



To: Council of the District of Columbia

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Re: Best Practices in Education to Inform an Equitable COVID-19 Recovery

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Introduction

Although important improvements have been made in public education in the District of Columbia during the past decade, the pandemic disrupted instruction and introduced new challenges for many students. Students of color and their families—many of whom were already being inadequately served before the pandemic¹—were disproportionately affected by job losses, COVID-19 infections, and obstacles to participation in virtual learning. This memo focuses on academic, social and emotional, and physical health strategies that have the potential to address these disparities.

In the beginning of the 2019–20 school year, the District of Columbia served 95,236² public school students in 240 schools across 68 local education agencies. Enrollment numbers were slightly lower in the beginning of the 2020–21 school year (94,546). [Students of color represented 88 percent](#) of enrollment in 2019–20.³ Attendance and achievement [data for the 2019–20 school year](#) were understandably limited,⁴ given the quick pivot that local education agencies (LEAs) had to make to continue learning online. DC received permission from the federal government to cancel standardized English-language arts, math, and science assessments during the 2019–20 and 2020–21 school years. The federal government [encouraged DC](#) to “use other assessments to measure student learning and progress and to provide information to parents and educators.”⁵ To date, data from other assessments have not been publicly available, making it difficult to understand what happened to key outcomes that year and to provide an updated profile for this memo. For that reason, much of the background that follows is focused on the 2018–19 school year or on specific LEAs that reported data in 2020–21.

Chronic absenteeism, which is the absence from school for 10 percent or more school days, can put individual students and entire classrooms at risk of falling behind academically. During the 2017–18 and 2018–19 school years, [chronic absenteeism held steady](#)⁶ at about 30 percent, with about 35 percent of

Black/African American students, 24 percent of Latinx¹ students, and 9 percent of Asian students chronically absent. In fall 2019, chronic absenteeism was about 20 percent, which was about two to three percentage points [lower than in September 2017 or 2018](#).⁷ Attendance data for the 2019–20 school year were [not collected systematically](#) after March 13, 2020.⁸ Attendance data for [school year 2020–21](#)⁹ are not currently publicly available but are expected to be part of the [2020–21 DC School Report Card](#) when it is published.¹⁰

The COVID-19 pandemic hit right before spring 2020 assessments of learning. In the 2018–19 school year, about 37 percent of students were meeting or exceeding expectations on English-language arts assessments, and 31 percent were meeting or exceeding expectations on math assessments. In both domains, these rates were improving over time but Black/African American, Latinx, and American Indian/Alaska Native¹¹ students were half as likely as white students to meet or exceed expectations. Metrics of *academic growth* between 2017–18 and 2018–19 show similar patterns of uneven growth for different racial groups. DC received permission from the US Department of Education to cancel assessments for 2020–21, but [one analysis](#) of student achievement for a subset of LEAs serving about 30,000 DC students suggests that academic growth rates were lower than normal for all groups and all subject areas except middle school math.¹² At-risk, Black, and Latinx students were disproportionately affected, experiencing larger achievement declines than their peers.

In addition, experts agree that the pandemic created the conditions for children to struggle with **mental health** because of social isolation, anxiety and stress, and economic need. Before the pandemic, [almost half of students had been exposed to an adverse childhood experience](#),¹³ and [survey data show](#) that 10 percent of DC children ages 12 to 17 reported experiencing at least one major depressive episode in the past year and 5 percent reported a substance use disorder. Of those reporting a major depressive episode, 49 percent did not receive treatment.¹⁴ During the past two years, children of color have been disproportionately affected by COVID-19’s health and economic effects, leading higher proportions of students of color to experience the loss of a caregiver, food insecurity, and housing insecurity. These stressors have the potential to worsen mental and physical health outcomes for these students.

Key Questions and Best Practices

Given the challenges that DC public school students faced before the pandemic, and conditions that were exacerbated by the pandemic, decisionmakers need to ensure that evidence-based policies are pursued during recovery. Although academic achievement is a primary goal of the DC education system, the health and well-being of students and staff are paramount for recovery. This memorandum offers strategies for addressing the academic, social and emotional, and physical needs of students so that they not only continue the trajectory that they were on before the pandemic but improve at a faster pace. To do that, we must double down on ensuring that all students have what they need to succeed. Table 1 presents an overview of the questions and best practices that we will cover in this memorandum.

TABLE 1
Summary of Key Questions and Best Practices

How can DC address the academic needs of students?
High-dosage tutoring
Out-of-school programs
Targeted intervention for English-language learners and students with disabilities
How can DC address the social and emotional needs of students?
Expand access to clinical services in schools as part of comprehensive school mental health systems

¹ This memo uses the term Latinx to describe people of Latin American origin or descent. The authors use this term because it helps us provide a more consistent and gender-neutral identifier that respects the diversity of this population.

Use Medicaid to support expanding mental health services
Train school staff on mental and physical health issues

How can DC address the physical needs of students?

Universal masking
Virus testing in school
Vaccinations and vaccine mandates
Nurses in schools

How Can DC Close Equity Gaps while Addressing the Academic Needs of Students?

High-Dosage Tutoring

High-impact or high-dosage tutoring is a school-based intervention that can lead to significant improvements in reading and math. The overall effects for reading and math interventions are similar; however, reading tutoring tends to have greater effects in earlier grades, whereas the effects of math tutoring tend to show up in later grades.

High-dosage tutoring is defined as more than three days per week or at least 50 hours over a period of 36 weeks. Timing and location of tutoring and tutor–student ratios are two particularly important elements influencing the success of a tutoring program. An [evaluation and meta-analysis](#) of tutoring programs taking place during school hours—such as Number Rockets, Saga Education, Time to Read, and the Minnesota reading and math programs—show that the impact of tutoring varies not only by the frequency of its implementation but also by the time it is administered.¹⁵ Tutoring programs conducted during school have greater impacts than those conducted after school. This evaluation of tutoring programs also shows that tutor-to-student ratios influence the quality and effectiveness of a tutoring program. One-on-one and small-group tutoring interventions allow for more engagement and immediate feedback. To ensure positive learning outcomes, it is recommended that a ratio of at most [four students to one tutor is maintained](#).¹⁶

High-dosage tutoring has become increasingly relevant in improving the efficiency and equity of student learning outcomes. [Insights from other states](#)¹⁷ implementing statewide tutoring initiatives to address interrupted learning can inform DC’s high-dosage tutoring approach. Although states have enacted broad legislation to support academic acceleration, school districts have the flexibility to implement recovery strategies. For example, Colorado established tutoring programs that must occur at least three days a week and during the regular school day. California also recently budgeted \$10 million for volunteer programs like the Foster Grandparent and Senior Volunteering Program that pairs older volunteers with children of all ages for intergenerational mentoring, tutoring, and connections.¹⁸

The Office of the State Superintendent of Education (OSSE) has prioritized high-dosage tutoring as a strategy to mitigate the effects of COVID on learning while providing implementation guidance to LEAs. [Elementary and Secondary School Emergency Relief](#) (ESSER) Fund spending standards require LEAs to reserve at least 20 percent of their funds for evidence-based programs.¹⁹

An [analysis of 70 continuous education plans](#) submitted by DC LEAs shows 25 of 43 LEAs (58 percent) plan to offer high-impact tutoring as part of the regular day.²⁰ This plan is an important first step in ensuring accelerated learning for all students, especially those most affected by the pandemic. As noted, [evidence on tutoring effects](#) suggests that in-school tutoring programs are twice as effective as those conducted outside school.²¹ At-school tutoring improves attendance and equalizes participation of students who would most benefit from tutoring. To optimize the investments on high-dosage tutoring, it is important that DC takes further action to attain a higher percentage of LEAs offering high-impact tutoring during the regular day. It is also crucial that DC obtains student demographic data and program participation rates from LEAs that are planning to offer high-dosage tutoring. Current assessments of continuous plans offer broad trends on LEAs’ objectives for high-dosage tutoring making it difficult to

gauge program participation. Therefore, as high-dosage tutoring continues to gain traction, it is necessary to track high-dosage tutoring participation data of students from disadvantaged backgrounds.

Out-of-School-Time Programs

School leaders and policymakers have the distinct opportunity to further students' learning through out-of-school-time (OST) programs. The structure and goals of out-of-school programs play a large role on the outcomes of the students participating. A [report on the value of OST programs](#) shows that incorporating intentional academic instruction and enrichment activities in OST programs leads to measurable student achievement.²² The same is true if OST programs are geared toward attaining behavioral and socioemotional outcomes or physical activity/health. An [evaluation of multiple OST programs](#)—such as Building Educated Leaders for Life, After Zone, and Chicago's After School Matters—demonstrate improved outcomes in a variety of domains, including mathematics achievement, reading/English-language arts achievement/science achievement, physical activity/health, attendance and enrollment, promotion of graduation, and social and emotional competencies.²³ OST programs can also serve to improve supervision and safety of youth through adult supervision and personal connections. To have significant and measurable benefits, youth must attend the program regularly.

DC's FY 2022 budget proposed a [\\$21.8 million investment](#) in OST programs compared with \$13.6 million in the prior year.²⁴ Currently, [54 percent of LEAs are pursuing after-school programming](#) as part of the accelerated learning strategy, and 28 LEAs have acquired additional vendor/community partner supports from 51 unique vendor or community partners.²⁵ With increased investments in OST programs, targeting and continuously tracking student participation in these programs are important. Effective collaborative partnerships between schools and OST programs rely heavily on [secure data sharing](#) about students and programming.²⁶ Therefore, providing the right data supports is crucial.

[Many states](#) are using OST programs to address interrupted learning, which may offer examples of ways that DC can enhance its own efforts.²⁷ The state of North Carolina requires school districts to offer a six-week school extension learning recovery and enrichment program. LEAs then identify at-risk students for participation in this program. Similarly, Louisiana targets high-priority students by requiring schools to provide expanded academic support to students who did not achieve mastery in the statewide assessment administered during the 2020–21 school year. In contrast, extended learning opportunities in Colorado include social and emotional and mental health supports. Although OST programs provide the opportunity to address interrupted instruction, they can also be redefined and customized to address behavioral and socioemotional needs.

Targeted intervention for English-Language Learners and Students with Disabilities

COVID-19 continues to exacerbate the persistent opportunity gaps and low achievement rates experienced by English-language learners (ELLs) and students with disabilities. A [policy brief](#) by the Migration Policy Institute highlights the significant barriers experienced by ELLs during the pandemic.²⁸ These barriers were related to technology, language, child care, and economic and food security. ELLs faced dual learning challenges with interruptions in [regular curriculum and a range of supports](#) and services embedded in in-person learning, such as English-language-development lessons, instructional support from a qualified teacher, or modified curricular activities.²⁹ Another [reported](#) challenge hindering ELLs' full participation in distance learning was additional caregiving responsibilities.³⁰

[Preliminary data](#) on the state of DC's ELL student learning over the 2019–20 academic year show a limited picture of ELLs' overall proficiency with only 59 percent of access testing (an English-language proficiency test) completed in spring 2020.³¹ This result can be expected as the pandemic inhibited many opportunities to track the progress of students. However, [enrollment data](#) point to a decrease in ELLs and immigrant students after the pandemic, from 12.5 percent to 11.9 percent of all students enrolled in DC schools in the 2020–21 school year.³² With the continued threat of COVID-19, it is crucial that DC builds extensive tracking mechanisms that can link ELLs at risk of leaving DC schools to individualized supports, culturally competent family engagement, trauma-informed interventions, and [other appropriate](#)

supports.³³ In addition to tracking mechanisms and targeted supports, it is necessary that the district aligns instruction designed specifically for ELLs with socioemotional supports.

Like ELLs, students with disabilities experienced widespread and significant interruptions in curriculum and specialized supports and services. Students with disabilities have a diversity of needs incorporated in their individualized education plans (IEPs). Therefore, the services provided along with the number of hours of specialized instruction differ per student, making it [difficult for school districts](#) to deliver the wide range of student supports needed.³⁴ As they shortened their school days during distance learning, school districts [reported challenges](#) in providing specialized education on top of regular instruction.³⁵ [Early evidence](#) on the state of interrupted learning shows that students with disabilities experienced higher rates of absenteeism, incomplete assignments, and course failures compared with their typical peers, and the effect is more significant in mathematics than reading.³⁶

A [landscape analysis](#)³⁷ by OSSE notes that one in five DC students has been identified as having a disability. This analysis sheds light on the significant academic gaps for students with disabilities, noting that only 2 in 20 students with disabilities performed at grade level in 2018–19 on the statewide English-language arts assessment. For students with a specific learning disability and students with disabilities who are at-risk, this number drops to [1 in 20 students performing at grade level in 2019](#) according to OSSE analysis. This gap will only widen because of closures and lost instruction time. Out of 15,297 students with disabilities enrolled in April 2021, the majority (11,743) were enrolled remotely or online only; 3,288 were enrolled in a hybrid model; and only 213 were enrolled in full-time in-person instruction. In-person instruction is crucial for providing the services needed by students with disabilities. Therefore, it is crucial for schools to prioritize in-person instruction for students with disabilities. To continually support students with disabilities, LEAs should consider increasing progress monitoring and evaluation processes.

How Can DC Address the Social and Emotional Needs of Students?

Schools are a [critical venue](#) for mental health services for children and youth because schools can reach large numbers of children, support ongoing treatment, and reduce the stigma associated with mental health care.³⁸ Comprehensive school mental health systems offer services and supports for preventing and treating mental health and behavioral health issues. One example is tiered supports, which start with a foundation of universal programming to increase awareness of mental health and to promote social and emotional learning. The next tier focuses more on students who could benefit from additional short-term support or light-touch support. The top tier is for students who need more support over a longer period. [Within each of these tiers](#) are more specific tools and strategies with their own evidence bases.³⁹

Expanding Access to Clinical Services in Schools

The National Academies of Sciences, Engineering, and Medicine convened a group of experts in May 2021 to discuss school-based strategies for addressing youth mental health and well-being after the COVID-19 pandemic. The group’s recommendations included enhanced [mental health screenings, supports, and resources](#) for students and their teachers.⁴⁰ The recommendations did not specify the number of clinical staff members needed in schools; however, they emphasized the importance of offering various tiers of support based on need. For example, experts recommend offering “supports to youth at higher risk for significant stress or trauma since the onset of the COVID-19 pandemic” and establishing “school-based health centers or community partnerships with health and mental health providers.”

The National Association of School Psychologists recommends [no more than 500 students per school psychologist](#).⁴¹ Although [pediatric psychologists](#) have the most academic training for supporting students’ mental health, there are not enough of them in many places in the country, and many do not accept insurance.⁴² However, [collaboration between psychologists and other clinicians](#) (social workers, school counselors, school nurses) can expand services and support for students.⁴³ The American School Counselor Association recommends a ratio of 250 students to each school counselor, and the National Association of Social Workers also recommends 250 students per social worker.⁴⁴

DC is already at the forefront of school-based mental health provision and has been working closely with DC government health agencies and the George Washington University School of Public Health and Health Services [for over a decade](#).⁴⁵ It has a [coordinating council](#)⁴⁶ that meets monthly to address students' mental and behavioral health needs across LEAs. DC's comprehensive school mental health system intends to place a full-time clinician in every school who can provide all three tiers of services. The DC Department of Behavioral Health [helps schools identify and work with community-based organization partners](#).⁴⁷ As of 2019, 76 out of 119 targeted schools had [clinicians from community-based organizations](#), and plans were in place to expand the program to all 244 public schools by the 2023–24 school year.⁴⁸ At that time, the DC Council's Committee on Education estimated that the fully scaled-up program would cost \$40 million a year. [In 2020](#), there were 400 DC public school students per psychologist and 217 students per social worker.⁴⁹

Use Medicaid to Support Expanding Mental Health Services

A variety of resources are available to support [mental health services in schools](#),⁵⁰ but one stands out as an opportunity for DC. States like Missouri and Utah have supported mental health service expansions in schools through Medicaid, as part of a broader effort to provide medical care for Medicaid-eligible students. In 2014, the Centers for Medicare and Medicaid Services allowed school-based Medicaid programs to cover all Medicaid-eligible students, not just those with special education plans documented by IEPs. By early 2019, 10 states had school-based Medicaid programs, and by 2021, a dozen more states were pursuing [school-based Medicaid programs](#).⁵¹ Although this change can take some time to process at the state and federal levels, it can establish an important funding mechanism for mental and physical health care in schools. DC currently provides school-based Medicaid services for students with IEPs but does not offer services for all Medicaid-eligible students.

Training for Staff on Mental Health

One of the foundational aspects of comprehensive school mental health systems is training for staff on mental health. In fact, “well-trained educators and specialized instructional support personnel” are one of the [core features](#) of a comprehensive school mental health system.⁵² Teachers who understand mental health literacy and help-seeking can reduce the stigma associated with mental illness and normalize treatment.

[DC law requires](#) all public school teachers and principals to complete a behavioral health training program every two years.⁵³ The Office of the State Superintendent of Education also provides [resources for schools](#), including wellness supports for educators, workshops on suicide prevention, and tools for engaging family members.⁵⁴ Since the pandemic has created novel conditions, this is an opportunity for DC to enhance its previous training opportunities.

The Education Commission of the States found that both [teachers and leaders want professional learning opportunities](#) related to social and emotional learning⁵⁵ and that many [states offer mentoring](#) for teachers to support their social and emotional health needs.⁵⁶ Washington state has passed legislation to [support teachers with the secondary trauma](#) they experience through their students. In Illinois, [coaching and mentoring programs](#) for teachers and school leaders help teachers integrate social and emotional learning in the classroom.⁵⁷ Similarly, a new state law in North Carolina establishes a requirement that school staff receive training on mental health. To support the social and emotional mental health needs of students, [Pennsylvania](#) requires that 30 percent of the American Rescue Plan (ARP) ESSER funds distributed to school districts be reserved for mental health services.⁵⁸ Pennsylvania has also allocated 10 percent of grant funds for professional development for educators, school support staff, school leaders, and health professionals related to supporting students' mental and social and emotional needs.

How Can DC Address the Physical Needs of Students?

The Centers for Disease Control and Prevention (CDC) [offered guidance](#) for states, districts, and schools to encourage a safe return to in-person learning in the fall of 2021.⁵⁹ The CDC has developed several resources intended to guide LEAs and school districts in their physical reopening plans. For LEAs to receive

government funding through the ARP ESSER grant, they must make health and safety plans publicly available. The CDC developed comprehensive guidance for [K–12 school operational strategies](#) for the 2020–21 school year, including virus transmission prevention strategies, data on community risk, and ways to use phased prevention strategies depending on community transmission.⁶⁰ This section will focus on the benefits and best practices in masking, vaccination, and testing. [Among 100 large and urban school systems](#), including the 30 largest in the country, 80 percent required masks for at least some.⁶¹ Only 10 percent required vaccinations for school staff, and just 18 percent required testing.

But these are not the only ways that DC can support the physical health of students. CDC guidance suggests improving ventilation in schools, and DC has invested \$24 million in upgrades to heating, ventilation, and air-conditioning systems to improve filtration and ventilation in DC public school buildings. [October 2021 data](#) suggest that these investments have been effective, with air quality scores and Wells-Riley estimates being within the acceptable range; and filter changes recorded within the past month.⁶² Air quality data are not publicly available for DC public charter schools.

Universal Masking

School districts without a universal masking policy were more likely to have COVID-19 outbreaks along with the surrounding communities, and those with a masking policy have generally been able to remain open for full in-person learning, as seen in [three detailed reports](#) released by the CDC in the fall of 2021.⁶³ Consistent with CDC guidance, all DC public schools have mask mandates for all students, staff members, and visitors who are inside school buildings, regardless of vaccination status.

Virus Testing in schools

The CDC recommends that schools conduct regular testing to prevent transmission, since asymptomatic people can spread the virus and early detection can keep schools open for in-person learning.

All 32 school districts in New York City have had a low positivity rate, suggesting that the reopening of schools in their pre-pandemic form has not prompted any significant outbreaks. New York City uses a plan of [randomly testing 10 percent](#) of unvaccinated children in schools each week. However, about 300 of the city's 1,600 schools are falling below the target of testing 10 percent of unvaccinated students. The city uses an opt-out strategy because of concerns that schools are not doing enough to explain the benefits and values to parents, and certain communities are opting in less because of general distrust in testing. New York City is using tests that take up to three days to return results, and such a delay could reduce the ability of testing to limit transmission, suggesting that tests with quicker turnarounds are necessary to better reduce transmission.

All students in DC public schools and charter schools are eligible for symptomatic and random asymptomatic testing as a part of [DC's school-based COVID-19 testing program](#).⁶⁴ Parents or students age 18 and older can revoke consent through an opt-out form. The city has set a goal of 10 percent testing, but the closest it has come to its asymptomatic testing goal was in late September, when it tested 8.8 percent. DC Public Schools [reports](#) that results of at-school COVID-19 tests are available for families to access in 6–12 hours from when the test is administered.⁶⁵ The pooled testing strategy employed by DC Public Schools is consistent with CDC guidance. In addition, when the Omicron variant was surging in January 2022, DCPS mounted a broad scale test-to-return effort that resulted in high participation rates and facilitated a safe reopening for thousands of students.⁶⁶

Vaccinations and Vaccine Mandates

Vaccination is the most effective protection against COVID-19, and the CDC recommends strategies that provide information about and access to vaccinations.

New York Public Schools had implemented a COVID-19 vaccine mandate for teachers and other staff. For those who do not receive the vaccine, former mayor Bill de Blasio warned that unvaccinated school employees would be placed on unpaid leave and would not be allowed to work, with the city planning to

bring in substitutes where necessary. [Vaccination rates rose](#) in every school job category after the mandate was announced.⁶⁷

Los Angeles Unified School District (LAUSD) implemented a COVID-19 vaccine mandate for teachers and other staff members. The vaccine mandate featured an ultimatum: “get vaccinated or lose your job.” The strategy worked as intended, with 99.4 percent of staff being vaccinated. A small fraction opted against vaccination.

Schools in [14 states are now requiring students to get the COVID-19 vaccine](#) if eligible.⁶⁸ Several states have made vaccine mandates specific to student athletes; however, some states and school districts are considering more sweeping mandates. In California, students are [required to be vaccinated](#) for in-person learning following the Food and Drug Administration’s full approval of the vaccine for their grade spans (7–12 and K–6).⁶⁹ Sacramento Unified School District has the earliest vaccine mandate date of November 30, 2021, for all students who are eligible.⁷⁰ LAUSD is also supporting an [incentive program](#) to encourage students to get vaccinated.⁷¹ Incentives include raffles for gift cards, tickets, and food trucks on campus.

Understanding vaccine hesitancy from a racial equity perspective is critical, and the reasons that communities of color have had to distrust the medical establishment need to be considered. Fortunately, [vaccine hesitancy among Black residents in DC decreased](#) during a short time in 2021, but some residents remain reluctant.⁷² Mayor Bowser announced a vaccine mandate by November 1, 2021, for any adult who is regularly in a DC school or child care facility, with no possibility to opt out of weekly COVID-19 testing as an alternative to the mandate.⁷³ As of November 1, more than 20 percent of staff members at DC public schools remain unvaccinated after the deadline. Those who are not in compliance will receive a warning letter initially, and none will be dismissed from their position for failing to be vaccinated. [Student athletes in DC](#) who are age 12 and older are now required to be vaccinated by November 1, 2021, to participate in sports.⁷⁴

Nurses in Schools

Although school nurses have always played an important role in supporting students with acute and chronic health issues during the school day, the roles and responsibilities of school nurses and other health care personnel have significantly changed as a result of the pandemic. According to the [CDC](#), school nurses and health care personnel routinely evaluate students for symptoms or exposures.⁷⁵ They assist administrators and teachers in implementing prevention strategies; tracing contacts; maintaining school-based clinics; implementing school-based testing strategies; and supporting students, families, and staff. School nurses and health care personnel are critical to maintaining a safe environment during in-person learning and the reopening of schools. The American Academy of Pediatrics and the National Association of School Nurses [recommend at least one registered nurse](#) in each school, and the National Association of School Nurses recommends a ratio of one nurse per 750 general-population students or per 225 students requiring daily professional nursing.⁷⁶

As recently as September 2021, the Children’s School Services Program, a collaboration between Children’s National Hospital and the DC Department of Health, supported 168 nurses in 117 DC public schools and 68 public charter schools. Some schools do not have a full-time registered nurse, and it is unclear whether school nurses have been engaged in COVID response efforts consistently across schools, suggesting that [opportunities exist to strengthen the presence and role of nurses in DC schools](#).⁷⁷

Most states have a school nurse consultant at the state level supporting statewide school health policy, [but DC is not among them](#).⁷⁸ Such a position can provide state-level guidance for school nurses and address policy issues that affect nurses and students across the state, including how to balance their COVID-19-related and non-COVID-19-related responsibilities. Although some school districts support nurses through local education funding, the cost of nurses can also be supported by [school-based Medicaid programs](#).⁷⁹ For example, school nurses in Massachusetts can bill Medicaid for all Medicaid-eligible services because the state’s [Medicaid State Plan Amendment covers school-based health services](#).⁸⁰

Conclusion

Through ARP ESSER investments, the District of Columbia can address learning disparities exacerbated by the pandemic. DC's efforts will need to continue to focus on the academic, social and emotional, and physical health of students. As school leaders leverage funds to support students, they will have to make important and intentional decisions on how to equitably deliver and target these resources. An equitable approach requires interventions for not only those recently affected by the pandemic but also those historically underserved.

The pandemic has deepened educational inequalities among vulnerable students. Equitable intervention involves providing targeted, holistic, and continuous support in every area of need. As school leaders and administrators adapt educational strategies—such as intensive tutoring, out-of-school programs, and social and emotional supports to meet students' needs—it is important to develop a vision where these strategies become permanent components in the way education is conducted.

Resources

This list of resources includes information about strategies not discussed in this memo.

Child Care/Early Education

- “Childcare after COVID-19: Balancing Precautions while Building Interactions” (Toronto: Hanen Centre, 2020), <https://www.hanen.org/MyHanen/Resource-Centre/Articles/Clinical-Tips/Childcare-After-COVID-19--Balancing-Precautions-Wh.aspx>.
- “Perspective: What’s Next for Child Care? What States Are Learning in the COVID-19 Crisis” (Cary, NC: Hunt Institute, 2021), <https://www.ednc.org/perspective-whats-next-for-child-care-what-states-are-learning-in-the-covid-19-crisis/>.

Learning Loss/Tutoring

- EdResearch for Recovery, Annenberg Institute at Brown University, <https://annenberg.brown.edu/recovery>.
- “Expanding Learning Time: A Strategy to Solve Unfinished Learning” (Washington, DC: Education Trust, 2021), <https://edtrust.org/resource/expanded-learning-time/>.
- *Learning in the Time of COVID-19* (blog), Learning Policy Institute, <https://learningpolicyinstitute.org/blog/covid-19-series>.
- “Reopening Programs,” Afterschool Alliance, <http://www.afterschoolalliance.org/covid/reopening-programs.cfm>.

English-Language Learner Support

- “How Administrators Can Support ELLs through COVID-19,” ¡Colorín Colorado!, <https://www.colorincolorado.org/covid/ells/administrators>.
- “Language Development Resources for EL Students by Language Strand and Content,” San Diego County Office of Education, https://docs.google.com/spreadsheets/d/1nwp9X6QX5W_itG767Nf6ymuJswAeKCUnoxdEhqkEVok/edit#gid=0.

- “Social-Emotional Support for ELLs during COVID-19,” ¡Colorín Colorado!, <https://www.colorincolorado.org/school-support/covid-19-ells/social-emotional-support-ells-during-covid-19>.

Social and Emotional Learning

- “COVID-19 Resources,” Bank Street College of Education, <https://www.bankstreet.edu/our-work-with-schools-and-communities/emotionally-responsive-practice/covid-19-resources/>.
- “Supporting the Whole Child,” IES: Regional Educational Laboratory Program, <https://ies.ed.gov/ncee/edlabs/regions/west/Priority/SupportingWholeChild>.

Mental Health

- “Considerations for Academic Assessments and Interventions upon the Return to School,” National Association of School Psychologists, 2020, <https://www.nasponline.org/return-to-school-academic>.
- National Center for School Mental Health, University of Maryland, <http://www.schoolmentalhealth.org/>.
- “Remote Learning Resources for SEL, Mental Health and Behavior,” Colorado Department of Education, 2020, <https://www.cde.state.co.us/cdesped/selremotelearningresources>.
- “Responding to COVID-19 School Mental Health,” Mental Health Technology Transfer Center Network, <https://mhttcnetwork.org/centers/global-mhbbc/responding-covid-19-school-mental-health-resources>.
- “Screening and Assessment,” National Child Traumatic Stress Network, <https://www.nctsn.org/treatments-and-practices/screening-and-assessment>.
- “Supporting Parents and Caregivers with Trauma Histories during COVID-19,” Child Trends, 2021, <https://www.childtrends.org/publications/supporting-parents-caregivers-trauma-histories-during-covid-19>.

Students with Disabilities

- *How to Spend CARES Act Funding to Support Students with Disabilities* (blog), EAB, <https://eab.com/insights/blogs/district-leadership/cares-act-funding-support-disabilities/>.
- *Promising Practices to Accelerate Learning for Students with Disabilities during COVID-19 and Beyond* (Washington, DC: National Center for Learning Disabilities, 2021), <https://www.nclld.org/reports-studies/promising-practices-to-accelerate-learning-for-students-with-disabilities-during-covid-19-and-beyond/>.
- *Supporting Students in Special Education through COVID-19*, Reading Rockets–NEA Guide, <https://www.readingrockets.org/reading-rockets-nea-guide/supporting-students-special-education-through-covid-19>.

Community Partner/Family and Stakeholder Engagement

- “Evidence-Based Strategies for Supporting and Enhancing Family Engagement,” Expanded Learning and Afterschool Project, 2013, <https://www.expandinglearning.org/expandingminds/article/evidence-based-strategies-supporting-and-enhancing-family-engagement>.
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