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Butler County
General Health District

EARLY CARE AND EDUCATION PROGRAMS/PROVIDERS COVID-19 GUIDANCE

BUTLER COUNTY, OH

GUIDANCE FOR BUTLER COUNTY EARLY CARE AND EDUCATION PROGRAMS AND PROVIDERS REGARDING QUARANTINE, ISOLATION, AND IDENTIFYING CLOSE CONTACTS.

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EXECUTIVE SUMMARY

The rapid spread and clinical course of illness caused by the Omicron variant of SARS-CoV-2 has made universal contact tracing and case investigation impractical for the general population. Butler County General Health District (BCGHD) will follow the lead of the Ohio Department of Health (ODH) and the recommendations of the American Public Health Association (APA) and the Council of State and Territorial Epidemiologists (CSTE) in adopting a targeted approach for public health interventions as it relates to contact tracing and case investigation for the general population.

Guidance pertaining to the Early Care and Education (ECE) Programs/Providers has been released for this new stage in the management and mitigation of COVID-19 by the Centers for Disease Control and Prevention (CDC). This guidance aims to supplement CDC's guidance. Universal contact tracing is no longer occurring on a county level for the general population, however it is still an expectation that ECE programs/providers complete this in a majority of circumstances. Most ECE programs/providers serve children in an age group that are not yet eligible for vaccination, therefore contact tracing will be of high impact and importance.

When a confirmed or probable case of COVID-19 is known to have been in the facility within 48 hours from symptom onset or test date, contact tracing within the facility should occur. Families or staff should be notified if their child or they are identified as a close contact, regardless of vaccination status or previous COVID-19 infection. The ECE program/provider should also educate the members of the community that it serves that COVID-19 at a high transmission level means that attendees/staff are in a near constant state of exposure, though the quality of the exposure will vary. Please report probable or confirmed cases of COVID-19 within the facility to BCGHD by the end of the next business day.

SECTION 1: INTRODUCTION

Coronavirus Disease-2019 (COVID-19) is a respiratory disease caused by the virus SARS-CoV-2. It was first discovered as a cluster of severe respiratory diseases and pneumonia of unknown etiology in Wuhan, China, in late 2019. The disease rapidly spread across the world and the United States saw its first case in January of 2020. Butler County had its first case reported on March 10, 2020. Contact tracing would later identify the first cases as occurring February 28, 2020. In the subsequent two years many different iterations of guidance have been published as the disease evolved as well as research regarding COVID-19. All expertise agrees that children thrive when they are in in-person learning. The best way to keep children both safe and in the classroom is to introduce layered prevention strategies when necessary.

SECTION 2: REPORTING OF COVID-19 CASES AND OUTBREAKS

The ECE program/provider should report all known facts of the case and demographics that the health department requests. This requested information will be in the form of the line list. At a minimum, it is required to send the case's demographic information. It remains the recommendation of BCGHD to report cases of COVID-19 within the program as often as is feasible. Known cases and outbreaks (see definition in relevant section) should be reported by the end of the next business day. Please see your ODJFS Communicable Disease Chart (JFS-08087) for further reporting requirements.

SECTION 3: EXCLUDING FOR ISOLATION AND QUARANTINE

Isolation and quarantine have been the predominant forms of secondary interventions in the COVID-19 pandemic to prevent the spread of illness. Isolation is the removal and limitation of movement of an infected person who is contagious from the general population in order to prevent the spread of the pathogen. Quarantine is the removal and limitation of movements of an individual who has been exposed to the causative agent of a quarantine-able condition.

GUIDANCE ON ISOLATION

An individual who has been infected with COVID-19 (see types of cases and criteria to determine; Appendix A) must be excluded from the facility for a minimum of 5 days from symptom onset. In the absence of symptoms (see asymptomatic infection; Appendix A) the individual must be excluded for a minimum of 5 days from the date of the test collection. Five days should be understood to be a minimum and symptom based. An individual whose symptoms have not improved should be excluded until they are fever free for 24 hours without the use of medication and a marked improvement in their symptoms. Individuals who are back in the facility before 10 full days (since either symptom onset or test collection date) need to be in a mask as part of their isolation, and they should be excluded if they cannot or will not wear a mask consistently and correctly for the full 10 days. Positive individuals who have returned after day 5 and before 10 full days should be physically distanced while doing anything that requires them to not be wearing a mask.

GUIDANCE ON QUARANTINE

It is important to note that ECE programs/providers are not to use the K-12 Guidance (Mask to Stay / Test to Play). There have been discussions with ODH about this, and the stance continues to follow CDC's guidance for this specific population. When and if this guidance changes, BCGHD will notify ECE programs/providers. As a reminder, BCGHD will allow private kindergartens and kindergarten classrooms that are connected to daycares to use the K-12 guidance.

EXEMPT FROM QUARANTINE

Individuals who are up-to-date with their vaccination series for COVID-19 are not subject to quarantine. (Please see Appendix C for information regarding staying up to date with COVID-19 vaccine). Individuals who have had COVID-19 (and illness can be verified) in the last 90 days are not subject to quarantine. Individuals who are exposed to COVID-19, regardless of vaccination status or previous 90-day infection, should symptom monitor for 14 days after last exposure. If symptoms develop with the 14-day period, the individual should get a test and isolate immediately. Notify close contacts.

QUARANTINE OPTION 1

If an attendee or staff member is subject to quarantine, the earliest they can return to the facility is day 6 after last exposure. Individuals must quarantine, and thus be excluded from the program, for a minimum of 5 full days after last exposure. Individuals returning to the program on day 6 after last exposure must wear a mask consistently and correctly through day 10. Children under two years of age are not to wear a face mask. If individuals are unable to wear a mask consistently and correctly, they are required to quarantine at home for a full 10 days. They may return to the program on day 11 after last exposure.

QUARANTINE OPTION 2

BCGHD will allow a reduced duration of quarantine when community levels are "Low" (please see Section 6 and Appendix C for information regarding community levels). If an attendee or staff member is subject to quarantine, they will need to quarantine, and thus be excluded from the facility, for a full 7 days after last exposure. They can receive a proctored antigen or PCR test on days 5-7 after last exposure, and if they test negative and remain without symptoms, they may return to the program mask free after day 7. Tests collected before day 5 after last exposure will not be accepted. It is the ECE program/providers responsibility to receive verified negative results before letting an attendee or staff member return to the facility.

SECTION 4: CASE INVESTIGATION

Whether a case will be considered a candidate for being linked to either a cluster or an outbreak will be based on if the case has an epidemiological linkage outside of the ECE program/provider setting. The case investigation must then determine if the case represents part of an outbreak or other high risk setting where additional mitigation and measures need to be taken. Case investigations that occur as part of an outbreak and an investigation of a single or non-outbreak related case are going to

have different aspects involved. Additionally, both BCGHD and the ECE program/provider will have roles to play in resolving the investigation (Please see the Appendix for definitions regarding cases and their criteria).

ROLE OF THE FACILITY IN CASE INVESTIGATION

The roles of the ECE program/provider is often defined by the fact that the facility often has an information advantage over public health and a time advantage that allows the facility to institute public health interventions immediately or to notify public health for additional measures. This includes, but is not limited to, classroom exposure, certain high risk settings, and potential outbreak transmission.

The primary role of the ECE program/provider should be seen through the lens of addressing the immediate threat of contagion in the program. This can be done by exclusion of attendees/staff who are actively shedding viable viral particles and/or sending attendees/staff home when they are subject to quarantine. With the rollout of widespread at home-tests, ECE programs/providers will find out about many positive cases due to staff or parental reporting that would not otherwise be reported to BCGHD. In this event, ECE programs/providers are to continue following the practice of not waiting for public health notification to exclude attendees/staff from the program, and then notifying public health of cases of which they are aware. Additionally, it is a shared role between the ECE program/provider and BCGHD for determining both the likely transmission history for outbreak reporting purposes as well as the risk for transmission.

RECOMMENDED STEPS IN CASE INVESTIGATION FOR THE ECE PROGRAM/PROVIDER

1. Identify cases:
    a. Establish a system for reporting cases to the ECE program/provider.
        i. Most ECE programs/providers have pre-existing systems for parents and staff members to report in illnesses, and have modified these systems appropriately for COVID-19. ECE programs/providers that have these systems in place should continue to use them.
    b. Use Appendix A to identify attendees and staff who meet case definition.
    c. Receive a report from public health of an individual who reported their ECE program/provider during independent case investigation.
2. Exclude attendees and staff members identified as cases:

a. If reported by a parent or staff member, convey recommended isolation guidelines.
    i. If within 5 days of their test or symptom onset, exclude from program until 5 days have passed from their test or symptom onset date.
    ii. If/when greater than 5 days but within 10 days of their test or symptom onset, allow back into program with a mask on until 10 full days have passed from their test or symptom onset date IF case is asymptomatic or symptoms have markedly improved.
    iii. If/when greater than 5 days but less than 10 days of their test or symptom onset and case remains symptomatic with no improvement in symptoms and/or febrile, continue to exclude from the program until afebrile with a marked improvement in symptoms without the aid of medication.
    iv. If after 10 days and case is asymptomatic or recovered, allow back into program with no additional precautions and move to step 3.
    v. If after 10 days and case remains symptomatic with no improvement in symptoms and/or febrile, continue to exclude from the program until afebrile with a marked improvement in symptoms without the aid of medication. Recommend medical guidance.

b. If an attendee is identified by symptoms and exposure (probable case definition), onsite screening, or notified by BCGHD:
    i. If within 5 days of symptom onset or test result date remove individual from shared space/classroom/activity.
        1. Move attendee to space safe for the individual to isolate, until he or she can be picked up by a guardian.
        2. Convey to legal guardian guidelines as stated in Step 2.a.
    ii. If/when greater than 5 days but within 10 days of their test or symptom onset AND case is asymptomatic or markedly improved, remove attendee from shared space/classroom/activity and place them in mask precautions until 10 full days have passed since their test or symptom onset. They must be able to wear a mask correctly and consistently. Individual two and younger should not be wearing a mask. See page 5 for quarantine guidance.
    iii. If/when greater than 5 days but within 10 days of their test or symptom onset AND case remains symptomatic with no improvement follow Step 2.b.i.

iv. If after 10 days and case is asymptomatic or recovered, allow resuming normal activities with no additional precautions and move to step 3.

v. If after 10 days and case remains symptomatic with no improvement in symptoms and/or febrile, continue to exclude until afebrile with a marked improvement in symptoms without the aid of medication. Recommend consultation with primary care provider to parent.

c. If staff case is identified by symptoms and exposure (probable case definition), onsite screening, or notified by BCGHD:

i. Notify staff member and exclude from work for recommended period.

ii. Follow isolation protocol as outlined above.

3. Determine transmission status of case:

a. Ask case, or case's guardian when applicable, if the case had any known exposure to COVID-19 within the previous 14 days outside of the ECE program, what kind of exposure it was (e.g. parent, friend, family member, etc.) and when.

b. Determine if there were any cases in attendee or staff members classes, activities, or known peer groups.

4. Determine if case is part of an outbreak or cluster

a. If the case is associated with the ECE program or unknown transmission, determine if there are 3 or more cases in a defined core group OR if there are multiple cases making up more than 10% of a core group.

SECTION 6: RECOMMENDATION ON THE USE OF FACEMASKS

BCGHD is currently following the CDC's Risk-based "COVID-19 Community Levels" for recommending when masks should be universally worn in indoor places. Individuals younger than two years old should not be wearing a mask. It is important to note that through the late pandemic this is a fluid guideline based on the circumstances on the ground with greatest importance placed on the stability of the

Community Level	Low	Medium	High
Recommended Actions	Stay up to date with COVID-19 vaccines. Get tested if you have symptoms. Wear a mask if you have symptoms, a positive test, or exposure to someone with COVID-19. Wear a mask on public transportation. You may choose to wear a mask at any time as an additional precaution to protect yourself and others	Stay up to date with COVID-19 vaccines. Get tested if you have symptoms. Wear a mask if you have symptoms, a positive test, or exposure to someone with COVID-19. Wear a mask on public transportation. You may choose to wear a mask at any time as an additional precaution to protect yourself and others. If you are at high risk for severe illness, consider wearing a mask indoors in public and taking additional precautions.	Wear a mask indoors in public and on public transportation. Stay up to date with COVID-19 vaccines. Get tested if you have symptoms. If you are at high risk for severe illness, consider taking additional precautions.

healthcare system in Butler County. The following guidelines are set for ECE programs/provider in BCGHD's jurisdiction. BCGHD will notify ECE programs/providers when or if the community levels change, and it will be publicly posted.

If there is an outbreak in your facility, we recommend that your facility begin an immediate mask-wearing policy for the duration of the outbreak.

ATTENDEES OR STAFF WHO CANNOT WEAR A MASK DUE TO MEDICAL OR DEVELOPMENTAL DISABILITY

In situations where this occurs it is important to contact BCGHD to consider whether or not an unmasked attendee or staff member can safely remain in the program.

Contributing factors:

- Social distancing strategies in place.
- Ability for attendee or staff to follow mitigation strategies
- Community transmission rates.

SECTION 8: OUTBREAK RESPONE

DEFINING OUTBREAKS AND CLUSTERS

CLUSTER DEFINITION

Multiple cases comprising at least 10% of attendees and/or staff within a specified core group* OR at least two (2)within a specified core group* meeting criteria for a facility-associated COVID-19 case; with symptom onset or positive test result within 14 days of each other§ , AND NO likely known epidemiologic link to a case outside of the program setting.

OUTBREAK DEFINITION

Multiple cases comprising at least 10% of attendees and/or staff, within a specified core group* OR at least two (2)cases within a specified core group* meeting criteria for a probable or confirmed program-associated COVID-19 case with symptom onset or positive test result within 14 days of each other§; who were not identified as close contacts of each other in another setting (i.e. household) outside of the program setting; AND epidemiologically linked in the program setting.

* A “core group” includes but is not limited to extracurricular activity, cohort group, classroom, before/after school care, etc.)

§ For onset, use symptom onset date whenever available. If symptom onset date is unknown or if a case is asymptomatic, use specimen collection date for the first specimen that tested positive. The 14-day period refers to 14 days before the date of first symptom onset or first positive test sample.

The interventions and recommendations for both clusters and outbreaks will be the same, and the difference between the two is mostly academic in nature.

OUTBREAK CONTROL

IDENTIFYING OR VERIFYING AN OUTBREAK

As mentioned above the first step is going to be to verify the existence of an outbreak. This is why maintaining a line list of reported cases will remain important even if that line list contains little information except the where, when, and who. Anytime multiple cases are identified that could possibly be associated together, the program/provider should look into it. The program should not rely solely on nurses to do this and should encourage any staff member or parent who believes an outbreak is occurring to report it to the program. Likewise, the program can rely on the outside guidance of BCGHD. If multiple cases are present and the program believes that there could be a risk for transmission leading to an outbreak, an epidemiologist will be available for consultation and to determine the status of the transmission.

Once the report or suspicion is looked into, the program/provider should use the above definitions in conjunction with an epidemiologist from the BCGHD to determine if the multiple cases meet the outbreak definition. Sometimes the cases will so clearly fit the definition for an outbreak or a cluster that the only consultation needed will be the mandatory reporting.

A core group can be a classroom, a grade level cohort, a club or extra-curricular activity, or in drastic circumstances it might even be an entire program (Using the 10%). Keep in mind that as cases go down in the community, the chances of multiple cases connected to each other being isolated incidences also goes down. Therefore, if we are seeing community levels go down to a very low level in transmission, but your program is seeing 14% of the population come down with COVID within 14 days of each other should trigger the initial outbreak notification.

REPORTING AN OUTBREAK

Once you believe that you have identified an outbreak, or you are not sure if it is an outbreak, you should report as soon as possible to BCGHD. You may call either of the two epidemiologists directly or email them. If you have not heard back within 24 hours, please call the General Number. [(513) 863-1770]

The following information will be asked when you report an outbreak:

- Number of cases
- Number of attendees
- Number of staff members
- Number of contacts
- Number of classrooms involved
- Type of group
- Date first individual became ill and the date the last individual became ill
- Any known hospitalizations or deaths
- How many were tested and how many were diagnosed based on symptoms
- If known, spread to members of the families
- What notification to families have been made
- What control measures have been taken

NOTIFICATION

While ECE programs/providers do not have to wait to report an outbreak, if they have not already they should notify all families and staff members involved. This would be all individuals who are part of the core group that the outbreak is occurring in. As a practical matter, we recommend that all other individuals in the same building be notified as well to prevent the rumor mill from spreading and for general situational awareness.

The specific notification can be in any manner that the program chooses, as long as it is something that all parents and staff members who are targeted will get and know that it is pertinent to them or their child. An example that is not acceptable is a general posting on the website that a parent or staff member may or may not read, and if they do read, may not know that

their child or they are in the impacted group. Rather, an email or a letter sent home with the child or staff member would work. A sign posted on the building is conspicuous and recommended for outbreaks of all infectious diseases in the program/facility.

INTERVENTIONS

In every outbreak the program will be working with one of BCGHD's Epidemiologists who will advise and recommend specific interventions for the specific situation. There are some interventions that the program can immediately put into place as they will be recommended in every outbreak of COVID-19 to be instituted to the best of the program's ability.

- Place physical signs.
    - Signs in and around the building are a good conspicuous reminder to attendees, staff, and parents that there is active transmission occurring in the facility.
- Reinstitute contact tracing for the specific setting.
    - This means identifying all known cases and all known contacts in that core group to the best of the program's ability. BCGHD will be helping in this area. Once the program sends BCGHD a line list, BCGHD can have their investigators and contact tracers conduct targeted interviews with the case(s) or case's guardian, asking for their close contacts in the program, for notification. There will be some cases that every child is a close contact. Families of children who are close contacts will get an additional notification from BCGHD along with the program notification that their child was part of an outbreak.
- Being in an active outbreak is considered epidemiological linkage. If a member of that core group has COVID-19 symptoms (see Appendix A) they will be considered a probable case until they get an alternative diagnosis from a healthcare provider.
- In the event that an entire program or other large group is in outbreak protocol, it may not be feasible to do universal contact tracing in the program. BCGHD will aid in performing the contact tracing to the best of our ability, but if an entire program or large grade cohort is above the outbreak threshold we will have to accept that many individuals who should be close contacts, will not be notified.
    - Close contacts need to be excluded from the facility/program if they are subject to quarantine.
- Attendees (2 years and older) and staff members involved are recommended to wear masks.
- Physical distancing.
- Improve ventilation.

- Child-safe fans that are available should be brought into the classroom and windows should be opened in places where it is safe to do so when temperatures allow.
- Programs that invested in filters should install them in the impacted areas.
- Educate attendees and staff on hand and respiratory hygiene.

ENDING AN OUTBREAK

Outbreaks for any disease are defined as 'closed' when two maximum incubation periods have gone by without any cases that can be linked to transmission in the facility. The incubation period of COVID-19 is 14 days. To end a COVID-19 outbreak, the facility must go 28 days after the last case, with no new cases linked back to the facility.

APPENDIX A: TYPES OF CASES AND THEIR CRITERIA

DEFINITIONS

Case: An individual with a suspected, probable, or confirmed infection with SARS-CoV-2 resulting in Coronavirus Disease 2019 (COVID-19).

Suspected Case: Meets Supportive laboratory evidence with no prior history of being a confirmed or probable case. There are no reporting requirements for a suspected case of COVID-19, and ECE programs/providers are not expected to report suspected cases.

Probable Case: Meets clinical criteria AND epidemiologic linkage with no confirmatory or presumptive laboratory evidence for SARS-CoV-2 **OR** meets presumptive laboratory evidence

Confirmed: Meets Confirmatory laboratory evidence.

Asymptomatic infections: *are reportable as confirmed or probable cases. In some cases, a SARS-CoV-2 genomic sequencing result may be available without an associated positive PCR result. These records should be classified as a confirmed case; however, public health action may be limited as SARS-CoV-2 genomic sequencing assays are non-diagnostic tests and generally not CLIA-validated.*

Not a Case: This status will not generally be used when reporting a case, but may be used to reclassify a report if investigation revealed that it was not a case.

- Cases will be reclassified as "Not a Case" if SARS-CoV-2 RNA is not detected using a laboratory based NAAT within 2 days following a POC NAAT <u>for an asymptomatic person with no known exposure</u> to SARS-CoV-2*.
- Cases will be reclassified as "Not a Case" if SARS-CoV-2 RNA is not detected using a confirmatory laboratory test within 2 days following a rapid antigen test <u>for an asymptomatic person with no known exposure to SARS-CoV-2</u>.

*For discordant test results from different types of tests, results from laboratory-based NAATs should be prioritized over POC or self-administered tests.

The RT-PCR test remains the most accurate test for detecting a SARS-CoV-2 infection. It is highly specific and highly sensitive, meaning that it is not likely to result in either a false negative or a false positive. However, both are possibilities. The test is more specific than it is sensitive. The short meaning is that a false negative is more likely than a false positive particularly when the pre-test probability is high. When a confirmatory test is negative but epidemiologic linkage and clinical criteria are met, persons should follow isolation protocols for COVID-19 unless an alternative etiology is identified after evaluation by a healthcare provider. If an alternative etiology is identified, persons should follow quarantine protocols for COVID-19 due to epidemiologic linkage.

CRITERIA

While determining an infection by COVID-19 has become dominated by the presence of ubiquitous testing and at-home testing, it needs to be restated that testing is one tool in the box when determining what a case is. It is undeniably the best tool that we have for definitive answers, but it is not perfect. There will be situations where the test could have a bad result. There will be situations where waiting for a test is impractical for initiating public health action.

Clinical Criteria: To meet the clinical criteria, a patient must meet either criteria 1 and 3, or criteria 2 and 3 below.

CRITERIA 1

- Acute onset or worsening of at least 2 of the following symptoms or signs:
    - Fever** (either measured or subjective),
    - Chills,
    - Rigors,
    - Myalgia,
    - Headache,
    - Sore throat,
    - Nausea or vomiting**,
    - Diarrhea**,
    - Fatigue,
    - Congestion or runny nose

OR

- Acute onset or worsening of at least 1 of the following symptoms or signs:
    - Cough,

- Shortness of breath,
- Difficulty breathing,
- Olfactory disorder,
- Taste disorder,
- Confusion or change in mental status,
- Persistent pain or pressure in the chest,
- Pale, gray, or blue-colored skin, lips, or nail beds, depending on skin tone,
- Inability to wake or stay awake

CRITERIA 2

- Severe respiratory illness with at least 1 of the following:
  - Clinical or radiographic evidence of pneumonia, or
  - Acute respiratory distress syndrome (ARDS)

CRITERIA 3

- No alternative more likely diagnosis

**While it takes two or more of these symptoms to be considered suspect COVID-19, ECE programs/providers should follow established communicable disease and illness protocol in excluding attendees/staff exhibiting these symptoms.

LABORATORY CRITERIA

Laboratory evidence using a method approved or authorized by the US Food and Drug Administration (FDA) or designated authority:

CONFIRMATORY LABORATORY EVIDENCE:

- Detection of SARS-CoV-2 RNA in a post-mortem respiratory swab or clinical specimen using a molecular amplification detection test; OR
- Detection of SARS-CoV-2 by genomic sequencing

PRESUMPTIVE LABORATORY EVIDENCE:

- Detection of SARS-CoV-2 specific antigen in a post-mortem respiratory swab or clinical specimen

Supportive laboratory evidence:

- Detection of specific antibody in serum, plasma, or whole blood; OR
- Detection of specific antigen by immunocytochemistry in an autopsy specimen

EPIDEMIOLOGICAL LINKAGE

One or more of the following exposures in the 14 days before onset of symptoms (or, for asymptomatic persons, the 14 days before a positive test for SARS-CoV-2 was collected):

- Close contact with someone with confirmatory or presumptive laboratory evidence of SARS-CoV-2 infection

  OR

- Member of a risk cohort (core group) as defined by public health authorities during an outbreak*.

Close contact is generally defined as being within 6 feet for a period of 15 minutes or more depending on the setting.

*See outbreak section for the relevant definition. If a core group or risk cohort is considered to be in an outbreak, the epidemiological linkage is considered met and close contact with a known case need not be established to be considered a probable case.

APPENDIX B DETERMINING TRANSMISSION STATUS

Program-Associated Transmission: A subset of program associated cases where the most likely place of exposure is determined to be the program setting.

APPENDIX C RESOURCES AND REFERENCES

Ohio Department of Health Infectious Disease Control Manual: COVID-19

https://odh.ohio.gov/wps/wcm/connect/gov/49c54aa2-6d58-45e1-9434-72ca8b4ea635/section-3-covid19.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_K9I401S01H7F40QBNJU3SO1F56-49c54aa2-6d58-45e1-9434-72ca8b4ea635-nZ5EQtb

CDC Community Transmission Levels

https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states

CDC Community Levels

https://www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html

Know What to Expect at Your Child's K-12 School or Early Care and Education Program

https://www.cdc.gov/coronavirus/2019-ncov/groups/expect-school-child-care.html

COVID-19 Guidance for Operating Early Care and Education/Child Care Programs

https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/child-care-guidance.html#anchor_1625771561068

Quick Guide: Isolation and Quarantine for ECE Programs/Providers

https://www.cdc.gov/coronavirus/2019-ncov/downloads/communication/print-resources/COVID-ChildCareProgram-Flowchart-H.pdf

Stay Up to Date with Your COVID-19 Vaccines

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html