



Supported by



The
ROCKEFELLER
FOUNDATION

COVID-19 Testing in K-12 Settings: “Day in the life of” (DILO) case study examples

For questions about this resource or to inquire about support in implementation, please contact Chiefs for Change at cfcta@chiefsforchange.org.

*This Document is Solely Intended to Provide Insights and Best Practices –
This Document does not Constitute Client Advice*



Disclaimer



Chiefs for Change and The Rockefeller Foundation do not guarantee the accuracy, completeness or integrity of the information collected from the secondary data sources and interviewees. Further, the information is provided for informational purposes only and is not intended as an endorsement, guidance, recommendations, or advice for any particular product, program or policy. Any use or interpretation of or reliance on the information for any purpose, is solely and exclusively the responsibility of the recipients of the information.

THE INFORMATION IS PROVIDED “AS IS”. NO WARRANTY OF ANY KIND IS GIVEN FOR THE INFORMATION UNDER ANY NATIONAL OR INTERNATIONAL LAW, INCLUDING WARRANTY AGAINST INFRINGEMENT OF INTELLECTUAL PROPERTY. CHIEFS FOR CHANGE AND THE ROCKEFELLER FOUNDATION expressly disclaims and assumes no responsibility for any losses, damages, claims, or other liabilities, including loss of goodwill, revenue, profits, or business interruption, or any consequential, special, indirect, incidental, punitive or exemplary loss, including costs of defense or attorneys’ fees, arising out of or relating to use of this information. It is expressly understood that The Rockefeller Foundation and Chiefs for Change, by providing this information, has no obligation to update the information or provide additional support or information to the recipient.

Testing can be considered in the context of broader measures to help mitigate COVID-19

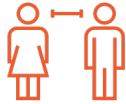


Establish hygiene protocol

Clean and disinfect surfaces and equipment routinely

Promote frequent and thorough hand washing and avoid touching ones' face

Improve ventilation to increase delivery of clean air; avoid indoor gatherings where possible



Limit person-to-person contact

Minimize contacts among students, teachers and other staff through measures such as staggering schedules, and cohorting

Install physical barriers, such as clear plastic sneeze guards



Institute masks and PPE usage

Require mask usage as a simple barrier to reduce respiratory droplets

Provide additional PPE (personal protective equipment), e.g. facemasks, eye protection, disposable gloves, and gowns, to be worn by individuals such as healthcare professionals



Test to identify/isolate cases

Monitor for symptoms and develop procedures for individuals to report COVID-19 symptoms or exposure to COVID-19

Encourage individuals to stay at home without fear of reprisal

Develop programs to test individuals

Mitigation measures, individual or several combined together, should be considered within other local contextual factors, e.g., government laws and regulations, supply availability, cost considerations, COVID-19 prevalence and trends, population density



Testing can be a part of a broader reopening plan, see additional reopening resources below

- [How Should Education Leaders Prepare for Reentry and Beyond](#)
- [School Reopening Workbook: Tool for School Districts](#)
- [State education agency resource guide](#)
- [Day in the life of \(DILo\) resources](#)

Source: The Rockefeller Foundation's COVID-19 Testing in K-12 Settings: A Playbook for Educators and Leaders, [CDC](#)

Districts that have implemented COVID-19 testing programs have reported several benefits

Reduce community spread



Benefits

- Screening testing enables greater identification of asymptomatic individuals with COVID-19 infections (~25-40% of infections) and can reduce community spread and prevent possible school outbreaks

Example

- In five districts, school screening testing **identified ~44% of all reported COVID-19 cases** from the students and staff in the districts

“ ”

Over time we're going to see kids being in school reduces the cases in the community. They are safer at school.
–Superintendent

Ensure equitable access to testing



- Some families may not be able to seek regular testing if it is not offered on school grounds (especially in under-resourced and rural communities)

- In one **district**, **mobile testing units** ensured students and staff no longer had to drive up to two hours to be tested

It wasn't convenient for a teacher to leave for 1-2 hours. We decided to have mobile sites go out to schools. So if teachers have a 15 minute break, they can run out, get tested, and be back in the classroom
–Assistant superintendent

Increase confidence



- Assurance** among staff and families of increased **safety of in-person learning**

- In one district, **82% of staff and 87% of parents** surveyed **felt reassured after screening testing was implemented** (while 12% of staff and 39% of parents felt comfortable returning without it)

Parents and staff feel a lot safer and the majority of our students and staff in buildings are taking advantage of the testing.
–Superintendent

Maximize in-person instruction



- Identifying positive and negative individuals quickly allows schools to avoid quarantines and **maximize students' in-person instructional time**

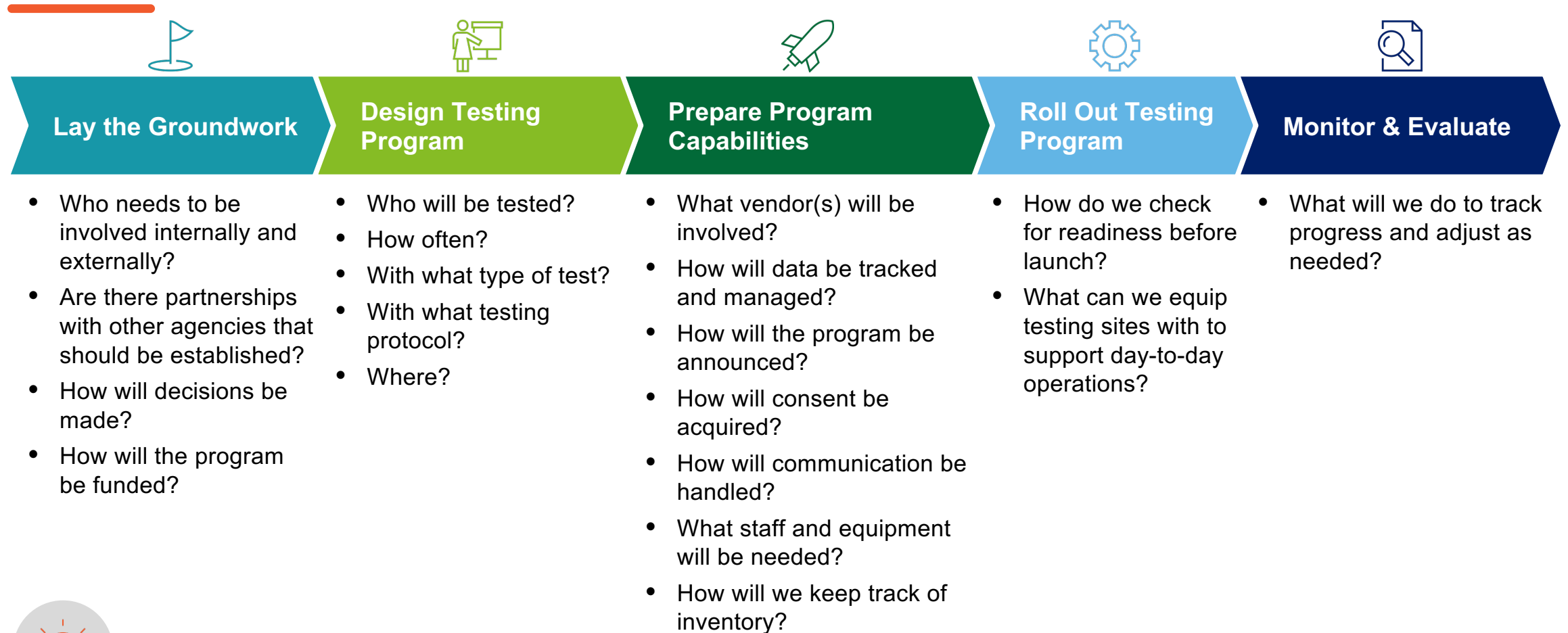
- Many district leaders noted the value of having access to rapid diagnostic testing to **avoid quarantining a significant number of students and staff** with potential COVID-19 symptoms

Right now, as we're talking, we just saved a cohort with a test. A nurse emailed me to look up a child with a sore throat. We have the results and can tell her he's negative and that classroom [won't need to quarantine].
–Director of Health Services

Source: Interviews with district leaders, The Rockefeller Foundation's *COVID-19 Testing in K-12 Settings: A Playbook for Educators and Leaders*, Mathematica's *COVID-19 Antigen Testing in K-12 Schools: Early Lessons from Six Pilot Sites*, RAND's *COVID-19 Testing in K-12 Schools: Insights from Early Adopters*

There are several steps that need to be taken to implement a COVID-19 testing program

INDICATIVE,
NON-EXHAUSTIVE



Purpose of this guide: Provide a perspective on how school districts can set up COVID-19 testing programs as one of many approaches to open schools safely

Source: The Rockefeller Foundation's *COVID-19 Testing in K-12 Settings: A Playbook for Educators and Leaders*

To lay the groundwork for a testing program, school systems have addressed several components

INDICATIVE,
NON-EXHAUSTIVE

Form a testing taskforce



Identify individuals to **be part of the “Central Response Team”** of the operation – which includes serving as the face of the testing program and managing the planning, implementation, and communications of the program

Identify community and healthcare partners



Engage **local public health authority and healthcare providers, state and local governments, and community organizations** to inform the testing strategy

Establish a governance structure



Establish **taskforce governance mechanisms** in first week, e.g.:

- Roles of each member
- Meeting cadence
- Information flows
- Decision-making mechanism

Secure financial support



Determine **how to pay** for testing as a district, e.g.,:

- State or federal government
- County funded (without district involvement)
- CARES Act funding
- Existing district budget
- Philanthropic support

In action

Key taskforce roles are often filled by staff that are redeployed; they include:

- District Coordinator (e.g., Chief of Staff)
- School Coordinator (e.g., Principal or Vice Principal)
- Test Coordinator (e.g., Nurse)




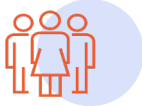




In Tulsa, Oklahoma, the health department and the district worked together to optimize the limited supply of tests they had by identifying the schools in areas with the highest risk of introducing an infection in school. They also partnered to offer testing to all elementary school teachers

In Ector County, Texas, the taskforce is divided into smaller divisions with specific roles that meet weekly. The leads of each division then meet every two weeks with the Superintendent

In Massachusetts, the state is paying for pooled testing resources and distributing them to districts.

There are several design dimensions involved in the testing strategy

INDICATIVE,
NON-EXHAUSTIVE

 <div>Testing objective</div>	 <div>Type of test</div>	 <div>Individual or pooled sample</div>	 <div>Who is tested</div>	 <div>Opt-in or required for in-person</div>	 <div>Testing frequency</div>	 <div>Sample type</div>	 <div>Where sample is collected</div>
<div>Diagnostic</div> <div>Screening</div>	<div>Antigen (rapid test)</div> <div>Molecular - PCR</div>	<div>Individual</div> <div>Pooled test (with individual samples)</div> <div>Pooled test (with pooled samples)</div>	<div>Staff</div> <div>Students</div> <div>Families</div>	<div>Opt-in</div> <div>Required</div> <div>Random sample</div>	<div>Twice a week</div> <div>Weekly</div> <div>Twice a month</div> <div>Other</div>	<div>Saliva</div> <div>Nasal swab</div> <div>Nasopharyngeal</div>	<div>At home</div> <div>At school</div> <div>External site</div>

Source: The Rockefeller Foundation's COVID-19 Testing in K-12 Settings: A Playbook for Educators and Leaders, [CDC](#)

Four case study examples illustrate different testing programs

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION

1

Diagnostic testing

Use tests (either rapid or PCR) to confirm if symptomatic individuals or close contacts of those infected have COVID-19

2

Screening testing using rapid tests

Screen¹ individuals and identify asymptomatic cases; results received within 15mins which means individuals with COVID-19 can be quickly identified

3

Screening testing using individual PCR tests

Screen¹ individuals and identify asymptomatic cases; PCR test results are more accurate than rapid tests (especially for asymptomatic cases)² but results are typically received within 24-48h rather than 15min

4

Screening testing using pooled PCR tests

Same as 3, with lower test costs than individual PCR tests;³ for some types of pool testing processes, may need to collect a second sample to confirm which individual(s) in a pool tested positive⁴

Each case study example includes a **Day In the Life Of (DILO) journey** for a student (Josh) and/or a teacher (Ms. Gomez)

Additional context and “**what if**” **scenarios** are provided



Josh
1st grade student



Ms. Gomez
High school teacher

1. Routine testing of all individuals, including those without symptoms or suspicion of exposure, to identify infected people sooner and reduce transmission by isolating potentially infected individuals; may be universal (required) or optional
2. The sensitivity of rapid tests varies, and is lower than molecular PCR tests. One [CDC study](#) of one specific rapid test found it had a sensitivity of 80% among symptomatic persons and 41% among asymptomatic persons compared to PCR testing
3. In areas of high COVID-19 prevalence, more pools may be positive, requiring retesting to isolate positive individuals which can increase the time it takes to identify and isolate the positive individual(s)
4. Some pool testing processes require individuals in the pool to be retested (i.e. a new sample needs to be collected) when there is a positive pool. However, some pooled testing process use only a portion of the sample in the pooled processing, so they can use the remainder for re-running individual tests if necessary

Source: Interviews with district leaders, The Rockefeller Foundation's *COVID-19 Testing in K-12 Settings: A Playbook for Educators and Leaders*, [Mathematica's COVID-19 Antigen Testing in K-12 Schools: Early Lessons from Six Pilot Sites](#), [RAND's COVID-19 Testing in K-12 Schools: Insights from Early Adopters](#)

Case study 1 – Diagnostic testing

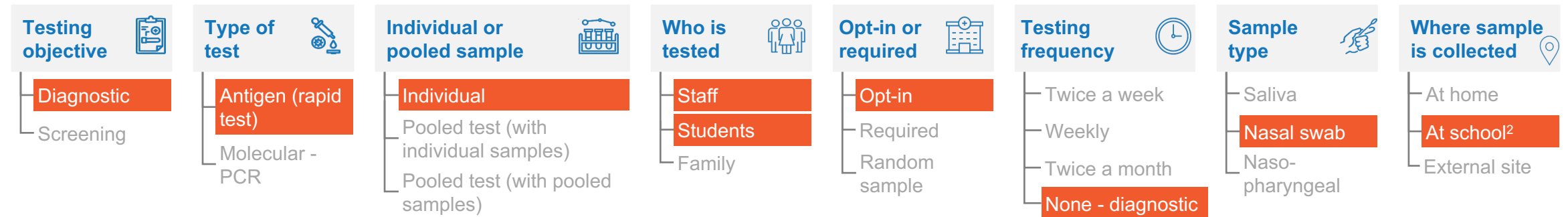
CASE STUDY EXAMPLE ONLY
–NOT A RECOMMENDATION

Urban district of >30k students with 2/3 in-person or hybrid¹ and 1/3 fully remote, began phasing in-person return as of Aug. 2020

In Dec. 2020, district launched diagnostic testing for symptomatic staff; in Jan. 2021, district expanded program to all students (first middle and high schoolers and then elementary)

Testing program design

Case-study testing strategy



Key enabling factors

- State purchased antigen tests and PPE and made them available for all districts in November 2020; district began phased implementation of diagnostic testing approach in December
- District supported communications campaign including texts, emails, calls, and virtual meetings; also shared FAQs for staff and families
- Nurses have been engaged throughout to ensure their input is incorporated in the program design

Impacts / benefits felt

- **Detection of positive cases to prevent spread:** Since testing started, ~480 staff and students have been tested and ~60 were positive; there have been 2 identified false negatives
- **Transparency and trust:** Before reopening, the district informed the community there would be positive cases and shared their safety protocols. Then, when 2 teachers tested positive on the first day, the community still trusted in schools to be candid and keep them safe

Lessons learned

- Requiring that a responsible adult sign the consent form in-person helps ensure that symptomatic students are picked up from school, regardless of their test result
- It was easier to get staff and community buy-in to conduct diagnostic testing of symptomatic individuals than to conduct screening testing

“ Our community appreciates the transparency and these testing opportunities. It gives them confidence that their school is keeping the community safe. – Superintendent ”

1. Elementary and middle schools are all in-person; some high schools are hybrid and some are in-person

2. Most staff are campus-based and have samples collected at school; non-campus based staff (e.g. some administrative staff, bus drivers, etc.) are tested separately at a non-campus administrative building

Source: Interviews with district leaders

1: DILO simulation of Josh, a student, taking a diagnostic test in an in-person learning setting

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION



**Josh –
1st grade in-person
GenEd student**

A Before the test



- 1 Josh goes to his homeroom. During class, Josh feels sick. His teacher calls the nurse.
Thurs, 8:15-11:25 AM

- 2 A nurse in PPE picks up Josh from class and walks him to the Care Room, where testing occurs.
Thurs, 11:25-11:30 AM

The district created Care Rooms (often referred to in other places as an isolation room) in schools to isolate symptomatic students from other students. It is also where COVID diagnostic testing occurs. It is distinct from the nurse's office so that the nurse's office can continue to operate normally



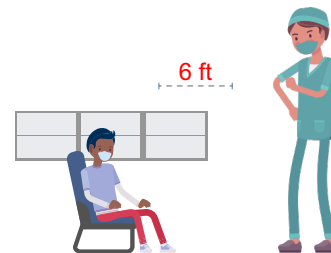
- 3 When they arrive, the nurse asks Josh to sanitize his hands, takes his temperature, and asks about his symptoms.
Thurs, 11:30-11:35 AM



- 4 The nurse calls a responsible adult¹ caring for Josh to share that Josh is sick and to ask if his symptoms are new. He tells them Josh needs to be picked up and can be tested with consent.
Thurs, 11:35-11:40 AM



- 5 Josh waits in the Care Room for his responsible adult to arrive. A nurse or another staff member in PPE watches him.
Thurs, 11:40-12:30 PM



- 6 Josh's responsible adult arrives and gives consent for Josh to be tested.
Thurs, 12:30-12:35 PM



B During the test



- 7 The nurse swabs Josh's nostrils and tells Josh and his responsible adult they will receive results in a few hours.
Thurs, 12:35-12:40 PM

The nurse reads the results on the antigen test ~15 minutes after taking the sample. He then enters those results into an app. Once the results are entered on the app, within 2 hours, they are automatically sent to the email and/or texted to the phone number on file for that student's responsible adult

1. A responsible adult is an authorized individual who is allowed to sign the consent form and escort the student from school grounds

Source: Interviews with district leaders

1: DILO simulation of Josh, a student, taking a diagnostic test in an in-person learning setting and testing positive or negative

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION



**Josh –
1st grade in-person
GenEd student**

C After the test *continued from previous page*



8 Josh's responsible adult drives Josh home from school.
Thurs, 12:40-1:10 PM

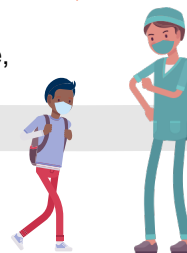


11+ Josh has brief, limited symptoms and attends virtual classes for the 10 calendar days after he tests positive.

12+ Josh's responsible adult drives Josh to school and reminds him to go to the nurse's office.
Mon (10 days after Josh's positive test), 7:15-7:45 AM



13+ Josh walks to the nurse's office, where the nurse takes his temperature and asks him questions about his symptoms.
Mon, 7:55-8:00 AM



14+ The nurse sends Josh to his homeroom for class.
Thurs, 8:00- 8:15 AM



9- Josh's responsible adult gets an automated email or text saying Josh tested negative and should consult his doctor for further guidance.
Thurs, 2:00 PM



10- Josh sees a doctor who diagnoses Josh's symptoms as a cold, though to be sure gets Josh to take a PCR test that comes back negative
Fri, 10 AM



11- Josh returns to school on Monday with a doctor's note after recovering from his cold. He no longer has symptoms and has been fever-free for more than 24 hours.
Mon, 8:15-2:00 PM



Josh tests positive

Josh tests negative



9+ Josh's responsible adult gets an automated email or text saying Josh tested positive.
Thurs, 2:00PM

10+

The nurse calls Josh's responsible adult to share the school's protocols for a positive test, including the earliest date Josh can return to class (10 calendar days later) and the screening Josh will need to complete when he returns. The nurse suggests they consult Josh's doctor for further guidance and consider obtaining a PCR lab-based test. After the call, the nurse begins contact tracing. He works with school staff to inform Josh's teacher and the families of Josh's classmates that someone in class tested positive and they all need to quarantine and shift to virtual learning for 10 days.

Thurs, 2:15 PM

Since Josh is in 1st grade, his whole class must quarantine. To expedite calls, the nurse divides up the students in Josh's class and assigns them to front office staff to help make calls. The staff calls the students' families and reads a scripted message. The script also has FAQs so they can answer questions.

Source: Interviews with district leaders

1: Alternate simulation plans for Josh in case of example ‘what if’ scenarios

CASE STUDY EXAMPLE ONLY
–NOT A RECOMMENDATION

CASE STUDY EXAMPLE ONLY – NOT A RECOMMENDATION

C



Josh – 1st grade GenEd student is symptomatic at school and...

What if...

Josh is too sick to participate in virtual learning

Josh tested positive and returns to school early or with symptoms

Josh’s responsible adult opts for Josh to not take the diagnostic test

Key questions

What happens to Josh if he is too sick to participate in virtual learning?

What safety protocols are in place to protect students and staff from a positive individual returning to school?

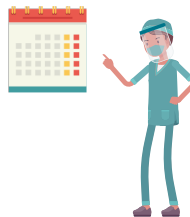
What happens if Josh’s responsible adult opts out of the COVID diagnostic test?

“Divergent” steps

Josh notifies his teacher that he is too sick to learn remotely and rests at home for 10 days. If he still has symptoms after 10 days, he gets a doctor’s note and stays home. Josh receives paper packets of work he missed that he can work on when he’s feeling better.



If Josh tests positive, the nurse calculates the earliest date Josh can return to school and informs Josh’s responsible adult and Josh’s teacher. When Josh returns to school, he must stop by the nurse’s office for a screening. There, the nurse notices if Josh’s test was less than 10 days ago and sends Josh home. If Josh goes straight to class, his teacher sends him to the nurse’s office for the screening. Josh cannot return for 10 days after testing positive, regardless of whether he later tests negative.



Josh stays in the Care Room and waits until a responsible adult can pick him up. He is supervised during this time by a nurse or staff member in PPE. To return to school, Josh must either get a doctor’s note with an alternative diagnostic, get a negative PCR test, or wait 10 days. When Josh returns to school, he must stop by the nurse’s office for a screening.



Source: Interviews with district leaders

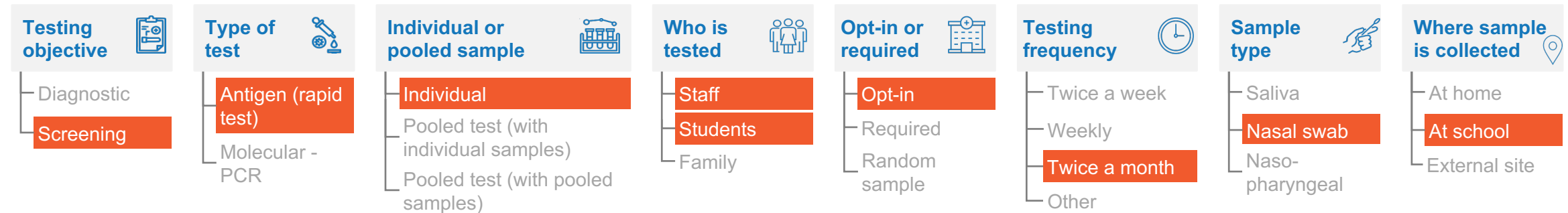
Case study 2 – Screening testing using rapid tests

CASE STUDY EXAMPLE ONLY
–NOT A RECOMMENDATION

Urban district with >20k students, high school in hybrid A/B schedule, elementary school fully in-person. 1/3 of all students have opted to be fully remote
In January 2021, district launched screening testing 2x per month for all interested students and staff

Testing program design

Case-study testing strategy



Key enabling factors

- State purchased antigen tests and made them available for all districts
- After the program was up and running, the State provided an EMT service of 6 people to supplement the districts' staff (not all schools use EMT service), with EMT personnel performing the sample collection
- Communications campaign at district and school level including texts, social media, and calls
- Diagnostic testing available through pop up sites around the city and state

Impacts / benefits felt

- More students chose to return to in-person school:** Total students opting for hybrid or in-person learning over virtual learning increased by ~10%, reflecting greater comfort with returning to schools
- Reassurance that positive cases are identified and overall community transmission low:** First round of baseline testing determined positivity rate of 0.75% among ~2k tests; ~1% students and staff quarantine each week for 10 days given exposures

Lessons learned

- Takes time and effort to collect consent forms; utilizing online survey and paper forms eventually secured permission for ~25% of students
- Elementary school parents often want to be with kids during testing, but space constraints limit that
- High school students may be less likely to get tested (e.g., hard to reach, fear of not being able to work) so nurses are finding time to explain to them why it's important

“ Parents have emailed thanking us for keeping the kids safe. A lot of our staff are also taking advantage of the testing. It's given everyone reassurance. – Head nurse ”

1. Elementary schools are in-person and middle and high schools are hybrid; 2. Testing program is in addition to existing state K-12 option and pop up 15 minute screening

Source: Interviews with district leaders

2: District and school testing plan context

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION

District testing plan

The district has set up twice monthly testing for students and staff at their **~40 schools**.

Initially, school nurses ran the testing program at each, but after a few weeks the State provided an **EMT service** of 6 people,¹ which travels directly to most schools to help conduct testing. Some schools have elected to keep doing testing on their own.

Testing takes **~2.5 hours for each school** including, sample collection, processing, and reporting. Teachers often get tested outside class time, such as before start of day, and students get tested during classes. **Testing takes ~5 minutes per person**

~15 middle and high schools

Hybrid on “A/B” schedule. Students are in-person on alternating days. Thus, each school schedules testing on 2 days per testing cycle (4 times per month).

~25 elementary schools

Fully in-person, 5 days a week
Each school schedules testing once every two weeks

Example DILO simulations next

Ms. Gomez’s high school has an assigned testing block of 2.5 hours in the morning every other Wednesday and Thursday, when it tests its staff (for the first 30mins of testing) and students (for the remaining 2 hours). During that 2.5 hour window, any individual with a positive test result is notified. Note the school schedule (e.g., classes) continues in parallel during testing.

	Monday	Tuesday	Wednesday	Thursday	Friday
Week 1					
08:00					
10:00	In-person class (Block A)	In-person class (B)	Testing (A) 8-10:30 AM	Testing (B) 8-10:30 AM	
12:00	8:30a-2:30p		In-person class (A)	In-person class (B)	In-person class (A)
02:00			8:30a-2:30p	8:30a-2:30p	
Week 2					
08:00					
10:00	In-person class (Block B)	In-person class (A)	In-person class (B)	In-person class (A)	In-person class (B)
12:00	8:30a-2:30p				
02:00					



Ms. Gomez – high school teacher



Josh – 1st grade student

Josh’s elementary school has an assigned testing block of 2.5 hours every other Thursday morning, during which students and staff may participate in testing. Note the school schedule continues in parallel during testing.

1. All 6 EMTs were assigned to different schools in the district in teams of 1-2 individuals; individual EMTs schedule specific days and times every two weeks when they will travel to their assigned schools to test; while the State provided tests to every district, the EMT service was a special grant provided to the district after testing began to lessen the burden on nurses

Source: Interviews with district leaders

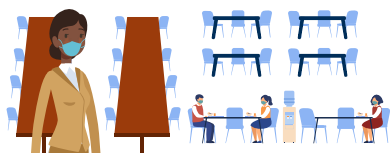
2: DILO simulation of Ms. Gomez, a teacher, taking a screening test in an in-person learning setting and testing negative

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION

**Ms. Gomez –
high school teacher,
in-person**



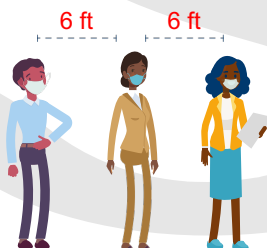
A Before the test



2 Ms. Gomez walks to the cafeteria where the testing occurs.
Wed, 7:45-7:50 AM

1 After already reading about it in the weekly school newsletter on Friday, Ms. Gomez checks her phone and sees an automated text reminder about COVID testing on Wednesday and Thursday morning, which are the assigned times for her school.
Mon, 2:00 PM

5 Following the nurse's directions, Ms. Gomez swabs each of her nostrils and puts the swab in the test card. She drops the test card off on a table, where the nurse seals it.
Wed, 8:05-8:10 AM



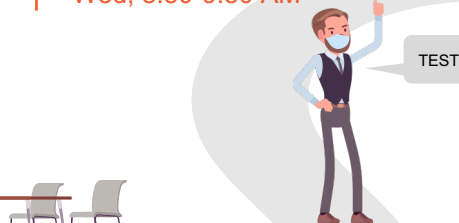
3 When she arrives, Ms. Gomez sanitizes her hands and waits in a single file line.
Wed, 7:50-8:00 AM

C After the test

4 When she reaches the front of the line, the school nurse asks Ms. Gomez for her name and birthday and writes them on the test kit.
Wed, 8:00-8:05 AM

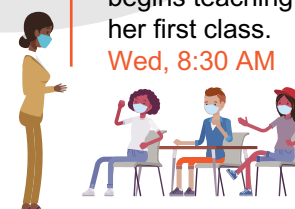


6 Ms. Gomez walks back to her classroom, knowing that she will be informed of her result if it is positive.
Wed, 8:10-8:15 AM



8 While Ms. Gomez teaches, a staff member enters the classroom and announces that anyone with consent in that class can leave for testing. Students with consent all leave and return one by one after ~15 minutes.
Wed, 8:30-9:30 AM

7 Ms. Gomez begins teaching her first class.
Wed, 8:30 AM



10 Ms. Gomez teaches in-person classes with an alternating group of students each day. In her first class on Wednesday, the other group of students with consent leave during class to get tested.
Wed-Fri



9 Ms. Gomez teaches the rest of her classes without interruption.
Wed, 9:30 AM-2:30 PM

11 Ms. Gomez receives the weekly school newsletter informing her of upcoming test dates in 2 weeks.
Fri, 2:00 PM



Source: Interviews with district leaders

2: DILO simulation of Ms. Gomez, a teacher, taking a screening test in an in-person learning setting and testing positive

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION



**Ms. Gomez –
high school teacher,
in-person**

continued from
previous page

C After the test

6 Ms. Gomez walks back
to her classroom.
Wed, 8:10-8:15 AM

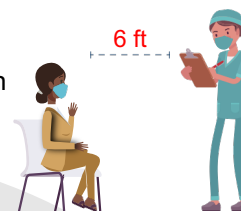
7 Before Ms. Gomez begins
teaching her class, a nurse
enters the room and informs
her that she tested positive.
Wed, 8:25 AM



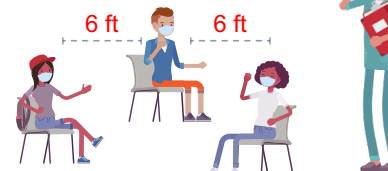
8 Ms. Gomez follows
a nurse to the Care
Room.
Wed, 8:25-8:30 AM



10 Ms. Gomez sits in the
care room as the nurse
asks her who she has
been in close contact with
over the past 2 days.
Wed, 8:30-8:45 AM



10b The school nurse notes the names of the three students
Ms. Gomez was in close contact with on Monday and picks
them up from class and brings them to the care room. The
students she was in close contact with on Tuesday (who
are at home due to the hybrid A/B schedule)
will also need to be contacted.
Wed, 8:45-9:00 AM



10c The school nurse calls the students' responsible adults¹ while the students sit in
the Care Room. The school nurse also calls the responsible adults of the two
students Ms. Gomez was in contact with on Tuesday. The school nurse waits
with the students until their responsible adults can pick them up. They sit at least
6 ft apart. Later that day, all the students in Ms. Gomez's classes receive a letter
to take home informing their household that someone in class tested positive.
Wed, 9:00-9:45 AM



11 Ms. Gomez leaves
the school and
drives home.
Wed, 8:45-9:15 AM

12 Ms. Gomez quarantines at home for 10
calendar days. Since she has limited
symptoms, she chooses to teach virtual
classes for some or all those days. At
school her students learn with her
virtually on their laptops and are
supervised by a substitute teacher.
Thurs-Fri and Mon-Fri



13 Ms. Gomez
teaches classes
in-person after
completing the 10
day quarantine.
Mon-Fri



1. A responsible adult is an authorized individual caring for the child and may include a parent, guardian, caretaker, family member, or friend
Source: Interviews with district leaders

2: Alternate simulation steps for Ms. Gomez in case of example ‘what if’ scenarios

C



Ms. Gomez – high school teacher, in-person tests positive at school and...

What if...

Ms. Gomez is too sick to teach virtual classes

Ms. Gomez tests negative within 10 days of her positive test result

Students and staff in close contact with Ms. Gomez test negative

Ms. Gomez goes to get tested at school 2 weeks later

Key questions

What happens to Ms. Gomez if she is too sick to teach virtual classes? Who takes over her classes?

What happens to Ms. Gomez if she tests negative while in quarantine?

What happens to students or staff Ms. Gomez was in close contact with if they test negative?

What happens if Ms. Gomez goes to get screening tested again within 90 days of her positive test?

“Divergent” steps

Ms. Gomez notifies the school that she is too sick to teach remotely and rests at home for 10 days. If she still has symptoms after 10 days, she gets a doctor’s note and stays home. While she rests, the principal finds a substitute teacher to take over her class and teach her students in-person. Her days resting are logged as “quarantine days” and do not impact her paid sick time.

Ms. Gomez is required to quarantine for the full 10 days following her positive test – regardless of whether she tests negative afterwards. If she is well, she can teach virtual classes. At school her students learn with her virtually on their laptops and are supervised by a substitute teacher.

Close contacts are told to quarantine for 10 calendar days, but 5-7 days later they can get tested, and if they are negative, they can return to school on day 8. To return, the negative test must be taken 5-7 days after Ms. Gomez’s positive result.

Before she gets tested, one of the screening questions the nurse asks Ms. Gomez is if she’s ever tested positive for COVID. When Ms. Gomez says “yes,” the nurse informs her that it is unnecessary for her to get tested for 90 days after her positive result.



Source: Interviews with district leaders

2: DILO simulation of Josh, a student, taking a screening test in an in-person learning setting and testing negative

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION

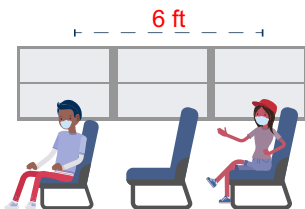


**Josh –
1st grade in-person
GenEd student**

A Before the test



- 1 After reading about it in the school newsletter, Josh's responsible adult gets a text message about testing and fills out the online consent survey for Josh.¹
Sat, 2:00 PM

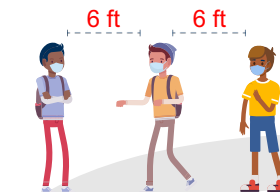


- 2 Josh takes the bus to school and sits by himself in his assigned seat. All the students wear masks and sit 6ft apart.
Thurs, 7:15-7:45 AM



- 3 Josh goes to his homeroom and attends in-person classes.
Thurs, 8:15-11:25 AM

B During the test



- 5 When they arrive, they are asked to sanitize their hands and wait in a single file line.
Thurs, 11:30-11:35 AM



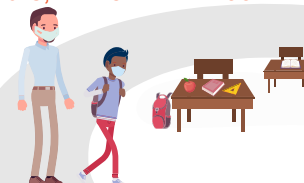
- 6 When he reaches the front of the line, the school nurse asks Josh for his name and birthday and writes them on a test kit.
Thurs, 11:35-11:40 AM



- 4 Given that he is in grades K-2, a school staff member picks all the students with consent up from Josh's class and walks them to the cafeteria, where testing occurs.
Thurs, 11:25-11:30 AM

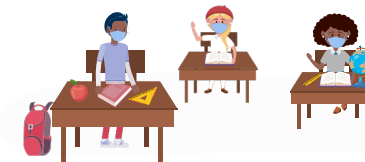


- 7 Josh stands still as the nurse swabs each of his nostrils. The nurse puts the swab in the test kit and hands it to the nurse assistant.
Thurs, 11:40-11:45 AM



- 8 Josh waits with the school staff member for students in his class to finish testing. Then, the staff member walks Josh's classmates back to their homeroom.
Thurs, 11:45 AM -12:00 PM

C After the test



- 9 Josh attends the rest of his classes and will not receive a notification of his negative test result (only positive results are notified).
Thurs, 12:00 PM-2:15 PM



- 10 Josh takes the bus home.
Thurs, 2:15-2:45 PM



- 11 Josh's responsible adult receives the weekly newsletter informing them of upcoming testing and informs Josh.
Fri, 2:00 PM

Source: Interviews with district leaders

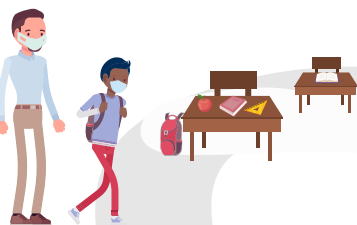
2: DILO simulation of Josh, a student, taking a screening test in an in-person learning setting and testing positive

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION



**Josh –
1st grade in-person
GenEd student**

C After the test

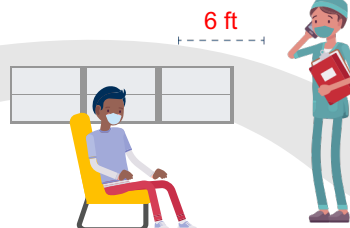


- 8 Josh waits with the school staff member for students in his class to finish testing. Then, the staff member walks Josh's class back to their homeroom.
Thurs, 11:45 AM -12:00 PM

- 10 As Josh follows a nurse to the Care Room, the nurse explains to Josh that he tested positive and takes time to reassure Josh.
Tues, 12:10-12:15 PM



- 11 Josh sits in the Care Room and the nurse asks him who he has been in close contact with over the past 2 days (within 6ft for 15 minutes or more). After speaking to Josh, the nurse calls his responsible adult to share that Josh tested positive and needs to be picked up. The nurse also asks who Josh has been in close contact with and what symptoms, if any, Josh had recently.
Tues, 12:15-12:25 PM



- 9 Josh attends ~10 minutes of his class when a nurse enters the room to pick him up.
Tues, 12:00 PM-12:10 PM



- 12 Josh waits in the Care Room for his responsible adult to pick him up. A nurse or another staff member in PPE watches him.
Tues, 12:25-1:30 PM



- 13 Josh's responsible adult picks Josh up from school and drives him home.
Tues, 1:30-2:00 PM



- 14 Josh has limited symptoms and attends virtual classes for 10 days after he tested positive with his same homeroom teacher.



- 15 After 10 days, Josh returns to school and attends in-person classes
Thurs, 12:00 AM-2:15 PM



After speaking to Josh and his responsible adult, the nurse calls Josh's teacher and other staff members to continue contact tracing and learn more information. The nurse looks at seating charts (for Josh's classroom and Josh's school bus) and attendance records for the past two days to identify who else Josh may have been in close contact with and inform them. Once the nurse identifies Josh's close contacts, they send an Excel sheet to the Dept. of Health informing the DoH who will be quarantined and for how long.

Source: Interviews with district leaders

2: Alternate simulation steps for Josh in case of example ‘what if’ scenarios

C



Josh – 1st grade GenEd student tests positive at school and...

What if...

Josh’s responsible adult cannot pick him up

Key questions

Where would Josh go if his responsible adult cannot pick him up? Who would supervise him?

“Divergent” steps

Josh stays in the Care Room and waits until a responsible adult can pick him up. He is supervised during this time by a nurse in PPE. At the end of the school day, if no one can pick Josh up, the staff work to reorganize the bus seating chart to significantly separate Josh to the back of the bus, ensuring he is several rows away from the other students.

In another district, if no one could pick Josh up at the end of the day, they would hire a taxi service to take Josh home

Many students in Josh’s class are also quarantined

What happens to Josh’s class if several students test positive or are close contacts of someone positive?

If a significant number of students in a class are quarantined, Josh’s principal or superintendent, after consulting with Josh’s teacher, may decide to move the class online for two weeks, and everyone in Josh’s class is temporarily shifted to remote learning.



Josh is on free or reduced lunch

How does Josh continue to receive meal service during the day?

One day a week, the school has a day when they distribute 5 meals. While Josh is quarantining, Josh’s responsible adult can pick up the meals on that day.



Josh then tests negative within 10 days of his positive test result

What happens to Josh’s learning environment if he tests negative while in quarantine?

Josh is required to quarantine for the full 10 days following his positive test. The district will provide Josh with the technology resources he needs to attend class virtually unless he is temporarily too sick to participate.



Source: Interviews with district leaders

Case study 3 – Screening testing using molecular PCR

CASE STUDY EXAMPLE ONLY
–NOT A RECOMMENDATION

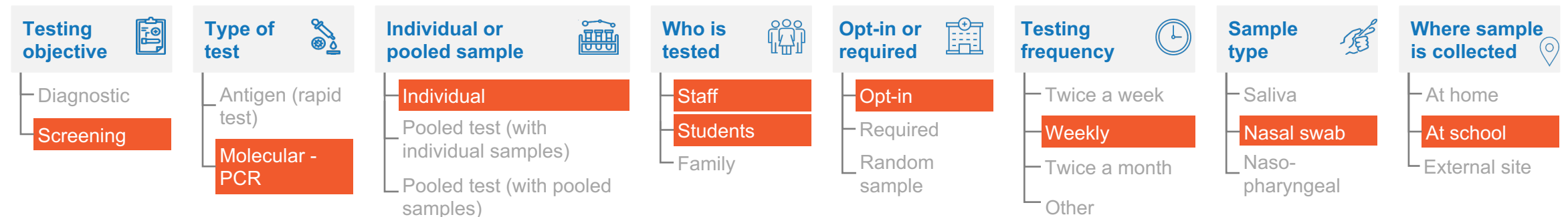
Urban district of ~90 schools with >45k students with 1/3 in-person¹ and 2/3 fully remote (limiting and phasing in in-person reopening due to high community transmission rates)

In November 2020, district launched screening testing for all students and staff in a few schools

In addition to the opt-in molecular screening (focus of case study, described below), the district also has two other testing initiatives (diagnostic testing using mobile units through a collaboration with the county and required rapid screening testing for extracurricular activities)

Testing program design for molecular screening test program

Case-study testing strategy



Key enabling factors

- Program initially started with philanthropic funding and then received city and county funding
- School leaders invest in extensive community outreach (e.g., principals call parents to encourage testing;² superintendent hosts townhalls)
- Nonprofit provides tests and supplies at cost, conducts testing, and takes responsibility for logistics of testing and collecting supplies

Impacts / benefits felt

- **Increase in opt-in rates and interest for testing:** Since Nov 2020, testing expanded from a few schools in high risk zip codes to ~90 schools; additionally, ~70% of in-person students and staff get tested; every week the number of people who opt-in increases
- **Reassurance that positive cases are identified and students are safe in schools:** School positivity rate is 0.3%; no evidence of transmission in schools (99% of identified spread came from the community; 1% is unknown)

Lessons learned

- The district initially managed contact tracing for student cases centrally but needed to shift to a local model led by campus nurses as the program expanded
- Stakeholder engagement of community leaders requires constant communication
- Scaling caused brief supply chain challenges; ensuing frustration by parents and staff was eased by messaging that things will improve

“ Parents and staff feel a lot safer and the feedback we’re getting is very positive. But you really have to have a tough skin and a soft heart to navigate this. ”
-Associate Superintendent

1. In-person students attend class 5 days per week but have flexibility on being in-person or remote; 2. Principals call parents to invite their students to attend school and get tested; while on the phone, they also ask about whether there are any high-risk individuals living with the student to ensure students feel comfortable remaining remote if necessary and proactive measures are taken to protect families

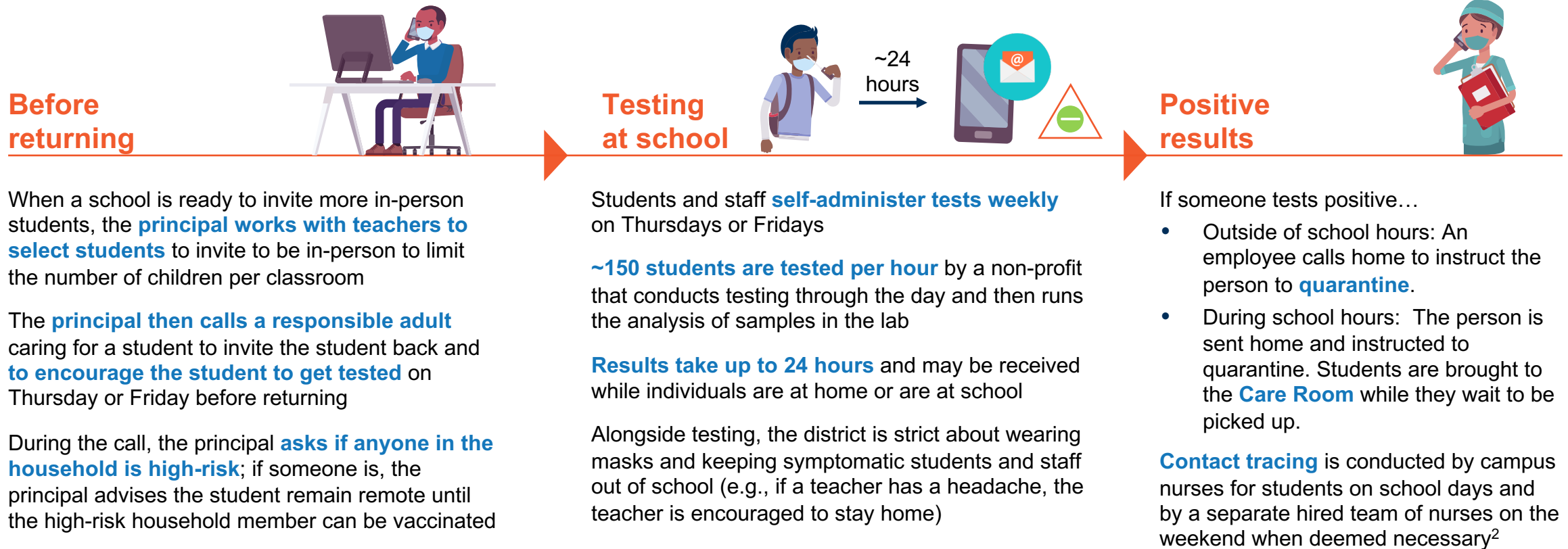
Source: Interviews; press search

3: The district provides weekly opt-in molecular screening testing for students and staff

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION

Molecular PCR test provided to students and staff at school

■ Pooled testing case study next



While the non-profit supporting the district is currently utilizing an individual molecular PCR testing process, they plan to shift to a **pooled approach to reduce test processing costs by 3-5x** per test as their volumes increase.¹

1. The non-profit currently conducts 10,000 tests per day and needs to get to 50,000 tests per day to shift to pooled testing; the non-profit supports other districts and community groups beyond the district described

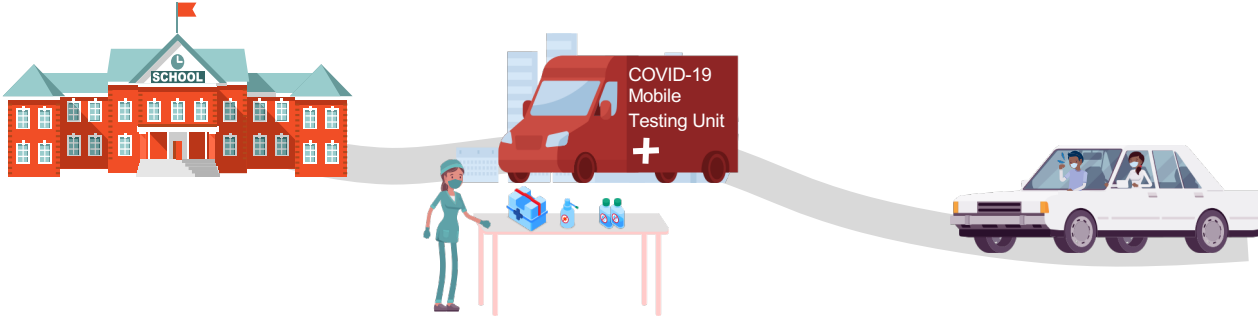
2. If an early childhood or special needs student tests positive, contact tracing is completed over the weekend

Source: Interviews with district leaders

3: The district has two other testing initiatives in addition to the opt-in molecular screening testing

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION

Diagnostic test provided through a mobile unit for staff, students, and community members



Through a county-community partnership, the district has a **mobile testing unit on campus** that is located at an easily accessible site every Wednesday from 8:30 AM to 3:30 PM.¹ The testing unit is a drive-up site run by a non-profit. It moves across 6 different sites in the county through the week, one of which is the school district campus site.

The mobile unit conducts diagnostic testing to encourage community members to get tested regularly and to provide access to testing for symptomatic students and staff.

Unlike the screening testing the district provides in schools, the mobile unit:

- Is **accessible to anyone** (incl. remote students and staff, parents, and the community)
- Enables **symptomatic** and **close contacts of positive individuals** to get tested
- Is **located outside of school buildings** (to keep symptomatic individuals separated)

Another district also set up **mobile testing units** on school campuses to provide a more **convenient testing option for students and staff**. The district's schools are spread out over a broad and mountainous area, and existing community testing centers are not easily accessible to all. The mobile units **started out as a diagnostic testing option** for symptomatic students and staff and later **expanded to also offer screening testing** every ~10 days as they travel around the district. The mobile units conduct ~1,000 tests per week

Rapid test required for extracurricular activities

“Test to play” – Josh, a 1st grade student, testing before playing soccer

- 1 Josh arrives at school for a soccer game and lines up for a test.
Sat, 2:00 PM

- 2 An athletic trainer in PPE hands Josh a swab. Josh swabs his nostrils, hands the swab back, and waits in a private area.
Fri, 2:10 PM

- 3 The athletic trainer tells Josh he is negative and free to play. Josh plays soccer in his mask.
Fri, 2:30 PM



Students are **required** to complete a rapid test once or twice a week when they participate in extracurricular activities (e.g., band, athletics, JROTC). The district trained athletic trainers to administer the rapid tests and nurses are available by phone to contact and support with contact tracing if anyone tests positive. Tests are taken before practice and games and are required for all students (in-person or remote)

1. Alongside the mobile testing unit on campus on Wednesdays, there is also a lab off-campus nearby where community members, students, and staff can get diagnostic tested Monday through Friday
Source: Interviews with district leaders

Case study 4 – Screening testing using pooled PCR tests

CASE STUDY EXAMPLE ONLY
–NOT A RECOMMENDATION

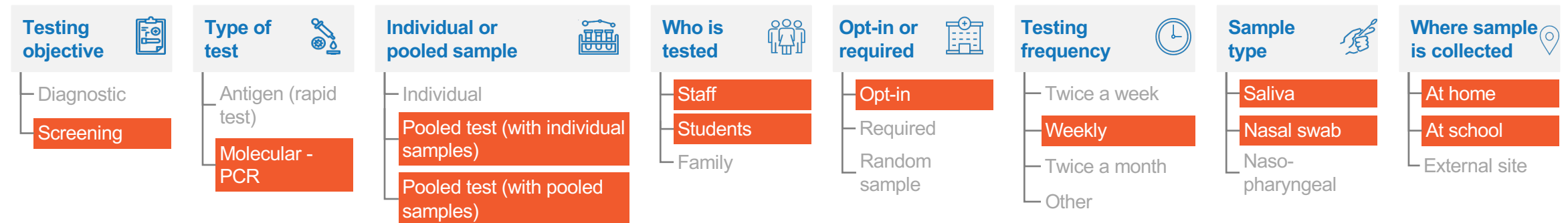
Small urban district of ~4k students with 2/3 in-person or hybrid¹ and 1/3 fully remote

In Nov. 2020, district launched screening pooled testing for staff; in Feb. 2021, district expanded program for students;

Two different pooled testing methods are used: Staff undergo pooled saliva testing that provides individual results, while students undergo pooled nasal swab testing that requires more samples to identify individual results; the former method is more expensive but used for staff because it gets faster final positive results, preventing staff shortages (detailed on next slide)

Testing program design²

Case-study testing strategy



Key enabling factors

- State sponsored 6-week pooled testing program for all districts; the district decided to:
 - Use the program to begin testing students
 - Continue using another method to test staff for faster individual results (funded through city's CARES Act)
- Community leaders (Superintendent and Mayor) championed the testing program
- The state requires testing to return to school for anyone who travels out of state

Impacts / benefits felt

- Consistent participation with a spike after the holidays:** Since staff testing pilot started in fall 2020, ~350 staff members (~60% of in-person staff) are tested through their school every week, with some additional staff testing at public community sites instead. After holiday break in 2021, ~500 were tested through their schools
- Reassurance that positive cases are identified and transmission is minimized:** At a drive-through event in January before schools reopened, of ~1.8k tests completed for staff and students, 1 staff member and 19 students were positive (~1%) – compared to the 5-9% community positivity rates

Lessons learned

- Pooled testing that requires more samples is a suitable method to test students but due to the time delays for individual positive results may be less viable for staff
- Testing results are timed after school hours or on weekends to ensure sufficient time for students to receive a follow-up test if needed
- Testing requires significant coordination and buy-in and planning for staffing

“ The most important thing to be thinking about is equity. We want to ensure that all students can be in school and have access to follow up testing or transportation. ”
– Chief of Opportunity and Response

1. K-2nd grade students and high-need students are in-person (high-need students make up ~15% of the district and include students who are in substantially separate settings, experiencing homelessness or foster care, new English learners, or without access to internet at home); 3rd-12th grade students are hybrid and attend classes just at the beginning of the week on Monday and Tuesday or at the end of the week on Thursday and Friday

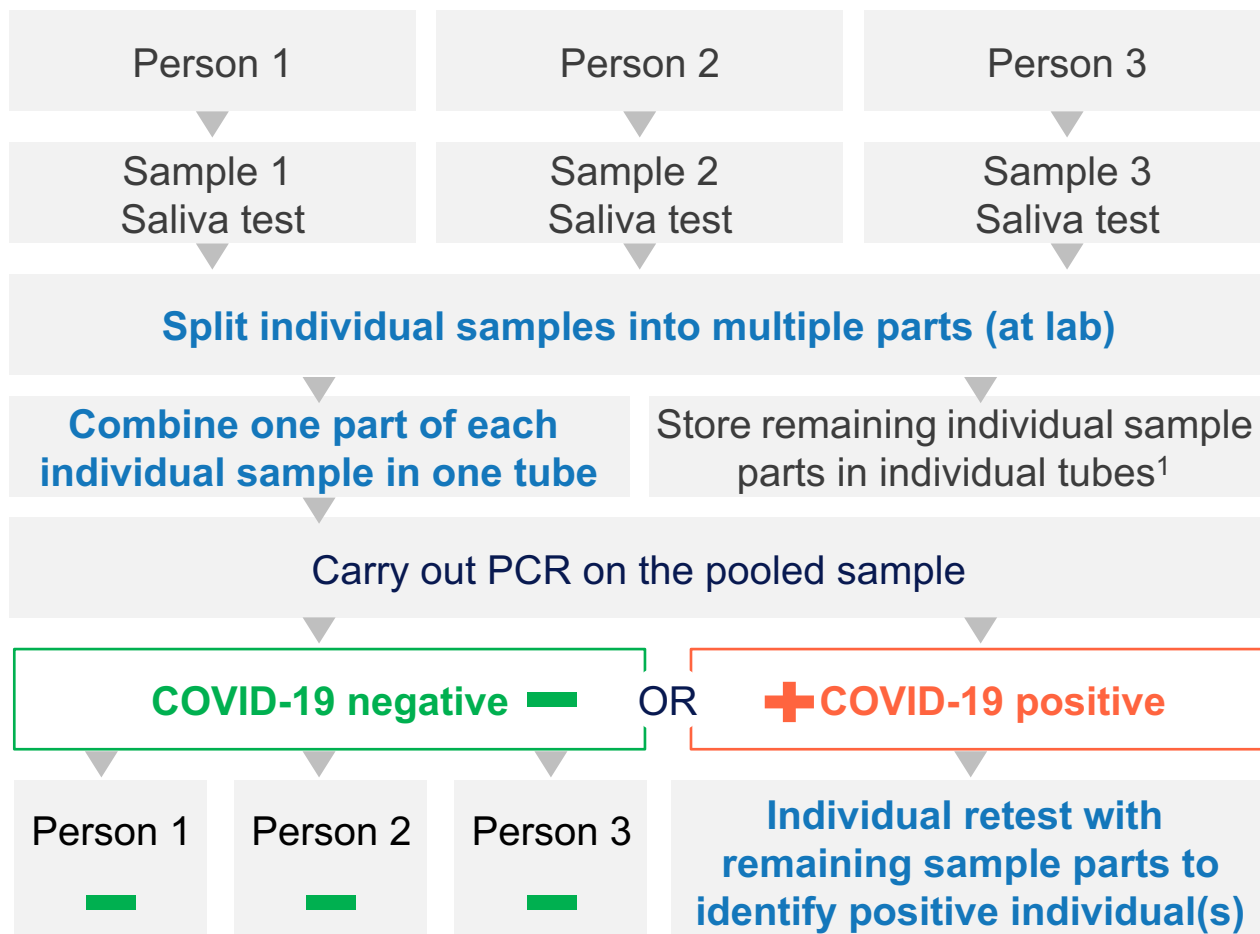
2. Free individual PCR testing is also available near the district and some students and staff opt to get tested there instead

Source: Interviews with district leaders

4: In this case study, the pooled testing method used for staff does not require collection of additional samples to confirm a positive case

CASE STUDY EXAMPLE ONLY
–NOT A RECOMMENDATION

Case study: staff pooled testing method



Ms. Gomez – teacher



If someone in her pool tests positive, **Ms. Gomez's journey looks the same** as someone taking an individual molecular test.

Summary

In pooled testing for staff, if a joint sample comes back positive, it is **possible** to rerun each sample individually **to identify positive individuals** – and no new samples need to be collected.

This collection method is ~3-5x more expensive per test than pooled testing that requires collection of additional samples to confirm a positive.²

It is **used for staff**, like Ms. Gomez, **to identify positive individuals quickly** and **prevent staff shortages**.

1. These individual sample parts are only used if the PCR on the pooled sample is COVID positive and a retest is required; if the pooled sample is negative, the individual samples are not used

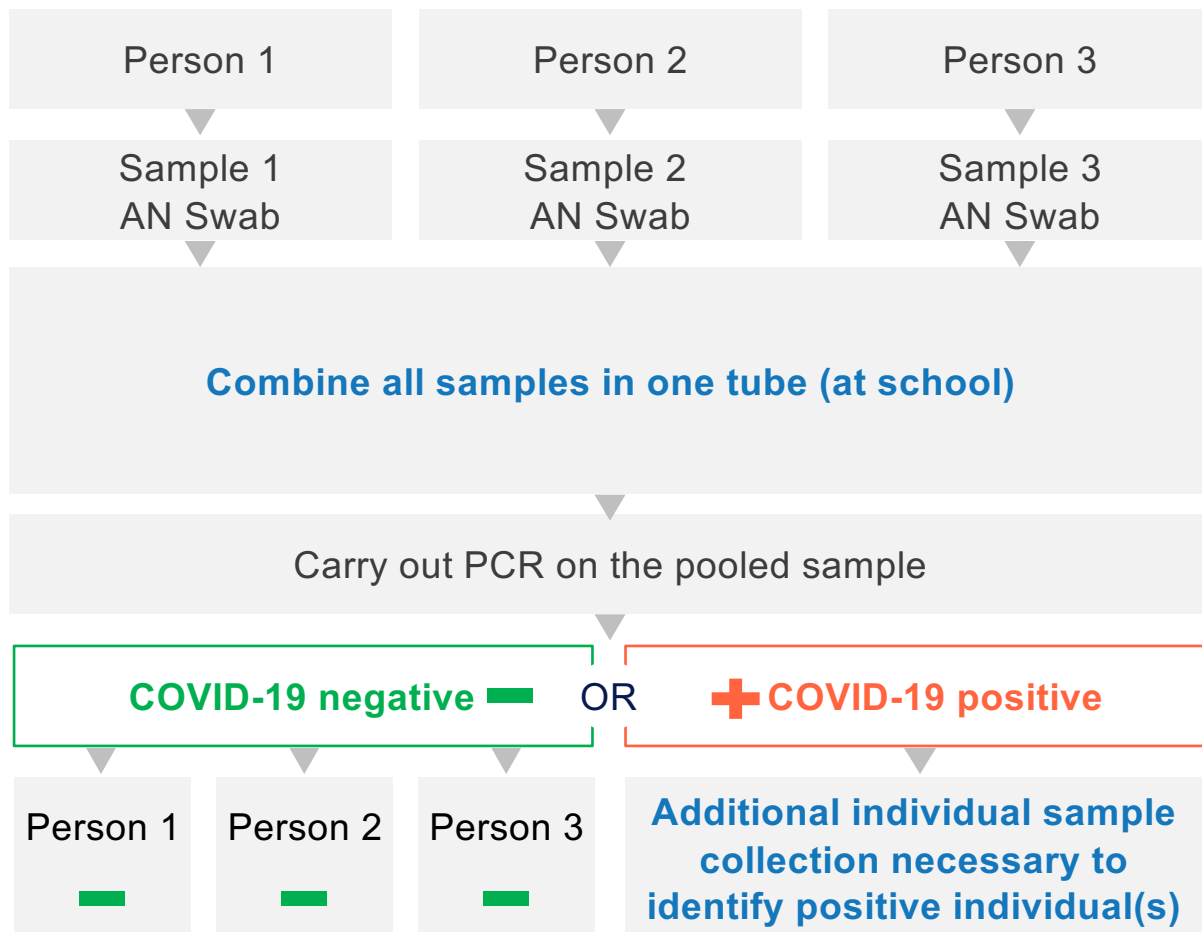
2. Pooled testing that does not require collection of additional samples is very cost competitive compared to pooled testing that requires a reflex test if there is a low positivity rate (because the cost of doing individual retests with remaining sample parts when a pool is positive is relatively expensive)

Source: Interviews with district leaders

4: In this case study, the pooled testing method used for students does require collection of additional samples to confirm a positive case

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION

Case study: student pooled testing method



Josh –
1st grade student



If someone in his pool tests positive, **Josh's journey looks different** after the positive pooled test result. **An example DILO simulation is detailed on the next slide.**

Summary

In pooled testing for students, if a joint sample comes back positive, it is **not possible** to rerun each sample individually **to identify positive individuals** – and **new samples need to be collected**.¹

This collection method is **used for students**, like Josh, as it is typically more affordable.

When a student tests positive, the district provides all individuals in the pool with a **rapid antigen test**.²

If no one in the pool tests positive on the antigen test, then the district runs **individual PCR tests** and anyone who tests positive must quarantine

1. Pooled testing that requires collection of additional samples to confirm a positive case is less effective in areas with a high positivity rate

2. Students also have the option to go to a community testing site for a molecular PCR test

Source: Interviews with district leaders

4: DILO simulation of Josh, a student, taking additional samples after testing positive in a pooled test

CASE STUDY EXAMPLE ONLY
—NOT A RECOMMENDATION

Josh – 1st grade in-person GenEd student



B Weekly screening test

- 1 The nurse swabs Josh's nostrils to collect a sample at school for the pooled test and Josh attends his full day of classes (Josh has been getting tested for weeks after getting consent).
Thurs



C Positive pool retest

- 2 A responsible adult¹ caring for Josh receives an automated notification (text or email) that Josh's pool tested positive and everyone in the pool will need to be retested. If they don't respond within an hour, they receive a phone call from the nurse. They are given two options to get Josh tested tomorrow.
Fri, 3:00 PM

Students have two options to be retested when someone in their pool tests positive:

- Rapid antigen test at school
- PCR test at a public testing site (24h results)

If neither option is possible for Josh, then the district offers a van service that drives to Josh's house

The district aims to test students a day before they would be home so that they do not receive their test results while on campus. Students grades K-2 – like Josh – are in-person all week and are tested on Thursday. Students on the hybrid schedule (either attending Monday and Tuesday or Thursday and Friday) are tested Tuesday or Thursday

- 5 Josh's responsible adult receives an automated notification (text or email) that they have identified the positive individual in his pool
Sat, 6:00 PM



Any individual in the pool who tests positive must quarantine (remaining individuals in the pool who are negative may return to classes).

- 6 Josh returns to school and attends in-person classes



- 4 Given that Josh tested negative for the rapid test, he is informed that they will also collect a sample for an individual **molecular PCR test**. This sample is only sent to the lab if everyone in Josh's pool also tests negative. The nurse swabs Josh's nostrils to collect a sample.
Sat, 12:20 PM

- 3 Josh's responsible adult drives Josh to school to take a **rapid antigen test**. The nurse swabs Josh's nostrils to collect a sample and waits 15mins to confirm Josh tests negative.
Sat, 12:00 PM



If no one in the pool tests positive on the antigen test, then the district will use the additional samples collected during antigen testing to run individual PCR tests. If that happens and the results from the individual PCR test are not back by Monday, Josh attends school remotely as he awaits his results.

1. A responsible adult is an authorized individual who is allowed to sign the consent form and escort the student from school grounds
Source: Interviews with district leaders

Steps system leaders have taken to implement a testing strategy

INDICATIVE,
NON-EXHAUSTIVE

Collect consent to test and promote participation

What legal consent requirements exist?

How will you collect parent/guardian consent?

What are the key barriers to participation? How will you mitigate against them?

In Providence, Rhode Island, guardians fill out a survey online to provide consent. The school district also provides physical forms

Engage testing vendors and design testing operations

What vendor options exist and how do they vary by cost, services provided, quality, and turnaround time?

What testing model, facility layout, and operation flow works best for your test type, staffing resources, and available space?

In Washington, DC, a public charter school designed a drive-through set up for screening testing because it was outdoors and served as a single, centralized location

Estimate staff and supply needs and tracking processes

How many people do you need to operate?

How many supplies (e.g., PPE, test kit, cleaning kit) do you need per test, per day, and per month?

How will you track, store, order, transport, and dispose of inventory?

In Texas, the Texas Education Agency (TEA) coordinates inventory allocation across schools and requires that each maintain a weekly inventory tracker

Stand up data management and reporting methods

What data management services does your testing vendor provide?

How will you collect and store information securely and legally?

How will you report results to individuals and the broader community?

In Tulsa, Oklahoma the superintendent strengthened existing data infrastructure by partnering with a non-profit to design a reporting system

Define a communications plan

How will you communicate with the community before, during, and after the testing program launches?

How will you communicate positive test results to individuals, close contacts, and the school community?

In New York City, New York, the district distributed a video indicating testing procedures to build comfort and familiarity with the process

In action

Actions system leaders have taken to roll out a testing program

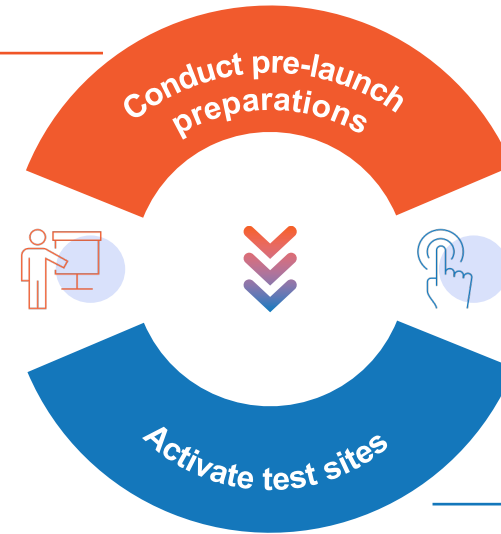
INDICATIVE,
NON-EXHAUSTIVE

A few weeks before launch districts have...

- Conducted **onboarding sessions** to prepare staff for operations roll out (e.g., on use of PPE; workflow of test site; waste management policies)

A few days before launch...

- Confirmed **inventory** and inventory management plans
- Ensured scheduling, registration, data management, and results notification **systems are ready to go-live** (where applicable)
- Conducted **dry runs** and final checks of all processes and systems



When activating test sites, districts and schools have...

Documented a **day-of testing timeline** to help guide staff (*example included in appendix*)

Established **day-of routines** to stand up the test site, including:

- Test Site Operations Checklists** of procedures to set up testing sites
- Test Site Teardown Checklists** of procedures to close down testing sites
- Staff walkthroughs of roles**, including traffic flows; locations of critical supplies; and meetings before shifts to discuss updates
- Clear signage and communication**

In action

In Ector County, Texas the district implemented the testing program using a phased approach, testing staff and then students and staff, to slowly scale operations. Additionally, some non-campus staff volunteered to be tested before the launch so nurses could practice and troubleshoot their testing operations.

A Test Site Operations Checklist asks questions about logistics, communication, site storage, and reporting (e.g., standardized labeling convention for samples?)

A Test Site Teardown Checklist asks questions about specimen handling, inventory management, and cleaning and waste disposal (e.g., Have all biohazard bags been double bagged and secured?)

After rolling out testing programs, schools and districts have monitored and evaluated them

INDICATIVE,
NON-EXHAUSTIVE

Districts and schools have tracked progress toward milestones and objectives

The testing task force might have a timeline to review the metrics and regularly report out progress and findings to the school community at large.

Using the defined objectives and metrics, they might set thresholds based on updated data to guide decision making.

Thresholds may include increasing testing when community prevalence crosses a certain level; deploying certain protocols to extra-curricular activities when test positivity rate meets a threshold; or shifting to a hybrid model when certain risk factors have been observed.

IN ACTION:

The National Governors Association has compiled a [summary](#) of COVID-19 metrics and thresholds that states and school districts can use to support their decision making.

TAKE THE FIRST STEP:

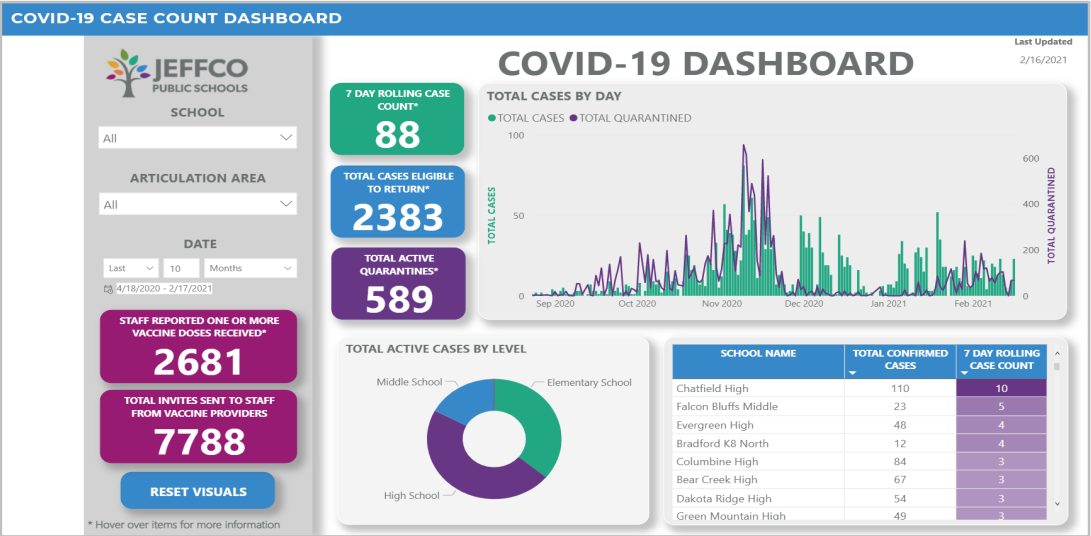
Review the decision making framework created by Chiefs for Change around school reopening decisions and testing models to use based on thresholds ([here](#) starting on slide 14 and [here](#) on page 11).

While collaborating with other stakeholders and creating transparency

Public health officials on the task force can help define thresholds that will be tracked and reported.





Districts might consider joining Communities of Practice or school networks to share best practices and ask questions other leaders.

Publishing results of the testing program can create transparency and community trust.



Example: publicly available [dashboard from Jeffco, CO](#)

Districts reported four key considerations for COVID-19 testing programs and potential enabling factors for each

Testing strategy considerations		Potential enabling factors
Costs of tests and supplies	 <p>Costs can be material in districts with limited resources and vary widely based on test type and volume (e.g., antigen tests may cost \$5-20, while PCR tests range from \$15-150 based on vendor, volumes, and testing method – pooled or not)</p>	<ul style="list-style-type: none">• Government support: Some states, counties, or cities purchased tests for districts, sometimes using local CARES Act funding• Philanthropic/non-profit support: Some districts received philanthropic funding to purchase tests or identified non-profit testing organizations to conduct testing at-cost
Staff needed	 <p>Additional staff may be required to administer tests, manage data, contact trace, and run programs (some districts estimated labor costs were one-half to two-thirds of their total testing costs)</p>	<ul style="list-style-type: none">• Repurposed staff: Many districts trained their staff to play new roles (e.g., one district trained athletic trainers to administer rapid tests)• External staff: A few districts hired external staff to support in new roles, sometimes using government support (e.g., one district hired a team of nurses to contact trace on weekends when school nurses were off)
Significant logistical feat	 <p>Significant planning, coordination, and careful implementation is required to set up programs and build trust in the community</p>	<ul style="list-style-type: none">• Partnerships: Districts cited partnership (e.g., with local public health agencies, academic institutions, non-profits) as being a critical support in planning and executing operations and in building trust• Phased approach: Many districts cited that pilot testing for a few iterations built confidence and allowed team to iron out details
Consent needed for students	 <p>All underage students require consent from a responsible adult before tests are administered; this requires time and effort by the district to collect forms</p>	<ul style="list-style-type: none">• Community engagement: Districts shared that a strong communications campaign that listens to the community and provides consistent, transparent messaging is important to build trust and confidence in school-based testing amongst students and staff

“

Implementing testing is actually easier done than said. It is easier to do it than it is to explain!

–District leader

”

Source: Interviews with district leaders, The Rockefeller Foundation's *Covid-19 Testing in K-12 Settings: A Playbook for Educators and Leaders*, Mathematica's *Covid-19 Antigen Testing in K-12 Schools: Early Lessons from Six Pilot Sites*, RAND's *Covid-19 Testing in K-12 Schools: Insights from Early Adopters*

Appendix

Design choices and sample options for each choice.



**Testing
objective**



Type of test



**Individual
or pooled
sample**



**Who is
tested**



**Opt-in or
required for
in-person**



**Testing
frequency**



**Sample
type**



**Where
sample is
collected**



Diagnostic

Targeted testing of symptomatic individuals and close contacts of those infected (5-7 days after close contact exposure) to check suspected cases for individual clinical decision-making. Foundation of testing program should always be ensuring that symptomatic individuals and the close contacts of positive cases can access testing (whether onsite at school or through referrals to a community testing resource)

Screening

Routine testing of individuals without symptoms or any reason to suspect exposure. Given pre-symptomatic and asymptomatic infection spread, screening testing aims to reduce infection spread by isolating potentially infected individuals faster. Recommended frequency to be at least 1x weekly testing with rapid turn-around of results for the entire population (lower frequency or some percentage of the population not opting-in to testing will reduce the effectiveness of this method to break chains of transmission)

Surveillance

Testing to understand prevalence in a community to inform workplace, local, or regional policies. Individual results are not returned so isolation and contact tracing is not possible.

[Click here
to return to
home](#)

Design choices and sample options for each choice.



Testing
objective



Type of test



Individual
or pooled
sample



Who is
tested



Opt-in or
required for
in-person



Testing
frequency



Sample
type



Where
sample is
collected



Antigen

Rapid diagnostic test, processed on site, results given in ~15mins, at a cost of ~\$5-20/test (cost of test and test processing)
Sensitivity (i.e. probability of detecting an infected individual) ranges from 30-80% compared to PCR test. Sensitivity is higher for symptomatic individuals and lower for asymptomatic (one FDA-approved rapid test had a sensitivity of 80% among symptomatic persons and 41% among asymptomatic persons)
Antigen testing might be preferred when frequency of retesting and time to results is more important than highly accurate tests.
Confirmatory tests may be needed for individual clinical decision-making

Molecular – PCR

Typically take 24-48 hours to receive results (actual times may be considerably longer based on operational considerations and backlogs), at a cost of ~\$30-100/test (cost of test and test processing) for an individual PCR test (pooled tests can be ~3-5x cheaper).
They are more sensitive (i.e. more likely to detect an infected individual)
PCR (Polymerase Chain Reaction) are the most common molecular tests, though other types, such as LAMP (Loop-Mediated Isothermal Amplification Process) and NGS (Next Generation Sequencing), also detect viral genetic material to diagnose active infection

Serology

Serology tests analyze blood to look for the antibodies a person has produced to fight a past SARS-CoV-2 infection. However, as these tests are not designed to find active infections, antibody tests are not recommended in the surveillance, screening, or diagnostic testing in K-12 schools

[Click here
to return to
home](#)

Design choices and sample options for each choice. Click on any for more detail



Testing objective



Type of test



Individual or pooled sample



Who is tested



Opt-in or required for in-person



Testing frequency



Sample type



Where sample is collected



Individual	Each sample is processed separately to return individual results
Pooled	<p>Samples are still collected individually, but they are combined into a batch to be tested together (rather than testing samples individually). Labs can then process several tests in the amount of time it would take for one individual sample. If a tested pool is negative, you can assume that all samples in the pool are negative. If a tested pool is positive or indeterminate, samples from all individuals in the pool would need to be retested to isolate the positive(s) (therefore in higher prevalence settings, when pools are more likely to be positive, this method can lose its efficiency)</p> <p>Pooling is potentially an especially good fit where there are natural cohorts – homeroom classes in grades K-5, or athletic teams, for example – because those groups are frequently considered close contacts</p> <p>One form of pooled testing may require a second reflex test. To identify positive individuals it is necessary to collect new samples for each individual. In this form of testing, samples are combined so it is not possible to rerun each sample individually</p> <p>Other pooled testing processes uses only a portion of the sample in the pooled processing, so they can use the remainder for re-running individual tests if necessary. Here the combined sample is joined at the lab using a part of each individual sample, it is then possible to rerun each sample individually to identify positive individuals without requiring a second sample</p>

Click here to return to home

Source: The Rockefeller Foundation's COVID-19 Testing in K-12 Settings: A Playbook for Educators and Leaders, [CDC](#)