Questions from PTA Call 8-19-2020

What happened to the JVA?

Can you tell us where we can find the membership of the new stakeholder group just created?
Rep Hudak, I believe the membership was here: http://www.cde.state.co.us/safeschools/covid-stakeholder-group

Why is nobody from PTA on this committee?
Colorado PTA is represented on this Advisory Committee

Are there any plans to seek to get Colorado aligned with the federal law allowing 529 plan funds to be used for K-12 expenses? With the remote learning aspects currently in effect and likely to be in effect going forward if/when there is a resurgence, this would be very helpful.

The past 2-3 Legislative Sessions bills have been introduced on the matter - both for & against - but neither have passed.

CollegeInvest is neutral on the topic and will honor Colorado State Law on the matter, which currently does not allow for 529 use for K-12.

Why specifically is the 6ft rule more important for secondary levels
Evidence continues to demonstrate that young children are less likely to spread the virus either to each other or to adults, and that the majority of transmission in settings where children congregate is adult-adult or adult-to-child. Our focus in the youngest age groups is minimizing the risk of an adult spreading virus to others in the classroom.

Is there a way to have schools get priority for testing results/contact tracing? It seems testing results is on the order of 4 days normally, but can be shorter - like 24 hrs for some entities - and it seems that the President has a test that provides results in 15 min.

We use CDC guidance to identify priorities for testing in COVID-19, and we adapt these to use in Colorado in the context of local testing availability and need. For PCR testing, which is the most accurate diagnostic test for COVID-19, around four days turnaround is typical, but hospitals and other institutions which run their own tests are sometimes able to get lab results faster, especially for critically ill and other high-priority patients. It is true that there are some rapid tests which use different technology that can return results in as few as 15 minutes, but these tests are generally less accurate and may miss some infections in people who are
nevertheless contagious. Information on testing from the CDC can be found here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html

**For ages 10 and younger are you saying that schools don’t have to require students to wear masks or keep them on during school hours?**

It is not mandated by the executive masking order for persons under 10 to wear a mask while indoors. However, schools can certainly make their own more protective masking policies. For context, childcare facilities have reported good, safe mask usage in children as young as 3.

**How many kids rec in a cohort?**


Cohort size should be determined by room capacity and logistical considerations specific to school, grade level, and setup. Creative scheduling practices (block schedule, alternate-day-in-person) can also support smaller cohort sizes even in facilities with restricted space and staffing.

**Can you speak to the CDE recommendations on how Cohorts move together throughout a school building? Is it ok for Cohorts to be in Specials classrooms immediately following another Cohort?**

The toolkit does not specify how long a room or space must be unoccupied between cohorts; a period of non-occupancy between cohorts is ideal, but the specific time required depends on many factors. Evidence shows that the best strategies to prevent the spread of COVID-19 included layering, cohorting, face coverings, hand hygiene, physical distancing, screening and keeping ill individuals out of schools and other public settings.

**Are schools updating bus schedules once they see how quickly buses fill up? Or will kids just need to wait at bus stops extended periods of time if the bus fills up and they have to drop off at school and then circle back on the same bus route to pick up more children?**

Bus transportation routes are a local school district decision. The CDE toolkit includes information to assist schools and districts as they make decisions for bus routes which may be found [here](https://www.nytimes.com/interactive/2020/07/31/us/coronavirus-school-reopening-risk.html). If physical distancing is not feasible on a bus, all students must wear cloth face coverings over the nose and mouth, unless the student has a health reason for not wearing a mask or if a child is unable to wear a mask safely without supervision.
I have been hearing that there is more evidence of children spreading the virus. Jeffco numbers of cases in 19 and younger is rising. Why would we not use 6 feet for elementary to be safe?

As we learn more about the transmission characteristics of all different groups in different contexts, we are updating our guidance. We look especially closely at large outbreaks, like the Georgia camp outbreak. In that case, mask wearing was not practiced, children slept in large cabins with minimal ventilation, and a number of other high risk factors were present.

Smaller is better for cohorts but is there guidance for the schools? From what I hear from my son’s school, his class may remain at the nearly 30 kids as last year

In regard to your follow-up about cohort size, a 30 person cohort that does not mix further within the school community is much better than a smaller class size that mixes indiscriminately with the rest of the school.

What type of guidance is the CDE providing for remote learning? Specifically combining grade levels with one teacher and remote class size?

CDE has guidance and considerations for remote learning. Here's the link to that part of the toolkit that might be helpful. http://www.cde.state.co.us/planning20-21/schoolscenarios

How are a students privacy rights being upheld at schools regarding the screening and questioning for COVID symptoms in front of other students and to staff, having to provide health information the student may not have chosen to disclose before, when required to wear a mask and asking for a waiver, use of identifying means to know if a student has a waiver for mask wearing (ie. A separate colored ID card or some other item they are being required to wear on the outside of their clothes.

Schools certainly should endeavor to preserve the privacy of their students, especially with regard to health information that students may not wish to disclose. This privacy concern is one of the reasons why we recommend students be asked for COVID-19 symptoms at home prior to entering the school environment. If further screening is required at school, it should be done away from other students both to protect the privacy of the student being screened and other students from exposure to a potentially symptomatic individual.

With regard to asking for accommodation for students or staff who are not able to wear a mask safely, schools should ensure that they are asking the minimum necessary information necessary to understand the needs of the student. The accommodations may take the form of a requirement to wear a clear face shield instead of a mask, or to not wear a mask in certain circumstances. See here for more information from the CDC: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html#face-shields

If a student has a known medical condition and it is clear that the condition makes mask wearing unsafe, it is likely that no further documentation would be necessary from the student as they work out an accommodation plan with the school. However, if the student is requesting
accommodation around mask wearing for a previously undisclosed condition, a school should balance the need for privacy of the student with the safety of the whole school environment in ensuring that the request is reasonable.

Unfortunately, there is likely no way for a student with a "mask waiver" to disguise the fact that they are not required to wear a mask when their peers are required to wear a mask. Similarly to students who require assistive devices for ambulation or additional educational support, schools should instead work to establish an environment of tolerance, sensitivity, and understanding.

**Wouldn’t distancing be more effective than cohorts since there is no saying what contact students and staff have outside of school?**

All of the measures in the guidance are considered separate layers of protection, and no single intervention is 100% effective, even when executed perfectly. Cohorts both decrease the number of contacts each individual has and allow for more rapid and limited public health response when a case is detected in the cohort; these benefits persist no matter what students or staff do off campus. However, schools may wish to create messaging around the relationship between off-campus activities and the continuation of in-person education. If students and staff act irresponsibly, more cases will arise in the school community.

*the previous slide mentioned testing potential cases .does svvsd have access to rapid testing*

*does SVVSD in particular but all the districts have access to rapid testing*

The St. Vrain Valley School District webpage provides a link to the Boulder County Health Department where testing information is provided. A list of clinics providing tests and types of testing is included [here](#).

**Do we have access to the slides after this call?**

The slide deck will be available on the Colorado PTA website: [copta.org](http://copta.org)

**At what point (data wise) would the recommendations no longer allow for in person? For example- at a specific positive case rate?**

There is no specific case rate, percent test positive rate, or other metric that should be used to solely guide decisions for schools about in-person versus remote education. Development is ongoing on a suite of regional- or county-level metrics to help inform decision-making for schools and other contexts. However, even following the release of these metrics, we encourage schools and other decision-makers to make choices in the context of local knowledge about your community, physical plant, and school population to make a holistic decision about school learning modality.
Is the preference for having the children Covid tested in order to return to school being communicated to pediatricians and institutions in the area? My understanding is many physicians prefer to not administer tests to children with more mild symptoms.

We are making these guidelines widely available via our public facing website, and our hope is that physicians will familiarize themselves with their role in implementing this guidance along with parents, school staff, and other members of the community which interact with schools. CDPHE is also participating in a number of educational outreach activities aimed at physicians. Parents and caregivers may also use the guidance on our website when requesting testing for their children.

Can CDPHE speak to the protocols and process if a child shows COVID-19 symptoms at school? Will they be isolated and parents required to pick up the student?

The tool titled “A child/teacher/staff feels or appears sick after arriving at school” describes what should be done if a child begins to show symptoms at school. In brief, the child should first be checked for any life threatening conditions, and then their symptoms should be further assessed in the context of their known pre-existing conditions, the specific type and severity of their symptoms, etc. This tool is designed to be applied by non-medical school staff (as well as by school nurses if available).

keeps parents from dosing students with tylenol prior to school so that parent can go to work and use school as free daycare

The tool titled “A child teacher staff feels or appears sick after arriving at school” describes what should be done if a child begins to show symptoms at school. While schools can create the expectation that an ill child should be kept at home for the safety of the school community, as in times prior to the emergence of COVID-19 there may be parents who give their child fever reducing medications in order to allow them to attend in-person education. If these children become symptomatic at school (which they likely would, given Tylenol’s 6 hour duration of action) the tool referenced above should be applied.

I need more information from Therese P, regarding fresh air in classrooms. Our school is discouraging teachers from opening windows for risk of “letting allergens into the classroom for sensitive children”. Instead, we have been told that our building has improved air quality within a range of 50-100%, however, our building is too old to receive the advanced filters that have been recommended

Air exchanges, or increasing how often air indoor air is replaced with outdoor air, is advisable in schools and other buildings in general to decrease indoor air contaminants and infectious viral particles. HEPA filters help capture outdoor contaminants such as allergens and wildfire smoke before they enter the building. Increasing air exchanges and filtration are strategies that work together to improve indoor air and decrease transmission. The toolkit includes links for schools to use to improve indoor air quality and circulation.