BENZIE COUNTY
BOARD OF COMMISSIONERS

448 COURT PLACE – BEULAH, MI 49617 – (231) 882-9671
www.benzieco.net

SPECIAL MEETING
BENZIE COUNTY BOARD OF COMMISSIONERS
AGENDA
September 1, 2021
11:00 a.m.
Frank F. Walterhouse Board Room, Government Center, Beulah, Michigan

Join Zoom Meeting
https://us02web.zoom.us/j/7493555921

Meeting ID: 749 355 5921
One tap mobile
+13126266799,,7493555921# US (Chicago)
+19292056099,,7493555921# US (New York)

11:00 a.m. Call to Order

Roll call

Invocation & Pledge of Allegiance

Approval of Agenda

Public Input
— Lisa Peacock

Discussions regarding recent public health mandate from Benzie Leelanau Health Department

Public Input

Adjournment

Times Subject to Change
The County of Benzie will provide necessary reasonable auxiliary aids and services for individuals with disabilities at the meeting upon five (5) working days' notice to the County. Individuals with disabilities requiring auxiliary aids or services should contact the County in writing or by calling the following:

BENZIE COUNTY CLERK
448 COURT PLACE
BEULAH MI 49617
(231) 882-9671

This notice was posted by Dawn Olney, Benzie County Clerk, on the bulletin board in the main entrance of the Benzie County Governmental Center, Beulah, Michigan, at least 18 hours prior to the start of the meeting. This notice is to comply with Sections 4 and 5 of the Michigan Open Meetings Act (PA 267 of 1976).

PUBLIC INPUT

Purpose: The Benzie County Board of Commissioners is a public policy setting body and subject to the Open Meetings Act (PA 267 of 1976). The Board also operates under a set of "Benzie County Board Rules (section 7.3)" which provides for public input during their meetings. It continually strives to receive input from the residents of the county and reserves two opportunities during the monthly scheduled meeting for you the public to voice opinions, concerns and sharing of any other items of common interest. There are however, in concert with meeting conduct certain rules to follow.

Speaking Time: Agenda items may be added or removed by the board but initially at least two times are devoted to Public Input. Generally, however, attendees wishing to speak will be informed how long they may speak by the chairman. All speakers are asked to give their name, residence and topic they wish to address. This and the statements/comments will be entered into the public record (minutes of the meeting). Should there be a number of speakers wishing to voice similar opinions, an option for a longer presentation may be more appropriate for the group and one or more speakers may talk within that time frame.

Group Presentations – 15 minutes
Individual Presentations – 3 minutes

Board Response: Generally, as this is an "Input" option, the board will not comment or respond to presenters. Silence or non-response from the board should not be interpreted as disinterest or disagreement by the board. However, should the board individually or collectively wish to address the comments of the speaker(s) at the approval of the Chair and within a time frame previously established, responses may be made by the board. Additionally, the presenter may be in need of a lengthier understanding of an issue or topic and may be referred to a committee appropriate to address those issues.

Public Input is very important in public policy settings and is only one means for an interchange of information or dialogue. Each commissioner represents a district within the county and he/she may be individually contacted should greater depth or understanding of an issue be sought. Personal contact is encouraged and helpful to both residents and the board.

Commissioner Contacts:

District I – Bob Roelofs (Almira East of Reynolds Road).....231-645-1187
District II - Art Jeannot (Almira Twp West of Reynolds Road, Platte and Lake Townships) 231-920-5028
District III – Andy Miller (Crystal Lake, Frankfort) 231-920-8300
District IV – Rhonda Nye (Benzonia).....231-510-8804
District V – Tim Markey (Homestead) 231-871-1399
District VI - Evan Warsecke (Colfax, Inland) 231-275-3375
District VII - Gary Sauer (Blaine, Gilmore, Joyfield, Weldon) 231-651-0647

Dawn Olney

From: Katelyn Zeits
Sent: Tuesday, August 31, 2021 4:42 PM
To: Art Jeannot; Rhonda Nye; Tim Markey; Bob Roelofs; Andy Miller; Evan Warsecke; garysauer53@yahoo.com
Cc: Katelyn Zeits; Dawn Olney
Subject: Health Department
Attachments: InterGov Agree forming BLHD 1996.pdf

Hi Everyone,

I wanted to reach out with some information related to tomorrow's meeting to discuss the recent order by the Health Department.

As most of you are probably aware, the County has an intergovernmental agreement with Leelanau County to form the Benzie-Leelanau District Health Department. I have attached a copy of that agreement for your review. In review of this agreement and in communication with our Legal Counsel, Benzie County could withhold some or all funding (close to $255,000) it plans to transfer to the Health Department, however, there are some things to consider.

In general, a County Board of Commissioners is required "to provide" for a Health Department, MCL 333.2413, except where two or more Counties form a multi-County District Health Department under MCL 333.2415.

Here, the Counties of Benzie and Leelanau have formed a District Health Department under MCL 333.2415, by Intergovernmental Agreement.

In Art. XII of the Intergovernmental Agreement establishing the BLDHD, each of the two constituent Counties expressly agreed to make a financial contribution as determined by the District Board of Health and assessed annually on a pro-rated population basis.

However, neither County is bound to accept the annual allocation proposed by the Board of Health.

The Counties further agreed that the Board of Health could take specific actions in its discretion if a County failed to make its financial contribution as assessed, taking into account the amount of the non-payment, its duration, the financial condition of the Health Department, and other relevant factors.

Those potential actions include (a) revising the budget by decreasing both Counties' financial contribution proportionately and reducing services across the District, and/or (b) reducing services in the non-paying County consistent with the non-payment.

The Board of Health could also (c) raise rates for services in the non-paying County, and/or (d) seek to dissolve the District Health Department.

Therefore, Benzie County must either make its financial contribution as assessed or face the consequences as may be determined by the Board of Health.

The County retains the option of withdrawing from the Agreement and dissolving the District Health Department.

I hope this helps with our discussion tomorrow.

Have a good evening.

Katie

Katelyn Zeits, MPA
County Administrator
Benzie County
448 Court Place
Beulah, MI 49617
231-882-0558

INTERGOVERNMENTAL AGREEMENT CREATING THE BENZIE-LEELANAU DISTRICT HEALTH DEPARTMENT

The counties of Benzie and Leelanau have terminated their Public Health Contract with Grand Traverse Public Health Department, effective September 30, 1996. The counties hereby formalize the right and obligations of each county to each other and to the Benzie-Leelanau District Health Department which is being created by this Agreement. Accordingly, the counties agree as follows:

I. PURPOSE

Each county has the statutory obligation to provide public health services. The counties have determined that it is a public benefit to provide such services pursuant to this Agreement. The counties hereby formally create the Benzie-Leelanau District Health Department ("Health Department"). The counties do not waive their rights to approve rules promulgated by the Health Department pursuant to Section 2441 of the Code.

II. LEGAL AUTHORITY

The Health Department shall be a local health department as defined in the Public Health Code ("Code"), being Act 368 of 1978 as amended. The authority to create a local health department is set forth in Section 2415 and 2419 of the Code.

III. PROPOSED LEGAL ENTITY

The Board of Health which has been created by this Agreement is authorized to explore the reorganization of Benzie-Leelanau District Health Department as a legal entity pursuant to the Urban Cooperation Act (Act 7 of 1967 – Extra Session) or to otherwise reorganize the Health Department pursuant to any appropriate statute. However, no such reorganization shall become effective unless it has been approved by the Board of Commissioners of each participating county. No county shall be obligated to participate in any such reorganization.

IV. POWERS AND LIMITATIONS

The Health Department shall have the following powers and be subject to the following limitations:

A. Those powers and limitations relating to a local health department as set forth in the Code now or as later amended.

B. It must be operated as a non-profit governmental department. However, the Health Department may maintain a reasonable fund balance. No part of its earnings shall inure to the benefit of any person. It shall not have the power to levy any type of tax or in any way place a county in debt unless a county by formal action of its Board of Commissioners elects to be so obligated.

C. It shall have the following additional powers: the power to sue and be sued, to make and enter into contracts, to employ agencies or employees, to acquire, construct, manage, maintain, or operate buildings, works, or improvement, to own, hold, or dispose of property, to incur debts, liabilities, or obligations which, except as expressly authorized by the counties, do not constitute the debts, liabilities, or obligations of any of the parties to the Agreement, to cooperate with a public agency,

an agency or instrumentality of that public agency or another legal or administrative entity created by that agency, and to accept gifts, grants or bequests.

D. The powers of the Health Department shall be liberally construed consistent with the Constitution and statutes of this state.

E. This agreement provides that an employee transferred shall not lose any benefit or right as a result of the transfer.

V. BOARD OF HEALTH

The Health Department shall be governed by a Board of Health ("Board"). The Board shall set policy and procedures governing the operation of the Health Department and shall have the ultimate authority regarding the exercise of Health Department powers. The Board shall be composed of two (2) members from each county Board of Commissioners and one (1) member at large from each county who has been appointed by the Board of Commissioners from that county. The Board shall elect a chairperson and vice-chairperson. It may create additional officers and such committees as it deems appropriate. The Board shall set its meeting dates and adopt rules of procedure and determine the number of members who will constitute a quorum of the Board; provided, however, the board may elect to dissolve the Department only by a majority vote of the entire Board. As used in this Agreement, the terminology "entire Board" shall mean the six members of the Board or a lesser number only if a vacancy exists in the three representatives to which each county is entitled. All meetings of the Board shall comply with Michigan's Open Meetings Act, being Act 267 of 1976 as Amended. The chairperson and vice-chairperson shall not be from the same county. Actions taken by the Board prior to the effective date of this Agreement are hereby ratified.

VI. DURATION

This Agreement shall continue indefinitely unless a county withdraws form the Health Department is dissolved as provided by this Agreement.

VII. TERMINATION/DISSOLUTION

This Agreement may be terminated by one of the following methods:

A. A county may give written notice of its desire to withdraw as a member of the Health Department to the Health Department and to the other counties which are a party to this Agreement. The request must be approved by a majority of the entire Board. If request to withdraw is approved by the Board, then this Agreement shall terminate and the withdrawing county shall no longer be a part of the Health Department. However, the Health Department shall continue with its remaining members. The effective date of the withdrawal by the withdrawing county shall be effective sixty (60) days from the date of approval unless an earlier effective date is specified in the approval resolution. The vote on the request to withdraw by the Board must be made within ninety (90) days of the last date on which the persons or entities specified in Paragraph XV receive the request to withdraw. The PROPERTY DIVISION provisions of Paragraph VIII shall continue to apply to all counties, including the withdrawing county, until the property division has been completed.

B. The Health Department may be dissolved by majority vote of the entire Board. A resolution shall specify the effective date of the dissolution. The Agreement shall be deemed terminated on the effective date of the dissolution; provided, however, the

property division provisions of Paragraph VIII shall continue to apply to all counties until the property division has been completed.

VIII. PROPERTY DIVISION

A. If a county withdraws pursuant to Paragraph VII . A, then the following procedure shall be used. The withdrawing county shall not be obligated to pay (or will be reimbursed if it already has paid) a pro-rata portion of its financial contribution attributable to the remainder of the Health Department's fiscal year after the effective date of the dissolution. In addition, the withdrawing county shall receive all real and personal property (except for motor vehicles) located within the boundaries of the withdrawing county. The withdrawing county will assume any existing debt applicable to the assets which it receives. The distribution of assets shall take place as soon as possible after the effective date of the withdrawal.

B. If the Board elects to dissolve the Health Department, then the following procedures shall be followed. After all liabilities have been paid and as soon as possible after its dissolution, the health Department shall distribute or convey the remaining real and personal property of the Health Department to the counties based on the then existing fair market value of such property and allocated to the counties on the average percentage of financial contributions of each county which were actually paid to the Health Department over the preceding three (3) years. The order of distribution shall be (1) real estate, if any, located in a county shall be conveyed to that county, (2) personal property, used for daily operation and for providing services, located in a county shall be transferred to that county except to the extent necessary to meet application requirements, and (3) money and personal property used for administrative purposes shall be divided as is necessary to meet allocation requirements. Property shall be valued at its current fair market value for distribution purposes.

C. Upon withdrawal or dissolution, if a county receives real estate and or personal property and the fair market value of these items exceeds that county's asset allocation, then the county receiving that real estate shall reimburse the other counties for such excess on a pro-rata basis. Such reimbursement shall be made prior to the transfer of title of the real estate to the county which is to receive the real estate.

IX. FEES

The Board shall have the power to set fees for Health Department services as authorized by Section 2444 of the Code. All fees shall be paid into the general fund of the Health Department.

X. COUNTY ORDINANCES

Nothing in this Agreement shall restrict the right of a county to enact a local ordinance affecting its public health needs and setting fees in any such ordinance. However, any such ordinance shall not impose an obligation or duty on the Health Department or its personnel unless (a) the ordinance has been approved by the Board; provided, however, that the Board's approval shall be limited to assessing the financial and personnel impact of the proposed ordinance on the Health Department, the legality and enforceability of the proposed ordinance and potential liability to the Health Department. (The general public policy considerations of whether the proposed ordinance is needed is solely the responsibility of the county which is

considering enacting the proposed ordinance.), (b) an agreement has been reached with the county which enacted the ordinance regarding the disposition of any fee required by the ordinance, and (c) an agreement has been reached with the county which enacted the ordinance regarding the reimbursement to the Health Department of any costs of enforcement.

XI. ORDINANCE UNIFORMITY

Each county understands the legal and practical importance of ordinance uniformity throughout the District. Each county agrees to make every effort to keep its public health ordinances uniform with those of other counties within the District. However, this Agreement acknowledges that local conditions and political desires within a particular county may result in some unique ordinance provisions.

XII. FINANCES

The Board shall have the budgetary and financial control over the Health Department. Each county's financial contributions to the Health Department shall be based on the budgetary needs of the Health Department. Payment of the financial contribution of each county shall be made under such terms as shall be specified by the Board. The financial contributions shall be assessed each county according to the financial needs of the District as determined by the Board and allocated proportionately between Benzie and Leelanau Counties based on the following formula: One Hundred (100%) based solely upon the latest official estimate of the total population of the two counties as published by the Vital Statistics Section of the Michigan Department of Community Health. Nothing in this Agreement shall bind a county to accept the annual allocation proposed by the Board.

If the county fails to pay its assessment, the Board may not reassess the shortfall to the other county. However, the Board in its discretion may elect one or more of the following options, taking into account the amount of the non-payment, its duration, the financial condition of the Health Department and such other factors as it deems relevant:

1. Revise the Health Department's budget for the year in which the non-payment occurs, decrease the contributions of all counties on a pro-rata basis and alter or eliminate such services in all counties as the Board deems appropriate.
2. Reduce services in the non-paying county consistent with the non-payment.
3. Raise rates for services in the non-paying county in such amount the Board deems necessary.
4. Dissolve the Health Department.

XIII. LIABILITY

The Health Department shall maintain liability insurance in such amounts as the Board shall determine. Each county hereby indemnifies and hold harmless the other counties from any liability stemming from enforcement of an ordinance enacted by the county and hereby indemnifies and holds harmless the Health Department from any liability stemming from the enforcement of any such county ordinance, except for liability arising out of any act or omission of the Health Department.

XIV. AUDIT

The Health Department shall have periodic independent audits as directed by the Board. A copy of the audit shall be given to each Board member upon its completion. If requested by a county, a representative of the Health Department shall appear before the Board of Commissioners of each county and answer questions regarding the audit or any other aspect of Health Department activities. The counties shall have access to all Health Department records except those records subject to a legally recognized privilege.

XV. NOTICES

Any notices required by this Agreement shall be deemed made when mailed certified mail, return receipt requested, to each county clerk, to each chairperson of the Board of Commissioners of each participating county and to the Administrator of the Health Department at the Administrator's principal office.

XVI. AMENDMENTS

Amendments to this Agreement shall be made in writing and shall become effective after ratification by the Boards of Commissioners of each county.

IN WITNESS OF THIS AGREEMENT the counties have passed resolutions authorizing the Chairperson of each Board of Commissioners to execute this document. This Agreement shall become effective when it is signed by the last of the counties.

BENZIE COUNTY

Date: 3/9/04

By: Donald R. Tauer

Attest: Dawn Olney

LEELANAU COUNTY

Date: 3/18/04

By: Ronald Hawley

Attest: G. Newton

Amended: October 8, 1996
February 17, 2004

Children's Health

Long Haul COVID in Kids

Author
Beata Mostafavi *May 07, 2021 5:00 AM*

New clinic focuses on children and teens who experience lingering symptoms after COVID, including respiratory issues, fatigue and joint pain.

Teens Jordyn Stickel and Madison Foor face long-lasting symptoms months after experiencing mild COVID cases.

Madison Foor is a fit, healthy teen who has spent the last five years as a competitive dancer.

But now, months after a mild case of COVID, the eighth grader uses an inhaler for the first time in her life.

Short walks can also leave her winded. Headaches are frequent. She needs more breaks during dance lessons.

The 14-year-old is believed to be among a small but growing group of pediatric patients who may be experiencing long haul COVID, a much more commonly reported condition in adults. While the majority of children and teens have mild COVID-19 symptoms or are asymptomatic, some face persistent symptoms

months after recovery or develop a rare but serious COVID-linked condition called multisystem inflammatory syndrome, or MIS-C.

In response, Michigan Medicine C.S. Mott Children's Hospital has opened the Pediatric Post-COVID Syndrome Clinic, believed to be the first in the state to specifically serve this population of young patients.

"We've seen children who have breathing issues and other lingering symptoms long after an initial infection," says Carey Lumeng, M.D., Ph.D., Mott pediatric pulmonologist who leads the new clinic.

"Most of their COVID infections were mild and didn't require hospitalization or even outpatient care. Our goal is to better understand this phenomenon in young people and ensure that patients see the right group of specialists to address their specific symptoms."

Last year, more than 2 million of the nearly 30 million confirmed cases of COVID-19 in the U.S. involved children, according to the Centers for Disease Control. That includes over 115,000 children in the state of Michigan.

But it's unclear how many young patients have long-term symptoms known as post-COVID syndrome or "long COVID." Symptoms may include fatigue, shortness of breath, joint pain, chest pain, cough and loss of taste or smell. Mott has seen more than a dozen cases so far.

The Mott post-COVID syndrome clinic is for patients under age 21 who've been referred by a primary care provider and whose symptoms have continued beyond six weeks after an infection. It brings together several specialties, including pediatric pulmonology, cardiology, physical medicine and rehabilitation, and pediatric psychology to address young patients' unique needs.

Madison's mom, Mariha, of Dundee, Mich., says her daughter is slowly gaining back strength after her bout with COVID in January, but for the first few weeks couldn't even manage five minutes walking on a treadmill.

"Understanding the short and long term effects in children after COVID will help us combat what may become a growing need."

Among lingering symptoms are fatigue, shortness of breath and a foul taste in her mouth. Madison, who is receiving care through the new Mott post-COVID syndrome clinic, is "progressively getting better" and easing back into ballet, jazz and tap dance. But she still needs to take more breaks than usual, Mariha says.

"You hear a lot about kids not getting COVID as bad as adults, but there's no way to know which ones may be impacted by this," she says. "Madison was a perfectly healthy, active teen who is now using an inhaler."

"People told me she just needed more rest but I knew something else was wrong. Parents should trust their gut if their child isn't acting like themselves."

Jordyn Stickel, 13, of Orion Township, Mich., is also facing long-lasting symptoms after a mild case of COVID in November that included body aches and a low-grade fever.

The eighth grader loves outdoor hobbies, school and robotics. But for nearly half a year, she hasn't enjoyed any of those activities.

Jordyn still faces severe fatigue that keeps her in bed for most of the day, joint pain, chest pain, headaches and shortness of breath that makes a flight of stairs challenging. She's now seeing specialists at the new Mott clinic.

Jordyn's mom, Heather, says she's hopeful that the right care will help Jordyn get back to her usual self.

"As a parent it's crushing to see your kid be so miserable and isolated and not be able to do anything about it," says Heather who recently joined a UK-based Facebook group to connect with other parents whose children are experiencing similar symptoms.

Part of the new Pediatric Post-COVID Syndrome Clinic: Pediatric pulmonologists Carey Lumeng, M.D., Ph.D.; Ixsy Ramirez, M.D.; Marc Hershenson, M.D.

"We're so grateful for the help we're getting at U-M from top tier doctors. We finally feel like we're being listened to and getting the right care to help Jordyn. My child deserves the best care possible."

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The National Institutes of Health has launched new research to better understand how SARS-CoV-2 affects children short term and long term, why some children are at greater risk of infection than others, why symptoms vary among children and how to identify those at greatest risk of developing severe complications.

Researchers are also hoping to better understand risk factors behind the rare condition MIS-C, which causes severe inflammation in vital organs and tissues and could be life-threatening to children.

As the clinic treats more children with these symptoms, Lumeng says he hopes Mott teams will be able to contribute to national research studies on COVID in kids.

"Understanding the short and long term effects in children after COVID will help us combat what may become a growing need," Lumeng says.

"It's going to take some time before we get vaccines for all children, and we know we'll be dealing with this for quite a while. We hope to provide a uniform way to serve these patients and to learn more about how we can help them recover and get back to normal as much as possible."

MORE ARTICLES ABOUT: CS Mott Children's Hospital, COVID-19, Community Health, Pediatric Health Conditions, Congenital Heart Disease, Lungs and Breathing , Growth and Development, Health Screenings, Wellness and Prevention, Hospitals & Centers

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August 26, 2021

Dear Charlevoix Board of Education members,

The Covid pandemic continues to be one of the biggest challenges facing all generations. No one is more aware of this than the families that have been directly impacted by the disease. We are now over 18 months into this pandemic and unfortunately about the only thing we can accurately predict is a continued state of uncertainty and change. No one is more frustrated by this than healthcare workers whose job it is to provide the needed care. It has been shown that the only clear path to get beyond this is through mass vaccination. We believe these vaccines are safe and this belief is demonstrated by the fact that 100% of the physicians endorsing this letter are fully vaccinated. While we have been largely successful at getting our most venerable population vaccinated with rates approaching 82%, we still have a large unvaccinated population which allows continued spread of the virus. And while we can celebrate the fact that many have been vaccinated, children younger than 12 are not yet eligible for the Covid-19 vaccine and thus not afforded the same level of protection as the rest of our population.

We are now faced with a new school year. It would appear that the decision has been made to proceed with in-classroom learning, a position that is supported by the American Academy of Pediatrics.[4] This year is a little different than last in that the great majority of Covid cases in Michigan and across the country are now caused by the Delta variant. We acknowledge that separating Covid-19 fact from fiction has become a big challenge but as representatives of the medical profession we feel there are some important facts to keep in mind.

The number of infections from the Delta variant are increasing across Northern MI including Charlevoix and Emmet County. Charlevoix and Emmet counties are now both classified as having high community transmission.[7] What we know about the Delta variant is that it is much more contagious than previous strains.[1] We now also know that in addition to droplet (cough/sneeze) and fomite (surfaces) mechanism of spread, Covid is also spread by small aerosol particles (breathing) that travel through the air. As of Aug 25, 2021 there have been 623,984 deaths from Covid in the US, 313 of these have been between the ages of 5-18.[5] Pediatric hospitalizations continue to rise and are occurring at the highest rate since the start of the pandemic.[6] Between July 22 and July 29, children accounted for 19 percent of reported new cases.[2]

With this information and given that the decision has been made to proceed with in-classroom learning, we feel that all prudent measures should be followed to protect our unvaccinated and slow the spread of the virus. We are recommending that all teachers, staff and students eligible for the vaccine should receive it as soon as possible and that along with hand hygiene and social distancing, schools follow the CDC July 2021 updated guidelines recommending "universal indoor masking for all teachers, staff, students, and visitors to K-12 schools, regardless of vaccination status."[3] This recommendation is also supported by the American Academy of Pediatrics who also recently updated there masking recommendation for universal masking in school. They cite the following reasons.[4]:

- a significant portion of the student population is not eligible for vaccination
- to protect unvaccinated students from COVID-19 and to reduce transmission
  - lack of a system to monitor vaccine status among students, teachers and staff
- potential difficulty in monitoring or enforcing mask policies for those who are not vaccinated; in the absence of schools being able to conduct this monitoring, universal masking is the best and most effective strategy to create consistent messages, expectations, enforcement, and compliance without the added burden of needing to monitor vaccination status
- possibility of low vaccination uptake within the surrounding school community
- continued concerns for variants that are more easily spread among children, adolescents, and adults

The Delta variant is highly infectious and no one can guess how long in-classroom learning will last but with the current state of affairs we believe we should all follow the science and the above measures are a sincere effort to protect the unvaccinated, slow the spread, minimize the need to quarantine large numbers and hopefully allow in-classroom learning to continue.

Thank you for your consideration.

Jim Jeakle, MD
Craig Boss, MD
Mike Harmeling, MD
Rachel Mason, MD
Lori Katzman, MD
Patrick Gartland,MD
Cathy Peqarl, PA
Cathy Wonski, MD
Rod Tinney, MD
Andrea Wendling, MD
Barrett Keilhorn, DO
Chris Loewen, MD
Caitlyn Monks, MD
Melodie Brown, MD
Tom Ling, MD
Anna Young, MD
Scott Nemec, DO
Megan Coggon, MD
Bevin Clayton, MD
Debra Smith, MD
Dan Mann, MD

References:

1. https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html
2. https://www.nytimes.com/2021/08/09/health/coronavirus-children-delta.html
3. https://www.michigan.gov/documents/coronavirus/MDHHS_Face_Mask_Recommendations_5.20.21_725941_7.pdf
4. https://www.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-planning-considerations-return-to-in-person-education-in-schools/
5. https://data.cdc.gov/NCHS/Provisional-COVID-19-Deaths-Focus-on-Ages-0-18-Yea/nr4s-juj3
6. Michael T. Osterholm, PhD, MPH, Director of the Center for Infectious Disease Research and Policy at the University of Minnesota
7. https://covid.cdc.gov/covid-data-tracker/#county-view

Children's rights group calls for all Michigan school boards to issue mask mandates

BY: SUSAN J. DEMAS - AUGUST 25, 2021 4:21 PM

More Michigan school districts and counties have been announcing mask mandates as COVID-19 cases and hospitalizations for children are rising with the spread the highly contagious Delta variant. Kids under 12 are not yet eligible to be vaccinated against COVID-19.

On Wednesday, Michigan's Children, a Lansing-based nonprofit advocating for children and families, urged all of the state's 891 school boards to "do their job and act to ensure school safety through effective mask-wearing by students and staff" to ensure a safe start to the 2021-22 school year.

The group notes that 1.4 million schoolchildren are returning to the classroom "against a politically charged landscape and rising infections due to the deadly coronavirus."

Large school districts with mask mandates include Detroit, Lansing and Grand Rapids.

"Nonpartisan, locally elected school board members hold the gravest responsibility to set policies that protect the wellbeing and health of our children during school hours. All politics aside, they hold our children's safety in their hands, and we're counting on them to act wisely and with courage," said President and CEO Matt Gillard.

"With no personal gain to themselves, these are individuals who have committed themselves through countless hours and personal sacrifice to serve

the children and families of their communities. Michigan's Children fully supports those who have taken action to enact mask-wearing policies that are proven to prevent the spread and infection of COVID-19 and any variants, and implores those who have not yet done so to act immediately," Gillard continued.

Medical experts from the American Academy of Pediatrics, the U.S. Centers for Disease Control and Prevention (CDC), the Michigan Department of Health and Human Services (DHHS), and the Michigan Association of Family Physicians, among others, are urging that masks be required in schools.

Michigan does not have a statewide mask mandate for schools, unlike several other states, including California, Delaware, Hawaii, Illinois, Louisiana, New Jersey, New York, Oregon, Virginia, and Washington. Dr. Joneigh Khaldun,

backs school boards mandating masks in schools.

According to CDC guidance, people in 81 of 83 Michigan counties as of Wednesday should mask up indoors or outdoors when social distancing isn't possible because of high or substantial COVID-19 transmission. Only Oscoda and Missaukee are in the moderate level.

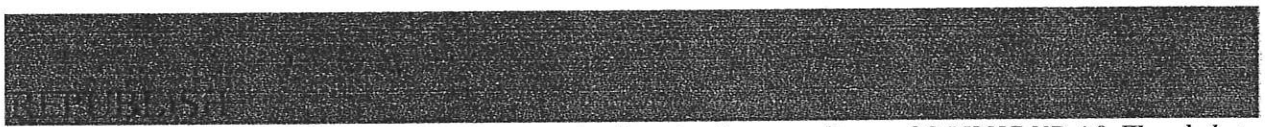
On Tuesday evening, Oakland County's health division issued an emergency health order requiring masks in daycares and elementary, middle, high and vocational schools, regardless of vaccination status, to prevent the spread of COVID-19. There are 28 school districts in Michigan second most populated county and the order also applies to charter schools.

"Our top priority is keeping students in school for in-person learning. Masking is one of the best defenses against increased transmission of COVID and higher hospitalization rates among kids," Oakland County Executive Dave Coulter said. "This order allows teachers to get back to educating our students and focusing on their success."

Allegan, Genesee, Kent, Ottawa and Kalamazoo counties also have school mask mandates. However, state Reps. Thomas Albert (R-Lowell), Mark Huizenga (R-Walker), Steven Johnson (R-Wayland) and Bryan Posthumus (R-Cannon Twp.) have threatened to pull funding from the Kent County Health Department over the school mask mandate.

Michigan's Children notes that boards in many districts have issued mask requirements even "when political pressure and opposition has been organized and vigorously mounted."

"This has to be an all-in approach to ensure that all kids, those who are immunocompromised and those under 12 who are not yet vaccinated, remain disease free," Gillard said. "Health officials tell us that anything less will lead to unnecessary infections of children as well as continued and widespread school closings that negatively interfere with students' education. No one wants that."



August 13, 2021

Dear Superintendent VanWagoner and the TCAPS Board of Education,

It is with great disappointment that we write to you in regards to the recent decision to return to the 2021-2022 school year with a mask-optional policy. TCAPS did a commendable job in the 2020-2021 school year, with a commitment to in-person learning with all possible safety measures in place. Our children had an outstanding year and quickly adapted to the mask, hand hygiene and physical distancing policies. To take a sharp turn away from these effective measures at a time when a far more transmissible variant of COVID is sweeping across the country and straining our healthcare systems, is unconscionable.

It is the responsibility of parents, educators, and community leaders to protect the young and vulnerable. Taking away the protection of masks paves the way for this virus to spread unchecked throughout our schools and could result in devastating consequences. Our country is currently experiencing another surge, this time with the highly contagious Delta variant, and our local region is experiencing a dramatic increase in hospitalized cases. Average daily hospitalizations of children with COVID has reached an all-time high in our country. Because the Delta variant is so contagious, the CDC and the MDHHS recommend masks indoors and the American Academy of Pediatrics recommends all students above the age of two be masked in school.

It is difficult to predict how this variant will act in an indoor learning environment and it is reckless to assume there will not be substantial spread without proper mitigation measures. Masks may not prevent all spread but they are the only protection available for children under the age of 12. Masking is far more effective and impactful when all people are masked, not just some. Universal masking will keep students healthier by decreasing transmission, reducing the number of quarantines, help avoid phases of virtual school, and ensure another year of successful in-person learning. A mask-optional policy will be woefully ineffective at protecting students.

The pandemic has taken a toll on our lives and we are all tired of wearing masks. Yet fatigue does not excuse us from making prudent and science-based decisions. We are experiencing another surge as a result of this highly contagious variant and it is only logical that students return to school with universal masking. As cases fall after the peak and if community transmission is low enough, then a mask-optional stance for vaccinated students could be implemented. Over time, and with the support of the health department and pediatricians, schools could ease into a mask-optional policy. Ideally, this phase would come after the vaccine is approved for younger children.

The mental health of children should not be taken lightly. However, it is overly simplistic to indicate that masking is what is taking a toll on mental health. Social isolation, quarantine concerns, fragmented learning, and fear of becoming sick or spreading illness to family members are all serious concerns for children. Consistency and safety are incredibly important

to their well-being and we can provide that by maintaining in-person learning through universal masking.

We implore you to give serious consideration to the weight of this decision. The health and welfare of the children in our community hangs in the balance. Bring our children back into the classroom fully masked.

Respectfully,

Christopher S. Ledtke, MD
Section Chief, Infectious Disease
Munson Medical Center

In support:

Glen N. Ackerman, MD
Neurology

Andrew M. Adams, DO
Internal Medicine

Stephan J. Andriese, MD
Physical Medicine and Rehabilitation

Peter F. Alvarado, DO
Family Medicine

Matthew G. Arnold, MD
Neonatology

Kathryn T. Aurand, PA-C
Trauma and Acute Care Surgery

Erica A. Austin, DO
Neurology

Harriet S. Barner, FNP
Family Medicine

Kathleen A. Behler, MD
Internal Medicine and Pediatrics

Kristin E. Betts, NP
Emergency Medicine

Michael J. Boros, MD, FACS
Vascular Surgery

Tara D. Bourmay, DO
Family Medicine

Jennifer L. Bowerman, MD
Internal Medicine

Andrew S. Boyce, DO
Orthopaedic Surgery

Kevin A. Brokaw, PA-C
Trauma and Acute Care Surgery

Dawn L. Brown, NP
Trauma and Acute Care Surgery

Natalie S. Brown, MD, FHM
Internal Medicine

Jill A. Burden, DO
Emergency Medicine

Jelanie R. Bush, MD
Pediatrics

Tuan A. Bui, MD
Pediatrics

David M. Calder, DO
Emergency Medicine

Mark L. Cannon, MD, PhD
Infectious Disease

Kyle A. Carr, MD
Pathology

Lisa B. Chimner, MD
Pediatrics

Christopher R. Chuinard, MD, MPH
Orthopaedic Surgery

Kelly J. Clark, MD
Family Medicine

Kevin Coles, PA-C
Trauma and Acute Care Surgery

Edward E. Craven, MD
Emergency Medicine

Kelly A. Covell, DO
Internal Medicine

Molly A., Craven, DO
Family Medicine

Leah C. Davis, DO
Radiology

Mark P. Davenport, MD
Family and Sports Medicine

Jay E. Dujon, MD
Trauma and General Surgery

Elayna H. Dush-Bryant, MD
Pediatrics

Adrienne E. Edgren, DO
Internal Medicine

AnnMarie D. Egan, PA-C
Trauma and Acute Care Surgery

Katie R. Elms, MD
Pediatrics

Andrew W. Freeborn, PA-C
Orthopedic Trauma

Kacie A. Freeborn, PA-C
Orthopedic Surgery

Patrick H. Friedli, MD
Family Medicine

Patrick T. Gartland, MD
Radiology

Stephanie B. Galdes, DO
Pediatrics

Todd L. Galdes, DO
Orthopaedic Surgery

Christopher F. Gerling, MD
Internal Medicine

Joan M. Griner, MD
Dermatology

Charles J. Gwizdala, MD
Pulmonary Medicine and Critical Care

Gail D. Gwizdala, MD
Internal Medicine

Joanna L. Heindl, DO
Family Medicine

Glen H. Henbest, DO
Gastroenterology

Jennifer L. Henbest, OD
Optometry

Laura M. Hill, MD
Family Medicine

Bradley S. Hochstetler, MD
Ophthalmology

Rebecca Z. Hoffman, DO
Family Medicine

Laura E. Howe, MD
Allergy and Immunology

Michael J. Howe, MD, FACC
Cardiology

Sara A. Hoye, FNP
Internal Medicine

Elizabeth R. Hunter, DO
Internal Medicine

Jesse C. Johnson, MD
Radiology

Andrew W. Kaiser, MD
Radiology

William A. Kanner, MD
Pathology

Todd W. Kennell, MD
Radiology

William T. Kern, MD
Internal Medicine and Pediatrics

Yelena E. Kier, DO, FACOI
Hematology and Oncology

David K. Klee, MD
Family Medicine and Emergency Medicine

Kelsey L. Knaack, DO
Internal Medicine

Kristian M. Koller, DO
Hematology and Oncology

Richard P. Kosinski, MD
Hematology and Oncology

Jennifer M. Kuiper, MD
Pediatrics

Mark D. Kuiper, MD
Internal Medicine and Pediatrics, Emergency Medicine

Christopher A. Lafond, MD
Trauma and General Surgery

Timothy R. Lambert, DO
Family Medicine

Benjamin G. Lamphere, MD
Internal Medicine and Pediatrics

Heather K. Lee, DO
Neurology

James Lee, PA-C
Internal Medicine

Susan L. Lehman, MD
Family Medicine

Lori A. Lemonnier, MD
Otolaryngology

Karin E. Licht, MD
Internal Medicine and Pediatrics

Erik D. Lindstrom, MD
Family Medicine

Brian A. Lishawa, MD
Internal Medicine and Pediatrics

Kristina A. Lishawa, MD
Pediatrics

Hillary A. Loomis-King, MD
Pulmonary Medicine and Critical Care

James R. MacKenzie, MD
Physical Medicine and Rehabilitation

Douglas L. McKay, MD, FACOG
Medical Staff President-elect, Munson Medical Center

John P. Macnowski III, MD
Internal Medicine

Lara C. Madigan, DO
Family Medicine

Jeffrey C. Magnatta, DO
Family Medicine

David B. Martin, MD
Infectious Disease

Matthew W. Martin, MD
Anesthesiology

Meredith McDonald, PA-C
Trauma and Acute Care Surgery

Thomas L. McElwee, MD
Internal Medicine

Erika M. McMahon, MD
Emergency Medicine

Tina M. Metropoulos, DO
Family Medicine and Neuromusculoskeletal Medicine

Farhaan R. Mir, MD
Radiology

Stephanie M. Morreale, DO
Obstetrics and Gynecology

Daniel M. Navin, MD
Pulmonary Medicine and Critical Care

Rachel B. Newman, MD
Pediatrics

Deborah J. Ochs, MD
Pulmonary Medicine and Critical Care

David S. Olson, MD
Pediatrics

Kevin M. Omilusik, MD
MHC Medical Director of System Transfers and Medical Director POMH ED

Angela J. Pohl, DO
Internal Medicine

Rachel H. Plum, MD
Psychiatry and Addiction Medicine

Marshall T. Poole, DO
Physical Medicine and Rehabilitation

Crystal J. Pulice, DO
Emergency Medicine

Paul T. Pulice, DO
Internal Medicine

J. William Rawlin, DO
Family Medicine

John R. Reineck, MD
Orthopaedic Surgery

Andrew J. Riddle, DO
Hematology and Oncology

Julia A. Riddle, DO
Family Medicine and Obstetrics

Tracy L. Riddle, DO
Physical Medicine and Rehabilitation

James W. Robertson, MD
Pediatrics

Matthew K. Ross, PA-C
Trauma Acute Care Surgery

Shruti Sevak, MD
General and Colorectal Surgery

Curt J. Schubert, MD
Internal Medicine and Pediatrics

Adrian S. Seah, MD, FACS
General Surgery

Jessica L. Slocum, MD
Nephrology

Rachel E. Soles, NP
Emergency Medicine

Douglas M. Spence, MD
Internal Medicine

John W. Stanifer, MD
Nephrology

Jay A. Starr, MD
Urology

Dennis S. Sula, MD
Infectious Disease

Corey K. Treadway, MD
Otolaryngology

Samuel R. Tredemeyer, DO
Internal Medicine

Andrew D. Tursman, MD
Pediatrics

Ethan S. Van Til, MD
Internal Medicine

Jill E. Vollbrecht, MD
Endocrinology and Metabolism

Timothy J. Vollbrecht, MD
Pulmonary Medicine and Critical Care

Petra C. von Kulajta, MD
Ophthalmology

Kenny Warner, PA-C
Family Practice

Lawrence H. Warbasse, MD, FACP
Internal Medicine

Timothy R. Weichert, DO
Internal Medicine

Alexander J. Weick, MD
Gastroenterology

Kayleigh A. White, DO
Internal Medicine

Brent M. Wiersema, DO, FAOAO
Orthopedic Surgery

Joseph G. Will, MD
Pulmonary Medicine and Critical Care

Abbigale Wilson, MD
Family Medicine

Thomas J. Yax, MD
Family Medicine and Internal Medicine

Hal R. Yost, DO
Department Chief, Internal Medicine

Kari L. Young, DO
Family Medicine

James D. Zeratsky, MD
Internal Medicine

Linda M. Zeratsky, PA-C
Urology

MIAAP
MICHIGAN CHAPTER
American Academy of Pediatrics

The Michigan Chapter of the American Academy of Pediatrics Urges Michigan Schools to Incorporate Safety Measures into School Guidance for Fall 2021

The Michigan AAP calls for universal masking in schools for students above age 2, staff, and teachers.

Lansing, Michigan – Today, the Michigan Chapter of the American Academy of Pediatrics is urging Michigan Schools to adjust school guidance to reflect the AAP's most recent guidance on safe, in-person learning.

This comes as Michigan experiences a surge in COVID-19 cases, as the virus's highly contagious Delta variant makes its way across the country. Increases in infections, hospitalizations, and deaths have concerned medical and educational professionals, who wish to bring children back into classrooms while minimizing the risk of a COVID-19 outbreak.

"The recommendation for universal masking of all children older than 2 years is one of multiple measures to reduce transmission in the school setting. Currently, children under age 12 do not have the option to be vaccinated, vaccination rates remain low in 12-18 year-olds, some members of the school community cannot be vaccinated due to underlying medical and immune system conditions," says MIAAP Past President and Pediatrician, Dr. Sharon Swindell.

To ensure children are able to return to school safely, the American Academy of Pediatrics recently updated its guidance around in-person learning, which includes – alongside vaccinations – a recommendation that everyone older than age 2 wear masks, regardless of vaccination status.

Other recommendations included in the AAP guidance are:

- Schools should be prepared to adopt an all-encompassing approach for mental health support.
- Adequate and timely COVID-19 testing resources must be available and accessible.

- Strategies should be revised and adapted depending on the level of viral transmission and test positivity rate throughout the community and schools.
- School policies should be adjusted to align with new information about the pandemic; administrators should refine approaches when specific policies are not working.
- School districts must be in close communication and coordinate with state and/or local public health authorities, school nurses, local pediatric practitioners, and other medical experts.

AAP also urges families to call their pediatrician and have children caught up on all vaccines they may have missed during the pandemic. This includes getting a vaccine to protect against influenza, which, like COVID-19, can cause severe illness and death.

Click here to view the AAP's full guidance for opening schools in Fall 2021.

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August 10, 2021

Dear Administrators and School Board Members of Northwest Lower Michigan,

We are writing as your northern Michigan community pediatric health experts. We have been on the front lines of the covid pandemic as physicians and caregivers to many of your students. We strongly support a universal masking policy for in-person schooling at all grade levels for the start of the 2021-2022 academic year, regardless of vaccination status.

Over the past 18 months we have learned a few things for certain. Vaccination is the best way to prevent COVID – 19. Universal masking is a close second. Third, with masking in place, in-school learning is safe and more effective than remote instruction, regardless of community rates of infection.

As you are likely aware, the delta variant of SARS- CoV-2 was recently identified in Grand Traverse County on July 21, 2021. Per the CDC, data shows this variant affects both children and adults. It has been shown to be much more contagious than the previous variants, and it causes more severe illness in unvaccinated individuals. With the original COVID-19 virus, one infected person could be expected to infect two other people, whereas the delta variant has shown one infected person infecting, on average, five others. Since delta was identified in GT county, our weekly average of new cases has doubled from 46 to 91 and similarly for hospitalizations. Within our own offices, we have witnessed this increase in test positivity on a local level over the past month. This is not a problem isolated to other regions of our country. In addition to being quickly and widely transmitted in indoor unmasked environments, delta variant has also been documented to be passed among vaccinated persons.

Experts agree, masks are proven to decrease transmission and infection. They are safe and effective, and our students wore them last year with few exceptions. Our students are a vulnerable population in that those under 12 have not had the opportunity to be vaccinated. In addition, we have a mental health crisis of depression and anxiety for which the routine of school and social interactions has been an important countermeasure. Furthermore, we should not ignore our immunocompromised or high-risk students, caregivers, and educators who have felt the isolation and vulnerability of this pandemic for the last 18 months. These at-risk children also deserve the opportunity to have as safe an in-person learning experience as possible.

It is reasonable to assume voluntary masking in schools will be less effective than universal masking. This could lead to unnecessary school closures and student quarantines. It might also become a significant source of community transmission. Grand Traverse County is already currently classified as having substantial community transmission, which according to current CDC, MDHHS and AAP recommendations, indicates that all individuals over age 2, regardless of immunization status, should be wearing masks at indoor gatherings.

Last year our group of pediatric practices advocated for a return to in-person schooling on the condition of implementation of appropriate safety measures in the best interest of our students. Removing one of the primary safeguards that led to that success, while battling a more

dangerous variant in our community, in a majority unvaccinated student population is counterproductive. This year our position is no different. Universal masking needs to be implemented in all schools for the start of the 2021-2022 academic year.

Regards,

The Pediatricians of Grand Traverse Children's Clinic, Kids Creek Children's Clinic, and Traverse Area Pediatric and Adolescent Clinic

David Olson, M.D.	Lisa Chimner, M.D.	Andrew Tursman, M.D.
Jelanie Bush, M.D.	Katie Elms, M.D.	Tuan Bui, M.D.
Sara Mulder, M.D.	Kristie Koehler, M.D.	Karla Smith, M.D.
LuAnn Labian, M.D.	James Roberson, M.D.	Stephanie Galdes, D.O.
Kimberly Hegewald, M.D.	Kristina Lishawa, M.D.	Rachel Newman, M.D.
Mark Israel, M.D.	Elayna Dush-Bryant, M.D.	Matt Arnold, M.D.
Alicia Classens, PNP	Cathy Carter, PNP	Becky Baker, PNP

References:

https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html

https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-guidance.html

https://www.aappublications.org/news/2021/07/18/schools-071821

https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-planning-considerations-return-to-in-person-education-in-schools/

https://www.michigan.gov/documents/coronavirus/MDHHS_Face_Mask_Recommendations_5.20.21_725941_7.pdf

https://www.gtcountymi.gov/DocumentCenter/View/17014/Delta_Moderna_PR-7-21-21?bidId=

https://www.healthychildren.org/English/health-issues/conditions/COVID-19/Pages/Return-to-School-During-COVID-19.aspx

Dear Administrators and School Board Members of Northwest Lower Michigan:

Thank you for your response and consideration on the issue of masking in our schools. We know you are hearing lots of information and opinions. The last 18 months have been a constant fountain of information for us as practitioners as well. This is often why we rely on evidence-based groups, like the American Academy of Pediatrics, who have assembled experts to review the new and limited data that we have available to help guide our diagnosis, treatment and in this case, public policy.

The list of schools that have opened with voluntary masking and either had to close to in-person classes immediately or change to required masking in our country continues to grow daily. We were already in an area with substantial spread and as noted in the record eagle article just a few days ago, our local hospitalizations continue to rise daily, https://www.record-eagle.com/collections/covid-hospitalizations-on-the-rise/article_5c727fa2-fb76-11eb-a22b-4796b1b2fb9e.html. On a national basis, this week we have seen a record number of children who are currently hospitalized with COVID-19. https://www.reuters.com/world/us/children-hospitalized-with-covid-19-us-hits-record-number-2021-08-14/ . As of August 12th, over 4.41 million children have tested positive for Covid, and 121,000 of those pediatric cases were just added this past week.

We would like to pass along these helpful evidence-based masking resources:

The following is a simulation model from North Carolina of the more contagious delta variant which suggests that with masks and testing, 40-70 percent of new infections can be prevented. They also note that VIRTUAL learning is associated with mental health concerns and little to no learning gain and thus making masking an important tool to mitigate those risks and issues as well.

https://covsim.hosted-wordpress.oit.ncsu.edu/school-level-modeling-results/

Second, the ABC collaborative used data, with support from scientists and physicians from 13 states to put together these recommendations on return to in person school.

https://abcsciencecollaborative.org/wp-content/uploads/2021/06/ABC_year-in-review_29jun2021-final.pdf

If you reference Table 1 on pages 14-15, a comparison of voluntary/incomplete masking and full masking, you will see with full-masking, distancing and cohorting is unnecessary for covid mitigation, as well as potentially shortening quarantines. Regarding the concern about bullying, universal masking would also prevent any one masked or unmasked child from being singled out in this way.

Recently, JAMA, the Journal of American Medical Association, published a meta-analysis of a multitude of global research studies regarding the prevalence of

depression and anxiety in our children and adolescents during the COVID pandemic. These research studies showed that the prevalence of anxiety and depression has doubled in this population compared to the pre-pandemic state. 1in 4 youth globally are experiencing clinically elevated symptoms of depression and 1 in 5 are experiencing clinical symptoms of anxiety. The analysis sites cause for this mental illness crisis being loss of peer interaction, social isolation, reduced contact with important supports including teachers and coaches, missed milestones, and school disruption. Required masking was not identified as a cause of these symptoms.

We understand there are a lot of opinions and anecdotal stories that you are hearing. We feel strongly that it is vital to follow the evidence and the science that is available to us, and institute mandatory masking, in an effort to save lives and decrease morbidity.

Thank you again for your time and effort on this matter.

Sincerely,

The Pediatricians from:

Grand Traverse Children's Clinic
Kids Creek Children's Clinic
Traverse Area Pediatric and Adolescent Clinic

July 28, 2021

Dear Sir/Madam,

It is our understanding that multiple school districts in the areas that Alcona Health Center serves have stated that they plan to start the upcoming 2021-2022 school year making masking in school optional.

In the face of a national COVID Delta variant spread in which our pediatric population remains highly susceptible to infection, we would like to endorse the recent recommendation made by the American Academy of Pediatrics (AAP) that all K-12 students start this school year with universal masking - COVID-19 Guidance for Safe Schools (www.aap.org).

At this time the approval of vaccine for children under the age of 12 years old appears to be months away and there is strong evidence that the new variant has become present in our area.

Masks have virtually no side effects and have been proven quite effective in reducing the spread of COVID. There have been many examples of schools where a supportive environment has resulted in overwhelming cooperation by the students and their parents.

Please review the enclosed AAP statement and accept our recommendation that you follow their lead and protect our children in this way.

Sincerely,

Tom Marshall, MD
Nicole Rice, PA-C
Nate Barden, PA-C
Katherine Erwin, LLMSW
Bernie O'Brien, PA-C
Andrea Eby, FNP-BC
Manuel Chavarri, MD
KiAnn Kruttlin, PA-C
Kathleen Dunckel, MD
Jennifer Attie, FNP-C
Susan Beatty-Page, PA-C
Leah Conboy, DO
Sarah Stevens, PA-C
Marcie Storey, LMSW
Claudio Duarte, MD
Lauren Meisel, MD
Darcie Sharapova, MD
Luke Gray, PA-C
Catherine Zimmerman, DO
Mark Drogowski, MD

McLaren
NORTHERN MICHIGAN

Medical Staff Office

416 Connable Ave.
Petoskey, Michigan
49770

231.487.4289 Phone
231.487.7998 Fax

northernhealth.org

August 18, 2021

As healthcare providers in Northern Michigan, we would like to express our appreciation and support for the Petoskey Public School District's clearly articulated Preparedness Plan. In an effort to prevent Covid-related illness, this document outlines a plan for a safer return to school using science as the backbone for its recommendations. Our entire community faces increased risk if we don't come together to protect each other. Petoskey's plan is a good approach, and we urge other local districts to take a similar strategy to keep our entire county as safe as possible.

Collectively, we care for all age groups throughout our community and the surrounding 22 counties that McLaren Northern Michigan serves. We do our best to care for individuals affected by Covid-19, while also treating other medical ailments and emergencies. However, since the onset of the pandemic, overall hospital capacity has continued to be a challenge. In addition, we unfortunately do not have the capability at McLaren Northern Michigan to care for children who may require a Pediatric ICU setting.

This is an especially challenging time for all of us in the healthcare industry and we remain vigilant as the highly infectious Delta variant continues to spread. As we watch the counties throughout Northern Michigan change from yellow (moderate transmission) to orange (substantial transmission) to red (high transmission) on the CDC Covid tracker map, we implore everyone to take action to prevent further viral transmission. Returning thousands of students to school this fall has the potential to further increase viral spread, especially without a comprehensive mitigation strategy from all school districts.

Multiple mitigation strategies are necessary to prevent Covid illness and outbreaks. While vaccines are still our best tool for preventing illness, hospitalization, and death, not all children have access to a vaccine at this time. For those who do have access, many parents are hesitant to rely on this tool, as evidenced by a vaccination rate of 30-40% for Emmet County children and adolescents ages 12-19 who have completed the series.

Mask wearing is our next best prevention strategy alongside social distancing, hand washing, proper ventilation, contact tracing, and

McLaren
NORTHERN MICHIGAN

Medical Staff Office

416 Connable Ave.
Petoskey, Michigan
49770

231.487.4289 Phone
231.487.7998 Fax

northernhealth.org

symptom surveillance. In addition, mask wearing is most effective when all people are masked. Therefore, universal masking will help kids remain healthy, decrease virus transmission, reduce potential for quarantines and help avoid phases of virtual learning. While universal masking is recommended by the American Academy of Pediatrics, the Centers for Disease Control, and the Michigan Department of Health and Human Services, we recognize that local school districts are facing enormous pressure to defy the scientific recommendations that exist to keep kids safe at school and allow them to continue in person learning.

We all want what is best for our children and it's not always easy to know what that is. As healthcare professionals, we are trained to interpret evidence and offer guidance that promotes the health and safety of our patients and the community. We thank the Petoskey School district for formulating the plan set forth and urge the school board to adopt it. Furthermore, we encourage all schools in Emmet County and surrounding communities to implement a similar approach. Petoskey's plan helps mitigate the spread of potential Covid illness among schools and children, inevitably leading to further prevention of illness for the entire community we serve. This pandemic isn't over and we need a comprehensive approach to ensure the wellbeing of our students and sustainability of their educational opportunities.

Sincerely,

Chandra Delorenzo, DO
Chief of Staff
Pediatric Hospitalist

As of 8am, August 20th, the following healthcare providers have signed the letter of support from Dr. DeLorenzo:

Naomi Overton, MD	Kyle Robertson, DO
Sarah Wolf, DO	Joe Zebelian, MD
Karen DenBesten, MD	Larry McMann, MD
Lauren Morelli, MD	Eugene Wang, D.O.
Katie Fulcher, DO	Shauna Stark, DNP
Quentin Doperalski, DO	Shafer Kurshuk, MD
Sue Sacdalan, NP	Jon A Sangeorzan MD, FACP
Luke McCrone, MD	Marcin Jankowski, DO
Emilee Kennedy, NP	Matthew Font, DO
Murphy Gillespie, NP	Kimberly Clark NP
Duane Nolff, PA-C	Laura Most, MD
Lauren Meisel, MD	Todd Decker, MD
Ashley Cook, MD	William Gretzinger, DO
Guy Golembiewski, MD	K.T. Farmer DO
Cynthia Dryer NP	Dwayne Griffin, D.O.
Todd M. Sheperd MD	Dr. Thomas Loomis, MD
Andrea Naylor, MD	Dr. Wendy Walker, MD
Justin Thomas, DO	Tymon Horn, DO
Isaac Kaufman, MD	Loren M. Wise, MD
Chaitanya V Brundavanam, MD	Kal A. Attie, MD, FACEP
Andrew Hollenbeck, MD	Jason Wolf, PTA
Melanie Manary MD	Rachel J. Burmeister, FNP
Rebecca Price PA-C	Amged Abdelaziz, MD
James A. Doull MD	Michael Olmstead, D.O.
Kara Cockfield, MD	Giffin Robertson, RN
David Knitter MD	Nicholas Frame, MD
Linda Zerby PA	Paul Hagan, MD
Richard Cardillo, MD	Nick Morelli, MD
Matthew Nedwicki PA-C	Jeff Baird, PA
Scott T. Maurer, MD	Alexander Perry, NP
Michael Howson, PA	Andrew Bielaczyc, MD
Jonathan Alterie, DO	Mark Antonishen, MD
Stephanie Rutterbush, MD	Julie Mariotti, MD

Alesia Brown, RN Kevin Markham, MD Heather Ferber, PA-C James Gracy, PA-C Melinda Short, NP Lindsay Knitter, PA-C	Jennifer Attie, FNP-C Paul Blanchard, MD Greg Putalik, MD Catherine Zimmerman, DO Kelly Flynn, DO

Petoskey
PEDIATRICS P.C.

Laura A. Most, MD, FAAP
Dennis E. McGrath, MD, FAAP
Jill S. Decker, MD, FAAP
Barbara C. Jaquith, DNP, APRN, PNP-BC

345 N. Division Rd., Suite D • Petoskey, MI 49770
(231) 347-8382 • Fax: (231) 347-6628

August 16, 2021

Dear School Board Members,

We are writing you regarding the plans for the upcoming academic year, and specifically the District's plans for mitigating the spread of COVID-19 in our schools.

First, we wanted to express deepest gratitude for an extremely successful 2020-2021 academic year, against all odds. The dedication of the Board of Education, administrators, teachers, and staff to the children of our community was nothing short of extraordinary. With the countless negative effects of the pandemic on our children and their educational development, it was no small feat that children were still able to be educated in a safe environment.

As you likely know, the pandemic is far from over. Although we've made many advancements in the prevention and treatment of COVID-19, the emergence of novel variants of concern continue to challenge our control of the pandemic. We fully support your decision to operate schools in person, especially for younger students, where in-person education has been shown again and again to be far superior to virtual or hybrid formats. However, we also recognize that there will be significant risk to our children, educators, staff, and community at large if appropriate mitigation strategies are not used to bring the risk of in-person education down to an acceptable level.

Reflecting on the last academic year, there were several different strategies that the Board put in place to keep schools operational without compromising the health and well-being of students and educators; of all these mitigation strategies, there is one that stands out in terms of keeping the doors open: the universal use of masks. Scientific report after scientific report demonstrate the extraordinary impact of using masks in spaces where people are indoors and in close proximity for prolonged periods of time. The universal use of masks is safe, inexpensive, and is a simple strategy to prevent the spread of Covid within the schools' walls. Masks alone were likely responsible for the extremely low secondary transmission rates of COVID-19 in schools across the country, despite high rates of community transmission of COVID-19. If no other mitigation strategies are used, masks alone may be able to keep our schools operational as we are beginning the next surge of COVID-19.

There are some simple facts that we need to recognize coming into this academic year.

1. Children less than age of 12 years have no access to COVID-19 vaccines, and they are fully naïve to the virus that causes COVID-19, and all of its negative impacts. Vaccine access may be available for children less than 12 years halfway through the academic year. Until then, our children are extremely vulnerable, and the more COVID-19 that replicates in this population, we are inviting the development of more variants of concern.

2. Of children who are eligible to receive a COVID-19 vaccine (those aged 12-17 years), only 30% have been vaccinated. This is well below the threshold for which we could prevent the spread of

COVID-19 through schools. Moreover, as the vaccine is not yet mandatory for children or adults, there is a portion of educators and staff who have not been vaccinated against COVID-19.

3. Currently in the United States, the Delta variant is the dominant variant, and it is the most contagious COVID-19 variant we have witnessed to date (2-3 times more contagious than the Alpha variant that rampaged in the Spring of 2021, and 8 times more contagious than the original variant that entered the US in winter 2020). The Delta variant will pose significant threat to our children and educators. With no preventative strategies in place, Delta will move very efficiently through schools, undoubtedly causing illness, school closures, and potentially severe infections in the pediatric population. Data from the United Kingdom shows that the Delta variant is 2-2.5 times more likely to cause severe disease in young persons. As we start this school year, we will likely be in a surge of COVID-19 due to Delta, with widespread community transmission.

4. This summer, we are seeing the emergence of other respiratory viruses that are not COVID-19, but that can cause symptoms very similar to COVID-19. We need to anticipate that these viruses will enter schools and cause a huge burden of COVID-19 testing, missed school, and disruption to education. This past academic year, we saw that with the universal use of masks in schools kept these other viruses at bay, thereby keeping our population healthy while trying to mitigate the spread of COVID-19.

5. If the use of masks is left to individual choice, it is likely that even children who *intend* to wear masks will not do so if it's not a firm expectation of the school. Also, if mask wearing is left to individual choice, this will undoubtedly cause negative psychological impacts for those who are, or are not, wearing masks, including bullying, intimidation, and other types of harassment.

6. While children generally fare well when infected with the virus that causes COVID-19, their parents, grandparents and community members often do not. The Delta variant may cause breakthrough infections in our vaccinated population, which may cause death and permanent disability in the medically frail. Also, not every child avoids intensive medical care when they develop COVID-19. We have seen hospitalization and maximal life support needed for healthy infants, children and teens from this infection, as well as life-threatening post-infectious complications (Multisystem Inflammatory Syndrome in Children) and chronic manifestations (Long COVID-19) in children as reported by the Director of Infectious Disease at Helen DeVos Children's Hospital.

7. Without universal masks in place, given the contagiousness of the Delta variant, children would need to be spaced out at least 6 feet in classrooms, but possibly much farther out, to avoid infecting their classmates. Also, without masking our students, we will not be able to avoid secondary transmission of COVID-19 in schools, which will result in long quarantines and run the risk of overwhelming our schools and public health departments with contact tracing. Indeed, following such universal mask guidance will likely make school logistically more feasible.

We understand that there are many factors at play when making decisions such as these. However, we need to put aside any motivations other than the health and well-being of our children, educators, and staff. Just because masks are worn universally in schools does not mean that other activities cannot be done; indeed universal mask wearing may allow for the most normal functioning of school and associated activities.

We hope that you will mandate the universal use of masks in schools within the district, but most importantly in schools where children less than 12 years of age do not have access to COVID-19 vaccines.

We hope that being an institute of education, you will rely heavily on all the scientific evidence and facts that have gone into making this recommendation. Information and recommendations provided here come from the recommendations of the American Academy of Pediatrics (AAP) who released their universal masking in school guidelines on July 19, 2021, the CDC who released their same guidelines on August 4, 2021 and the strong recommendations for universal masking made by MDHHS on August 13, 2021. This letter was drafted by Rosemary Olivero, MD, the Division Chief of Pediatric Infectious Disease, Director of HIV Clinical Services, and Director of Antimicrobial Stewardship at Helen DeVos Children's Hospital and modified here with her permission.

Respectfully,

Petoskey Pediatrics

A Moss, MD

[illegible] MD

Barbara Jaquith, DNP, PNP-BC

August 20, 2021

Despite the high rates of community transmission of COVID-19 in the 2020-2021 academic year, we saw very low rates of transmission of COVID-19 in classrooms due to the dedication and commitment to safe schools by teachers, staff, parents and guardians, administrators, boards of education, and our community.

Previously healthy infants, children, and teens in West Michigan have faced hospitalization, life support, life-threatening complications (Multisystem Inflammatory Syndrome in Children) and chronic symptoms (Long COVID-19). The risk of COVID-19 continues with the emergence of a new, more contagious variant. The Delta variant is already the dominant variant in Michigan and is significantly more contagious than the original variant that entered the US in winter 2020.

Nationwide, cases in children have been increasing since the beginning of July 2021 and there are now more children hospitalized with COVID-19 than ever before. While we have not yet seen this happen in Kent County, we predict from what we are seeing in other states and in our local rising incidence of COVID-19, that without protective measures we will see an increase in cases and hospitalizations in children in Kent County as well.

By protecting our children, we will also help protect other vulnerable people in our community. People who have chronic medical conditions, are 65 years of age or older, or have compromised immune systems are especially vulnerable, even when vaccinated, and may experience hospitalization, disability, or death if they become infected.

Our goal for this academic year is to allow schools to provide in-person learning by minimizing the risk of transmission. Given our growing body of knowledge about this virus, **the most effective way to prevent transmission within school buildings is to encourage all eligible individuals to get vaccinated, ensure the universal use of masks, encourage social distancing where possible, continue COVID-19 testing, and to practice quarantining of the sick and exposed while maintaining healthy environments.** Layering these multiple prevention strategies recommended by the Centers for Disease Control and Prevention (CDC) is the best tool to minimize disruptions to student learning this academic year.

The Importance of Masks in Reducing Risk:
Given the presence of the more contagious Delta variant in Kent County, *this Fall masks are even more important than ever.* The universal use of masks in schools is a safe, essential, and proven strategy to reduce the spread of COVID-19 in schools that is recommended by the American Academy of Pediatrics (AAP), the CDC, the Michigan Department of Health and Human Services (MDHHS), and the Kent County Health Department (KCHD).

Recommendations: The KCHD public health orders outline the minimum requirements for schools. However, for schools to reduce disruption to in-person learning and create a safe environment for students, staff, and educators it is also strongly recommended that they:

1. Require universal masking of students and staff in grades 7-12 following the guidance of the CDC
2. Follow the KCHD School Framework for masking, quarantine, testing, and extracurricular activities
3. Follow the KCHD K-12 COVID-19 Symptom and Testing Protocol for staff and students
4. Follow MDHHS Recommendations for Safer School Operations during COVID-19

As we learn more about transmission and prevention of the virus that causes COVID-19 and monitor the incidence of COVID-19 in Kent County, we will adjust our recommendations as necessary to protect the health and well-being of students, educators, and staff in our schools.

Respectfully,

Adam London, PhD, RS, DAAS
Administrative Health Officer, Kent County Health Department

Nirali Bora, MD

Medical Director, Kent County Health Department
Assistant Professor of Family Medicine, Michigan State University College of Human Medicine

We are grateful to the group of health professionals and physicians below who have reviewed and support the recommendations of the Kent County Health Department.

We Are For Children, Pediatric Physician Organization in West Michigan representing 54 pediatricians: ABC Pediatrics, Alger Pediatrics, Bright Start Pediatrics, Cascade Pediatrics, Kent Pediatrics, Forest Hills Pediatric Associates, MiKids Pediatrics, Rockford Pediatrics, Western Michigan Pediatrics

Ben Braun MD
Pediatric Intensivist, Helen DeVos Children's Hospital
Assistant Professor of Pediatrics and Human Development, Michigan State University College of Human Medicine

Jenny Bush, MD, FAAP
Director of Pediatrics, Cherry Health
COVID Response Coordinator, Cherry Health

Ronald G. Grifka, MD, FAAP, FACC, FSCAI
Chief Medical Officer, Metro Health-University of Michigan Health
Professor of Pediatrics, University of Michigan Medical School
Attending Cardiologist, C.S. Mott Children's Hospital

Andrew Jameson, MD, FACP, AAHIVS
Division Chief, Infectious Diseases, Mercy Health West Michigan
Assistant Professor of Medicine, Michigan State University College of Human Medicine

Daliya Khuon, MD
Pediatric Infectious Diseases, Medical Director Helen DeVos Children's Hospital of Spectrum Health, Infection Prevention
Assistant Professor of Pediatrics, Michigan State College of Human Medicine

Lisa M. Lowery, MD, MPH, FAAP, FSAHM
Section Chief -Division of Adolescent & Young Adult Medicine
Associate Professor Department of Pediatrics and Human Development, Michigan State University College of Human Medicine

Erica A. Michiels, MD
Associate Medical Director, Spectrum Health Helen DeVos Children's Emergency Department
Vice Chair, Department of Pediatrics Helen DeVos Children's Hospital
Emergency Care Specialists

Rosemary M. Olivero, MD
Helen DeVos Children's Hospital of Spectrum Health, Division Chief of Medical Specialties, Director of HIV Clinical Services, Director of Antimicrobial Stewardship
Associate Professor of Pediatrics and Human Development, Michigan State College of Human Medicine

Rajat Pareek, MD
Pediatric Critical Care Medicine, SH Helen DeVos Children's Hospital,
Associate Program Director, SH/ MSU Pediatrics Residency Program

Assistant Professor of Pediatrics, MSU College of Human Medicine

Candace Smith-King, MD, FAAP
Academic General Pediatrics, Adolescent and Young Adult Medicine
Assistant Professor of Pediatrics, Michigan State University College of Human Medicine

Barbara E. Stanford, MD
Section Head, Mercy Health Saint Mary's Family Medicine
Associate Program Director, Mercy Health Grand Rapids Family Medicine Residency

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

COVID-19 Guidance for Safe Schools

The AAP strongly advocates that all policy considerations for school plans should start with the goal of keeping students safe and physically present in school.

Purpose and Key Principles

The purpose of this guidance is to continue to support communities, local leadership in education and public health, and pediatricians collaborating with schools in creating policies for safe schools during the COVID-19 pandemic that foster the overall health of children, adolescents, educators, staff, and communities and are based on available evidence. As the next school year begins, there needs to be a continued focus on keeping students safe, since not all students will have the opportunity or be eligible to be vaccinated before the start of the next school year. Since the beginning of this pandemic, new information has emerged to guide

safe in-person learning. Remote learning highlighted inequities in education, was detrimental to the educational attainment of students of all ages, and exacerbated the mental health crisis among children and adolescents. [1,2] Opening schools generally does not significantly increase community transmission, particularly when guidance outlined by the World Health Organization (WHO),[3] United Nations Children's Fund (UNICEF), and Centers for Disease Control and Prevention (CDC) is followed. [4,5] There are still possibilities for transmission of SARS-CoV-2, especially for individuals and families who have chosen not to be vaccinated or are not eligible to be vaccinated. In addition, SARS-CoV-2 variants have emerged that may increase the risk of transmission and result in worsening illness. However, the AAP believes that, at this point in the pandemic, given what we know about low rates of in-school transmission when proper prevention measures are used, together with the availability of effective vaccines for those age 12 years and up, that the benefits of in-person school outweigh the risks in almost all circumstances. Along with our colleagues in the field of education,[6] the American Academy of Pediatrics (AAP) strongly advocates for additional federal assistance to all schools throughout the United States, irrespective of whether the current local context allows for in-person instruction.

Schools and school-supported programs are fundamental to child and adolescent development and well-being and provide our children and adolescents with academic instruction; social and emotional skills, safety, reliable nutrition, physical/occupational/speech therapy, mental health services, health services, and opportunities for physical activity, among other benefits.[7] Beyond supporting the educational development of children and adolescents, schools can play a critical role in addressing racial and social inequity. As such, it is critical to reflect on the differential impact the COVID-19 pandemic and the associated school closures have had on different racial and ethnic groups and populations facing inequities. Disparities in school funding, quality of school facilities, educational staffing, and resources for enriching curricula among schools have been exacerbated by the pandemic. Families rely on schools to provide a safe, stimulating, and enriching space for children to learn; appropriate supervision of children; opportunities for socialization; and access to school-based mental, physical, and nutritional health services.

Everything possible must be done to keep students in schools in-person. Many families did not have adequate support to the aforementioned educational services, and disparities, especially in education, did worsen, especially for children who are English language learners, children with disabilities, children living in poverty, and children who are Black, Hispanic/Latino, and American Indian/Alaska Native. [8,9,10,11]

The AAP strongly recommends that school districts promote racial/ethnic and social justice by promoting the well-being of **all** children in any school COVID-19 plan, with a specific focus on ensuring equitable access to educational supports for children living in under-resourced communities.

It is critical to use science and data to guide decisions about the pandemic and school COVID-19 plans. All school COVID-19 policies should consider the following key principles and remember that COVID-19 policies are intended to mitigate, not eliminate, risk. Because school transmission reflects (but does not drive) community transmission, it is vitally important that communities take all necessary measures to limit the community spread of SARS-CoV-2 to ensure schools can remain open and safe for all students.
The implementation of several coordinated interventions can greatly reduce risk:

- **All eligible individuals should receive the COVID-19 vaccine.**
    - It may become necessary for schools to collect COVID-19 vaccine information of staff and students and for schools to require COVID-19 vaccination for in-person learning.
    - Adequate and timely COVID-19 vaccination resources for the whole school community must be available and accessible.
- **All students older than 2 years and all school staff should wear face masks at school (unless medical or developmental conditions prohibit use).**
    - **The AAP recommends universal masking in school at this time for the following reasons:**
        - a significant portion of the student population is not eligible for vaccination
        - protection of unvaccinated students from COVID-19 and to reduce transmission
            - lack of a system to monitor vaccine status among students, teachers and staff
        - potential difficulty in monitoring or enforcing mask policies for those who are not vaccinated; in the absence of schools being able to conduct this monitoring, universal masking is the best and most effective strategy to create consisent messages, expectations, enforcement, and compliance without the added burden of needing to monitor vaccination status
        - possibility of low vaccination uptake within the surrounding school community
        - continued concerns for variants that are more easily spread among children, adolescents, and adults
- An added benefit of universal masking is protection of students and staff against other respiratory illnesses that would take time away from school.

- Adequate and timely COVID-19 testing resources must be available and accessible.
- It is critically important to develop strategies that can be revised and adapted depending on the level of viral transmission and test positivity rate throughout the community and schools, recognizing the differences between school districts, including urban, suburban, and rural districts.
- School policies should be adjusted to align with new information about the pandemic; administrators should refine approaches when specific policies are not working.[12]
- Schools must continue to take a multi-pronged, layered approach to protect students, teachers, and staff (ie, vaccination, universal mask use, ventilation, testing, quarantining, and cleaning and disinfecting). Combining these layers of protection will make in-person learning safe and possible. Schools should monitor the implementation and effectiveness of these policies.
- Schools should monitor the attendance of all students daily inclusive of in-person and virtual settings. Schools should use multi-tiered strategies to proactively support attendance for all students, as well as differentiated strategies to identify and support those at higher risk for absenteeism.
- School districts must be in close communication and coordinate with state and/or local public health authorities, school nurses, local pediatric practitioners, and other medical experts.
- School COVID-19 policies should be practical, feasible, and appropriate for child and adolescent's developmental stage and address teacher and staff safety.
    - Special considerations and accommodations to account for the diversity of youth should be made, especially for populations facing inequities, including those who are medically fragile or complex, have developmental challenges, or have disabilities. Children and adolescents who need customized considerations should not be automatically excluded from school unless required in order to adhere to local public health mandates or because their unique medical needs would put them at increased risk for contracting COVID-19 during current conditions in their community.
- School policies should be guided by supporting the overall health and well-being of all children, adolescents, their families, and their communities and should also look to create safe working environments for educators and school staff. This focus on overall

health and well-being includes addressing the behavioral/mental health needs of students and staff.

- These policies should be consistently communicated in languages other than English, when needed, based on the languages spoken in the community, to avoid marginalization of parents/guardians of limited English proficiency or who do not speak English.
- Ongoing federal, state, and local funding should be provided for all schools so they can continue to implement all the COVID-19 mitigation and safety measures required to protect students and staff. Funding to support virtual learning and provide needed resources should continue to be available for communities, schools, and children facing limitations implementing these learning modalities in their home (eg, socioeconomic disadvantages) or in the event of school re-closure because of a resurgence of SARS-CoV-2 in the community or a school outbreak.

With the above principles in mind, **the AAP strongly advocates that all policy considerations for school COVID-19 plans should start with a goal of keeping students safe and physically present in school.** The importance of in-person learning is well-documented, and there is already evidence of the negative impacts on children because of school closures in 2020.[13]

Policy makers and school administrators must also consider the scientific evidence regarding COVID-19 in children and adolescents, including the role they may play in the transmission of the infection.[14,15,16,17,18,19,20,21,22] Although many questions remain, the preponderance of evidence indicates that children and adolescents are less likely to have severe disease resulting from SARS-CoV-2 infection.[23,24] We continue to learn more about the role children play in the transmission of SARS-CoV-2. At present, it appears that children younger than 10 years are less likely to become infected and less likely to spread the infection to others, although further studies are needed.[25,26,27] Some data suggest children older than 10 years may spread SARS-CoV-2 as efficiently as adults. Additional in-depth studies are needed to truly understand the infectivity and transmissibility of this virus in anyone younger than 18 years, including children and adolescents with disabilities and medical complexities. Current SARS-CoV-2 variants may change both transmissibility and infection in children and adolescents even in those who have been vaccinated.

Visit the CDC COVID-19 Prevention Strategies for additional information on mitigation measures including physical distancing, testing, contact tracing, ventilation, and cleaning and disinfecting.

In the following sections, some general principles are reviewed that policy makers and school administrators should consider as they safely plan for in-person school. There are several other documents released by the CDC, the **National Association of School Nurses**, and the **National Academy of Sciences, Engineering, and Medicine** that can be referenced as well. For all of these, engagement of the entire school community, including families, teachers, and staff, regarding these measures should be a priority.

Special Considerations for School Health During the COVID-19 Pandemic

School Attendance and Absenteeism: Studies performed throughout the pandemic demonstrated wide variability in tracking of school attendance. As of January 2021, only 31 states and the District of Columbia required attendance to be taken.[28] Definitions of attendance for individuals participating in distance learning have varied between and within states. Among jurisdictions that did report on attendance during the pandemic period, several studies demonstrate disparities in impact of chronic absence.[29] In an evaluation of Connecticut's attendance data from school year 2020-21, rates of chronic absenteeism were highest among predominantly remote students compared with students who were primarily in-person; that gap was most pronounced among elementary and middle school students. Chronic absence was more prevalent among Connecticut students who received free or reduced-price lunch, were Black or Hispanic, were male, or identified as English learners or having disabilities.29 National prepandemic chronic absenteeism data mirror several of these demographic trends.[30]

The best way to reduce absenteeism is by closely monitoring attendance and acting quickly once a pattern is noticed.[31] During the the 2021-22 school year, daily school attendance should be monitored for all students; for students participating in in-person and distance learning. Schools should use multi-tiered strategies to proactively support student attendance for all students. Additionally, schools should implement strategies to identify and differentiate interventions to support those at higher risk for absenteeism. Local data should be used to define priority groups whose attendance has been most deeply impacted during the pandemic. Schools are encouraged to create an attendance action plan with a central emphasis on family engagement leading up to and through the start of school.

With the beginning of the 2021-22 school year, plans should be in place for outreach to families whose students do not return for various reasons. This outreach is especially critical, given the high likelihood of separation anxiety and agoraphobia in students. Students may have difficulty with the social and emotional aspects of transitioning back into the school setting, especially given the unfamiliarity with the changed school environment and experience. Special considerations are warranted for students with pre-existing anxiety, depression, and other mental health conditions; children with a prior history of trauma or loss; children with autism spectrum disorder; and students in early education who may be particularly sensitive to disruptions in routine and caregivers. Students facing other challenges, such as poverty, food insecurity, and homelessness, and those subjected to ongoing inequities may benefit from additional support and assistance. Schools should identify students who are at risk for not returning and conduct outreach prior to the beginning of the school year. Resources should be available to assist families with preparing their student for transition back to school.

Students with Disabilities: The impact of loss of instructional time and related services, including mental health services, as well as occupational, physical, and speech/language therapy during the period of school closures and remote learning is significant for students with disabilities. All students, but especially those with disabilities, may have more difficulty with the social and emotional aspects of transitioning out of and back into the school setting because of the pandemic. As schools prepare for or continue in-person learning, school personnel should develop a plan to ensure a review of each child and adolescent with an IEP to determine the needs for compensatory education to adjust for lost instructional time and disruption in other related services. In addition, schools can expect a backlog in evaluations; therefore, plans to prioritize students requiring new referrals as opposed to reviews and re-evaluations will be important. Many school districts require adequate instructional effort before determining eligibility for special education services. However, virtual instruction or lack of instruction should not be reasons to avoid starting services such as response-to-intervention (RTI) services, even if a final eligibility determination is delayed.

Each student's IEP should be reviewed with the parent/guardian/adolescent yearly (or more frequently if indicated). All recommendations in the IEP should be provided for the individual child no matter which school option is chosen (in person, blended, or remote). See the **AAP Caring for Children and Youth with Special Health Care Needs During the COVID-19 Pandemic** for more details.

Additional COVID-19 safety measures for teachers and staff working with some students with disabilities may need to be in place to ensure optimal safety for all. For certain populations, the

use of face masks by teachers may impede the education process. These include students who are deaf or hard of hearing, students receiving speech/language services, young students in early education programs, and English language learners. There are products (eg, face coverings with clear panels in the front) that may be helpful to use in this setting.

Adult Staff and Educators: Universal use of face masks is recommended, given that certain teachers must cross-over to multiple classes, such as specials teachers, special educators, and secondary school teachers, and in consideration of new SARS-CoV-2 variants. At this time, this recommendation for use of face masks includes staff and educators who have been fully vaccinated, especially for teachers with students who are unvaccinated (including pre-K, kindergarten, and elementary schools). School staff working with students who are unable to wear a face mask or who are unable to manage secretions, who require high-touch (hand over hand) instruction, and who must be in close proximity to these students should consider wearing a surgical mask in combination with a face shield.

School health staff should be provided with appropriate medical PPE to use in health suites. This PPE should include N95 masks, surgical masks, gloves, disposable gowns, and face shields or other eye protection. School health staff should be aware of CDC guidance on infection control measures.

On-site School-Based Health Services: On-site school health services, including school-based health centers, should be supported if available, to complement the pediatric medical home and to provide pediatric acute, chronic, and preventive care. Collaboration with **school nurses** is essential, and school districts should involve school health services staff and consider collaborative strategies that address and prioritize immunizations and other needed health services for students, including behavioral health, vision screening, hearing, dental and reproductive health services. Plans should include required outreach to connect students to on-site services regardless of remote or in-person learning mode.

Immunizations: Pediatricians should work with schools and local public health authorities to promote childhood vaccination messaging well before the start of the school year and throughout the school year. It is vital that all children receive recommended vaccinations on time and get caught up if they are behind as a result of the pandemic. The capacity of the health care system to support increased demand for vaccinations should be addressed through a multifaceted, collaborative, and coordinated approach among all child-serving agencies including schools.

Existing school immunization requirements should be discussed with the student and parent community and maintained. In addition, **although influenza vaccination is generally not**

required for school attendance, it should be highly encouraged for all students and staff. The symptoms of influenza and SARS-CoV-2 infection are similar, and taking steps to prevent influenza will decrease the incidence of disease in schools and the related lost educational time and resources needed to handle such situations by school personnel and families. School districts should consider requiring influenza vaccination for all staff members.

Schools should collaborate with state and local public health agencies to ensure that teachers and staff have access to the COVID-19 vaccine and that any hesitancy is addressed as recommended by the **Advisory Committee on Immunization Practices (ACIP) of the CDC.** Pediatricians should work with families, schools, and public health to promote receipt of the **COVID-19 vaccine and address hesitancy** as the vaccine becomes available to children and adolescents.

In order to vaccinate as many school staff, students, and community members as possible, **school-located vaccination clinics** should be a priority for school districts. Schools are important parts of neighborhoods and communities and serve as locations for community members after school hours and on weekends.

Vision Screening: Vision screening practices should continue in school whenever possible. Vision screening serves to identify children who may otherwise have no outward symptoms of blurred vision or subtle ocular abnormalities that, if untreated, may lead to permanent vision loss or impaired academic performance in school. Personal prevention practices and environmental **cleaning and disinfection** are important principles to follow during vision screening, along with any additional guidelines from local health authorities.

Hearing Screening: Safe hearing screening practices should continue in schools whenever possible. School screening programs for hearing are critical in identifying children who have hearing loss as soon as possible so that reversible causes can be treated and hearing restored. Children with permanent or progressive hearing loss will be habilitated with hearing aids to prevent impaired academic performance in the future. Personal prevention practices and environmental **cleaning and disinfection** are important principles to follow during hearing screening, along with any additional guidelines from local health authorities.

Children with Chronic Illness: Certain children with chronic illness may be at risk for hospitalization and complications with SARS-CoV-2. These youth and their families should work closely with their pediatrician and school staff using a shared decision-making approach regarding options regarding return to school, whether in person, blended, or remote. See the **AAP Caring for Children and Youth with Special Health Care Needs During the COVID-19 Pandemic** for more details.

Behavioral Health/Emotional Support for Children and Adolescents: The COVID-19 pandemic has created profound challenges for communities, families, and individuals, leading to a range of emotional and behavioral responses. There are many factors unique to this pandemic (eg, grief/loss, uncertainty, rapidly changing and conflicting messages, duration of the crisis, and need for quarantine) that increase its effects on emotional and behavioral health (EBH). Populations with a higher baseline risk, such as historically under-resourced communities, children and youth with developmental disabilities and other special health care needs, may be especially vulnerable to these effects. [32,33] The impact of the pandemic is also compounded by isolation and an interruption in the support systems families utilize.

Schools are a vital resource to continue to address and provide resources for a wide range of mental health needs of children and staff. The emotional impact of the pandemic, grief because of loss, financial/employment concerns, social isolation, and growing concerns about systemic racial inequity—coupled with prolonged limited access to critical school-based mental health services and the support and assistance of school professionals—demand careful attention and supports in place during all modes of learning, whether remote or in-person. Schools should be prepared to adopt an approach for mental health support, and just like other areas, supporting mental health will require additional funding to ensure adequate staffing and the training of those staff to address the needs of the students and staff in the schools.

Schools should consider providing training to classroom teachers and other educators on how to talk to and support children during and after the COVID-19 pandemic including how to support grief and loss among students. The United States has already accumulated more than 600,000 deaths from COVID-19; on average, it is estimated that each of these deaths impacts 9 people – many of these 4.5 million grieving individuals are children. Bereavement has a significant impact on the short- and long-term adjustment of children, their developmental trajectory, academic learning, psychosocial functioning, and emotional adjustment and behavior. Students experiencing significant personal losses can be referred to school and community-based bereavement support programs, centers, and camps, as well as to their **pediatrician or other pediatric health care provider**.[34] Students with additional mental health concerns should be referred to school mental health professionals.

Suicide is the second leading cause of death among adolescents or youth 10 to 24 years of age in the United States.[35] Schools should develop mechanisms to evaluate youth remotely and in-person if concerns about a risk of suicide are voiced by educators or family members and

should be establishing policies, including referral mechanisms for students believed to be in need of in-person evaluation, even before schools resume in-person instruction.

School mental health professionals should be involved in shaping messages to students and families about the response to the pandemic and the changing school learning plans based on a variety of community SARS-CoV-2 factors. Fear-based messages widely used to encourage strict physical distancing may cause problems when schools resume in-person instruction, because the risk of exposure to COVID-19 may be mitigated but not eliminated. Communicating effectively is especially critical, given potential adaptations in plans for in-person or distance learning that need to occur during the school year because of changes in community transmission of SARS-CoV-2.

Schools need to incorporate academic accommodations and supports for all students who may still be having difficulty concentrating or learning new information because of stress or family situations that are compounded by the pandemic. It is important that school personnel do not anticipate or attempt to catch up for lost academic time through accelerating curriculum delivery at a time when students and educators may find it difficult to even return to baseline rates. These expectations should be communicated to educators, students, and family members so that school does not become a source of further distress

(See: **Interim Guidance on Supporting the Emotional and Behavioral Health Needs of Children, Adolescents, and Families During the COVID-19 Pandemic**)

Mental Health of Staff

The personal impact on educators and other school staff should be recognized. In the same way that students need ongoing support to process the information they are being taught, teachers cannot be expected to be successful at teaching children without having their mental health needs supported. The strain on teachers, as they have been asked to teach differently while they support their own needs and those of their families, has been significant. Additional challenges with staff shortages, changing learning modalities, and prolonged duration of the crisis are continuing to present additional challenges and further impact teachers and school staff. Resources such as Employee Assistance Programs and other means to provide support and mental health services should be prioritized. The individual needs and concerns of school professionals should be addressed with accommodations made as needed.

Although schools should be prepared to be agile to meet evolving needs and respond to increasing knowledge related to the pandemic and may need to institute partial or complete closures when the public health need requires, school leaders should recognize that staff, in addition to students and families, will benefit from sufficient time to understand and adjust to changes in routine and practices. During a crisis, people benefit from clear and regular communication from a trusted source of information and the opportunity to dialogue about concerns and needs and feel they are able to contribute in some way to the decision-making process. Change is more difficult in the context of crisis and when predictability is already severely compromised.

Food Insecurity: According to the United States Department of Agriculture, the number of food-insecure households has increased during the pandemic with a currently estimated 30 million adults and 12 million children living in households where they may not get enough to eat.[36] We also know that disparities with food insecurity exist, with Black and Latino adults being twice as likely as white adults to report their households did not get enough to eat.[34] School planning must consider the many children and adolescents who experience food insecurity already (especially at-risk populations and those living in poverty) and those who will have limited access to routine meals through the school district in the event of school closure or if a child is ill. The short- and long-term effects of food insecurity in children and adolescents are profound.[37] Schools can partner with community resources including federal and state food programs to mitigate the effects of food insecurity on children and families. More information about how families can access federal nutrition programs can be found in the **AAP/FRAC Food Insecurity Toolkit**.

Housing Insecurity: Like food insecurity, housing insecurity is a significant and sometimes overlooked issue that affects many families and will impact children's ability to return and re-engage with school. With pandemic-associated job losses, there have been significant numbers of families with children who have been evicted or will soon be evicted from their homes. According to the US Census Bureau, as of February 2021, there are 5.2 million households with children who are behind on rent and 4.5 million homeowners with children behind on mortgage payments.[38] Housing insecurity impacts a child's education directly through missed school days and through transferring to a new school, which is associated with a 4 times higher risk of chronic absenteeism, lower grades and test scores, and increased risk of dropping out of school.[39] Housing insecurity also impacts education indirectly by impacting a child's overall physical and mental health, which can have negative consequences for educational achievement. Children who experience homelessness are at increased risk for

malnutrition, asthma, obesity, and dental, vision, emotional, behavioral, and developmental problems.[40] In addition, the increased toxic stress children experience when they live in unstable housing situations can contribute to anxiety and other mental health conditions that interfere with a child's education. The interconnectedness of employment, housing, health, and education and the disproportionate impact this has had on communities of color because of structural racism must be considered as children return to school.[41] Schools are encouraged to partner with community agencies to address the effects of housing insecurity and mitigate the impact this will have on the education of children.

Digital Divide: The digital divide has been a known disparity for decades, contributing to the "homework gap"—the gap between school-aged children who have access to high-speed internet at home and those who do not. According to a Pew research study in 2015, 35% of lower-income households with school-aged children did not have a broadband internet connection at home. According to the Pew Research Center, 1 in 5 teenagers are not able to complete schoolwork at home because of a lack of a computer or internet connection.[42] This technological homework gap disproportionately affects Black families living in poverty.9 With the transition to virtual learning during the pandemic, this divide was highlighted as families struggled to adapt to school from home. In April 2020, **59% of parents** with lower incomes who had children in schools that were remote because of the pandemic said their children would likely face at least 1 of 3 digital obstacles to their schooling, such as a lack of reliable internet at home, no computer at home, or needing to use a smartphone to complete schoolwork. Gains have been made over this past year with creative local and state solutions working toward providing improved access to both technology devices and internet connections for students, but a significant gap still exists, particularly for students living in poverty. **This digital divide is a critical component to be addressed in schools even as children return to in-person learning as they navigate the increasing digital learning environment, academic recovery, and extended home learning materials. Access to both reliable high-speed internet and adequate devices beyond a smart phone are critical to promote equity and support academic success.** Long-term sustainable funding is needed to support school districts in providing universal internet access and technology for all students.

Organized Activities: It is likely that sporting events, practices, and conditioning sessions as well as other extracurricular activities will be limited in some locations while reopening fully in other locations. **The AAP Interim Guidance on Return to Sports** helps pediatricians inform families on how best to ensure safety when considering a return to sports and physical activity participation. Preparticipation evaluations should be conducted in alignment with the **AAP Preparticipation Physical Evaluation Monograph, 5th ed**, and state and local guidance.

Additional Information

- AAP Guidance Related to Childcare During COVID-19
- AAP Guidance on Providing Pediatric Well-Care During COVID-19
- AAP Guidance on Face Masks
- AAP Guidance on Testing
- AAP Guidance on Use of Personal Protective Equipment (PPE)
- AAP Guidance on Caring for Children and Youth with Special Health Care Needs During the COVID-19 Pandemic
- AAP Guidance on Supporting the Emotional and Behavioral Health Needs of Children, Adolescents and Families During the COVID-19 Pandemic
- AAP Guidance on Return to Sports
- List of latest AAP News articles on COVID-19
- Pediatrics COVID-19 Collection
- AAP COVID-19 Advocacy Resources (Login required)
- Centers for Disease Control and Prevention: Guidance for COVID-19 Prevention in K-12 Schools
- US Department of Education: COVID-19 Resources for Schools, Students, and Families
- Information for Parents on HealthyChildren.org: Returning to School During COVID-19

Resources

- Coalition to Support Grieving Students
- Using Social Stories to Support People with I/DD During the COVID-19 Emergency
- Social Stories for Young and Old on COVID-19

References

Interim Guidance Disclaimer: The COVID-19 clinical interim guidance provided here has been updated based on current evidence and information available at the time of publishing. Guidance will be regularly reviewed with regards to the evolving nature of the pandemic and emerging evidence. All interim guidance will be presumed to expire on December 31, 2021 unless otherwise specified.

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Source American Academy of Pediatrics