Increase the awareness and understanding of the MA Comprehensive Health Framework among administrators, principals, classroom teachers and all other school faculty.

Develop clear expectations for all elementary teachers defining the number of lessons, content and frequency of health.

Utilize elementary principals to ensure that health is taught according to the implementation plan.

Ensure that curriculum that will infuse the Massachusetts Health Curriculum Framework objectives in a sequential manner at all three levels.

Ensure that staff responsible for health education instruction have the health education training needed to teach effectively.

Determine an assessment plan to track students' learning of knowledge and skill at the elementary level.

A certified health teacher should be hired or assigned to teach adaptive classes to K-12 students that cannot have full access to the curriculum or succeed in the mainstreamed health classes.

Strengths and Recommendations Summary
6-8

Strengths

Health instruction utilizes research-based curricula.

Certified health educators deliver the instruction and are trained and skilled to address sensitive subjects with age appropriate delivery.

Resources have been provided for health teachers. District developed content has also been implemented to fill the need.

The district uses risk behavior data to identify and prioritize content. This results in customized instruction, matched to the MA Comprehensive Health Curriculum Framework and National Standards for Health to best meet the community needs.

Recommendations

Increase awareness and understanding of the MA Comprehensive Health Curriculum Framework among administrators, principals, classroom teachers and all other school faculty.

Review the scheduling options by grade level, to bring the content hours closer for students in all Upper Schools.

Because the class composition is heterogeneous and students often have a wide range of academic and behavioral needs, health teachers should be provided the professional development needed to meet the needs of their diverse student population.

Explore assessment practices at each school and offer professional development to create common assessments and assessment practice to ensure inter rater reliability.

Facilitate collaboration with Special Education staff and Structured English Immersion staff to best deliver and reinforce the content.

Health teachers should complete the 15-hour WIDA course to be able to better meet the needs of the SEI students. Health teachers should also work with SEI core subject teaches to suggest appropriate health content and skills to be incorporated into their teaching to reinforce learning.

Health teachers should complete the 15-hour required Special Education course to be able to better meet the needs of the mainstreamed SPED students. Health teachers should also work with SPED core subject teaches to suggest developmentally appropriate health content and skills to be incorporated into their teaching to reinforce learning.

A certified health teacher should be hired or assigned to teach adaptive classes to K-12 students that cannot have full access to the curriculum or succeed in the mainstreamed health classes.

Strengths and Recommendations Summary
9-12

Strengths

Health instruction utilizes research-based curricula.

Certified health and/or physical educators deliver the instruction and are trained and skilled to address sensitive subjects with age appropriate delivery.

The district has implemented a required 9th grade course and elective options to prepare students to maintain their own health and safety.

Including the 9th grade course as a graduation requirement reinforces the value students must put on completing and passing the course.

Offering a new course as an elective for older students in grades 10 – 12 at the high school will address mature students' needs and appeal to students that have a personal interest in learning about lifelong wellness.

Recommendations

Increase the awareness and understanding of the MA Comprehensive Health Curriculum Framework among administrators, principals, classroom teachers and all school faculty.

Because the class composition is heterogeneous and students often have a wide range of academic and behavioral needs, health teachers should be provided the professional development needed to meet the needs of their diverse student population.

Explore assessment practices of teachers and offer professional development to create common assessments and assessment practice to ensure inter rater reliability.

Facilitate collaboration with Special Education staff and Sheltered English Immersion staff to best deliver and reinforce the content.

Consider including the new 10th grade course as a graduation requirement in the future.

Health teachers should complete the 15-hour WIDA course to better meet the needs of the SEI students.
Health teachers should complete the 15-hour required Special Education course to be able to better meet the needs of the mainstreamed SPED students. Health teachers should also work with SPED core subject teaches to suggest developmentally appropriate health content and skills to be incorporated into their teaching to reinforce learning.

A certified health teacher should be assigned to coordinate instruction at the Extension School and ensure the curricula activities parallel what is taught at the High School.
A certified health teacher should be hired or assigned to teach adaptive classes to K-12 students that cannot have full access to the curriculum or succeed in the mainstreamed health classes.

Recommended Work For Curriculum Review Cycle Year 2

PreK_-5

Convene an elementary health education committee to develop a plan that will incorporate the MA Comprehensive Health Curriculum Frameworks performance objectives and the National Standards for Health skills for teaching health education in grades PreK-5. Activities may include but are not limited to:

- *Identify key stakeholders to participate on the committee including at least one representative for principals, classroom teachers, physical education teachers, nurses and counselors, department director and program leader.*
- *Explore other core subjects for current content coverage including physical education, science, social studies and the new social emotional framework initiative.*
- *Explore a collaboration model that identifies specific time requirements in terms of numbers of lessons for each framework content standard.*
- *Develop a sequential model using the Understanding by Design format that identifies in which grade each content standard will be taught or reinforced and who is responsible for the instruction. Prioritizing content standards should be matched to community data, such as risk behavior data, discipline reports, medical circumstances, etc. and be reviewed at least every three years.*
- *Include specifically designed instruction for inclusive classrooms.*
- *Identify or develop high quality common formative, summative and performance assessments.*
- *Establish a district wide assessment calendar.*
- *Determine the mechanisms to record and report student performance outcomes to students and parents/guardians.*

6-12

Teacher teams work to create or refine unit plans in Understanding by Design format with common assessments. Activities may include but are not limited to:

- *Prioritizing content standards should be matched to community data, such as risk behavior data, discipline reports, medical circumstances, etc. and be reviewed at least every three years.*
- *Examine the scheduling diversity at the Upper Schools and make a recommendation to the administration about the minimal amount of time students should have for health lessons.*
- *Identify or develop high quality common formative, summative and performance assessments.*
- *Ensure health and/or physical educators assigned the responsibility of teaching health have the opportunity to collaborate frequently to share best practices, analyze student performance data and revise instruction and assessments when needed.*

References

1. Botvin GJ, Botvin EM, Ruchlin H. School-Based Approaches to Drug Abuse Prevention: Evidence for Effectiveness and Suggestions for Determining Cost-Effectiveness. In: Bukoski WJ, editor. *Cost-Benefit/Cost-Effectiveness Research of Drug Abuse Prevention: Implications for Programming and Policy*. NIDA Research Monograph, Washington, DC: U.S. Department of Health and Human Services, 1998; 176:59–82.
2. Contento I, Balch GI, Bronner YL. Nutrition education for school-aged children. *Journal of Nutrition Education* 1995; 27(6):298–311.
3. Eisen M, Pallitto C, Bradner C, Bolshun N. *Teen Risk-Taking: Promising Prevention Programs and Approaches*. Washington, DC: Urban Institute; 2000.
4. Gottfredson DC. School-Based Crime Prevention. In: Sherman LW, Gottfredson D, MacKenzie D, Eck J, Reuter P, Bushway S, editors. *Preventing Crime: What Works, What Doesn't, What's Promising*. National Institute of Justice; 1998.
5. Kirby D. *Emerging Answers: Research Findings on Programs to Reduce Teen Pregnancy*. Washington, DC: National Campaign to Prevent Teen Pregnancy; 2001.
6. Kirby D, Coyle K, Alton F, Rolleri L, Robin L. *Reducing Adolescent Sexual Risk: A Theoretical Guide for Developing and Adapting Curriculum-Based Programs*. Scotts Valley, CA: ETR Associates; 2011.
7. Lohrmann DK, Wooley SF. Comprehensive School Health Education. In: Marx E, Wooley S, Northrop D, editors. *Health Is Academic: A Guide to Coordinated School Health Programs*. New York: Teachers College Press; 1998:43–45.
8. Lytle L, Achterberg C. Changing the diet of America's children: what works and why? *Journal of Nutrition Education* 1995; 27(5): 250–60.
9. Nation M, Crusto C, Wandersman A, Kumpfer KL, Seybolt D, Morrissey-Kane, E, Davino K. What works: principles of effective prevention programs. *American Psychologist* 2003; 58(6/7): 449–456.
10. Stone EJ, McKenzie TL, Welk GJ, Booth ML. Effects of physical activity interventions in youth. Review and synthesis. *American Journal of Preventive Medicine* 1998; 15(4): 298–315.
11. Sussman, S. Risk factors for and prevention of tobacco use. Review. *Pediatric Blood and Cancer* 2005;44:614–619.
12. Tobler NS, Stratton HH. Effectiveness of school-based drug prevention programs: a meta-analysis of the research. *Journal of Primary Prevention* 1997; 18(1): 71–128.
13. · U.S. Department of Health and Human Services. Preventing Tobacco Use Among Young People–An Update: A Report of the Surgeon General. Atlanta (GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2011: 6-22–6-45.
14. · Weed SE, Ericksen I. *A Model for Influencing Adolescent Sexual Behavior*. Salt Lake City, UT: Institute for Research and Evaluation; 2005. Unpublished manuscript.