

COVID Relief for K-12: Use of Funds Advisory Memo¹

OVERVIEW

The goal of safely and sustainably reopening K-12 schools for in-person learning is widely recognized as critical to minimizing the impact of academic, social, emotional, and mental strains brought forth by the COVID-19 pandemic. In order for in-person learning to succeed on an on-going basis, schools must be able to offer safe environments taking into account high levels of community spread of COVID-19. **Health and safety are foundational for learning and educating.** Based upon scientific research and case studies, we now know that a key to establishing this solid foundation is a robust, school-based **infection prevention and control (IPC) program**. While this is not the only aspect of health that is foundational to learning, it is a vital element that schools should employ to provide the safest strategies and environmental modifications to suppress the transmission of the SARS-CoV-2 virus. IPC programs will be an important part of successful education in response to COVID well into the 2021-22 academic year, at a minimum.

With the knowledge of *what* to do now clearly articulated by the CDC, OSHA, and scientific experts, implementing this function effectively for K-12 schools requires focusing on *who* should do the work of infection prevention and control and *how* it should get done. To answer these questions, COVID Collaborative, Harvard's Edmond J. Safra Center for Ethics, Brown School of Public Health, and New America formed a Task Force on infection prevention and control in schools, and that Task Force has now published an operational roadmap, "Roadmap to Healthy Schools: Building Organizational Capacity for Infection Prevention and Control (IPC)."

The next question is how to fund this work. Over the course of 2020 and 2021, Congress has authorized several tranches of funding to support the K-12 sector in preventing, preparing for, and responding to Coronavirus and to support the sector in doing so in ways that align with equity goals.

This advisory memo outlines how states can support LEAs in making strategic use of authorized funds to implement robust infection and prevention control programs throughout their K-12 systems, while also

¹ We are grateful for input and review by staff at the Council of Chief State School Officers, the Federal Education Group, and the National Education Association as well as by members of the National Council on School Facilities, Emily Oster (Brown University) and David Deming (Harvard University).

addressing equity concerns that have left some school communities more vulnerable to the negative impacts of the pandemic. We propose four key areas of investment:

1. Creation of state guidance;
2. Facilities;
3. Training and Professional Development;
4. School health workforce and public health workforce assigned to support schools.

Federal funds should be used to supplement or augment existing funding, or serve as the startup funds for new initiatives, not to supplant existing funding. Some investments would be one-time; others would be ongoing and would require states to undertake forward budget planning in order to prepare for potential budget re-prioritizations when the relief funding expires in 2024.² Please note that this is an advisory framework; states and jurisdictions will make their own strategic determinations of the appropriate use of funds in their contexts.

FUNDING STREAMS

To support their programs of K-12 infection prevention and control, states and school districts can use funds from the Elementary and Secondary School Emergency Relief (ESSER) Fund established in the CARES Act, the Coronavirus Response and Relief Supplemental Appropriation (CRRSA) Act, and the American Rescue Plan Act (ARP). Non-public schools can also request support for infection prevention and control activities through the Emergency Assistance for Non-Public Schools Funds (EANS) administered by states. Importantly, those funds must be obligated on specific timetables as follows:

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| CARES Act- ESSER 1 | For costs dating back to March 13, 2020 | Must be obligated by Sep. 30, 2022* |
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| CRRSA- ESSER 2 | For costs dating back to March 13, 2020 | Must be obligated by Sep. 30, 2023* |
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² ARP ESSER expires 9/30/2024, ESSER 1 expires 9/30/2022, and ESSER 2 expires 9/30/2023.

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|---------------------|---|--|
| CRRSA-EANS | For costs dating back to March 13, 2020 | In general, EANS funds must be obligated within six months of receipt by the state; unobligated funds then revert to the GEER fund. Please see B-10 of this guidance for more information. |
| ARP- ESSER 3 | For costs dating back to March 13, 2020 | Must be obligated by Sep. 30, 2024* |
| ARP- EANS | For costs dating back to March 13, 2020 | TBD |

** Please note that the while the law itself says funds must be obligated a year earlier than listed in this chart, funds administered by the U.S. Department of Education – including ESSER and GEER funds – are subject to another rule called the Tydings Amendment. The Tydings Amendment extends the period of availability by a year. For example, the CARES law says funds must be obligated by September 30, 2021, but that is extended by a year because of the Tydings Amendment, so ESSER CARES Act funds must be obligated by September 30, 2022.*

Relief funds directed toward local public health can also be activated in support of K-12 infection prevention and control. In the American Rescue Plan, for instance, Title II, Subtitles F & G, which direct funds to the Department of Health and Human Services, can be activated in support of K-12 IPC work. Indeed, there is a critical need to braid together the two streams of funding.

This is not a complete review of all available funding sources but does represent the major funding streams.

IMPLEMENTING EFFECTIVE INFECTION PREVENTION AND CONTROL IN THE K-12 SECTOR

Thanks to [updated guidance from the Centers for Disease Control and Prevention \(CDC\)](#) and the [Occupational Safety and Health Administration \(OSHA\)](#),³ and [a robust body of scientific evidence](#)⁴ we now have concrete information about the key components of a multilayered mitigation strategy: universal and

³ CDC, “K–12 School Operational Strategy,” updated March 19, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/operation-strategy.html#:~:text=CDC%E2%80%99s%20K-12%20operational%20strategy%20presents%20a%20pathway%20for,and%20correct%20use%20of%20masks%20and%20physical%20distancing> and OSHA, “Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace.” Posted January 29, 2021, <https://www.osha.gov/coronavirus/safework>

⁴ “The Science Is Clear: Layered Infection Prevention and Control Measures Allow Return to Safe In-Person Learning,” April 26, 2021, <https://static1.squarespace.com/static/5f85f5a156091e113f96e4d3/t/6088352ca985de7585b38684/1619539244698/Scientific+Conse+nsus+Statement+Schools+4.26.21.pdf>.

correct use of masks; maintaining healthy facilities, including improved ventilation and air filtration; handwashing and respiratory etiquette; symptomatic testing and contact tracing in combination with isolation and quarantine; physical distancing; cleaning; and vaccination. In addition, a comprehensive prevention approach that combines asymptomatic testing (whether screening or surveillance) with these mitigation strategies can assist with evaluating the effectiveness of infection prevention and control efforts and can ensure that all members of the school community are as safe from infection as possible.

Many states, local educational agencies (LEAs), tribal authorities, schools, unions, and employees have already been hard at work to make schools safe, and many schools are already providing in-person instruction. Taken together, comprehensive planning, training, and adoption of mitigation strategies constitute practices commonly known as **infection prevention and control (IPC)**.

A school-based infection prevention and control program would:

1. Sustain safe in-person learning;
2. Ensure schools are prepared for other outbreaks of infectious diseases (e.g., seasonal influenza) and for future pandemics;
3. Be modeled on infection prevention and control in the healthcare sector, with school-based infection prevention and control (IPC) teams supported by city/county/tribal situation rooms⁵;
4. Support COVID-19 testing and contact tracing;
5. Integrate promising practices and (where available) validated best practices from schools and districts and from existing successful occupational safety and health models; and
6. Include processes of continuous quality improvement, including data collection and reporting, so that the program continues to evolve and improve over the school year.

While many educational stakeholders have been working on infection prevention and control and have been developing a wide array of partnerships with public health officials to do so, formalizing this area of activity for the K-12 sector is critical.

⁵ The term “situation room” is used to designate a team-based partnership between local public health and LEAs and schools and to distinguish from the school-based teams.

We recommend five core organizational functions for successful K–12 infection prevention and control:

1. Set up coordinating structures (e.g., "Situation Rooms"), linking local public health officials to LEAs and schools to support school-based IPC, from hazard assessments and planning to implementation, review, revision, and troubleshooting.
2. Form and train school-based infection prevention and control (IPC) teams.
3. Assess and invest in ventilation, filtration, and related building upgrades.
4. Train the whole school community on IPC.
5. Analyze and respond to workforce implications.

For further detail on these five organizational functions, please see the Roadmap, which provides operational guidance on implementing an IPC program.

In this supporting “Use of Funds” guidance memo, we propose a framework to guide and prioritize use of the Elementary and Secondary School Emergency Relief Funds (ESSER), the Emergency Assistance for Non-Public School Funds (EANS), and Public Health COVID Relief Funds to provide healthy and safe in-person learning.

If we respond to this crisis strategically, we can lay the foundation for a transformation in American education that establishes health as foundational for learning.

FUNDING PRIORITIES FOR ESSER I, II, AND III (IN CARES, CRRSA, AND ARP), FOR EANS FUNDS, AND FOR PUBLIC HEALTH RELIEF FUNDS

The Roadmap recommends a framework for building the organizational capacity for IPC into the K-12 sector as a foundational element of responding to COVID-19 and preparing for future outbreaks. The effective implementation of IPC in the K-12 sector requires four categories of strategic investment. We distinguish between one-time and ongoing investments. Investments are needed in:

1. Creation of state guidance;
2. Facilities;
3. Training and Professional Development;
4. School health workforce and public health workforce assigned to support schools.

ONE-TIME EXPENSES

- (1) *State guidance and standard setting:* States are encouraged to reserve at least 1% of ESSER and/or ARP funding toward state level functions related to school facilities. States should assist districts with facilities assessments and facilities data management and work to determine which operational standards should be applied at the state level. Additionally, states should identify resources and technical assistance to help districts get good value from their facilities related spending.
- (2) *Facilities investments for ventilation evaluations and ventilation/building upgrades:* We encourage districts to allocate at least 15% of their ESSER funding (excluding 20% for learning loss, as per the legislative mandate) for healthy school facilities. Nationally, this would mean that districts would have at least \$20 billion to reduce the deferred maintenance that inhibits the effective layering of facilities-related mitigation strategies advised by the Centers for Disease Control.⁶ This 15% allocation will help to address disparate impacts of the pandemic, since school districts with high levels of deferred maintenance and repairs are often also districts with high numbers and percentages of low income students and communities of color. **A foundation for equity is built when all students have access to healthy buildings.**

The U.S. Department of Education and state Departments of Education should encourage district flexibility in the use of federal funds. Local districts should be encouraged to use COVID relief funds to address a wide range of deferred maintenance and repairs in school buildings and grounds, including, but not limited to the specific facilities project examples included in the text of CARES, CRRSA, and ARP. This flexibility in the use of funds is critically important to ensure that funds meet local needs, that they are equitably distributed, that districts get the highest value from the funding available, and that

⁶ Go to <https://www.facilitiescouncil.org/covid19-general-guidance> to see estimates of a 15% allocation of Relief and Rescue Plan funds by school district.

districts can afford to sustain the improvements. The [June 2020 GAO report](#) on the nation's facilities makes clear the wide range of deficiencies in schools.

With ESSER funds, districts will be able to:

- Modify buildings and grounds to support physical distancing—e.g., create outdoor classrooms, outdoor eating areas, and other outdoor spaces for school programs, in a manner that ensures physical distancing and gives students and teachers direct access to an abundant supply of fresh outdoor air during their classes and programs;
- Modify buildings and grounds to support healthy, safe, and equitable facilities, for instance with improvements to bathrooms;
- Repair, upgrade, or replace equipment, components, systems, furniture, and fixtures in support of healthy, safe, and equitable facilities, including for instance upgrades to ventilation/filtration, windows, etc;
- Make limited capital improvements to address emergency system or component failures, and to support learning loss programming and mental health, for example install air conditioning and add trees and other plants to school grounds, where they can be viewed from building windows and where they will be used by outdoor classes and programs;⁷
- Assess the condition of school facilities, including key equipment, systems, components, finishes, furniture and fixtures for near-, medium- and long-term requirements for healthy, safe, educationally appropriate, and environmentally sustainable buildings and grounds;
- Develop plans for routine and deferred maintenance to ensure equipment, systems, components, furniture and fixtures are working as they were designed, particularly with regard to health objectives;
- Develop a schedule and assignments or contracts for repairs on existing equipment, systems, and components to reduce deferred maintenance and repair backlogs, particularly with regard to health objectives.

⁷ See for instance: Han, K. T., (2009). Influence of limitedly visible leafy indoor plants on the psychology, behavior, and health of students at a junior high school in Taiwan. *Environment and Behavior*, 41(5), 658-692. See also: <https://www.jhsph.edu/research/scibar/funded-scibar-projects/can-restoring-vacant-lots-improve-adolescent-health-disparities.html>

ONGOING EXPENSES

School-based infection prevention and control teams & local public health situation rooms: Every school should consider having an infection control team supported by a situation room in their district or area staffed by local public health officials, personnel from federally qualified health centers, and/or experts in occupational safety and health. School IPC teams may have a variety of staffing structures, but would ideally include a health professional, for instance a school nurse. The coordinating structure linking the LEA to local public health may also have a variety of configurations. Please see Roadmap for examples.

Funds should therefore be invested in ensuring that every school has a school nurse or other trained health professional in the building and that local public health (city, county, and tribal health departments) and/or community health centers have staffing adequate to support K-12 schools. Other downstream workforce implications may require increases of compensation for role changes and/or increases in personnel.

While a short-term investment in school-based health personnel and public health/health center personnel through increased FTE, improved compensation, and role upgrades can address the immediate crisis, the investment also presents an opportunity for strategic prioritization of education-health partnerships in the longer term.

IPC expense is cost-saving when considered within a broader systemic framework. Fewer infections mean fewer hospitalizations, and less burden on a region's medical system. Fewer infections also mean fewer days lost from school for students and school personnel, reducing the magnitude of annual learning loss from disease.

Better IPC can also ease parent concerns about sending kids back. It will help build public trust that schools are healthier and safer than before.

Investments in school-based health personnel and public health/health center personnel assigned to support the K-12 sector should be structured as 2-3 year pilot programs, linked to efficacy studies. Infection control programs in hospitals routinely prove to deliver cost-savings. We have good reason to think that similar programs, even in the lower-risk environment of schools, will also bring net benefits. Local education agencies (LEAs) and states should seek to track the impact of these investments on the uptake of preventive health care (e.g. flu shots), Average Daily Attendance rate, annual learning loss deriving from infectious disease, and schools as vectors of disease for the community, among other potential indicators of impact.

For pilot programs of this kind, LEAs should aim to cap the increase of personnel expense to HEPI + 5%.⁸ In addition, 10-15% of that increase should be directed toward evaluation and assessment of the impact of the education-health partnership on school and public health outcomes. Alternatively, state education agencies or the U.S. Department of Education (IES) should commission and pay for studies across LEAs, in order to build the research base we need.

ONE-TIME OR ONGOING EXPENSE

Infection prevention and control training: LEAs (and/or schools allocated funding by their LEAs) should use COVID Relief Funds to invest in IPC training. A routine training budget is typically in a range of 1-3% of an organization's salary pool.⁹ In this context of a need for training in new areas, decision-makers should consider bringing the training budget to a level of 5-6% of the salary pool for the period of allowable expenses.

While LEAs might plan to frontload infection prevention and control training during this time period, successful IPC programs over time require ongoing learning and training. The training element of a well-established IPC program should ideally become an ongoing expense. Consequently, we recommend that the investments in training should be folded into the IPC Pilot programs described above and aligned/coordinated with school and LEA educator and staff development training programs. They should be included in the evaluation and efficacy study so that evidence is available to support budget investments in on-going IPC after the expiration of COVID Relief funds.

⁸ We recommend using HEPI (the higher education price index) rather than CPI (the consumer price index) because it tracks costs in personnel intensive sectors.

⁹ LEA budget proportion estimates from Hayes Mizell, *Why Professional Development Matters* (Oxford, OH: Learning Forward, 2010).

EQUITY IMPERATIVES

Often in the educational context, the effort to achieve equity leads education decision-makers to craft programs to align with the requirements of programs such as Title I, Title II, or Title III. It is important to recognize that the equity concerns captured in these titles do not exhaust the categories of equity investments that might be made in response to the calls for equity in COVID relief legislation. Health is foundational for learning for all students, and effective infection prevention and control in all schools should help reduce health disparities and would thereby contribute to equity in education. Achieving healthy buildings for all learners, including learners in high-poverty schools, requires setting universal goals but then targeting processes and funding for those most in need. In this case, schools and communities with highest poverty numbers and possibly highest infection or health risks, disproportionately communities of color, should be prioritized. Transforming educational opportunity, so that all have full access, requires directly countering the racial inequities that have long undermined that goal.

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