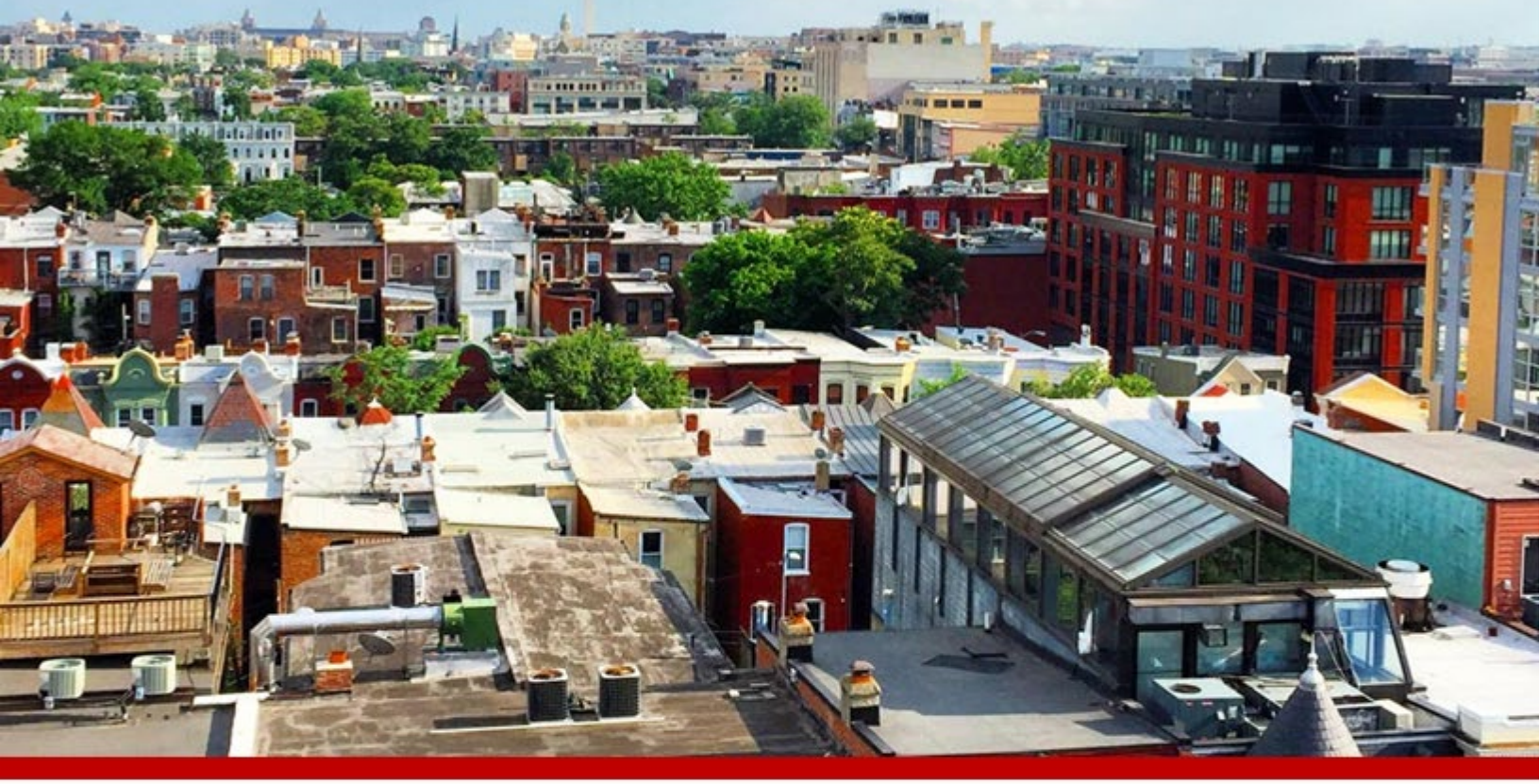
DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

OIG Project No. 20-I-04GA

November 2020

DISTRICT OF COLUMBIA PUBLIC SCHOOLS AND OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION

Evaluation of Compliance with The Healthy Schools Act Health Education Requirements



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Evaluation of Compliance with the Healthy Schools Act Health Education Requirements

EXECUTIVE SUMMARY

WHY WE DID THIS EVALUATION

We included this evaluation in the Office of the Inspector General's (OIG) *Fiscal Year 2020 Audit and Inspection Plan* due to the criticality of delivering effective sexual health education, and public concern that such education is not uniformly delivered in District schools subject to the Healthy Schools Act (HSA) of 2010. Recent statistics regarding the incidence of HIV in the District have raised concerns among health and advocacy groups. For example, the District is experiencing a plateau in the decrease in new HIV diagnoses, and between 2014 and 2018, young people (ages 0-24) represented approximately 20 percent of new HIV diagnoses.

OBJECTIVE

The OIG conducted this project to assess the extent to which the Office of the State Superintendent of Education (OSSE) and District of Columbia Public Schools (DCPS) have implemented key provisions in HSA curriculum standards that focus on health education and HIV/AIDS.

WHAT WE FOUND

OSSE and DCPS depend upon each other to monitor and comply with the HSA requirements, and each has a distinct role. Although HSA health education requirements are reasonable for schools to achieve, not all DCPS middle schools are meeting the requirements. The requirements are challenging for schools because of limited resources (staff and budget) and a lack of consequences to incentivize compliance. OSSE collects data to determine compliance with the HSA, but neither OSSE nor DCPS adequately verifies the accuracy of the self-reported data, which negates its usefulness. OSSE administers an assessment to test student health education outcomes but is not using the results to ensure schools modify instruction to address shortcomings.

EXECUTIVE SUMMARY

WHAT WE RECOMMEND

The OIG makes 12 recommendations to improve compliance with the HSA. The recommendations will help schools prioritize meeting the health education requirements and ensure they address all topics within the educational standards. They will also improve the data OSSE uses to measure compliance and ensure that OSSE, DCPS, and their school partners use collected data to improve the quality of health education. Finally, the recommendations will help to clarify questions schools and Local Education Agencies (LEAs) may have about the HSA.

MANAGEMENT RESPONSE

Of the 12 recommendations, DCPS agreed with 5 recommendations and OSSE agreed with 4 recommendations.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

November 23, 2020

Shana Young
Interim State Superintendent of Education
Office of the State Superintendent of Education
1050 First Street, N.E.
Washington, D.C. 20002

Lewis D. Ferebee
Chancellor
District of Columbia Public Schools
1200 First Street, N.E.
Washington, D.C. 20002

Dear Interim State Superintendent Young and Chancellor Ferebee:

Enclosed is our final report, *District of Columbia Public Schools and Office of the State Superintendent of Education: Evaluation of Compliance with the Healthy Schools Act Health Education Requirements* (OIG Project No. 20-I-04GA). Our objective was to assess DCPS' and OSSE's compliance with key provisions in the Healthy Schools Act of 2010 (HSA), in particular, curriculum standards that focus on health education and HIV/AIDS. We conducted this evaluation under standards established by the Council of the Inspectors General on Integrity and Efficiency (CIGIE) and assessed OSSE's and DCPS' internal controls using the Government Accountability Office's (GAO) *Standards for Internal Control in the Federal Government.*[1]

We provided the draft report to OSSE and DCPS on September 18, 2020, and received DCPS' response on October 5, 2020, and OSSE's response on October 27, 2020. OSSE's and DCPS' comments are quoted in the body of the final report and presented in their entirety in Appendices E and F, respectively.

In total, the OIG made 12 recommendations to OSSE and DCPS for actions deemed necessary to improve compliance with the HSA. DCPS agreed with 5 recommendations, partially agreed with 2 recommendations, and disagreed with 1 recommendation. DCPS did not indicate whether it agreed or disagreed with recommendations 4, 7, and 8, and did not provide a response for recommendation 12. OSSE agreed with 4 recommendations, partially agreed with 4 recommendations, and disagreed with 4 recommendations. The OIG included responses to the agencies' comments when necessary. The OIG plans to follow up with both OSSE and DCPS on the implementation status of these recommendations during fiscal year 2021.

[1] U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-14-704G, STANDARDS FOR INTERNAL CONTROL IN THE FEDERAL GOVERNMENT (Sept. 2014), https://www.gao.gov/assets/670/665712.pdf (last visited Nov. 18, 2020).

If you have any questions about this report, please contact me or Edward Farley, Assistant Inspector General for Inspections and Evaluations, at (202) 727-9249 or edward.farley@dc.gov.

Sincerely,

Daniel W. Lucas
Inspector General

DWL/ef

Enclosure

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BACKGROUND

The D.C. Council enacted the Healthy Schools Act (HSA) in 2010 in an effort to improve the health and wellness of students attending District of Columbia schools. The HSA applies to both D.C. Public Schools (DCPS) and D.C. Public Charter Schools (DCPCS).[2] It establishes standards and requires oversight of health-related aspects of school operations, including school nutrition, the farm-to-school program, physical education and activity, environmental literacy, and health education.

Both the Office of the State Superintendent of Education (OSSE) and DCPS have distinct responsibilities related to monitoring schools' compliance with requirements specified in the HSA. Although each entity plays a unique role in ensuring compliance with the HSA, both entities depend on each other to implement the requirements.

OSSE is the District's state education agency.[3] As such, it fills the following roles related to implementing the health education portion of the HSA:

- establishing and updating health education standards;[4]
- creating and updating curriculum guidance documents[5] that allow schools to make informed decisions about which curriculum best serves its needs;
- ensuring that every school submits a School Health Profile (SHP), an electronic submission that helps to evaluate schools' compliance with the HSA, and posting the SHPs on its website; [6]
- developing, collecting, and analyzing the Health and P.E. Assessment (HPEA), an annual standardized test assessing students' knowledge of health education topics;
- administering the Youth Risk Behavior Survey (YRBS);[7]

[2] The term "public charter school" means a publicly-funded school in the District of Columbia that: **(A)** Is established pursuant to subchapter II- Definitions; and **(B)** Except as provided under § 38-1802.12(d)(5) and 38-1802.13(c)(5), is not a part of the District of Columbia public schools. D.C. Code § 38-1800.02(29).

[3] D.C. Code § 38-2601.01. The term "state educational agency" means "the State board of education or other agency or officer primarily responsible for the supervision of public elementary and secondary schools in a State. In the absence of this officer or agency, it is an officer or agency designated by the Governor or State law." 34 CFR 77.1 (c) [Title 34 – Education; Subtitle A -- Office of the Secretary, Department of Education; Part 77 -- Definitions that apply to Department Regulations].

[4] "Health education standards" means the specific learning requirements related to health that the Office of the State Superintendent of Education requires students to learn at each academic level, from Kindergarten through Grade 12. D.C. Code § 38-824.02(b-2)(2)(B).

[5] This guidance collectively is known as the Health Education Curriculum Analysis Tool (HECAT). The tool consists of a variety of documents and topics, including Sexual Health. The Sexual Health Curriculum Review Guidance Document in particular can be found at: https://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/Sexual%20Health%20Curriculum%20Review%20Guidance%20Document.pdf.

[6] D.C. Code § 38-826.02(a).

[7] The YRBS is a biennial survey of students conducted by the Centers for Disease Control and Prevention (CDC). It surveys all D.C. students, including DCPS students and D.C. Public Charter Schools students, and measures their behaviors in a variety of "risk"-related fields.

- submitting to the Mayor, the D.C. Council, and the Healthy Youth and Schools Commission[8] a biennial comprehensive report on District schools' compliance with HSA requirements[9] (including the health education requirements) and reporting students' achievement related to the health education standards; and
- providing technical assistance to schools that need it based on the results of the SHP and HPEA.

DCPS, as a Local Education Agency (LEA),[10] acts as a liaison between OSSE and individual public schools in the District, where approximately half of all District students attend. The DCPS Central Office plays the following roles in administering the health education portion of the HSA:

- assisting schools with establishing their budget, master schedule, and curriculum;
- reviewing and revising the health education curriculum, and making the curriculum available to teachers on CANVAS, which is DCPS' website for teachers and students dedicated to curricula resources and content;
- providing professional development to teachers;
- ensuring schools administer the HPEA; and
- using SHP data to provide technical assistance to schools that require it.

Principals and teachers also play an essential role in health education at the school level. Principals, who are primarily responsible for the day-to-day operations of schools, have the following responsibilities related to health education:

- establishing class schedules;
- assisting with completing and submitting the SHP;
- implementing the testing schedule that includes the HPEA; and
- monitoring teachers' performance.

Teachers fill perhaps the most vital role in health education, as they are responsible for actually teaching the lessons and evaluating students' performance throughout the year. Also, teachers are responsible for:

- planning health lessons guided by the education curriculum found on CANVAS;
- attending professional development to refine and improve skills; and

[8] The Healthy Youth and Schools Commission is tasked with advising the Mayor and the Council on health, wellness, and nutritional issues concerning youth and schools in the District, including health education and sexual health programming. D.C. Code § 38–827.01(a).
[9] D.C. Code § 38-823.03.
[10] An LEA is "an educational institution at the local level that exists primarily to operate a publicly funded school or schools in the District of Columbia, including the District of Columbia Public Schools and a District of Columbia public charter school." D.C. Code § 38-2601.02(3).

- assisting schools with completing the SHP.

This evaluation assessed the extent to which OSSE and DCPS – both the Central Office and individual schools – have complied with vital HSA provisions related to health education[11] in middle schools. The OIG focused specifically on the standards pertaining to HIV/AIDS prevention, with a goal to identify obstacles that hinder schools from complying with the requirements, and assess gaps in policies or procedures related to monitoring compliance. The HSA applies to DCPS and DCPCS. Due to limits on the OIG's jurisdiction over DCPCS, this evaluation focused on the implementation of the HSA in DCPS.

The specific objective of the evaluation, as well as its scope and methodology, are provided in Appendix A. We conducted this evaluation under standards established by the Council of the Inspectors General on Integrity and Efficiency (CIGIE). To assess DCPS' and OSSE's implementation of the HSA, the OIG used the Government Accountability Office (GAO) *Standards for Internal Control in the Federal Government* (GAO-14-704G, the Green Book). The Green Book sets internal control standards for federal entities and may be adopted by state and local entities as a framework for an internal control system.

Internal control is "a process used by management to help an entity achieve its objectives."[12] Further, internal control helps assure accurate financial reporting and helps to prevent fraud, waste, and abuse. The Green Book explains that "[m]anagement is directly responsible for all activities of an entity, including the design, implementation, and operating effectiveness of an entity's internal control system."[13] The internal control system is comprised of five components that "must be effectively designed, implemented, and operating, and operating together in an integrated manner, for an internal control system to be effective."[14]

It is important to note two limitations to this evaluation. First, the COVID-19 pandemic began during the fieldwork phase of the project. Restrictions resulting from the District's response to the pandemic did not significantly impact the OIG's work, but they did prohibit in-person interviews after the declaration of a public health emergency. Second, the OIG was unable to observe health education classes during which an HIV-prevention lesson was occurring. Even if the OIG had been able to conduct observations, we would not have been able to observe enough classes to get a clear picture of the content taught throughout the year, and the team is not qualified to assess the quality of instruction. Therefore, this evaluation focuses primarily on gathered data and the processes through which OSSE and DCPS monitor and comply with HSA requirements.

[11] "Health education" means instruction of the District of Columbia Health Education Standards. D.C. Code § 38-821.01(1F).
[12] U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 1, at 2.
[13] *Id.* § OV2.14 at 12.
[14] *Id.* § OV2.04 at 7.

FINDINGS

SOME SCHOOLS DO NOT PROVIDE STUDENTS WITH THE REQUIRED HEALTH EDUCATION MINUTES, AND SOME CLASSES DO NOT INCLUDE MANDATORY HIV-PREVENTION LESSONS.

The HSA mandates that beginning in school year (SY) 2014-2015, elementary and middle school students must receive an average of at least 75 minutes of health education per week.[15] It requires a school's health education to "meet the curricular standards adopted by the State Board of Education."[16] Those standards, established in 2016, include several specifically related to the prevention of HIV and other sexually transmitted infections (STI).[17]

The District of Columbia Municipal Regulations (DCMR) assigns OSSE monitoring responsibilities for health education, stating: "The Superintendent shall ensure that health instruction … is taught through the use of appropriate monitoring and establishment of minimum proficiencies or learning outcomes in[,]" among other education subjects, "HIV/AIDS and other sexually transmitted diseases."[18]

Meeting the Minute Requirement

Many DCPS middle schools are not providing an average of 75 minutes of health education per week to all of their students. The SHP, which schools submit to OSSE annually through an online portal called Quickbase, requires schools to self-report the average number of health education minutes students receive weekly.[19] In 2019, 9 of the 31 DCPS middle schools self-reported on their SHP that they were not meeting the 75-minute requirement, listing averages between 30 and 60 health education minutes per week. The SHP did not require schools to provide a reason for their deficiencies.[20] During interviews with principals and health educators, the OIG found that although 22 schools reported meeting the 75-minute requirement, many of

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[15] D.C. Code § 38-824.02(b)(2).
[16] D.C. Code § 38-824.02(d).
[17] OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION, *2016 HEALTH STANDARDS* 58, *available at* https://osse.dc.gov/node/2219 (last visited Aug. 4, 2020). Standards related to HIV prevention for grades 6 through 8 include:

3.3.13:	Identify school-based, medical-based, and community-based support services for sexual health services, including STI/HIV testing/treatment, contraception, and abortion.
3.5.17	Analyze the short-term and long-term consequences of adolescent sexual activity including the various costs of STI/HIV testing/treatment, unplanned pregnancy and parenting.
3.7.24	Explain why abstinence is the most effective way to prevent HIV/STIs and unintended pregnancy.
3.7.25	Analyze behaviors that place one at risk for HIV/AIDS, STIs, or unintended pregnancy.
3.7.27	Define and describe STI/HIV, protection methods (e.g., male/insertive and female/receptive condoms; dental dams; finger cots; and Pre-Exposure Prophylaxis), symptoms, confidential testing, treatment, risks, and modes of transmission.
3.1.7	Explain the precautions necessary during labor and delivery, including when HIV and STIs are present.

[18] 5E DCMR § 2304.3(a).
[19] D.C. Code § 38-826.02(a)(3)(B).
[20] Beginning in school year 2019-2020, schools were required to submit a "Master Scheduling Exception Process Form" if they did not meet P.E. requirements. The HSA does not require DCPS to submit a waiver for health.

the schools appeared to misreport their averages.[21] One interviewee, whose school reported meeting the 75-minute requirement, indicated that the number of minutes the school reported could not be accurate because providing that many minutes in excess of the requirement would be unlikely. Two interviewees from schools that reported meeting the 75-minute requirement on their SHP indicated that students in their schools took health class in specific grades and did not in others. These schools' SHPs did not show this disparity. The SHP asks only for an average number of minutes of health education for all middle school students. It does not break down minutes per grade. Other schools reported an average of up to 300 minutes per week on their SHPs, a number that is unlikely to be an accurate average given other subjects' time requirements.[22]

Reasons for the shortfall in providing mandatory health education minutes vary significantly amongst schools, as each school's population and circumstances present unique obstacles to compliance. The OIG has isolated and highlighted some of the primary contributing factors below.

Lack of Prioritization

Some interviewees indicated that schools' lack of prioritizing health education might have driven noncompliance. For example, OSSE distributed a letter to schools, which is attached as Appendix D. The letter explains the HSA requirements and emphasizes the importance of meeting these requirements. It instructs schools that do not meet the P.E. requirement to "submit an action plan to OSSE" containing "strategic steps the school will take to improve their physical education outcomes and performance for the next school year."[23] However, the letter lacks instructions as to whether schools that do not meet the health education requirements must submit similar plans.

Representatives in the schools indicated that they are much more likely to sacrifice health instructional minutes if it becomes a choice between providing health education minutes or meeting other requirements that have consequences for noncompliance. The lack of prioritization may result from the fact that OSSE and DCPS are unwilling to enforce the consequences for failure to comply with HSA health education requirements. For example, OSSE can withhold specific HSA-related grants if schools do not submit the SHP on time. OSSE and DCPS are reticent to impose a monetary penalty for noncompliance because doing so may further hinder schools from meeting the requirements. Other than the letter, OSSE has not enforced the 75-minute requirement. Interviewees indicated that OSSE believes its role is to "encourage" HSA compliance rather than enforce requirements.

OSSE also has non-monetary incentives and penalties available to enforce compliance but does not employ them. For example, D.C.'s School Report Cards, which rate schools on a variety of factors, contain measures about compliance with other aspects of curriculum requirements, but

[21] The OIG did not try to determine whether the misreporting was intentional or unintentional. Some interviewees reported being confused about how to average minutes when, for example, students received health education for one quarter, but not for the other three quarters.
[22] For students in grades 6 through 8, it shall be the goal of all schools to provide an average of 225 minutes of physical education per week, and at least one recess of at least 20 minutes per day. D.C. Code § 38-824.02(a)(2)(A).
[23] D.C. Code § 38-824.02(a)(2)(B).

none related to health education.[24] Additionally, principals, who are required to create master schedules that meet curriculum requirements, are not evaluated on their compliance with the health education requirement in their evaluations.

Lack of Resources

Many schools seem to want to meet the requirements, but a lack of staffing or space makes meeting health education minutes difficult. For example, many schools use only one teacher to teach both health and P.E. for an entire middle school. In one case, one teacher was responsible for teaching health and P.E. to over 500 students. Meeting the minutes requirements in such a case would be logistically and mathematically impossible. In other schools, space is indirectly a factor in noncompliance with the health education minutes requirement. One school the OIG visited did not have a gym. Students received P.E. in an oversized hallway or a supply closet that the school had converted into a small weight room. The teacher chose to teach health only when he/she could not conduct P.E. outside. Health became the "bad weather subject" and was not consistently taught.

HIV-Related Curricular Standards in Health Classes

It is difficult to determine conclusively what topics teachers address in each of the health courses throughout DCPS middle schools. Still, evidence suggests that some schools do not include the curriculum-mandated lessons related to HIV/STI prevention.[25] The results of the 2019 YRBS indicate that many schools did not include HIV prevention in their health curriculum. Only 45.8 percent of students reported learning about HIV prevention during the previous year, an 11 percent decrease from 2012. The CDC also administers a survey of teachers' health education practices.[26] On the 2018 survey, eight percent of middle school teachers indicated they had not taught HIV prevention.

It is unclear to the OIG why some teachers are not teaching HIV prevention during health class as required. One health educator admitted during an interview that he/she did not teach HIV prevention in his/her health classes because it was not a "comfortable topic." The OIG found that neither OSSE, DCPS Central Office, nor principals diligently monitor what teachers addressed during health courses. Although principals' efforts to monitor teachers differed, principals we interviewed indicated monitoring was sporadic. Further, principals cannot require teachers to submit lesson plans unless there is a performance issue in the area of lesson planning, according to the Teachers Union contract.[27] Principals cannot rely on lesson plans for assurance that

[24] DCPS website https://dcps.dc.gov/release/majority-dc-public-schools-highly-rated-or-improving-according-new-dc-school-report-cards. According to DCPS: "Both the report card and accountability framework are requirements for all states under the federal Every Student Succeeds Act (ESSA)[, Pub. L No. 114-95]. OSSE designed the School Report Card to provide families with a range of information, including school points of pride, academic performance, attendance, and each school's STAR Rating." *Id*.
[25] 5E DCMR § 2304.3(a).
[26] The CDC survey is administered biennially; the most recent CDC survey was conducted in 2018.
[27] *See* Collective Bargaining Agreement Between the Washington Teachers' Union Local #6 and the District of Columbia Public Schools, § 23.18.2, Oct. 1, 2016 – Sept. 30, 2019, Washington, D.C. (Aug. 1, 2017). Note that after the Agreement's September 30, 2019 expiration date, in accordance with Article 42, "[i]t shall be automatically renewed from year to year thereafter unless either party shall notify the other in writing by October 1 of the contract year in which this Agreement is due to expire that it desires to modify or terminate this Agreement." *Id*. § 42.1.

teachers have accounted for health education instruction, and they generally lack time to monitor teacher instruction in classrooms daily.

OSSE, which also lacks the resources to observe each classroom, relies exclusively on the self-reported SHP to monitor compliance with these aspects of the HSA. The SHP asks schools to indicate both the average minutes of health education students receive and the curriculum used. It does not ask teachers to indicate that they are addressing each content area required by the DCMR. As such, OSSE has no reasonable assurance that schools are addressing the required topics.

Gaps in DCPS' "Cornerstones" curriculum, which is the curriculum most used for health education in DCPS middle schools, also contribute to the absence of instruction in HIV prevention in health class.[28] The Cornerstones Scope and Sequence documents indicate DCPS focuses on HIV prevention only in 7th grade. It is nearly nonexistent in the 6th-grade curriculum and appears just briefly in the 8th-grade scope and sequence. The lack of instruction in HIV prevention is problematic in that students' knowledge is not refreshed and reinforced yearly, but is especially problematic in schools that are trying to meet scheduling demands by offering varying amounts of health education to each of their grades.

The ultimate effects of students not receiving required health education minutes and not receiving information on HIV prevention are difficult to specify. The issue of whether additional HIV prevention education would reduce the instances of HIV in the District is unsettled, but logic suggests that it would be beneficial. D.C. Appleseed, an organization that extensively works on HIV/STI reduction in the District, has theorized that education could be an effective way of ultimately combatting infection, especially in younger age groups.

There are more tangible, immediate effects of students not receiving the required minutes and necessary content for health education. DCPS students' average HPEA scores, the assessment OSSE has chosen to evaluate student knowledge in health education, have not exceeded 70 percent since SY 2015-2016, and the average score dropped by 14 percent between SY 2017-2018 and SY 2018-2019. The average score on the "Human Body and Health" section of the HPEA, which is the section that tests knowledge of STI prevention, was 58.8 percent in SY 2018-2019. Additionally, some YRBS results also suggest that students lack critical knowledge related to HIV/AIDS and STI prevention. While the YRBS indicated that the percentage of middle school students who have ever had sexual intercourse has decreased since 2012, it also indicated that only 63 percent of those sexually active students reported using a condom during their last instance of sexual intercourse, a decrease of 10 percent since 2012.

[28] Schools also listed DCPS Health Education Standards or Canvas as curricula used; both are terms for the Cornerstones curriculum.

Therefore, to improve compliance with both the HSA minute and curricular requirements, we recommend that the Superintendent, OSSE and Chancellor, DCPS:

1. Require schools to attest prior to the school year, and after classes have been scheduled, that every student will receive the required number of health education minutes during each school year;

   Agree DCPS (partial); OSSE (partial) Disagree _____

   DCPS' October 2020 Response to Recommendation 1:[29]

   DCPS partially agrees with this recommendation. We believe that we have implemented a process that meets the requirements of this Act. Currently, DCPS' scheduling protocol requires each school's master schedule to be reviewed and authorized by the District's Master Scheduling team, the Office of Teaching and Learning (OTL) and the designated Instructional Superintendent (IS). DCPS tracks and maintains this data in a QuickBase application. As a part of this process, principals are required to provide a rationale and acquire authorization from their respective IS when the school's master schedule does not fully accommodate the requirements of the HSA.

   OSSE's October 2020 Response to Recommendation 1:[29]

   We partially agree with the recommendation. We agree that an attestation may serve a role to further support school compliance with the mandated health education requirements; however, we take a different approach as to the timing of such attestation.

   In accordance with the Healthy Schools Act, we collect health education data from public and public charter schools annually on February 15 via the School Health Profiles (SHP) (DC Official Code § 38–826.02(a)). Beginning in the 2021-22 school year, OSSE will implement a new optional attestation process following the administration of the 2022 SHP.

   After the 2022 SHP is administered and OSSE has validated and reviewed the data, we will request an annual attestation for schools that are out of compliance with the health education requirements in spring or summer. OSSE will work with LEAs to provide outreach and technical assistance to schools that are out of compliance with the health education requirements and support them in identifying and addressing barriers ahead of the next school year. As part of this process, these schools will attest they will meet the health education requirements for next school year. Conducting this annual process in the spring and summer timeframe is in sync with the time of year when schools create their schedules, begin planning, and select curriculum for the next school year. This timeframe is optimal for schools, LEAs, and OSSE.

[29] DCPS' and OSSE's complete responses, which contain footnotes not included here, are at Appendix E.

OIG Comment: The OIG received the Master Scheduling Exception Process Forms ("Form") that middle schools submitted to DCPS for SY 2019-2020. None of the schools that submitted a Form acknowledged that health education was a requirement they could not meet in SY 2019-2020. Some of the schools that submitted a Form, however, self-reported on the 2019-2020 SHP that they did not meet the 75-minute requirement.

2. Require schools to submit waivers of the HSA requirements if they are not able to meet the health education requirement and to develop an action plan before the next school year to ensure that they will not submit a waiver the following year;

Agree DCPS; OSSE (partial) Disagree _____

DCPS' October 2020 Response to Recommendation 2:

DCPS agrees with this recommendation and will continue to require schools to submit waiver requests in cases where budget and/or space do not allow the requirements to be met. Waiver requests are due from schools annually by June 1st. For schools unable to meet the HSA requirements in consecutive years, DCPS central office will review the school's barriers to identify mechanisms that will help to support progress toward meeting the goals of the HSA.

OSSE's October 2020 Response to Recommendation 2:

We partially agree with this recommendation. OSSE does not have the authority to waive any of the health education provisions of the Healthy Schools Act (HSA) under existing statute, but will develop a process for LEAs to submit a self-assessment and action plan for non-compliance.

After the administration of the 2022 SHP and health education attestation, schools that are found to be out of compliance with the health education requirements will be asked to submit a self-assessment and action plan to OSSE in the spring or summer. This self-assessment and action plan will contain strategic steps the school will take to improve their health education outcomes and performance, as well as a statement if the school does not believe it will meet the health education requirements for the next school year. We agree that self-assessments and action plans may serve a role in further supporting school compliance with the health education requirements.

3. Implement an enforcement mechanism for schools that do not meet the health education requirement for 2 consecutive years;

Agree DCPS (partial) Disagree OSSE

DCPS' October 2020 Response to Recommendation 3:

DCPS partially agrees with this recommendation. As noted above, for schools unable to meet the HSA requirements in consecutive years, DCPS' policy is to work to

review the school's barriers to identify mechanisms that will help to support progress toward meeting the goals of the HSA. DCPS continues to collaborate with OSSE to support compliance in accordance with the Act's requirements.

OSSE's October 2020 Response to Recommendation 3:

We respectfully disagree with this recommendation.

This recommendation exceeds the bounds of the existing statute. The HSA does not prescribe or permit OSSE to take any enforcement action on schools and LEAs for a lack of health education compliance. Further, OSSE believes monitoring and technical assistance as described in our responses to recommendations 1 and 2 are more effective approaches.

OIG Comment: The OIG stands by its assessment that some type of mechanism should be implemented to hold schools that repeatedly do not meet the health education standards accountable.

4. Modify the SHP to require schools to attest that they have addressed each of the topics listed in the DCMR in each health course; and

Agree _____ Disagree OSSE

DCPS' October 2020 Response to Recommendation 4:

OSSE creates the SHP; DCPS is pleased to continue to collaborate with OSSE on any review and revision and to utilize the updated SHP should any changes be made.

OSSE's October 2020 Response to Recommendation 4:

We respectfully disagree with the recommendation.

OSSE disagrees with the OIG assessment that the District of Columbia Municipal Regulations (DCMR) assign OSSE monitoring responsibilities for health education under 5E DCMR § 2304.3(a). This regulation addresses health education monitoring responsibilities of DCPS, not OSSE or public charter schools. The term "superintendent" within the regulation does not refer to the State Superintendent of Education, but instead the head of DCPS. The regulations were written and adopted in 1994, when the head of DCPS was referred to as the Superintendent. The Chancellor position was not established until the Public Education Reform Amendment Act of 2007. Title 5E gives a number of authorities to the "Superintendent" that are only appropriate for the head of DCPS. Additionally, the regulations do not describe state-level functions and, therefore, do not make sense as an authority provided to OSSE. The monitoring authorities described within the regulation refer completely to health education provided wholly within DCPS and do not apply to public charter schools. To ensure the compliance within both DCPS and public charter schools, OSSE state-level responsibilities for health education are

mandated within the Healthy Schools Act, as amended, and OSSE disagrees with modifying the SHP to match topics listed at 5E DCMR § 2304.3(a).

OSSE and the State Board of Education have authority regarding state education standards. We agree there is benefit to modifying the SHP to include topical coverage and curriculum used by schools in accordance with the state Health Education Standards. OSSE will make this update to the 2022 SHP questionnaire to begin gathering this modified data point and publishing all school-level data in a raw data excel file on the OSSE website by fall 2022.

OIG Comment: OSSE disagreed with this recommendation, but "agree there is benefit to modifying the SHP to include topical coverage and curriculum used by schools in accordance with the state Health Education Standards." DCPS said it "is pleased to continue to collaborate with OSSE on any review and revision and to utilize the updated SHP should any changes be made." Despite OSSE's disagreement, these planned actions should meet the OIG's intent for this recommendation – review and revision of the SHP.

5. Engage an outside entity to review the scope and sequence of DCPS' health courses for 6th, 7th, and 8th grades, specifically to determine whether HIV-prevention needs to be taught more frequently.

Agree _____ Disagree DCPS; OSSE

DCPS' October 2020 Response to Recommendation 5:

DCPS disagrees with this recommendation. DCPS currently uses the 3Rs curriculum, a comprehensive, skills based sexual health curriculum developed by Advocates for Youth, which aligns to local and national health standards. This curriculum is evidence based and medically accurate. The lessons on HIV begin in 6th grade and are in each grade level through high school health. DCPS evaluates the implementation of the HIV lessons with our School Based HIV Prevention Grant. In SY 2019-2020, DCPS began using a Centers for Disease Control (CDC) School Health Profile data collection tool to more accurately assess implementation. It is our belief that this curriculum meets the requirements of the HSA.

OSSE's October 2020 Response to Recommendation 5:

We respectfully disagree with the recommendation.

The recommendation is outside the scope of OSSE's authority regarding the selection of curriculum and course scheduling. These responsibilities reside with the LEA's role to engage with its curriculum and community.

OIG Comment: The OIG stands by its assessment. The OIG reviewed DCPS' health education scope and sequence and curriculum located on the CANVAS Portal and, based on the topics listed, concluded that HIV, as a topic, was not being addressed in

each of the middle school grades. The OIG did not evaluate whether the sexual health curriculum DCPS used met the health requirements; instead, it reviewed whether HIV was included as a topic in each grade level.

OSSE AND DCPS DO NOT ADEQUATELY VET DATA TO ENSURE VERACITY AND COMPLIANCE WITH THE HEALTHY SCHOOLS ACT REQUIREMENTS.

The Green Book states that "[m]anagement should use quality data to achieve [an] entity's objectives."[30] This data should "have a logical connection with, or bearing upon, the identified information requirements . . . [and come from] [r]eliable . . . sources [that] provide data . . . reasonably free from error and bias and faithfully represent what they purport to represent."[31] 0The Green Book also states that management should evaluate the data for reliability.[32]

OSSE's LEA Data Management Policy states: "Under federal and state law, LEAs are responsible for ensuring the accuracy of their records and data submissions. To that end, LEAs must ensure that all data and reports are reviewed for completeness, accuracy, and validity prior to submission to OSSE using prescribed protocols."[33]

OSSE uses SHPs to gather data related to schools' compliance with the HSA requirements. OSSE reviews submissions to ensure that all schools have complied and follows up with those that have not. Once schools provide the data, OSSE uses it to create a biennial "Healthy Schools Act Report" that includes a section related to health education minutes and submits the report to the Mayor, D.C. Council, and the Healthy Youth and Schools Commission.[34]

The SHP instructions state that the health education minutes listed "should represent the average number of minutes per week over the course of a school year."[35] It specifies, "If a student only receives health education for one semester or one quarter, please average the total weekly minutes for the whole school year. Do **NOT** include physical education instruction time in this figure."[36] The SHP seeks the average number of minutes collectively for 6th through 8th grades and fails to distinguish the average health education minutes by grade or how a class splits its time between health and P.E. if they are taught together.

According to the 2018-2019 SHP, 31 of 32 health educators in DCPS taught both health and P.E. within the same class. Health educators reported dividing their classes in a variety of ways, including: alternating between P.E. and health every 3 weeks; teaching health for one semester and P.E. for the remaining semester; alternating days of the week between health and P.E.; and

[30] U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 1, § 13.01, at 59.
[31] *Id*. § 13.04.
[32] *Id*.
[33] OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION, LEA DATA MANAGEMENT POLICY 1-2 (Dec. 2017).
[34] D.C. Code § 38-823.03. Although D.C. Code § 38-823.03 requires OSSE to submit its report to the Mayor, Council, and Healthy Youth and Schools Commission every 2 years, schools continue to submit the SHP to OSSE annually as D.C. Code § 38-826.02(a) requires.
[35] OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION, 2018-2019 SCHOOL YEAR SCHOOL HEALTH PROFILE FORM, § 3.
[36] *Id*.

even teaching P.E. outside when the weather allowed it to take place and health when inclement weather prevented it. Additionally, some health teachers taught students in one grade more frequently than students in another grade. For example, one health educator stated that he/she did not teach health to 6th-grade students, taught health to 7th-grade students for a full year, and taught health to 8th-grade students for just one semester. Because of differing class structures, many health educators reported that they were confused about how to report health education minutes, despite the instructions on the SHP. DCPS scheduling guidance does not recommend how to apportion P.E. and health within the class to fulfill the HSA requirements; it leaves that decision to principals or health educators.

The OIG found indications that data submitted through the SHPs were not always accurate. During an interview, one educator stated that the health education minutes its school reported for SY 2018-2019 were inaccurate because it would have been impossible for the school to have averaged the reported number of health education minutes. The educator believed that many schools were likely including P.E. minutes in the health education minutes total. The OIG found other seemingly inaccurate entries for SY 2018-2019. Specifically, five middle schools reported an average of 225 to 300 minutes of health education per week. If these totals are accurate, students in those schools would have received *only* health education for 45 to 60 minutes, 5 days per week. Given that schools combine health and P.E., this schedule would leave no time for P.E., and SHPs indicate that is not the case because schools also reported that they met the P.E. minutes requirement.

OSSE and DCPS personnel acknowledged that self-reported data can be inaccurate and unreliable. Both entities have discussed ways to improve the accuracy of schools' health education minutes reporting. One OSSE employee stated that, although it is a red flag when a school reports an average of 300 minutes of health per week, OSSE's focus is on assisting schools that self-report fewer than 75 minutes, rather than those reporting significantly more.

OSSE has a data certification process in place, but that process apparently only confirms schools have submitted the SHP. After schools submit the SHP, OSSE asks schools and LEAs to review their responses and certify that the data are accurate. The certification process involves the user re-entering their password and acknowledging a statement that affirms the accuracy of the data. Principals and teachers reported that after they certified the data, they did not have any additional contact with OSSE. During SY 2018-2019, no schools certified the SHP data; OSSE did not have an explanation for this omission.

Submitted SHP data are often inaccurate because of an ineffective vetting process. There is confusion between OSSE and DCPS about which entity is responsible for vetting the data. According to OSSE's policy and OSSE personnel, an LEA should validate the data before submitting it to OSSE. DCPS Central Office reported, however, that it did not review the SHP data until the SHPs were posted publicly on OSSE's website. Other than the certification process, no other vetting occurs to verify the schools' self-reported health education minutes. One interviewee suggested utilizing ASPEN, DCPS' management information system, to help verify the data. ASPEN, among other uses, tracks school schedules. Through ASPEN, OSSE could access student schedules to validate the reported health education minutes and identify and correct outliers.

Because schools are reporting inaccurate minutes, OSSE and DCPS are unable to evaluate or report schools' progress toward meeting the health education minute requirement effectively, and inaccurate data makes it difficult to assess the effectiveness of the requirement. The OIG attempted to evaluate the correlation between health education minutes offered by individual schools and those schools' HPEA scores, but could not complete the analysis due to outliers that seem to be errors. OSSE uses the self-reported data to inform stakeholders about compliance at both the individual school and District-wide level; however, the data do not provide decision-makers an accurate representation to make informed decisions. Also, because both OSSE and DCPS use the SHP data to identify schools that require technical assistance with issues such as budgeting, curriculum, and professional development, failing to submit accurate data may leave a school that needs help meeting the requirement without it.

To correct these data errors and ensure that OSSE and DCPS are using accurate data to make informed decisions and monitor compliance with the HSA requirements, we recommend that the Superintendent, OSSE and Chancellor, DCPS:

6. Collaborate to revise the vetting procedure for verifying self-reported health education minutes;

Agree DCPS; OSSE Disagree _____

DCPS' October 2020 Response to Recommendation 6:

DCPS agrees with this recommendation and will collaborate with OSSE to strengthen the procedure for verifying self-reported health education minutes.

OSSE's October 2020 Response to Recommendation 6:

We agree and are currently implementing the recommendation.

OSSE revised our data validation procedure during the 2018-19 school year to address potential issues of data accuracy. In that school year, the OSSE Division of Health and Wellness collaborated with the OSSE Division of Data, Assessments and Research to include the SHP health education minutes data point in our annual data validation processes which ensure accurate and high-quality data is reported from LEA partners and schools. The data validation process is critical for ensuring LEA data accuracy and reliability when submitted to OSSE and it has significant impacts on LEA funding, public reporting like annual assessment results and graduation rates, as well as our annual STAR Framework and Report Card results. As such, each data point requires that the Heads of School certify the data, and it is incumbent on the LEA to ensure all school-level data submitted to the SEA is accurate. OSSE currently fulfills the OIG recommendation to establish and revise a validation procedure allowing schools and LEAs to confirm health education minutes.

7. Revise instructions related to recording the average number of health education minutes per week to account for the various ways schools structure health classes; and

Agree OSSE Disagree _____

DCPS' October 2020 Response to Recommendation 7:

OSSE creates the SHP; DCPS is pleased to continue to collaborate with OSSE on any review and revision and to utilize the updated SHP should any changes be made.

OSSE's October 2020 Response to Recommendation 7:

We agree with the recommendation.

We agree with the challenge OIG has noted regarding the need for schools to fully understand the health education question and respond accurately to that element of the SHP questionnaire. In an effort to fully support the submission of accurate health education minutes, we will review and revise the SHP health education instructions where appropriate to further emphasize the importance of submitting valid data and note considerations schools should make when calculating average weekly health education minutes. It is important to recognize that revised instructions will not likely cover all possible instances of school health education class structures, and there will likely continue to be questions that schools should address with their LEA for clarity and support. OSSE has always and will continue to engage with LEAs on the SHP and offer technical assistance and support for schools and LEAs that need clarifications when completing the SHP.

8. Revise the SHP to include questions seeking the average number of health education minutes received by each middle school grade.

Agree OSSE Disagree _____

DCPS' October 2020 Response to Recommendation 8:

OSSE creates the SHP; DCPS is pleased to continue to collaborate with OSSE on any review and revision and to utilize the updated SHP should any changes be made.

OSSE's October 2020 Response to Recommendation 8:

We agree with the recommendation.

Although the existing method of data collection aligns with the statute, OSSE will revise the SHP questionnaire to capture health education instruction provided by schools for each specific grade rather than grade band in order to offer greater data transparency. This re-framing of the health education minutes question(s) will be added to the 2022 SHP questionnaire, and OSSE will publish the totality of SHP data

following our existing process of publishing all school-level data in a raw data excel file on the OSSE website by fall 2022.

OSSE AND DCPS DO NOT COLLABORATE TO ANALYZE HEALTH AND PHYSICAL EDUCATION ASSESSMENT RESULTS, IDENTIFY ASSESSMENT AND INSTRUCTIONAL WEAKNESSES, AND IMPROVE INSTRUCTION.

The DCMR tasks OSSE with "ensur[ing] that health instruction … is taught through the use of appropriate monitoring and establishment of minimum proficiencies or learning outcomes in at least *eleven* (11) content areas" including HIV/AIDS and other sexually transmitted diseases; human sexuality and family; and prevention and control of disease.[37]

To formulate an effective control activity, the Green Book recommends that an entity process obtained data into quality information,[38] communicate that quality information down reporting lines to enable personnel to perform critical roles in achieving the objective of providing quality health education,[39] and evaluate and document the results of the assessment to identify any deficiencies.[40]

OSSE administers the HPEA to monitor, assess, and measure proficiencies of health education. The HPEA is a 21-question multiple-choice test consisting of three questions from each of the following 7 categories:

- Alcohol, Tobacco, and Other Drugs;
- Disease Prevention;
- Human Body and Personal Health;
- Mental and Emotional Health;
- Nutrition;
- Physical Education; and
- Safety Skills.

The 3 questions are selected randomly from a question bank of between 3 and 14 questions per category, and each student receives different questions. The HPEA has not been modified since its inception in 2016.

Students take the HPEA online during their school's standardized test schedule. Completed tests are submitted directly to OSSE, which publishes the District-wide results of the HPEA assessment as an appendix to the biennial Healthy Schools Act Report. OSSE makes HPEA

[37] 5E DCMR § 2304.3(a) (emphasis added).
[38] *See supra* note 30.
[39] U.S. GOV'T ACCOUNTABILITY OFFICE, *supra* note 1, § 14.03, at 60.
[40] *Id.* § 16.09 at 66.

results available to LEAs in a database known as Qlik[41] and gives access to select people at the DCPS Central Office.

The OIG found that teachers are not aware of their students' results because they were never presented with the scores directly. OSSE does not communicate results to the schools, and no one tells health educators the results are available. OSSE publicly posts a webinar that explains how to access scores in Qlik. However, school administrators are not accessing the webinar and seemed to be unaware of Qlik's existence when we asked about its use. In 2017, OSSE claimed that it would provide schools with both individual school-wide scores and guidance on how to access and use Qlik by 2018; it did not.[42] An OSSE employee explained that providing individual school-wide scores and guidance on Qlik did not occur because OSSE wanted to shift its focus to using the HPEA scores and other health data to inform a more data-driven, targeted approach to their technical assistance and grant supports.

The OIG also found that OSSE and DCPS do not collaborate to discuss HPEA results or formulate remediation needed based upon those results. Additionally, OSSE and LEAs, including DCPS, have not discussed the validity of the HPEA or any adjustments to the HPEA that would better assess student learning outcomes.

Schools do not know how their students performed on the HPEA. As a result, they cannot accurately assess their students' performance in each of the content areas at a school-specific level. Consequently, schools cannot make adjustments to classes to address areas of need for their specific student populations and attempt to improve those scores. At the LEA level, a lack of collaboration between OSSE and DCPS results in no adjustments being made to address LEA-wide deficiencies. As Figure 1 on the next page shows, HPEA scores declined in SY 2018-2019, and scores in certain categories are consistently below those of other categories. By neglecting to evaluate the results through a collaborative process, DCPS and OSSE are not analyzing whether the DCPS curriculum or scope and sequence of health education should be adjusted to improve learning outcomes in those areas.

[41] Qlik is a data application that allows users to monitor HPEA scores, and create reports and visualizations.
[42] OSSE website https://osse.dc.gov/node/1289721 (last visited June 29, 2020).

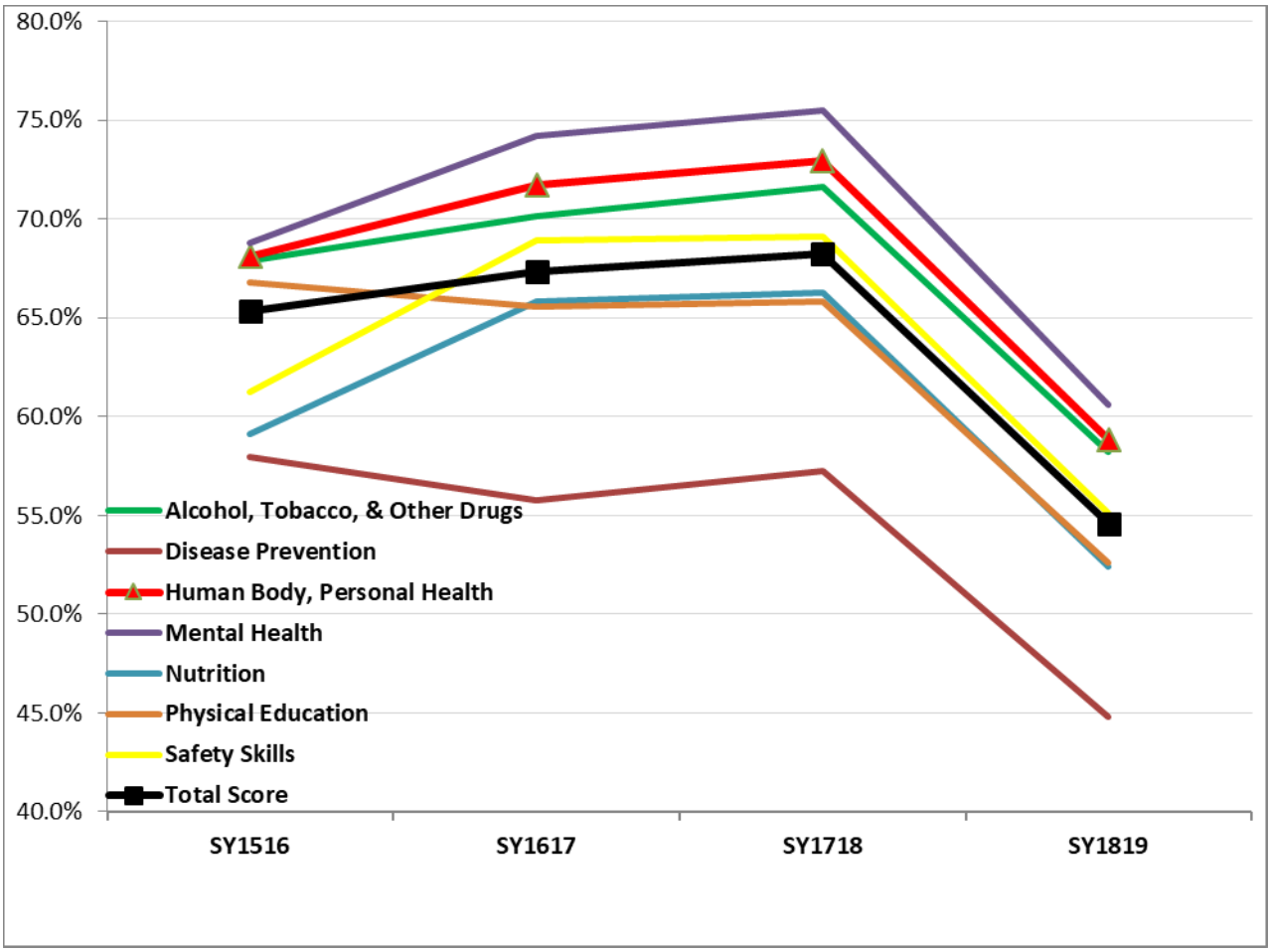

Figure 1: Average Score on HPEA by Category

Further, OSSE has not evaluated the utility of the assessment to determine whether the HPEA needs adjustments, or whether there is a better mechanism to monitor learning outcomes.

To better ensure that OSSE and DCPS are using data collected to improve policies and procedures, we recommend that the Superintendent, OSSE and Chancellor, DCPS:

9. Transmit all school-level results annually to principals and health educators;

Agree DCPS; OSSE Disagree _____

DCPS' October 2020 Response to Recommendation 9:

DCPS agrees with this recommendation. Once notification of data results is received from the OSSE, DCPS will reinforce notification to schools to ensure that schools utilize the information in the most efficient way.

OSSE's October 2020 Response to Recommendation 9:

We agree and are currently implementing the recommendation.

We have developed a complete, up-to-date, and interactive data visualization and discovery tool that allows all LEAs to easily view Health and Physical Education Assessment (HPEA) score snapshots and trends. Through this Qlik data tool, LEA leaders are able to monitor real-time completion of the HPEA; view and download assessment results for their LEA and each school within the LEA, filterable by school year (2015-16, 2016-17, 2017-18, and 2018-19), grade, and test category; and view and download student-level assessment results, filterable by school, grade, and test category. OSSE continues to instruct and expect all LEAs to transfer these data to their school leaders and health educators to indicate needs for further development or modifications to the school health education practice and approach and raise scores in specific health and physical education domains.

OIG Comment: Although OSSE may be communicating the HPEA results to the LEA level, the results are not reaching principals and teachers. As noted in the finding, many of the teachers interviewed were unaware that these results had been transmitted or that the Qlik data tool existed. The OIG reiterates the importance of seeing that this data reaches its intended target.

10. Establish a process to review HPEA results and trends periodically and adjust how schools teach health accordingly; and

    Agree DCPS; OSSE (partial) Disagree _____

DCPS' October 2020 Response to Recommendation 10:

DCPS agrees with this recommendation and will work with OSSE to establish a process to review Health and Physical Education Assessment (HPEA) results to inform professional development and implement curricular changes to support growth for teachers and students.

OSSE's October 2020 Response to Recommendation 10:

We partially agree with the recommendation. OSSE currently evaluates HPEA results and trends in order to develop resources and targeted supports, but OSSE does not have the authority to enforce how schools teach health education or the curriculum selected by an LEA.

We will continue to review and publish state-level HPEA results and trends in resources such as the "Data to Action Guide: Addressing Youth Risk Behavior through Health Education," which is informed by notable trends in the HPEA and the DC Youth Risk Behavior Survey (YRBS). This resource identifies key curricula, resources, and training to support schools with delivering instruction on critical health education topics through a variety of settings to include synchronous and asynchronous classroom instruction, guidance lessons, and health promotion activities. OSSE will continue to offer such resources in addition to technical assistance, training, and targeted supports for schools and LEAs to understand how

to meet the Health Education Standards and how to utilize actionable data in their health education decision-making.

As the SEA, OSSE will ensure these resources and supports are made available to LEAs, but it is outside our scope of authority to enforce how schools teach health accordingly or to enforce any specific standards-aligned health curriculum. These responsibilities reside with the LEA.

11. Convene a group of LEA and OSSE representatives to review assessment questions and make modifications as required.

Agree DCPS; OSSE (partial) Disagree _____

DCPS' October 2020 Response to Recommendation 11:

DCPS agrees with this recommendation and would be pleased to participate in a working group initiated for this purpose.

OSSE's October 2020 Response to Recommendation 11:

We partially agree with the recommendation.

OSSE relies on educator expertise to design statewide assessments at various parts of the development process. The HPEA is no different. OSSE will engage LEAs for feedback as appropriate in the review of any items on the HPEA.

RULES TO IMPLEMENT THE HEALTHY SCHOOLS ACT HAVE NOT BEEN PROMULGATED.

According to D.C. Code § 38–828.01, "[t]he Mayor, pursuant to subchapter I of Chapter 5 of Title 2 [§ 2-501 et seq.], shall issue rules to implement the provisions of [Chapter 8A. Healthy Schools]."[43] The OIG found no evidence that rules implementing the HSA have been issued. Representatives from OSSE indicated that formal rules had not been issued because "rules" are broadly defined by the Administrative Procedures Act, and, as such, OSSE's internal policies should suffice. Although OSSE leadership has internally discussed whether rules are necessary, they concluded that the wording in the HSA is sufficiently specific to administer the law without implementing rules or regulations. An OSSE interviewee suggested that implementing rules would not improve a school's compliance with HSA requirements.

However, interviews with DCPS employees and principals suggested that the lack of rules had detrimental effects that the issuance of formal rules might correct; specifically, confusion amongst DCPS and OSSE about responsibilities for data verification. Formal rules could clarify OSSE's and DCPS' roles in data processes related to the HSA. Additionally, although the HSA is specific in some places, it does not include many details that may help implementation. Rules

[43] Under D.C. Code § 2-502(1)(A), "[t]he term 'Mayor' means the Mayor of the District of Columbia, or his or her designated agent." Designees could include subordinate and independent agencies like OSSE.

could provide additional guidance related to resource requirements and adjustments to scheduling based on limited resources. They could also provide additional instructions about how to report the average number of health education minutes students receive based on differing schedules.

Implementing rules could create opportunities for OSSE and DCPS to provide more detailed instructions to schools and other stakeholders on how to allocate resources, roles that each entity is required to perform, and enforcement of the HSA.

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Therefore, we recommend the Mayor or the Superintendent, OSSE as a designated agent:

12. Promulgate rules implementing the HSA.

Agree _____ Disagree OSSE

OSSE's October 2020 Response to Recommendation 12:

We respectfully disagree with the recommendation.

The Healthy Schools Act is already detailed and prescriptive. We do not believe regulations would meaningfully support improved performance by schools against the Healthy Schools Act health education requirements. OSSE is already actively supporting compliance and accountability with the Healthy Schools Act and alignment of instruction with the Health Education Standards, including through: assessments of student knowledge and behavior (HPEA and YRBS); data analysis and reporting; training, technical assistance, and resources; and greater public transparency. Further, OSSE cannot regulate outside our authority granted by statute, including imposing additional penalties on schools for non-compliance with health education requirements. The DC Council may grant OSSE additional enforcement authority via amendments to the Healthy Schools Act.

OIG Comment: The OIG stands by its assessment that rules should be promulgated for the HSA. The HSA states the Mayor "shall" issue rules. During its fieldwork, the OIG found significant confusion between OSSE and DCPS about agency roles and responsibilities. In addition, as highlighted in OSSE's and DCPS' responses to Recommendation 9 of this report, the two agencies are not always aligned regarding which entity is responsible for ensuring information has been disseminated.

CONCLUSION

Eliminating HIV in the District has taken and will continue to take a multi-faceted effort. In this regard, educating students about the existence of HIV, how to prevent it, how to treat it, and where to get help will undoubtedly affect how successful the District's eradication efforts are. The HSA, in part, serves to establish requirements to ensure schools are educating students about HIV and other STIs.

OSSE, as the state agency in charge of ensuring that schools comply with HSA standards, and DCPS, as the largest LEA in the District responsible for educating approximately 50 percent of District students, both play a vital role in ensuring that students receive HIV-prevention instruction. OSSE and DCPS will be more effective and efficient if they collaborate further to ensure that schools meet mandated health education minutes and the HIV-prevention curriculum requirements, accurately measure student outcomes, and adjust instruction based upon those outcomes.

The OIG believes the implementation of the recommendations in this report will serve to better measure and encourage compliance with the HSA, as well as better assess the results of compliance.

APPENDIX A. OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The primary objective was to assess the extent to which OSSE and DCPS have implemented key provisions in the Healthy Schools Act (HSA), in particular, curriculum standards that focus on health education and HIV/AIDS.

Scope

The OIG limited its scope of this evaluation to DCPS middle schools from school year (SY) 2017- 2018 to present. The OIG also examined test data outside of this timeframe to show trends related to current results.

Methodology

During the assessment, the OIG team researched the HSA, DCMR, OSSE's 2016 Health Education Standards, and DCPS' CANVAS curricula. We reviewed D.C. Appleseed's "Ending the HIV Epidemic in DC: 2018 Progress Report," the results of the HPEAs, the DCPS SHPs, the CDC's SHP results, and YRBS reports. We also visited OSSE and DCPS' websites for publicly available information.

Finally, the OIG conducted interviews with DCPS health educators and principals, OSSE and DCPS Central Office personnel, and a member of the Healthy Youth and Schools Commission. The fieldwork for this evaluation spanned from February 2020 through May 2020.

APPENDIX B. ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
CDC	Centers for Disease Control and Prevention
DCMR	D.C. Municipal Regulations
DCPS	D.C. Public Schools
HIV	Human Immunodeficiency Virus
HPEA	Health and Physical Education Assessment
HSA	Healthy Schools Act
OIG	D.C. Office of the Inspector General
OSSE	Office of the State Superintendent of Education
P.E.	Physical Education
SHP	School Health Profile
STI	Sexually Transmitted Infection
SY	School Year
YRBS	Youth Risk Behavior Survey

APPENDIX C. TABLE OF RECOMMENDATIONS

Responsible Agency	Recommendations	Potential Monetary Benefits	Agency Response
DCPS	1. Require schools to attest prior to the school year, and after classes have been scheduled, that every student will receive the required number of health education minutes during each school year.		DCPS partially agreed with this recommendation. OSSE partially agreed with this recommendation.
DCPS	2. Require schools to submit waivers of the HSA requirements if they are not able to meet the health education requirement and to develop an action plan before the next school year to ensure that they will not submit a waiver the following year.		DCPS agreed with this recommendation. OSSE partially agreed with this recommendation.
DCPS	3. Implement an enforcement mechanism for schools that do not meet the health education requirement for 2 consecutive years.		DCPS partially agreed with this recommendation. OSSE disagreed with this recommendation.
OSSE	4. Modify the SHP to require schools to attest that they have addressed each of the topics listed in the DCMR in each health course.		OSSE disagreed with this recommendation.
DCPS	5. Engage an outside entity to review the scope and sequence of DCPS' health courses for 6th, 7th, and 8th grades, specifically to determine whether HIV-prevention needs to be taught more frequently.		DCPS and OSSE both disagreed with this recommendation.
OSSE and DCPS	6. Collaborate to revise the vetting procedure for verifying self-reported health education minutes;		DCPS and OSSE both agreed with this recommendation.
OSSE	7. Revise instructions related to recording the average number of health education minutes		OSSE agreed with this recommendation.

APPENDIX C. TABLE OF RECOMMENDATIONS

Responsible Agency	Recommendations	Potential Monetary Benefits	Agency Response
	per week to account for the various ways schools structure health classes.		
OSSE	8. Revise the SHP to include questions seeking the average number of health education minutes received by each middle school grade.		OSSE agreed with this recommendation.
OSSE and DCPS	9. Transmit all school-level results annually to principals and health educators.		DCPS and OSSE both agreed with this recommendation.
OSSE and DCPS	10. Establish a process to review HPEA results and trends periodically and adjust how schools teach health accordingly.		DCPS agreed with this recommendation and OSSE partially agreed with this recommendation.
OSSE and DCPS	11. Convene a group of LEA and OSSE representatives to review assessment questions and make modifications as required.		DCPS agreed with this recommendation and OSSE partially agreed with this recommendation.
OSSE	12. Promulgate rules implementing the HSA.		OSSE disagreed with this recommendation.

APPENDIX D. OSSE HEALTH EDUCATION AND P.E. LETTER

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

[DATE], 2019

Dear Principal NAME [Or other contact],

The purpose of this letter is to inform you of Healthy Schools Act health and physical education requirements, share your school's compliance from last year, and offer OSSE's assistance for increasing your school's compliance.

Our records indicate that [SCHOOL NAME] did not meet all health and physical education requirements for the 2018-19 school year. OSSE is focusing on supporting schools' compliance with health and physical education requirements because, as illustrated by the CDC's Whole School, Whole Community, Whole Child (WSCC) model, health and physical education support the development of healthy bodies and minds, which are the foundation of academic success. OSSE is aware that DCPS is facilitating the action plan process through its Health and Physical Education department and will submit the plan to OSSE on your behalf.

In the 2018-19 school year, schools that served grades 6-8 were required to provide an average of 75 health education and 225 physical education minutes per week.[1] The table below shows how many minutes your school reported in your 2019 School Health Profile, and how that compares to other public and public charter schools.

Health and Physical Education Weekly Average Minutes Compliance Status (2018-19 School Year)

	REQUIRED WEEKLY MINUTES	MIDDLE SCHOOL AVERAGE	YOUR SCHOOL	COMPLIANCE STATUS
PHYSICAL EDUCATION	225	110	50	NOT IN COMPLIANCE
HEALTH EDUCATION	75	73	30	NOT IN COMPLIANCE

The newly passed Healthy Students Amendment Act of 2018, which amends the Healthy Schools Act and about which you received a letter from OSSE on Aug. 1, 2019, includes new requirements for health and physical education. Beginning in the 2019-20 school year, the goal of schools serving grades 6-8 is to provide an average of 225 minutes per week of physical education and at least 20 minutes per day of recess. Additionally, physical education must devote at least 50 percent of the class time to moderate-to-vigorous physical activity. A school that provides less than an average of 135 minutes per week of physical education will be required to submit an action plan to OSSE detailing the efforts it will take to increase physical education for the 2020-21 school year. Schools must also provide an average of 75 minutes per week of health education. As a reminder, health education instruction must meet the District of Columbia Health Education Standards, and physical education instruction must meet the District of Columbia Physical Education Standards.

OSSE understands that schools may have questions about the new requirements. Please refer to the frequently asked questions on the next page. We will share additional resources in the coming months, including a guide and training webinars, to assist schools with understanding and implementing the requirements.

Please contact Miriam.Kenyon@k12.dc.gov with any questions or concerns, or to request technical assistance. Thank you for your continued partnership.

Sincerely,
Heidi Schumacher, MD
Assistant Superintendent, Health & Wellness

[1] DC Official Code § 38–824.02

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APPENDIX D. OSSE HEALTH EDUCATION AND P.E. LETTER

Healthy Students Amendment Act of 2018
Frequently Asked Questions for Physical Education and Physical Activity Requirements

On Jan. 16, 2019, Mayor Muriel Bowser signed the Healthy Students Amendment Act of 2018 (HSAA or Act), and the Act was later funded as part of the Fiscal Year 2020 Budget Support Act of 2019. The HSAA amends the Healthy Schools Act of 2010, with key changes to nutrition, physical education, and physical activity requirements for schools. Please find below a summary of the major changes in physical education and physical activity.

Q1: Why is OSSE placing focus on health and physical education requirements?
Regular physical activity in childhood and adolescence is important for promoting lifelong health and well-being and preventing various health conditions.[2] School-based physical education and physical activity also impacts cognitive skills, such as concentration and attention, and enhances classroom attitudes and behavior that set students on a path for improved academic performance and success.[3] Beyond dedicated physical education instruction, schools can also increase access to physical activity by including movement in classroom instruction and instructional breaks, before- and after-school activities, athletic programs, promoting walking and biking to school, offering at least 20 minutes of daily recess, and using physical activity as a reward for student achievement and good behavior.[4]

Q2: What are the new weekly minute requirements for physical education?
A: Students in grades 6-8 must receive an average of 135 minutes of physical education per week. It shall be the goal of schools to provide an average of 225 minutes of physical education per week, but 135 minutes is the minimum. Physical education means instruction based on the District of Columbia Physical Education Standards, of which at least 50 percent of time must be spent on moderate-to-vigorous physical activity. Schools must begin implementing the new minute requirements beginning in the 2019-20 school year.

Q3: What happens if a school does not meet the physical education requirements?
A: OSSE will identify schools that do not meet the minimum physical education minute requirements via the annual School Health Profile. OSSE will begin monitoring schools for the new minute requirements beginning with the 2019-20 School Health Profile. Schools that do not meet the minimum physical education minute requirement will be required to submit an action plan to OSSE. The action plan will outline strategic steps the school will take to improve their physical education outcomes and performance for the next school year, beginning with the 2020-21 school year. OSSE will use these action plans to provide schools with additional professional development and technical assistance to support increased performance. Schools will receive more information about physical education action plans later in the 2019-20 school year.

Q4: What is the requirement for recess and physical activity?
A: It shall be the goal of schools to incorporate at least 20 minutes of daily recess for students in kindergarten through grade 8. This is a goal, not a requirement for schools.

Q5: What counts as physical activity, and what is moderate-to-vigorous physical activity?
A: Physical activity is any bodily movement, including walking, dancing, and gardening. Schools can maximize opportunities for students to be physically active through before and after-school activities, encouraging students to walk or bike to school, promoting active recess, supporting athletic programs, physical activity breaks during classroom instructional time, and the use of physical activity as a reward for student achievement and good behavior. Moderate-to-vigorous physical activity means movement resulting in substantially increased heart rate and breathing.

[2] https://www.cdc.gov/healthyschools/physicalactivity/facts.htm
[3] https://www.cdc.gov/healthyyouth/health_and_academics/pdf/pa-pe_paper.pdf
[4] DC Official Code § 38–824.01

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APPENDIX D. OSSE HEALTH EDUCATION AND P.E. LETTER

Q6: Is there local funding available to support physical education and physical activity?
A: The Nutrition Education and Physical Activity (NEPA) grant supports physical activity initiatives in District schools.

Q7: What professional development and technical assistance will OSSE provide?
A: OSSE offers a variety of professional development opportunities to support physical education including Comprehensive School Physical Activity Programs (CSPAP), OSSE's Physical Education Standards, Physical Education Curriculum Analysis Tool (PECAT), and out-of-school time training. OSSE understands the existing challenges around scheduling, building space, and dedicated physical education teachers can create barriers to meeting the physical education minute requirements. OSSE will continue to create new resources in the 2019-20 school year to assist schools in mitigating these challenges. Please contact Charles Rominiyi (Charles.Rominiyi@dc.gov) for more information.

APPENDIX E. OSSE RESPONSE TO THE DRAFT REPORT

DISTRICT OF COLUMBIA
OFFICE OF THE STATE SUPERINTENDENT OF
EDUCATION

October 27, 2020

Mr. Daniel W. Lucas
Inspector General
Office of the Inspector General
717 14th Street NW, Fifth Floor
Washington, DC 20005

Dear Mr. Lucas,

I am writing in response to your September 18, 2020 letter summarizing the results of the Office of the Inspector General's (OIG) draft report, *District of Columbia Public Schools and Office of the State Superintendent of Education: Evaluation of Compliance with the Healthy Schools Act Health Education Requirements* (OIG Project No. 20-I-04GA). Thank you for the opportunity to review this draft report. I appreciate your recognition of the important role high quality health education plays in the development of students in the District of Columbia.

We agree with four of the recommendations, partially agree with four of the recommendations, and respectfully disagree with four of the recommendations. Our responses are provided on behalf of the District of Columbia Office of State Superintendent of Education (OSSE), the District's state education agency (SEA), and do not reflect responses offered by the District of Columbia Public Schools (DCPS), the District's largest local education agency (LEA). Our responses provide clarity on where we interpret our role as the SEA regarding enforcement of health education requirements under the Healthy Schools Act (DC Official Code § 38–821.01 *et seq.*), and where we interpret the LEA role for enforcement. We believe we are currently meeting our requirements of the Healthy Schools Act; however, we agree or partially agree with recommendations made for how we can support schools and LEAs in meeting their health education requirements.

As noted in our response, adoption of some of these recommendations may not be feasible until the 2021-22 school year due to the current complications and disruption caused by the COVID-19 public health emergency to school operations. OSSE, LEAs, and schools will hopefully be better positioned in the 2021-22 school year to implement new health education initiatives and changes to data collection if public health measures allow.

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APPENDIX E. OSSE RESPONSE TO THE DRAFT REPORT

OIG Recommendations and OSSE responses:

1. Require schools to attest prior to the school year, and after classes have been scheduled, that every student will receive the required number of health education minutes during each school year.

Response: We partially agree with the recommendation. We agree that an attestation may serve a role to further support school compliance with the mandated health education requirements; however, we take a different approach as to the timing of such attestation.

In accordance with the Healthy Schools Act, we collect health education data from public and public charter schools annually on February 15 via the School Health Profiles (SHP) (DC Official Code § 38–826.02(a)). Beginning in the 2021-22 school year, OSSE will implement a new optional attestation process following the administration of the 2022 SHP.

After the 2022 SHP is administered and OSSE has validated and reviewed the data, we will request an annual attestation for schools that are out of compliance with the health education requirements in spring or summer. OSSE will work with LEAs to provide outreach and technical assistance to schools that are out of compliance with the health education requirements and support them in identifying and addressing barriers ahead of the next school year. As part of this process, these schools will attest they will meet the health education requirements for next school year. Conducting this annual process in the spring and summer timeframe is in sync with the time of year when schools create their schedules, begin planning, and select curriculum for the next school year. This timeframe is optimal for schools, LEAs, and OSSE.

2. Require schools to submit waivers of the HSA requirements if they are not able to meet the health education requirement and to develop an action plan before the next school year to ensure that they will not submit a waiver the following year.

Response: We partially agree with this recommendation. OSSE does not have the authority to waive any of the health education provisions of the Healthy Schools Act (HSA) under existing statute, but will develop a process for LEAs to submit a self-assessment and action plan for non-compliance.

After the administration of the 2022 SHP and health education attestation, schools that are found to be out of compliance with the health education requirements will be asked to submit a self-assessment and action plan to OSSE in the spring or summer. This self-assessment and action plan will contain strategic steps the school will take to improve their health education outcomes and performance, as well as a statement if the school does not believe it will meet the health education requirements for the next school year. We agree that self-assessments and action plans may serve a role in further supporting school compliance with the health education requirements.

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APPENDIX E. OSSE RESPONSE TO THE DRAFT REPORT

3. Implement an enforcement mechanism for schools that do not meet the health education requirement for 2 consecutive years;

Response: We respectfully disagree with this recommendation.

This recommendation exceeds the bounds of the existing statute. The HSA does not prescribe or permit OSSE to take any enforcement action on schools and LEAs for a lack of health education compliance. Further, OSSE believes monitoring and technical assistance as described in our responses to recommendations 1 and 2 are more effective approaches.

4. Modify the SHP to require schools to attest that they have addressed each of the topics listed in the DCMR in each health course.

Response: We respectfully disagree with the recommendation.

OSSE disagrees with the OIG assessment that the District of Columbia Municipal Regulations (DCMR) assign OSSE monitoring responsibilities for health education under 5E DCMR § 2304.3(a). This regulation addresses health education monitoring responsibilities of DCPS, not OSSE or public charter schools. The term "superintendent" within the regulation does not refer to the State Superintendent of Education, but instead the head of DCPS. The regulations were written and adopted in 1994, when the head of DCPS was referred to as the Superintendent. The Chancellor position was not established until the Public Education Reform Amendment Act of 2007. Title 5E gives a number of authorities to the "Superintendent" that are only appropriate for the head of DCPS. Additionally, the regulations do not describe state-level functions and, therefore, do not make sense as an authority provided to OSSE. The monitoring authorities described within the regulation refer completely to health education provided wholly within DCPS and do not apply to public charter schools. To ensure the compliance within both DCPS and public charter schools, OSSE state-level responsibilities for health education are mandated within the Healthy Schools Act, as amended, and OSSE disagrees with modifying the SHP to match topics listed at 5E DCMR § 2304.3(a).

OSSE and the State Board of Education have authority regarding state education standards. We agree there is benefit to modifying the SHP to include topical coverage and curriculum used by schools in accordance with the state Health Education Standards. OSSE will make this update to the 2022 SHP questionnaire to begin gathering this modified data point and publishing all school-level data in a raw data excel file on the OSSE website by fall 2022.

5. Engage an outside entity to review the scope and sequence of DCPS' health courses for 6th, 7th, and 8th grades, specifically to determine whether HIV-prevention needs to be taught more frequently.

Response: We respectfully disagree with the recommendation.

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APPENDIX E. OSSE RESPONSE TO THE DRAFT REPORT

The recommendation is outside the scope of OSSE's authority regarding the selection of curriculum and course scheduling. These responsibilities reside with the LEA's role to engage with its curriculum and community.

6. Collaborate to revise the vetting procedure for verifying self-reported health education minutes.

Response: We agree and are currently implementing the recommendation.

OSSE revised our data validation procedure during the 2018-19 school year to address potential issues of data accuracy. In that school year, the OSSE Division of Health and Wellness collaborated with the OSSE Division of Data, Assessments and Research to include the SHP health education minutes data point in our annual data validation processes[1] which ensure accurate and high-quality data is reported from LEA partners and schools. The data validation process is critical for ensuring LEA data accuracy and reliability when submitted to OSSE and it has significant impacts on LEA funding, public reporting like annual assessment results and graduation rates, as well as our annual STAR Framework and Report Card results. As such, each data point requires that the Heads of School certify the data, and it is incumbent on the LEA to ensure all school-level data submitted to the SEA is accurate.

OSSE currently fulfills the OIG recommendation to establish and revise a validation procedure allowing schools and LEAs to confirm health education minutes.

7. Revise instructions related to recording the average number of health education minutes per week to account for the various ways schools structure health classes.

Response: We agree with the recommendation.

We agree with the challenge OIG has noted regarding the need for schools to fully understand the health education question and respond accurately to that element of the SHP questionnaire. In an effort to fully support the submission of accurate health education minutes, we will review and revise the SHP health education instructions where appropriate to further emphasize the importance of submitting valid data and note considerations schools should make when calculating average weekly health education minutes. It is important to recognize that revised instructions will not likely cover all possible instances of school health education class structures, and there will likely continue to be questions that schools should address with their LEA for clarity and support. OSSE has always and will continue to engage with LEAs on the SHP and offer technical assistance and support for schools and LEAs that need clarifications when completing the SHP.

[1] OSSE Data Validation Deadline Policy: SY19-20
https://osse.dc.gov/sites/default/files/dc/sites/osse/service_content/attachments/2019-20%20School%20Year%20Data%20Validation%20Policy.pdf

APPENDIX E. OSSE RESPONSE TO THE DRAFT REPORT

8. Revise the SHP to include questions seeking the average number of health education minutes received by each middle school grade.

Response: We agree with the recommendation.

Although the existing method of data collection aligns with the statute, OSSE will revise the SHP questionnaire to capture health education instruction provided by schools for each specific grade rather than grade band in order to offer greater data transparency. This re-framing of the health education minutes question(s) will be added to the 2022 SHP questionnaire, and OSSE will publish the totality of SHP data following our existing process of publishing all school-level data in a raw data excel file on the OSSE website by fall 2022.

9. Transmit all school-level results annually to principals and health educators.

Response: We agree and are currently implementing the recommendation.

We have developed a complete, up-to-date, and interactive data visualization and discovery tool that allows all LEAs to easily view Health and Physical Education Assessment (HPEA) score snapshots and trends. Through this Qlik data tool, LEA leaders are able to monitor real-time completion of the HPEA; view and download assessment results for their LEA and each school within the LEA, filterable by school year (2015-16, 2016-17, 2017-18, and 2018-19), grade, and test category; and view and download student-level assessment results, filterable by school, grade, and test category. OSSE continues to instruct and expect all LEAs to transfer these data to their school leaders and health educators to indicate needs for further development or modifications to the school health education practice and approach and raise scores in specific health and physical education domains.

10. Establish a process to review HPEA results and trends periodically and adjust how schools teach health accordingly.

Response: We partially agree with the recommendation. OSSE currently evaluates HPEA results and trends in order to develop resources and targeted supports, but OSSE does not have the authority to enforce how schools teach health education or the curriculum selected by an LEA.

We will continue to review and publish state-level HPEA results and trends in resources such as the "Data to Action Guide: Addressing Youth Risk Behavior through Health Education," which is informed by notable trends in the HPEA and the DC Youth Risk Behavior Survey (YRBS). This resource identifies key curricula, resources, and training to support schools with delivering instruction on critical health education topics through a variety of settings to include synchronous and asynchronous classroom instruction, guidance lessons, and health promotion activities. OSSE will continue to offer such resources in addition to technical assistance, training, and targeted supports for schools

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APPENDIX E. OSSE RESPONSE TO THE DRAFT REPORT

and LEAs to understand how to meet the Health Education Standards and how to utilize actionable data in their health education decision-making.

As the SEA, OSSE will ensure these resources and supports are made available to LEAs, but it is outside our scope of authority to enforce how schools teach health accordingly or to enforce any specific standards-aligned health curriculum. These responsibilities reside with the LEA.

11. Convene a group of LEA and OSSE representatives to review assessment questions and make modifications as required.

Response: We partially agree with the recommendation.

OSSE relies on educator expertise to design statewide assessments at various parts of the development process. The HPEA is no different. OSSE will engage LEAs for feedback as appropriate in the review of any items on the HPEA.

12. Promulgate rules implementing the HSA.

Response: We respectfully disagree with the recommendation.

The Healthy Schools Act is already detailed and prescriptive. We do not believe regulations would meaningfully support improved performance by schools against the Healthy Schools Act health education requirements. OSSE is already actively supporting compliance and accountability with the Healthy Schools Act and alignment of instruction with the Health Education Standards, including through: assessments of student knowledge and behavior (HPEA and YRBS); data analysis and reporting; training, technical assistance, and resources; and greater public transparency. Further, OSSE cannot regulate outside our authority granted by statute, including imposing additional penalties on schools for non-compliance with health education requirements. The DC Council may grant OSSE additional enforcement authority via amendments to the Healthy Schools Act.

Sincerely,

Shana Young

Shana Young
Interim State Superintendent of Education
Government of the District of Columbia
Office of the State Superintendent of Education

Cc: Justin Tooley, Deputy Chief of Staff, Office of the State Superintendent of Education
Sarah Jane Forman, General Counsel, Office of the State Superintendent of Education
Dr. Heidi Schumacher, Assistant Superintendent, Division of Health and Wellness

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APPENDIX F. DCPS RESPONSE TO THE DRAFT REPORT

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS
Office of the Chancellor

VIA EMAIL

October 2, 2020

Daniel W. Lucas
Inspector General
717 14th St., N.W.
Washington, DC 20005

Dear Inspector General Lucas:

The District of Columbia Public Schools (DCPS) is in receipt of your September 18, 2020 draft evaluation report entitled *District of Columbia Public Schools and Office of the State Superintendent of Education: Evaluation of Compliance with the Healthy Schools Act Health Education Requirements, OIG Project No.20-I-04GA.* Thank you for conducting this evaluation and providing your opinion as well as allowing us the opportunity to respond and provide feedback. Our responses to the 11 recommendations jointly addressed to the OSSE and DCPS are set forth below.

DCPS is committed to ensuring that all students receive a well-rounded educational experience, and we believe that physical activity and health education are critical components to ensuring that our students feel loved, challenged, and prepared.

We are pleased that DC is on the forefront nationally as it relates to understanding the mind-body connection that supports our youth's ability to be ready to learn and to succeed academically and socioemotionally. It is for this reason that we work to meet the ambitious goals of the Healthy Schools Act (hereinafter HSA or the Act). At the same time, it is important to note that the Act[1] contemplates that schools may not always be able to meet the tenets of the Act, and sets forth a series of benchmark goals to which schools should aspire, with the requirement that schools which are not able to meet these benchmarks develop a plan to support continued progress. With this in mind, we are pleased to share that DCPS works diligently to meet the goals of the HSA as set forth, through the policies and procedures outlined below. Our responses to the 11 recommendations jointly addressed to the Office of the State Superintendent of Educations (OSSE) and DCPS are set forth below.

OIG RECOMMENDATIONS AND DCPS RESPONSES

To improve compliance with both the HSA minute and curricular requirements, we recommend that the Superintendent, OSSE and Chancellor, DCPS:

1. Require schools to attest prior to the school year, and after classes have been scheduled, that every student will receive the required number of health education minutes during each school year.

[1] See § 38-824-02, Physical and health education requirements.

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APPENDIX F. DCPS RESPONSE TO THE DRAFT REPORT

DCPS Response
DCPS partially agrees with this recommendation. We believe that we have implemented a process[2] that meets the requirements of this Act. Currently[3], DCPS' scheduling protocol requires each school's master schedule to be reviewed and authorized by the District's Master Scheduling team[4], the Office of Teaching and Learning (OTL) and the designated Instructional Superintendent (IS). DCPS tracks and maintains this data in a QuickBase application. As a part of this process, principals are required to provide a rationale and acquire authorization from their respective IS when the school's master schedule does not fully accommodate the requirements of the HSA.

2. Require schools to submit waivers of the HSA requirements if they are not able to meet the health education requirement and to develop an action plan before the next school year to ensure that they will not submit a waiver the following year.

DCPS Response
DCPS agrees with this recommendation and will continue to require schools to submit waiver requests in cases where budget and/or space do not allow the requirements to be met. Waiver requests are due from schools annually by June 1st. For schools unable to meet the HSA requirements in consecutive years, DCPS central office will review the school's barriers to identify mechanisms that will help to support progress toward meeting the goals of the HSA.

3. Implement an enforcement mechanism for schools that do not meet the health education requirement for two (2) consecutive years.

DCPS Response
DCPS partially agrees with this recommendation. As noted above, for schools unable to meet the HSA requirements in consecutive years, DCPS' policy is to work to review the school's barriers to identify mechanisms that will help to support progress toward meeting the goals of the HSA. DCPS continues to collaborate with OSSE to support compliance in accordance with the Act's requirements.

4. Modify the School Health Profile (SHP) to require schools to attest that they have addressed each of the topics listed in the DCMR in each health course.

DCPS Response
OSSE creates the SHP; DCPS is pleased to continue to collaborate with OSSE on any review and revision and to utilize the updated SHP should any changes be made.

5. Engage an outside entity to review the scope and sequence of DCPS' health courses for 6th, 7th, and 8th grades, specifically to determine whether HIV-prevention needs to be taught more frequently.

DCPS Response
DCPS disagrees with this recommendation. DCPS currently uses the 3Rs curriculum, a comprehensive, skills based sexual health curriculum developed by Advocates for Youth, which aligns to local and national health standards. This curriculum is evidence based and medically accurate. The lessons on HIV begin in 6th grade and

[2] See attached screen prints of our scheduling protocol tool which is tracked in a Quick Base application.
[3] This process was implemented in SY18-19 for high schools. This process was expanded to middle schools during SY18-19 and implemented in SY19-20.
[4] The Secondary Academic and Scheduling and Support (SASS) team supports all master scheduling efforts for DCPS.

APPENDIX F. DCPS RESPONSE TO THE DRAFT REPORT

are in each grade level through high school health[5]. DCPS evaluates the implementation of the HIV lessons with our School Based HIV Prevention Grant. In SY 2019-2020, DCPS began using a Centers for Disease Control (CDC) School Health Profile data collection tool to more accurately assess implementation. It is our belief that this curriculum meets the requirements of the HSA.

To correct the data errors and ensure that OSSE and DCPS are using accurate data to make informed decisions and monitor compliance with the HSA requirements, we recommend that the Superintendent, OSSE and Chancellor, DCPS:

6. Collaborate to revise the vetting procedure for verifying self-reported health education minutes.

DCPS Response
DCPS agrees with this recommendation and will collaborate with OSSE to strengthen the procedure for verifying self-reported health education minutes.

7. Revise instructions related to recording the average number of health education minutes per week to account for the various ways that schools structure health classes.

DCPS Response
OSSE creates the SHP; DCPS is pleased to continue to collaborate with OSSE on any review and revision and to utilize the updated SHP should any changes be made.

8. Revise the SHP to include questions seeking the average number of health education minutes received by each middle school grade.

DCPS Response
OSSE creates the SHP; DCPS is pleased to continue to collaborate with OSSE on any review and revision and to utilize the updated SHP should any changes be made.

To better ensure that OSSE and DCPS are using data collected to improve policies and procedures, we recommend that the Superintendent, OSSE and Chancellor, DCPS:

9. Transmit all school-level results annually to principals and health educators.

DCPS Response
DCPS agrees with this recommendation. Once notification of data results is received from the OSSE, DCPS will reinforce notification to schools to ensure that schools utilize the information in the most efficient way.

10. Establish a process to review HPEA results and trends periodically and adjust how schools teach health accordingly.

DCPS Response
DCPS agrees with this recommendation and will work with OSSE to establish a process to review Health and Physical Education Assessment (HPEA) results to inform professional development and implement curricular changes to support growth for teachers and students.

[5] High school health typically goes through 10th grade.

APPENDIX F. DCPS RESPONSE TO THE DRAFT REPORT

11. Convene a group of local education agency (LEA) and OSSE representatives to review assessment questions and make modifications as required.

DCPS Response

DCPS agrees with this recommendation and would be pleased to participate in a working group initiated for this purpose.

Thank you again for conducting this evaluation and for the opportunity to respond to the draft report. DCPS takes compliance with all District legal requirements seriously and looks forward to working collaboratively with OSSE to support compliance with the HSA.

Sincerely,

Lewis D. Ferebee
Chancellor
District of Columbia Public Schools