Woodbridge BOE Feb 23, 2022

Dr. Martinello's thoughts

1. I thank the BRS admin and staff for all their hard work over the last few years. This has been incredibly challenging.
2. BRS status: We have really done well overall. We have great access to good mitigation, good community support and families have been overwhelmingly thoughtful about monitoring and managing symptoms and cases. **PLEASE KEEP IN MIND THAT MY THOUGHTS TONIGHT ARE REFLECTIVE OF THE BRS COMMUNITY. I AM ACUTELY AWARE THAT NOT ALL SCHOOLS AND COMMUNITIES HAVE HAD THE SUPPORT AND RESOURCES THAT THE BRS COMMUNITY HAS HAD DURING THIS PANDEMIC AND THIS IS NOT NECESSARILY APPLICABLE TO OTHER COMMUNITIES.**
3. COVID-19 status. There finally seems to be some light at the end of the tunnel barring any unexpected new variants. Rates are coming down from omicron wave. The vaccine has been working incredibly well, is incredibly safe and we have had great uptake of vaccine among staff and moderate uptake among eligible students. 99% and 68%
   -Disappointing that we don't have vaccine available for our youngest pre-k students yet leaving them vulnerable with no current option to vaccinate.

4. With the appropriate strategy I think we can start moving toward the "off ramp" of mitigation with the full understanding that things could evolve rapidly if another variant arises and public health recommendations could change. Luckily, BRS community has been fantastic at working quickly to change gears with changes in the science and data over the last 2 years.

5. Goals going forward:
   a. Keep school open and keep as many kids in school as possible as much as possible
   b. Protect our most vulnerable in the school community and the WB community by being flexible in the future if the pandemic situation were to change.
   c. Maintain a predictable school day and schedule with consistent messaging to give our students a sense of security.
   d. Keep our school healthy and our kids thriving.
6. Planning the off ramp should be done based on science and public health/medical best practice information meeting criteria before each step down in mitigation—masks, spacing, ventilation, etc.

   -There is wide consensus that areas with high vaccination rates and low C19 rates are best suited for decreasing mitigation strategies.

   -Moderate to low spread in a community has been measured since the beginning of the pandemic as <10/100,000 cases. We were over 240/100k a few weeks ago in New Haven County and now down to about 30/100k so we really are getting close. **there are likely more cases but home tests are not always being reported so rates may be a bit higher than that. Nonetheless, they are moving in the right direction and approaching that lower risk category.

-We also need to be sure that as we move forward there is a period of monitoring each step of the way. Typically, public health looks at 1-2 week trends, not just one day of reaching a data point.
-We cannot remove all mitigation at once. We need to monitor closely as we decrease our mitigation strategies.

7. Thoughts on masks:
    a. Overwhelming and compelling evidence that masks decrease spread and increase protection across all settings from hospitals to schools to workplaces to homes.
    b. Unequivocal association between mask use and decreased rates of school closures, daycare closures, decreased rate of spread in schools, and decreased numbers of students in quarantine and isolation.
    c. CDC and AAP both are maintaining firm recommendation to continue universal masking in schools pre-k-12
    d. There is no credible evidence or studies that demonstrate harm to children as a result of masking. You can find several weakly done studies supporting and not supporting this but there are no credible studies to support harm as a direct result of masking.
    e. If we meet the above criteria and feel comfortable at some point to move forward with optional masking, we need to be closely monitoring our student and staff population and be diligent about our other mitigation strategies.
    f. If we arrive at a time where we can move forward with optional masking, we need to continue to support our most vulnerable and understand that there are families who are just as worried about the REAL risk to their child or their family as there are families who have low risk and want to be done with masking. Both are valid and we need collaboration. Masking not only benefits the person wearing it but it also benefits the people surrounding them. Unmasking clearly increases risk to other students and staff and this should be approached thoughtfully. We all want our children to be safe but families with particularly vulnerable children really require the effort to be made on a community level to protect their children too.
        i. There are children with medical concerns in our school
        ii. There are staff with underlying health issues
        iii. There are children who live in multigenerational homes or with high-risk family members
        iv. There are children with siblings who are not eligible for vaccine
        v. There are pregnant parents and potentially pregnant staff within the building
        vi. While an individual child's risk may be lower than other children, that doesn't outweigh the real concerns for their classmates.
8. What mask-optional plans mean going forward.
    a. This will take community effort and responsibility to these vulnerable populations.
    b. We must take responsibility to test and report tests when asked to do so and when there is concern that there may be a case in your home or classroom. The school should be notified of positive tests or high risk exposures (parent positive in a home with unvaccinated 6 year old student, for example)

c. Quarantine and isolation guidelines should continue to be followed for positive cases as per CDC and DPH guidelines.
d. Children and staff MUST stay home if they are sick regardless of when/if any changes are made. Testing must be done even with mild symptoms or for exposures. This is the responsibility we all have if given the privilege of mask optional school days.
e. We must support families whose risks may be different from your own. While a particular child may have lower risk profile, that does not mean the student sitting next to him or her has the same risk profile. We must support and respect that others have differing risks in their own families.
f. We need to think about our family decisions going forward as things change for the better or for the worse. We know that activities outside of school have been the biggest drivers of community spread. We don't want school to be a driver of community spread. If cases rise, we need families to pull back on things like large gatherings or sleepovers.
g. Many families may be planning travel over the spring break week in April. It would not be unreasonable to think that this could lead to an uptick in cases in the following week. I would recommend testing students and staff again at the end of that break and have families consider what risks are taken during the break and ways that they could decrease their risks when possible.

9. Thoughts on C19 for children
    a. Thankfully C19 has been less devastating to the pediatric population but not entirely benign. Serious complications, long term symptoms, and over a thousand deaths have been described and we are still gathering data from the most recent omicron wave which had far more cases affecting children and the highest number of children hospitalized of any of the waves to date and this was with the "mildest" variant. There is no real certainty about "knowing" the long-term risks of C19 for children. More and more data are being evaluated and we just don't have the data yet for actual risk but we do have real concerns about these long term findings. We do know that the risk is substantially higher than with influenza and we do not yet have any data to solidly predict what will happen to C19 in the future regarding seasonality or future variants. We are also seeing post-covid complications that we do not see with other viruses so the future of these symptoms and what they mean for long term health are still under investigation. We must remain diligent and thoughtful in our approach.
        i. 2.4% of hospitalizations for C19 were children
        ii. MIS-C cases have been on the rise with the latest wave and have led to many intensive care admissions, most in unvaccinated children, some deaths, many will have life long cardiac complications.
        iii. C19 is now the 6th leading cause of death among school aged children in the USA
        iv. 10-30% of people, including children, have long covid.
        v. There is a link between C9 in unvaccinated children with increased risk of type1 diabetes post-covid infection.
    b. We do have real time worldwide data about the vaccine and it is overwhelmingly safe and effective. No other vaccine in the history of vaccines has been studied in such depth, on such a grand scale and with such scrutiny as this vaccine and we are very

fortunate that it has worked as well as it has to keep people from becoming seriously ill, from requiring hospitalization and from developing complications from C19. We do need to continue to encourage vaccination in the pediatric population as we are not yet at the numbers that would confer herd immunity in the Beecher population.

c. What has been devastating for children is ongoing uncertainty, school closures, separation from peers, family, activities, mixed messaging and witnessing the illness and deaths that so many families have endured. We need to prioritize keeping schools open and keeping our community healthy so that we can continue to work and thrive outside the home. This will require all our effort to do our due diligence to keep cases down in school.

10. I am very hopeful, again, barring any unforeseen new variants of concern, that the upcoming late spring/summer and most importantly, the next school year really can be more "normal" but on a global scale, we will really need stronger effort for worldwide availability to vaccine and increased mitigation where there are increases in cases and for large and small communities to be willing to be flexible and responsible if their situation changes in time.
11. My current recommendations would be summarized as follows
    a. Continue mandatory masking until we reach the lower risk community rates <10/100,000 as recommended by DPH and QVHD (which is very likely in the upcoming weeks)
    b. Availability of equitable access to testing across the BRS community prior to allowing optional masking as per QVHD and DPH recommendations to test the day before /morning of starting this new phase. Test kits may be delayed this week due to weather.
    c. Continue robust testing and reporting and communication of these findings to the BRS community and DPH
    d. Strong recommendation to stay home when sick with ANY symptoms and get tested when there are symptoms or exposures. Continue with isolation as per current recommendations from DPH and CDC if test positive.
        i. If I may put in a plug as we approach allergy season yet again—if a child has sneezing, coughing, runny nose, etc. as part of their spring allergy symptoms, it would be best to stock up on their allergy supplies and talk to the pediatrician about optimizing their allergy regimen now before they are required to be sent home for symptoms that would be similar to covid symptoms.