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August 19, 2020

The Honorable Robert R. Neall
Secretary, Maryland Department of Health
201 W. Preston Street
Baltimore Maryland 21201-2399

Sent via electronic mail only

Dear Secretary Neall,

We appreciate the work and guidance the State Department of Health's (MDH) has provided thus far with local county health departments. However, it cannot be overstated, that this pandemic is a public health crisis that has in turn, created a crisis in the delivery of public education. As we navigate the difficult decisions returning children and staff to school buildings, the Public School Superintendents' Association of Maryland (PSSAM) seek your department's leadership. We are educators and rely on medically-based guidance from your department and assistance from other public health experts. We strongly advocate for MDH to use its statewide authority and resources to create a strategy for our return to school buildings.

As we begin the 2020-2021 school year, all twenty-four school systems in Maryland will be opening virtually, with some exceptions for special populations and pilot in-person programs. This is not ideal, and as educators, we know that in-person synchronous learning is what our schoolchildren need. As we and our local boards consider our options transitioning through phases, we need additional guidance from MDH. Specifically, we are seeking uniform statewide protocols in three areas: (1) the appropriate usage of ***PPEs***, (2) clarifications on the role of school systems and local health departments in ***contact tracing***, and (3) clear ***metrics*** based on medical research for re-opening, transitioning to new hybrid models, or future closures of schools.

We believe it is appropriate that MDH provide this uniform information just as has been done in other states, such as Minnesota and Washington (links to these plans are in Appendix 1). Statewide guidance and protocols in these areas will help suppress the spread of the virus, and provide equity in the health and well-being of every Maryland student or staff member. We

recognize there may be some regional differences, but we must start by using the same metrics and statewide strategies as we transition to re-opening our school buildings.

With regards to *Personal Protection Equipment (**PPE**)*, we need MDH to provide more in-depth and clearer guidance than what was previously issued in July. It has also been suggested that your department could help facilitate a statewide purchasing consortium for equipment, which would provide tremendous financial and operational assistance to the twenty-four school systems. Appendix 2 also lists specific questions that have been raised during our review of your July guidance, in collaboration with medical health experts who are assisting school systems in recovery planning. Your attention to those specific issues is appreciated, and we hope that your staff will seek our input in any subsequent guidance issued so it is appropriately tailored to the on-the-ground experiences and challenges that we face in school systems across Maryland.

In general, we believe that referring to CDC guidelines is insufficient because many of the recommendations do not address health and safety concerns specific to an educational setting. Also, we need clearer guidance on the appropriate use or level of PPEs when we transition to in-person learning, and, if there are different or tiered considerations based on a student's age, a staff members function in the school, etc. Lastly, we are gravely considered about the sustainability of our PPE supplies. While funding is not the focus of this letter, a discussion about sustainability and future costs must be taken into consideration.

It is also imperative that we receive more specific guidance regarding ***contact tracing***. Clarification is needed regarding the responsibilities of the school systems, specifically school nurses, and local health departments. Uniformity is crucial in that many staff and teachers work in one school system but live in a neighboring county. Effective contact tracing must be tied to testing protocols that provide for equal identification and treatment. Until we can provide priority access to quick-turnaround molecular (as opposed to antigen) testing for symptomatic staff and students, we could be facing weeks of interrupted education. Using your departments' significant economies of scale, we believe a statewide strategy and provision of rapid testing is another opportunity for the state to help, similar to the nursing home initiative at the beginning of the pandemic.

Lastly and most importantly, we seek your medical and public health expertise on creating clear ***statewide metrics*** for reopening school buildings that can be uniformly implemented, while recognizing regional differences. All local school systems have been working diligently with our respective local health departments in recovery planning for the safest re-entry into school buildings, but more is needed at the state level. Again, we point to other states whose state health departments have not only issued these requirements, but they have helped ensure their equal implementation. We need uniform benchmarks or measurement of issues such as positivity rates, new cases, hot spots, or absenteeism.

A statewide strategy will allow for the dissemination of clear, transparent and accurate information to the public. It is essential that parents, students, teachers, and staff are assured of a seamless collaboration between the state, the local health departments and school systems. We need to bolster the public's confidence in returning to school and better understand why and

when a school is ready to re-open, or may need to close in the future. This information should be standard and predictable across the state.

Time is of the essence in addressing these needs as many boards of education will be contemplating the structure of transitioning through phases – with some planning to make decisions as early as October in order to allow for an appropriate amount of transition time for children, staff and families. As superintendents and educators, it is our responsibility to create and support curriculum and its delivery, which has been a challenge for some of our most vulnerable students who lack devices and connectivity. During this pandemic we have also become the de-facto food provider for families in need, a responsibility we have taken on without reservation. What we ***cannot*** provide is medical guidance on when it is safe to return to buildings. We need the state's leadership on these key health and safety protocols that are vital to the recovery planning and ultimately our return to public school buildings.

We take the obligation to provide the highest quality public education to ***all*** Maryland students extremely seriously as our core mission. Let us work together to provide the highest health and safety conditions for ***all*** Maryland students as well. Thank you in advance and we look forward to a strong partnership moving forward.

Sincerely,

Dr. Kelly L. Griffith
President, PSSAM
Superintendent, Talbot County Public Schools

cc: Local superintendents
Dr. Karen Salmon, Superintendent, Maryland State Board of Education
Keiffer Mitchell Jr., Governor's Acting Chief of Staff
President Bill Ferguson, Senate President
Chair Paul Pinsky, Senate Education, Health, and Environmental Affairs
Frances Hughes Glendening, Executive Director, MABE
Mary Pat Fannon, Executive Director, PSSAM

Appendix 1 – Existing State Plans

Washington State

https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/DecisionTree-K12schools.pdf

Minnesota

https://www.health.state.mn.us/diseases/coronavirus/schools/index.html#youth

Appendix 2 – Questions regarding July 21, 2020 MSDE and MDH Guidance

These comments and questions are in response to the July 21, 2020 documents issues by MSDE and MDH (a) Response to a Laboratory Confirmed Case of COVID-19 and Persons with COVID-19-like Illness in Schools, Child Care Programs, and Youth Camps; and (b) Guidance for Use of Cloth Face Coverings in Schools.

1. **Use of Cloth Face-Coverings in Schools and on School Buses**. The joint MSDE and MDH guidance states: "School staff must wear cloth face coverings while in the school building, on school grounds when not contraindicated due to a medical condition, intellectual or developmental disabilities, or other conditions or safety concerns." In addition, the guidance states: "All students, school staff, and bus drivers must wear a cloth face covering while on school bus when not contraindicated due to a medical condition or developmental or safety considerations." It would be helpful to obtain clarification on several points – all of which appear to be consistent with the statement in the joint guidance that: "[t]he use of cloth face coverings is most important at times when physical distancing measures cannot be effectively implemented especially when indoors."

    1. To avoid any grounds for confusion, an explicit exception would be helpful to incorporate into the guidance for students or staff to remove their face coverings while eating, so long as meal protocols are in place that follow all health and safety guidance. It also would be helpful to clarify that students and staff may remove masks for brief breaks for health reasons or for social and emotional well-being, preferably outdoors or in large spaces where physical distancing measures can be implemented.

    2. We are committed to requiring face-coverings to be worn at all times inside school buildings in common spaces and when more than one person is in a room (i.e., an office) or when an individual is in a room and the door to the office is open. However, it would be helpful to permit some latitude, consistent with guidance from the CDC and other health experts, when individuals are alone in their office with the door closed (with other health and safety protocols in place, such as disinfecting the room prior to departing to prevent potential droplet exposure), as well as for school bus drivers who are alone on a bus without passengers and with windows open.

2. **Screening for COVID-Like Illness Symptoms**. The guidance is very helpful in providing a clear decision-tree for screening based on a list of symptoms for COVID-like illness defined as: **"**New onset cough or shortness of breath **OR** At least **2** of the following: fever of 100.4 or higher, chills, shivering, muscle pain, sore throat, headache, loss of sense of taste or smell, and gastrointestinal symptoms (nausea, vomiting or diarrhea)." School districts would benefit from clarification with respect to this definition and the accompanying guidance that we should exclude any person with one new symptom until the symptom improves, and we should exclude anyone with symptoms

meting the definition of a COVID-19 like illness pending test results or evaluation by their health care provider.

1. Prior to the COVID-19 pandemic, the vast majority of visits to student health services, especially in elementary schools, involved at least one of these symptoms. For example, a child who did not have an opportunity to eat breakfast may report a headache. In this example, the guidance could be interpreted not to permit a school counselor, or even a nursing assistant in school health services, to ask follow up questions, prior to sending the student home, and to determine that the most likely source of the headache was failure to eat breakfast, rather than COVID-19 like symptoms. The CDC definition referenced in the guidance (available at https://wwwn.cdc.gov/nndss/conditions/coronavirus-disease-2019-covid-19/case-definition/2020/) includes a provision absent from the guidance, which clarifies that the clinical criteria are met when these symptoms are present and there is "no alternative more likely diagnosis." It would be helpful to add this provision to the guidance and/or to insert a modifier to clarify that school staff should be screening for "prolonged" symptoms on this list.

2. Relatedly, some of our students and staff have pre-existing medical conditions that can manifest one of these symptoms on a periodic or even frequent basis (e.g., shortness of breath for an individual with asthma). The guidance references "new" symptoms, and, thus, we do not understand that MSDE and MDH intend for school districts to exclude a student with asthma solely based on the student's self-report that she sometimes experiences shortness of breath due entirely to her asthma and manages this condition with an inhaler; but further clarity would be helpful to avoid the legal and equity concerns that could arise by excluding such an individual based solely on a pre-existing medical condition. The addition of the "no alternative more likely diagnosis" provision, as discussed above, also would be helpful to address this issue as well.

3. **Collaboration with Local Health Department in Contact Tracing.** Further clarification would also be helpful as to the scope of the role that school staff are expected to play in contract tracing and notification in collaboration with local health departments. As we understand it, school systems are responsible for the initial, school-based immediate steps in the process – e.g., identifying students or staff, based on their schedules and attendance, who may have been exposed to the individual who tests positive, so we can promptly notify those in the school community who should immediately self-quarantine. However, it is our understanding that local health departments will be responsible for taking that initial information provided by school districts and expanding it to other school and non-school based contacts — potentially both of the initial student and staff identified, as well as others they deem as having significant exposure. Confirmation of this delineation of roles would be very useful. There also is an undefined reference to SHS in the guidance, which we assume to reference school health services, but that term applies differently across school districts depending on whether the school health staff are employed by the school district or the

local health department. It would be helpful to clarify since this designation implicates the collaborative roles that the respective agencies are expected to play in the contact tracing process and the responsibilities placed on school nurses, in particular.

4. **Rapid Testing**. It will be much more challenging to implement this guidance without school systems obtaining — ideally with support and resources from the state — priority access to quick-turnaround molecular (as opposed to antigen) testing for symptomatic staff and students. If test results take 5-10 days to come back, a class of 12 students could end up missing 60-96 instructional days each time someone has symptoms of a COVID-19 like illness, even if the test is ultimately negative.