MONUMENT ACADEMY
"A Charter School, a Public School of Choice"
Board of Directors Regular Meeting

July 15th, 2021 at 6pm MST
Monument Academy West Campus MPR

Mission Statement:
The mission of Monument Academy is to provide a challenging, content – rich, academic program offered within an engaging, caring, and positive learning environment. Established on a solid foundation of knowledge, Monument Academy emphasizes academic excellence, respect, responsibility, character and exemplary citizenship.

A. CALL TO ORDER/MISSION STATEMENT/PLEDGE OF ALLEGIANCE/ROLL CALL/QUORUM:
Mr. Graham opened the meeting at 6:00 pm, read the mission statement, led the pledge of allegiance, took roll call, and declared a quorum.

Board Members in Attendance:
1. Mr. Buczkowski
2. Mrs. Clinton
3. Mr. Dole (virtual)
4. Mrs. St. Aubyn
5. Mr. Graham
6. Mrs. McCuen (absent, excused)

Others in Attendance:
1. Mr. Holmes

A. ADDITIONS TO/APPROVAL OF AGENDA:
a. Mr. Graham moved that we give Mrs. Seymour time to spotlight one of our previous board members. Mrs. St. Aubyn seconded and the motion passed unanimously.

B. SCHOOL SPOTLIGHT (to be discussed under Section G): Principal Seymour and Mrs. St. Aubyn presented gifts to former board president, Mrs. Melanie Strop.

C. CITIZEN'S COMMENTS PERTAINING TO AGENDA ITEMS (Sign-ups received via Google Form): *Limit 3 minutes per person*
Amy McKenzie: Mrs. McKenzie commented on the issue of mask efficacy. Asked that there be no COVID vaccination requirements for students, no COVID testing on students without parental consent, and that the school ensure students are in school full time and with minimal restrictions.
Tammy John: Mrs. John commented on her concern about mask restrictions and encouraged in person learning as well as accommodations for students that are quarantined and do not respond well to online learning.

D. CONSENT AGENDA:
a. With no objections or corrections, the minutes from June 14th were approved as distributed with unanimous consent.
b. With no objections, the August 19th meeting was approved by unanimous consent. It will be at 6pm at the West Campus.

E. REPORTS OF ADMINISTRATION & COMMITTEES:
a. COO: Mr. Holmes
   i. Meeting with Dr. Somers next week to continue building Monument Academy's relationship with the district.
   ii. The School Administration continues to work on the teacher hiring process. Open positions are on the Monument Academy website.
   iii. The Administration team met with Mr. Holmes to brainstorm the strengths and challenges at both MA campuses.
   iv. Friday, July 23rd at 12:30pm, the architect and owner's rep for the East Campus building project will walk through the school and examine items that still need to be

fixed from this first year at the new campus. One or two board members are welcome to attend that tour.

v. Working on professional development plan that will go into place before the school year begins.

b. CFO: No report provided for this meeting.

c. Committees
   i. Highway 105 Committee Report: Mrs. St. Aubyn
      1. Progress has been made on the Highway 105 recirculation project. Attorney David Kunstle is working on MA's behalf with the county to make sure the plan being presented truly works for Monument Academy.
      2. The committee met with the Mormon church attorneys and their risk management team. The church wants to discontinue the reciprocal parking agreement they have had with the school. Future parking options will need to be examined once the highway project is complete.

F. ITEMS REQUIRING BOARD DISCUSSION/ACTION:

a. Determination of Committee Assignments for the 2021-2022 School Year –
   Highway 105 – Mrs. St. Aubyn will remain as chair. Mr. Graham as committee member.
   Curriculum – Mrs. Clinton will chair.
   SAAC – East – Mrs. McCuen will remain as chair.
   SAAC – West – Mrs. St. Aubyn will chair.
   Governance – Mr. Graham will remain as chair. Mr. Buczkowski as committee member.
   Finance – Mr. Dole will chair.
   Buildings & Facilities – Mr. Buczkowski will chair.
   i. Mr. Dole inquired about the Resource Development Committee. Mr. Holmes stated the financial and decision making components for Phase 2 are covered by the Finance and Buildings/Facilities committees. If there is future interest in large scale fundraising, this committee would become relevant. Further discussion on the RDC is tabled.
   ii. Mr. Graham motioned that the committee assignments for the 2021/2022 school year will be as follows: the Highway 105 committee will be comprised of Mrs. St. Aubyn and Mr. Graham, Curriculum committee will be comprised of Mrs. Clinton and Mrs. St. Aubyn, SAAC-West will be comprised of Mrs. St. Aubyn, SAAC-East will be comprised of Mrs. McCuen, Governance will be comprised of Mr. Graham and Mr. Buczkowski, Finance will be Mr. Dole, Building & Facilities will be Mr. Buczkowski. The motion was amended to remove Mrs. St. Aubyn from the curriculum committee. Mr. Buczkowski seconded and the motion passed unanimously. Committee assignments are effective for 2021 school year. Further discussions to come regarding committee requirements.

b. Update on COVID Impacts for upcoming school year
   i. Mr. Graham read a synopsis of the letter from the CDPHE regarding their serial testing program. Please see the attachment for that full letter. The program is available by opt-in and is incentivized by the state. Mr. Graham stated that Monument Academy will not support weekly testing of our students regardless of financial incentives.
   ii. Mr. Graham read a synopsis of a letter from five of the State Board of Education Congressional District Representatives to Governor Polis. Please see attached for the full letter. The representatives wrote in full support of unrestricted, in-person learning and local control of education decision making. Mr. Graham is encouraged by this statement and its alignment with where we stand as a school.
   iii. El Paso County Public Health (ECPH) expects guidance from the Colorado Department of Public Health (CDPHE) prior to the start of the school year. Mr. Graham wanted to remind the MA Community that a resolution was passed on May 3, 2021 that this board

would only look at the least restrictive measures and the board will uphold that resolution as they move forward. There are two CDPHE recommendations regarding case reporting/outbreaks and quarantines that may be required. Please see attached Cases and Outbreaks Definitions for more details. As of today's meeting, the Board's intent is to move forward with normal school operations. The Board respectfully asks our parent community to keep sick kids home and help us keep this situation from being exacerbated.

iv. Mr. Holmes reiterated the learning platforms for the 2021/2022 school year. Full in person, online option (requires quarterly or semester commitment), and parent-led homeschool.

v. Mr. Graham asked Mr. Holmes questions received from our community. Mr. Holmes stated that unvaccinated staff will not be required to wear masks. No one will be asked for proof of vaccination status. Visitors to the school will not be required to wear masks or show proof of vaccination. The sneeze guards in kindergarten rooms and the temperature scanners at the entries will not be used this year. Monument Academy will have to comply with guidance regarding case reporting and quarantining sick individuals and close contacts.

c. Education Alliance of Colorado (EAC) Updates:

   i. Mr. Graham advised that EAC representatives and member schools (represented by a board member) will hold a back-to-school meeting at the end of July to discuss COVID related items and provide those findings to ECPH. They will also meet in August to discuss proactive policy issues pertaining to the 2021-2022 legislative session.

d. Board Meeting Format and Streaming/Recording Accessibility

   i. Discussion was held and it was unanimously agreed upon to return to pre-COVID operating procedures with in-person meetings and no livestreaming.

   ii. Mrs. St. Aubyn motioned that for the 2021-2022 school year, all Monument Academy board meetings be held in person with the option for board members to join via video conference or conference call and add that we discontinue livestreaming and recording board meetings. Mrs. Clinton seconded the motion and the motion passed unanimously. Mr. Graham added if this becomes problematic and the need arises for livestreaming, we can entertain a motion and bring it back to the table.

e. Technology Package Proposal for Board of Directors:

   i. Mrs. Clinton motioned that the MA Board of Directors allocate up to $2700 from discretionary board funds towards the purchase of technology equipment that will better help facilitation of board meetings. Mrs. St. Aubyn seconded and the motion passed unanimously.

f. Edits to Public Comment Google Form:

   i. The board is now only meeting in person. Mrs. St. Aubyn motioned to remove the google form used for public comments and revert to a sign-up sheet at the live meetings each month. Mr. Buczkowski seconded and the motion passed unanimously.

g. Board Composition Discussion:

   i. Mr. Dole reintroduced a discussion that was tabled at the May meeting. With the increase of work the board has taken on and practicality of having an odd number for voting, he is proposing the addition of a seventh board member.

   ii. Mr. Dole motioned hereby that the Monument Academy Board of Directors amend the bylaws to change the number of voting directors from six to seven starting with the current or upcoming school year 2021-2022. Mr. Buczkoski motioned to postpone to the next board meeting. Mrs. St. Aubyn seconded the motion.

iii. Discussion: Mrs. St. Aubyn proposed the board have a detailed plan with the actual wording of the bylaws and the selection plan before the next board meeting. Roll call was taken. The motion carried with 4 yes votes and 1 no vote from Mr. Graham.

h. School Spotlight Agenda Item:

i. Mr. Graham would like to make an addition to the board meeting agenda to include a "School Spotlight" each month. Mrs. McCuen will seek suggestions from the school administration on who to highlight. This segment will be to showcase great happenings at the school. A spotlight segment for each campus was suggested. No Objections. Unanimous Consent.

i. Account Signers:

i. Mr. Graham motioned that the Monument Academy account signers for the 21/22 school year will be as follows by respective title within the Monument Academy organization to include Chief Operating Officer, Elementary Campus Principal, Secondary Campus Principal, Board President and Board Treasurer. Motion was amended to remove Chief Financial Officer. Mrs. St. Aubyn seconded and the motion passed unanimously.

G. BOARD COMMENTS/ANNOUNCEMENTS:

a. PTO Highlights: Mrs. Clinton announced that the East Campus PTO is holding a fundraiser on Sept 24th, 2021: Lynx Warrior Games. Look for more information to come from the East Campus PTO President. Tanja Curtis is the East Campus PTO President Kimberly Kays is the West Campus PTO President

H. NEW BUSINESS

a. East Campus Phase II Status and Updates

i. Further discussion will be held at the August Board meeting.

I. CITIZEN COMMENTS NOT PERTAINING TO AGENDA ITEMS – None to report.

J. ADJOURNMENT

a. Mrs. St. Aubyn motioned to adjourn the meeting. Mr. Buczkowski seconded and the motion passed. The meeting was adjourned at 7:19pm.

June 25, 2021

RE: Status on Updated School Guidance for Prevention of SARS-CoV-2 Spread

Dear School Superintendents:

Thank you for your tremendous work facilitating learning for your students while managing the unprecedented effects of the pandemic, including disease control measures. Because of your efforts, schools have been successful in preventing large-scale outbreaks among students.

For the 2021/22 school year, the Colorado Department of Public Health and Environment will be updating school guidance based on feedback we have received, and additional study, feedback, and research this summer. The important thing I wanted you to know now is that the state's public health order mandating the use of the current school guidance will expire on July 3rd. Counties may still make the guidance mandatory, based on disease and vaccination levels in their community. We hope you will continue to use the guidance in your COVID-19 prevention efforts. The guidance will be a culmination of best practices, while also considering vaccination and disease transmission levels. We plan to engage education stakeholders, including school districts and educators, as we implement this new phase of statewide guidance.

Please note that there are disease reporting requirements in the law that will continue to need to be followed. These include:

- State statute at section 25-1-122, C.R.S. authorizes reporting to public health of diseases identified by the state Board of Health, and those rules at 6 CCR 1009-1 require reporting to public health of all cases of COVID-19
- State statute and state Board of Health rules also authorize investigations by public health into these reportable conditions, including access to records pertaining to these conditions, receipt of test results, interviews of individuals with relevant information, etc.
- Based on information obtained through these reports and investigations, public health may require isolation and/or quarantine of ill or exposed individuals pursuant to sections 25-1-506(3)(b)(VI) and 25-1.5-102(1)(c), C.R.S.

Additionally, CDPHE will be offering a testing service at no cost to schools, through a partnership with Abbott BinaxNOW to provide testing on a weekly basis. The tests are easy to

use and provide rapid results. CDPHE will provide supplies and the staff needed to administer the program to make the implementation as easy and least disruptive to schools as possible. We are exploring options to offer incentives to K-12 students who get tested, as well as financial support to districts who opt-in to the testing program. We will be sharing additional information in the coming weeks.

Thank you for your continued partnership and leadership. CDPHE is here to assist in your disease prevention efforts and to listen as we continue to navigate this unprecedented event.

My best,

Jill Hunsaker Ryan, MPH
Executive Director

COLORADO
State Board of Education

201 East Colfax Avenue
Denver, CO 80203-1799

Angelika Schroeder
Chairwoman
2nd Congressional District

Steve Durham
Vice-Chairman
5th Congressional District

Lisa Escárcega
1st Congressional District

Joyce Rankin
3rd Congressional District

Debora Scheffel
4th Congressional District

Rebecca McClellan
6th Congressional District

Karla Esser
7th Congressional District

June 29, 2021

The Honorable Jared Polis
Governor of Colorado
State Capitol Building
200 E. Colfax Ave., Rm. 136
Denver, CO 80203

Dear Governor Polis,

Thank you for your leadership to the State of Colorado during the COVID-19 pandemic and for your commitment to education during these difficult times. We appreciate all you have done to support students and educators over the past year, including securing needed masks and other personal protective equipment, providing options for COVID-19 testing, and prioritizing educators and school staff when the vaccine became available.

As we enter the recovery phase of the pandemic, it is paramount for us to prioritize both academic progress and well-being of students who experienced disruptions in their learning opportunities last year. We, the undersigned members of the Colorado State Board of Education, believe unrestricted in-person learning is best for students, and trust superintendents and local boards to make decisions that best support their students, families and communities.

We want to encourage little-to-no state-level regulation of in-person learning next year. The experience gained during the COVID-19 pandemic, as well as in previous years of experience mitigating influenza and other infectious disease outbreaks, have taught superintendents and their staff what strategies work best in their communities. During the upcoming 2021-22 school year, superintendents and local boards must have the authority to make decisions in support of unrestricted in-person learning.

With COVID-19 transmission rates at a much less dangerous level, we believe it is safe to return to our normal operating practice in Colorado, which is to give superintendents and local boards the authority to make sound decisions about instruction and school procedures.

Thank you for considering our position. We are grateful for your partnership and look forward to working together to ensure Colorado's students are able to make up any learning opportunities

they missed last year and have a wholly successful year in 2021-22 that includes robust academics and a full range of arts, sports and extracurricular activities.

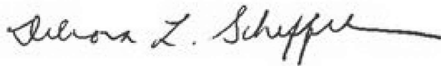
Sincerely,

Angelika Schroeder
Chair - CD 2

Joyce Rankin
Member - CD 3

Steve Durham
Vice-Chair - CD 5

Lisa Escárcega
Member - CD 1



Debora Scheffel
Member - CD 4

Colorado COVID-19 Case and Outbreak Definitions

Case Definitions -- used for individual persons

Case definition updated 08/18/2020 based on CSTE position statement (released 8/7/2020):
https://cdn.ymaws.com/www.cste.org/resource/resmgr/ps/positionstatement2020/Interim-20-ID-02_COVID-19.pdf

Confirmed:
Case who has tested positive using a molecular amplification test (such as PCR, rapid molecular/NAAT, etc)

Probable:
(1) Meets clinical criteria* AND epidemiologic linkage† with no confirmatory laboratory testing** for SARS-CoV-2
OR
(2) Has tested positive using an antigen test in a respiratory specimen, with report date on or after 8/17/2020.
OR
(3) Has a death certificate that lists COVID-19 disease or SARS-CoV-2 as an underlying cause of death or a significant condition contributing to death with no confirmatory laboratory testing performed for COVID-19.

Suspect^:
Someone with no prior history of being a confirmed or probable case
(1) who has tested positive using an antibody test in serum, plasma, or whole blood (IgA, IgG, IgM, total antibody)
OR
(2) Has tested positive for specific antigen by immunocytochemistry in an autopsy specimen
OR
(3) Meets clinical criteria* AND epidemiologic linkage† with no positive test result and a negative molecular amplification test (such as PCR) in the fourteen days after symptom onset.

Notes:
***Clinical Criteria: patient must have one of the following AND no alternative more likely diagnosis**
- At least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, nausea or vomiting, diarrhea, fatigue, congestion or runny nose
  OR
- Any one of the following symptoms: cough, shortness of breath, or difficulty breathing, new olfactory disorder, new taste disorder
  OR
- Severe respiratory illness with at least one of the following:
  - Clinical or radiographic evidence of pneumonia
  - Acute respiratory distress syndrome (ARDS)

†Epidemiologic Linkage: patient must have one of the following in the 14 days prior to symptom onset
- Close contact‡ with a confirmed or probable case of COVID-19 disease
  OR
- Member of a risk cohort as defined by public health authorities during an outbreak

****Beginning October 19, 2020,** CDPHE interprets "no confirmatory laboratory testing" as the absence of any positive molecular test.

‡**Close Contact:** defined as having direct contact or being within 6 feet for a total of 15 minutes or more. In healthcare settings, this may be defined differently. Data are insufficient to precisely define the duration of exposure that constitutes prolonged exposure and thus a close contact. Determination of close contact should be made irrespective of whether the person with COVID-19 or the contact was wearing a face mask.

^Antibody tests and suspect cases

- All antibody positive results will be entered as suspect cases in CEDRS.
- IgM, IgA positive results may indicate acute infection and should be followed up for interview. If the individual has COVID-related symptoms within 30 days or has an epi-link, let your CDPHE epi team know and they will update the case status to "probable." Appropriate disease control recommendations should be made for isolation.
- IgG positive only (or with IgM negative) and total antibody positive results do not need public health-follow up.

Distinguishing new cases

A repeat positive test for SARS-CoV-2 RNA using a molecular amplification detection test within 3 months of the initial report should not be enumerated as a new case for surveillance purposes. To date, there has been minimal evidence of re-infection among persons with a prior confirmed COVID-19 infection and growing evidence that repeat positive RNA tests do not correlate with active infection when viral culture is performed. Similarly the experience with other coronaviruses is that reinfection is rare within the first year. NOTE: The time period of 3 months will be extended further when more data becomes available to show risk of reinfection remains low within one year of the initial report.

COVID-19 vaccine breakthrough cases

Cases with SARS-CoV-2 RNA or antigen detected on a respiratory specimen collected ≥ 14 days after completing the primary series of an FDA-authorized COVID-19 vaccine.

Death Definition -- used for individual persons

A death in a COVID case is defined as a death if:

the decedent died within 30 days of collection date if the decedent was a Colorado resident and is considered a case, either probable or confirmed

OR

the decedent has a death certificate that lists COVID-19 disease or SARS-CoV-2 as an underlying cause of death or a significant condition contributing to death with no confirmatory laboratory testing performed for COVID-19.

Outbreak Definitions -- used for facilities and groups of ill people

Confirmed COVID-19 Outbreak for all settings/events unless otherwise stated under special settings:
This includes: factories, workplaces, events, parties/gatherings, shelters, and independent living facilities/senior communities that do not offer healthcare.

Five or more confirmed or probable cases of COVID-19, of which at least one case has had a positive molecular amplification test **or** antigen test, in a facility or (non-household) group with onset in a 14 day period.

- Antigen tests must be in a respiratory specimen.
- No more than 14 days between the earliest and latest onsets (or test dates if asymptomatic) of the five cases used to initiate an outbreak.
- The 5 or more cases that are used to meet outbreak definition must be from at least 5 different households. Residence halls, camp cabins, employer-provided housing, and cells in a correctional facility are not considered households.

Outbreak Definitions -- special settings

Residential Care Facilities:
Skilled nursing facilities, assisted living residences, intermediate care facilities, and group homes

Confirmed COVID-19 Outbreak in a Residential Care Facility:
Two or more Confirmed cases of COVID-19 among residents/staff in a facility with onset in a 14 day period.
[or]
One Confirmed case and two or more Probable cases of COVID-19 among residents/staff in a facility with onset in a 14 day period.

How to determine if you have an outbreak:

- When determining if an outbreak has occurred in a facility, to assess whether disease transmission occurred in the facility:
  - Exclude residents with a diagnosis of COVID-19 known at time of admission to the facility.
  - Exclude residents who test positive for COVID-19 in the 14 days after admission AND are in observation for signs/symptoms of COVID-19 and following appropriate Transmission-Based Precautions to prevent transmission to others in the facility.

Who to include in case counts and linelists:

- Include all staff at the facility: healthcare workers, administrative staff, kitchen staff, maintenance staff, etc.
- Exclude residents admitted to the facility with COVID-19 or who tested positive for COVID-19 in the 14 days after admission IF they were placed in appropriate Transmission-Based Precautions to prevent transmission to others in the facility.

- If a single staff person with COVID-19 works in multiple facilities with outbreaks, they should be included in case counts for the outbreak with the earliest onset date.

For an outbreak in a residential healthcare setting to resolve, follow the outbreak testing decision tree for residential settings (found at the end of this document).

All other Healthcare Settings:
Non-residential care settings that provide inpatient and/or outpatient services

Confirmed COVID-19 Outbreak in a Healthcare Facility:
Five or more Confirmed or probable cases of COVID-19, of which at least one case has had a positive molecular amplification test **or** antigen test, in staff/patients with onset in a 14 day period with epi-linkage.

Epi-linkage is defined as:
- Patients in the same unit or ward within 14 days
- Patients cared for by the same healthcare worker within 14 days
- Patients cared for by a staff members with COVID-19 within 14 days
- Staff who worked together and had potential to be within 6 ft of one another for a cumulative 15 minutes or longer within 24 hours and had onset within 14 days

How to determine if you have an outbreak:
- When determining if an outbreak has occurred in a facility:
    - Exclude patients with a diagnosis of COVID-19 (suspected or confirmed) at time of the appointment or admission
    - Include admitted patients if they develop symptoms and/or test positive for COVID at least 7 days after hospital admission

Who to include in case counts and linelists:
- Include all staff at the facility: healthcare workers, administrative staff, kitchen staff, maintenance staff, etc.
- Exclude patients with a diagnosis of COVID-19 (suspected or confirmed) at time of the appointment or admission
- Include admitted patients if they develop symptoms and/or test positive for COVID at least 7 days after hospital admission

Resolution of outbreaks in healthcare settings:

A COVID-19 outbreak in a healthcare setting is considered resolved when:
28 days have passed since the symptom onset date (or collection date, if asymptomatic) of the last newly identified COVID-19 case.

Inpatient facilities implementing outbreak testing, may also follow the test-based method for outbreak resolution.

Correctional Settings

Including state prisons, county and city jails, community corrections, detention settings, work release facilities.

Confirmed COVID-19 Outbreak in a Correctional Setting:

Two or more Confirmed COVID-19 cases in residents/inmates/detainees/etc with onset in a 14 day period.

[or]

One confirmed and two or more probable COVID-19 cases in residents/inmates/detainees/etc with onset in a 14 day period.

Notes:

- A resident with a diagnosis of COVID-19 known at time of admission to the facility should not be the only lab confirmed case for the purposes of outbreak definition. Residents who test positive at booking (or within 48 hours of entry into correctional setting) may be excluded from case counts.
- Criteria to define an outbreak excludes staff; though staff should be included in case counts.
- Staff include all staff in the correctional setting: guards, law enforcement, healthcare workers, administrative staff, kitchen staff, maintenance staff, etc.
- If a single staff person with COVID-19 works in multiple correctional facilities, they should be included in case counts for the outbreak with the earliest report data.
- This document is not intended to be used as guidance for disease control and mitigation. Refer to Outbreak response recommendations for correctional settings for testing recommendations.

Resolution of outbreaks in correctional settings:

1. **A COVID-19 outbreak in a correctional facility is considered resolved when:**
    a. 28 days have passed since the symptom onset date (or collection date, if asymptomatic) of the last newly identified incarcerated/detained COVID-19 case
    AND
    b. No newly identified COVID-19 like illness are identified in incarcerated/detained individuals
    AND
    c. Staff are following universal masking while in the facility.
    AND
    d. Newly identified positive staff members have been isolated and excluded from the workplace.

OR

2. **If widespread testing includes everyone (incarcerated/detained individuals & staff) in the facility,then the outbreak can be resolved when:**
    a. All incarcerated/detained individuals & staff in affected units with unknown COVID status are tested using PCR testing.
    AND
    b. Testing per recommendations in affected units is conducted. Testing guidance can be found here.
    AND
    c. No new cases (confirmed or probable) are identified in incarcerated/detained individuals during this time.
    AND
    d. Staff are following universal masking while in the facility.

AND

e. Any newly identified positive staff members have been isolated and excluded from the workplace.

Schools

Including all public and private schools, childcare settings, other educational settings for children, and higher education.

Confirmed outbreak definition

Five or more cases of COVID-19, of which at least one case has had a positive molecular amplification test **or** antigen test, among students/teachers/staff from separate households with onset within 14 days in a single classroom/activity or other close contact in the school setting (including transportation to- from- school and affiliated events).

K-12 Outbreaks will be named for the school, not classroom or activity, regardless of whether they are identified in a class, school or extracurricular activity associated with the school. Subsequent cases will be included under the current active outbreak.

Higher education

Outbreaks can be named for specific groups or teams, or if there is a university-wide outbreak, all cases will be included in the university-wide outbreak.

When is an outbreak over?

Unless noted in the definitions above, outbreak resolution is defined as 28 days after the onset of symptoms of the last case.

Frequently Asked Questions + Tips to applying case and outbreak definitions

Case definition FAQ's:

1. **How was the case definition developed?** Case definitions are developed by epidemiologists around the country and voted on by state epidemiologists through the Council of State and Territorial Epidemiologists (CSTE). The COVID-19 case definition may be updated by CSTE as more data about testing is available.
2. **If a person has symptoms and epi-linkage compatible with the Probable Case Definition (without positive antigen test result), but has a negative PCR test for COVID-19, are they a Probable Case of COVID-19?** If the negative PCR test was in the 14 days after symptom onset, the person is **not** a probable case. If the negative PCR test was performed more than 14 days after symptom onset (or before symptom onset), the case should be counted as a probable case.Providers should continue infection precautions and retest if clinical suspicion for COVID-19 is high, especially in hospitalized patients (https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html).
    - People with close contact or known exposures to a case of COVID-19 must complete their quarantine period.

- Local public health may choose to perform contact tracing on a case with a negative test if suspicion is high, even if the case no longer meets the probable case definition.

3. **What if a provider diagnoses a person with COVID even though they have a negative test?** Surveillance case definitions and clinical case definitions are different. A surveillance case definition is used to capture case counts consistently. It does not reflect how a case is clinically managed by a healthcare provider.

4. **When should I assign a case status as probable?** You may have a case that you are investigating that meets probable case definition by symptom and epi-linkage criteria (without a positive antigen test result) and then has a negative molecular test within 14 days of onset, resulting in the case being suspect. Any disease control efforts should be based on exposure, symptoms and your concerns about transmission. The disease control related to an exposure (such as a child in a classroom being quarantined) is different than a case status.

5. **How should indeterminate results be interpreted?** Indeterminate (or inconclusive) results can be considered similarly to as if the patient was not tested (although should be repeated if possible); therefore a patient with an indeterminate result should be considered probable if they otherwise meet the probable case definition.

6. **How will the county of residence/exposure be assigned?**
    - The county where the case primarily lives should be used to complete the “event county” field on the CEDRS event page.
    - If the case lives in another state or another country, “event county” should be completed with “out of state” or “international”, respectively.
    - Out of state cases who are exposed and investigated in Colorado should have the “County Where Exposure Occurred, if Event County is 'Out of State'” field in the surveillance form completed using the county where the case was staying when they were identified so CDPHE can continue track where COVID-19 cases are occurring.
    - Information from “event county”, not “County Where Exposure Occurred, if Event County is 'Out of State'” will be used to populate county-level data on the COVID-19 website.
    - Out of state cases who are identified in Colorado but thought to have been exposed elsewhere should have event county completed as “out of state” and “County Where Exposure Occurred, if Event County is 'Out of State'” should be blank.

7. **Is there a difference between confirmed and probable death?** No, while there are confirmed and probable definitions for cases, there are not for death. A probable case can have an outcome of death. Please see “Death Definition--used for individual persons” section above.

8. **What if a case lives in another state?** Out of state cases can be part of a Colorado outbreak (and included in outbreak case counts) if their exposure was part of a Colorado outbreak.
    Cases that reside out of state, but are exposed/identified in Colorado are not counted in Colorado surveillance case counts. Please see “How will the county of resident/exposure be assigned?” question above.

9. **Which cases should be contacted for interview and contact tracing?** All confirmed and probable cases should be interviewed (including contact tracing) and provided isolation instruction. Suspect cases are not prioritized for interview.

10. **How can we distinguish mild COVID-19 from other mild, transient, common symptoms from other causes?** While the major symptoms of COVID-19 classic triad presentation of COVID-19 (fever, cough, shortness of breath) areis now fairly recognizable, some people with COVID-19 may only have mild or few symptoms, many of which may be common and non-specific. When such mild and non-specific symptoms occur, it may be difficult to distinguish between a mild case of COVID-19 or other causes.
    In general, if a patient has COVID-19 symptoms that seem to be persistent (even if mild), are out of character from the patient's baseline, are associated with a general unwell feeling, and/or begin 2-14 days after a potential exposure to the virus, such patients should be considered possible or even probable (if epidemiologically-linked) COVID-19 cases until proven otherwise.
    If a patient has a symptom that is mild, transient, and non-specific that is either clearly explained by another condition diagnosed by a healthcare provider or is clearly within the patient's normal baseline (e.g., sneezing after cutting grass in a person with grass allergies, typical headache in a person with migraines, a child throwing up after eating too quickly), they can be reasonably considered to not likely have COVID-19. However, they should continue following COVID-19 prevention guidance.

Outbreak definition FAQ's:

11. **How were the outbreak definitions developed?** The outbreak definitions were developed by epidemiologists at CDPHE. They sought to create standardized outbreak definitions that could be consistently applied to multiple settings.

12. **In which order should I use these definitions?** Apply case definitions to individual cases first. Then apply the outbreak definitions.

13. **How do you count a case who works and/or lives in two facilities having outbreaks?** Each case is counted one time. If a case worked and/or lived in two facilities having concurrent outbreaks, the case is counted with the outbreak with the earlier "date determined to be an outbreak."

14. **How do you know a case wasn't exposed elsewhere in the community and not the outbreak facility?** It is possible that a person may have been exposed elsewhere (and we can rarely prove where any individual was exposed with a person-to-person pathogen), but when a person worked/lived/spent time in a facility with a known outbreak, we attribute their illness to the outbreak even if there is no definitive determination that the case acquired the illness at the facility. This approach is consistent across all outbreak types.

15. **What if employees are housed together for work---does that make them household contacts?** If the housing is provided by or required by work, we do not consider the employees lodging together as household contacts since these settings are an extension of the workplace. Examples include: dorm-style housing for agricultural workers, hotel rooms for construction workers while on site, group housing or apartments provided by resorts for their employees, or employees asked to stay with colleagues near a work site.

16. **What if cases in the outbreak normally live outside of Colorado?** Outbreak cases who normally reside outside of Colorado still must be reported to public health and will be counted in the outbreak.

17. **An employee/resident at a facility with an outbreak was diagnosed with COVID-19, but they hadn't been at work recently. Are they still an outbreak case?** If the case was in the facility during the 14 days before their onset (symptom onset or for asymptomatic cases, the test date), the case will be counted in the outbreak.

18. **Can an outbreak be associated with an event, rather than a facility?** Yes, an outbreak may be associated with an event such as a social gathering or sporting event. An outbreak associated with an event would be defined as five or more cases of COVID-19, of which at least one case has had a positive molecular amplification test **or** antigen test, from separate households with onset within 2 to 14 days of the event. Event outbreaks will be reported with the name of the event.

19. **Does timing matter when epi-linking cases?** The order of epi-linking cases does not matter, as it is often a result of testing practices. For example, if 7 students in a classroom have symptoms compatible with COVID-19 one week and an 8th student gets tested the following week (and tests positive), the previous 7 kids are epi-linked probable cases.

20. **How do we apply the epi-linkage criteria to 5 or more cases?** In order to meet the minimum of 5 epi-linked cases, each of those 5 cases would need to be linked to at least one of the other cases, and all cases in the group must be connected by epi linkage.

21. **Should we count positive unproctored, self- administered, at home tests towards an outbreak?** Yes. Unproctored, self-administered tests are becoming more common but are unlikely to make it into our surveillance systems (CEDRS, Dr. J.) and since we would like to identify as many outbreaks as possible, we would like to include all possible sources to identify cases.

22. **If a confirmed or probable case is reported more than 14 days before an outbreak started, should the case be counted in the outbreak?** No, this case would not be counted in the outbreak if the case's onset date was more than 14 days before the onset of the first case in the outbreak.

23. **If a business identifies a new case 29 or more days after the last case, can the outbreak still close?** Yes, the outbreak will still close because 28 days have elapsed without new cases. However, If a sufficient number of new cases with appropriate epi linkage meeting outbreak definition occur, a new outbreak will be reported."

24. **Should public health seek evidence of confirmatory laboratory diagnoses for cases reported by facilities on outbreak line lists?** If a case is reported as confirmed on an outbreak line list, but not found in CEDRS, public health should confirm the diagnosis using medical records, electronic laboratory reporting, asking the case during case interview, and other methods. Testing and symptom information will be used to determine case status of each outbreak case. Cases listed as confirmed on an outbreak line list will be reclassified as probable until confirmation of lab testing and entry into CEDRS.
    If a facility has questions about reclassification of the case, explain that public health is working to confirm case status without releasing private health information about the employee.k

25. **If a case is asymptomatic, what date do you use for "onset" to determine the start or end of an outbreak?** If a case is asymptomatic, specimen collection date is used as a proxy for identifying and ending outbreaks. However, in the CEDRS records, mark "asymptomatic" and do not enter an onset date. A blank onset date for asymptomatic cases is not counted as missing for investigation metrics.

26. **Should cases that meet the surveillance definition of COVID-19 reinfection or vaccine breakthrough be included in an outbreak?** Yes. Because a case that meets the reinfection or vaccine breakthrough definition is counted as a distinct COVID-19 event and requires public health intervention (e.g., isolation, contact tracing),

such cases should also be included in determining if/when an outbreak has occurred and included in outbreak counts.

27. **Are visitors included in residential facility outbreak case counts?** A positive result in a visitor tested prior to a visit to a residential facility would not automatically count as a facility case, even if the visitor had been in the facility within the prior 14 days. It would be counted as a facility case if there is a specific epi link identified.

28. **How are outbreaks named?**

Outbreak Type	**Outbreak Naming Convention**	**Example**
Healthcare facility	Name of facility (licensure number)	ABC Assisted Living (123456)
Retail Business (non chain)	Business name	Restaurant A Grocery B Retail Shop C
Chain/business with multiple locations	Name (location number) If no location number: Name (location description)	Grocery B #123 Restaurant A (City B)
Construction Site	Name or address of construction project	123 Main St Construction Site School A Construction Site
Event or social gathering	Description of event or gathering (location)	Adolescent gathering (City A) Sport tournament (City B)
Office or work group	Name of Business	Business A
School, university, childcare, camp, or affiliated extracurricular taking place at school, university, childcare, or camp	Name of school, university, childcare, camp	Childcare A University B Camp C
Corrections, law enforcement	Name of program or facility	County A Jail County B work release
Second and subsequent outbreaks in the same facility	Name of Facility: month OB confirmed	ABC Assisted Living (123456): June 2020 *Go back and add month OB confirmed to first OB*

29. **When is an outbreak's address or business name suppressed?**
Suppressing an address: When the outbreak location is in a person's home (ex. Home daycares, host homes) or the outbreak address is a sensitive location that shouldn't be made public (domestic abuse shelter, youth corrections homes)
Suppressing name: When the outbreak location is in a person's home **and** the business name contains their name. For example, a home daycare named "Matilda's Day Camp" would be suppressed but that same daycare named "Little One's Day Camp" would not. Such allows us to protect a case's identity but ensures the public has information they need to assess risk.