Safe Learning Plan for 2020-21

A Localized, Data-Driven Approach

Introduction

Spring 2020 brought unprecedented changes to society and our education system. Following two months of statewide distance learning, Minnesota public schools have spent summer 2020 developing contingency plans for the 2020-21 school year, based on guidance from the Minnesota Department of Education (MDE) and public health guidelines from the Minnesota Department of Health (MDH). During this time, MDE has made significant public engagement efforts to understand how we can better serve all Minnesota students and families, while protecting the health and safety of our school communities.

This document explains the Safe Learning Plan for the 2020-21 School Year and outlines resources and supports that are available to school districts and charter schools for the upcoming school year.

While reopening school buildings for in-person instruction is what we want for our students, the main priority must continue to be the health, safety and wellness of our students, staff and community.

Vision

Minnesota is the best state in the country for children to grow up in—those of all races, ethnicities, religions, economic statuses, gender identities, sexual orientations, (dis)abilities and ZIP codes.

Purpose

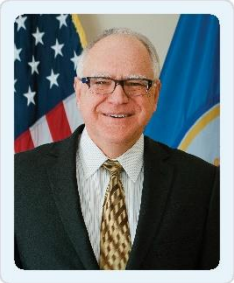
Ensure that every student in the state of Minnesota receives an equitable education and has equal access to learning and instruction during the COVID-19 pandemic.

Safe Learning Plan Goals

1. Prioritize the safety of students and staff
2. Prioritize in-person learning, especially for younger learners
3. Consider infectiousness and transmission risk among different ages
4. Support planning, while permitting flexibility for districts
5. Take into account disease prevalence at a local level

Contents

Letter from Governor Tim Walz



Minnesotans,

While our state continues to combat COVID-19, we know Minnesotans have conflicting feelings about the upcoming school year. Some families are afraid for the safety of our students, school staff, and the families they go home to. Others are eager to get teachers and children back into the classroom, where our kids learn best. Many more feel a mixture of both. As a former teacher for more than 20 years and the parent of a child in public school, I am committed to providing the best education to our students while keeping them and their teachers safe.

I followed three principles as I worked with the Departments of Education and Health on a plan for the 2020-21 school year. First, our top priority was the safety, health, and well-being of students, staff, and families. Second, we continue to make data-driven decisions, leaning on science and research to make the best decisions for our state. And finally, we would respect the importance of local school districts, their expertise of their unique communities, and their commitment to making the best decisions for their students.

That is why we are taking a localized, data-driven approach to the 2020-21 school year that will put student and staff safety first. By bringing together the local education leaders who know their students, staff, and communities the best, and the public health experts who know the virus the best, this plan will help determine a learning model that makes the most sense for each community.

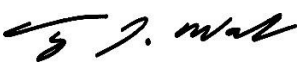
School districts and charter schools will begin in one of three models: in-person, distance learning, or a hybrid model. Experts at the Departments of Health and Education will partner with local school districts and charter schools to help determine which learning model they should use to start the school year. While there are many factors to take into consideration before opening our schools, the decision-making process will center on local data indicating the prevalence of COVID-19 in the surrounding county.

Throughout the school year, we will need to be flexible and adapt with the fluid nature of this pandemic. The Departments of Education and Health will work with school districts and local health professionals to consistently track the virus to determine if and when a school may need to adjust their learning plan. School districts and charter schools will be required to ensure all families have the option to choose distance learning for their student, no matter where they live. Teachers and staff will be given similar flexibility.

And the state will provide more than $430 million to support help schools, educators, students, and families through this uncertain time. We will provide face coverings for every student, educator, and staff member. We will fund a comprehensive testing plan for educators and staff, and we will help cover costs for cleaning supplies, technology needs, Wi-Fi access, and mental health support.

School districts and public health officials have a lot of important work to do, but the ultimate success of this process isn't just up to them. It's also in the hands of each and every Minnesotan. Our schools reflect their surrounding communities. For this to work, we need Minnesotans to come together to slow the spread of COVID-19. We need everyone to do their part to help get our kids and our teachers back in the classroom safely.

Stay safe,



Governor Tim Walz

Overview: Localized, Data-driven Approach to the 2020-21 School Year

Governor Walz's Executive Order 20-82 states that all Minnesota public schools must adhere to parameters determined by MDH in implementing or shifting between the three learning models laid out in the 2020-21 school year planning guidance: in-person learning, hybrid learning and distance learning.

To begin the 2020-21 school year, MDH has developed parameters using county public health data to support the determination of learning models for each school district and charter school. These parameters are detailed in the Safe Learning Model Guidance section of this document. To be responsive to the ever-changing public health situation throughout the state, MDH will update this plan as needed.

If a school district or charter school chooses to dial back to a more restrictive learning model than what is required by the Safe Learning Model Guidance, it must notify the education commissioner through the Learning Model Portal within 24 hours of beginning the new learning model. This portal is in development.

If a school district or charter school is considering dialing forward to a less restrictive learning model than what is required under the Safe Learning Model Guidance, it must work with its Regional Support Team to consult with local public health officials, MDH or MDE as needed.

Pursuant to Minnesota Statutes, section 12.21, subdivision 3(11), the education commissioner is authorized to order a school district or charter school to dial back to a more restrictive learning model if the commissioner, in consultation with MDH and the school district or charter school, determines the learning model being used by the district or charter school is no longer safe. More restrictive models of instruction may be necessary for individual classrooms within a school based on household exposure.

As explained in MDE's 2020-21 School Year Planning Guidance, regardless of learning model, all school districts and charter schools must offer an equitable distance learning option to all families who choose not to attend in-person learning due to medical risks or any other safety concerns. Families are not required to provide documentation of risks.

Public Health Guidelines

As school districts and charter schools implement in-person learning, hybrid learning and distance learning throughout the 2020-21 school year, they must continue to ensure they are adhering to the requirements and recommendations outlined in MDH's 2020-2021 Planning Guide for Schools, which provides guidance in the following areas:

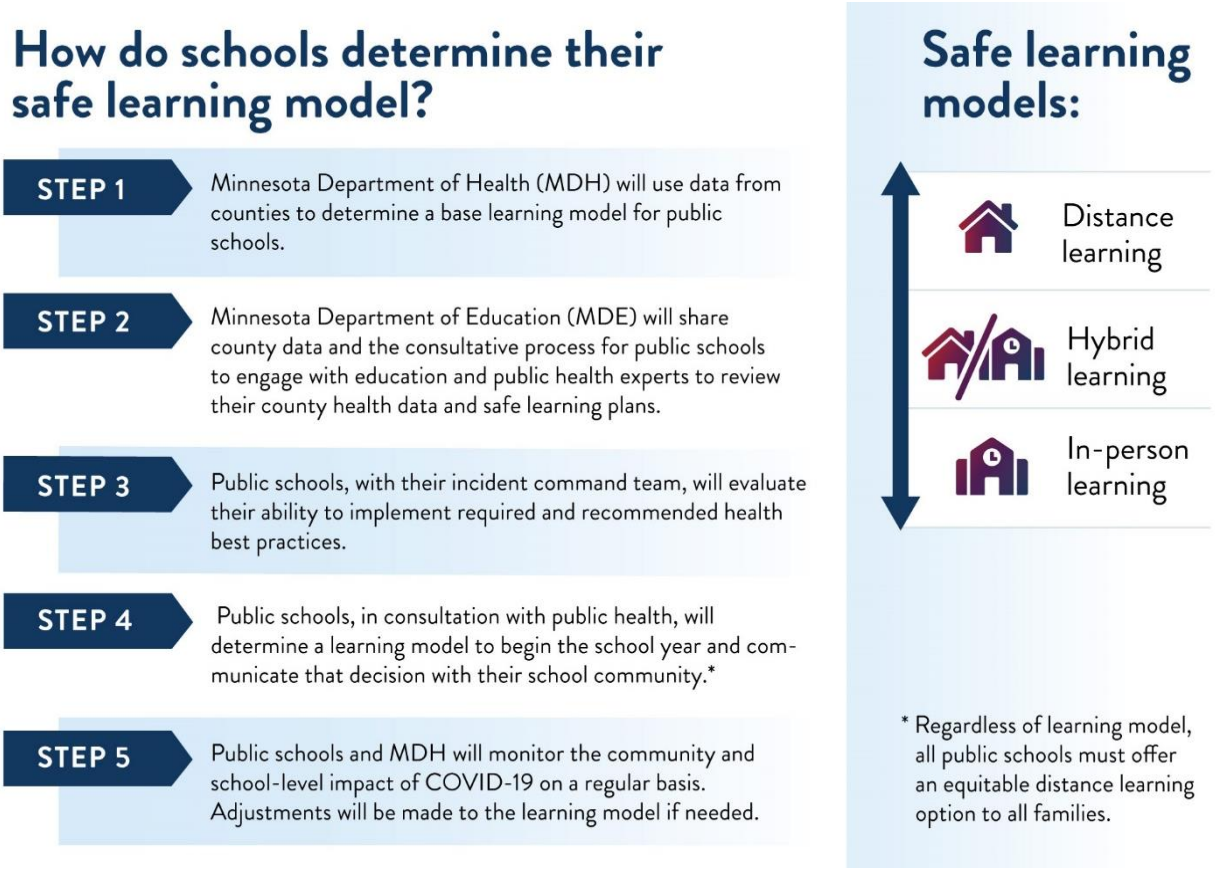
- Social distancing and minimizing exposure
- Face coverings
- Protecting vulnerable populations
- Hygiene practices
- Cleaning and materials handling
- Monitoring for illness
- Handling suspected or confirmed COVID-19 cases
- Water and ventilation systems
- Transportation guidance
- Supporting mental health and well-being

Safe Learning Model Guidance

This section outlines localized determinations of the safest learning models for the start of the 2020-21 school year, as well as some of the critical questions and factors that school districts and charter schools, in consultation with local public health officials, Regional Support Teams, MDH and MDE, must consider when making the decision to select or transition to another learning model, based on the impact of COVID-19 in their community. See Appendix A for a list of key terms.

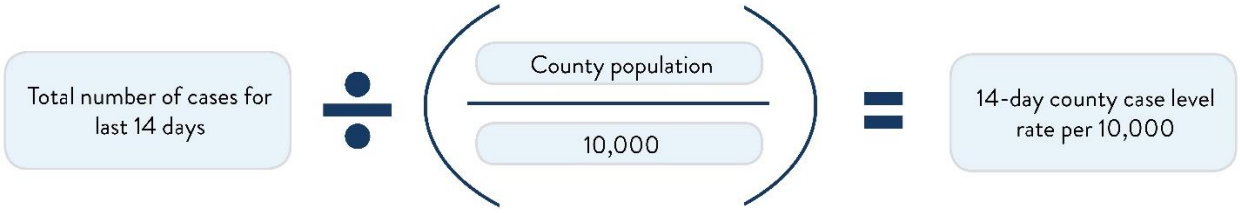
Determining a Safe Learning Model at the Start of the School Year

Communities across Minnesota are experiencing the impact of COVID-19 in different ways. While some areas of the state have seen significant outbreaks, other communities have experienced steady or relatively low numbers of new cases. While there are many factors to take into consideration when determining an appropriate learning model for school opening, the decision-making process should first center on local data indicating the level of viral activity in the surrounding community. School districts and charter schools are encouraged to use the following process in assessing and determining an appropriate learning model for school opening:



1. ***Consult the MDH learning model selection parameters as indicated by county-level data to determine the base learning model.***

To determine the base learning model, school districts and charter schools will be advised of the **bi-weekly case rate (over 14 days) by county of residence**. These data are the number of cases by county of residence in Minnesota over 14 days per 10,000 people by date of specimen collection (when a person was tested). While any increase in case incidence represents greater potential risk, schools may consider a bi-weekly case rate of 10 or more cases per 10,000 to be an elevated risk of disease transmission within the local community, especially when the level of cases per week is sustained or increasing over time.



Learning Model Parameters

Number of cases per 10,000 over 14 days, by county of residence	Learning Model
0-9	In-person learning for all students
10-19	In-person learning for elementary students; hybrid learning for secondary students
20-29	Hybrid learning for all students
30-49	Hybrid learning for elementary students; distance learning for secondary students
50+	Distance learning for all students

A school district or charter school whose enrollment includes a large proportion of students from an adjacent county should use data from the county with the highest bi-weekly case rate to inform the recommended learning model. It is also important to take into account any notable increases or decreases in county-level case data to inform decision-making. For example, a school district or charter school whose most recent bi-weekly county-level data is 28 cases per 10,000 over 14 days would be recommended to operate a hybrid learning model for all students; however, if the case count has increased each week for the last month, a school may consider whether it is more appropriate to operate using a model which has fewer students learning in-person.

The learning model determination may not be the same for all grades. The research has shown much more limited transmission of COVID-19 in younger children. This knowledge, combined with understanding that distance learning is more difficult with younger learners and creates a more significant burden on families, should lead districts and schools to always consider ways to keep elementary students in-person where it is safe and possible.

Note: Districts and charter schools may have already decided to be more restrictive in their learning model prior to the consultative process and may choose to engage with a consultant to confirm or modify their plan.

2. ***Consult with health officials as needed to examine the local epidemiology behind county-level data to assess whether increases or higher numbers of cases are likely the result of isolated outbreaks or whether they may be indicative of more widespread community transmission.***

Local information about outbreaks, community spread, and the groups of people becoming ill at the highest rate are also useful components in understanding how COVID-19 is impacting the community. In some cases, high county-level case rates may be the result of a known, isolated outbreak in a specific local employer or workplace that may be unlikely to impact the school setting. However, the high county-level case rates may also be indicative of more widespread community transmission as the result of larger exposures. It is important for school districts and charter schools, particularly those who would like to discuss operating a different learning model than the model determined based on the defined parameters, to consult with health officials when they have questions about the local epidemiology of COVID-19 in their community.

Note: Districts and charter schools may have already decided to be more restrictive in their learning model prior to the consultative process and may choose to engage with a consultant to confirm or modify their plan.

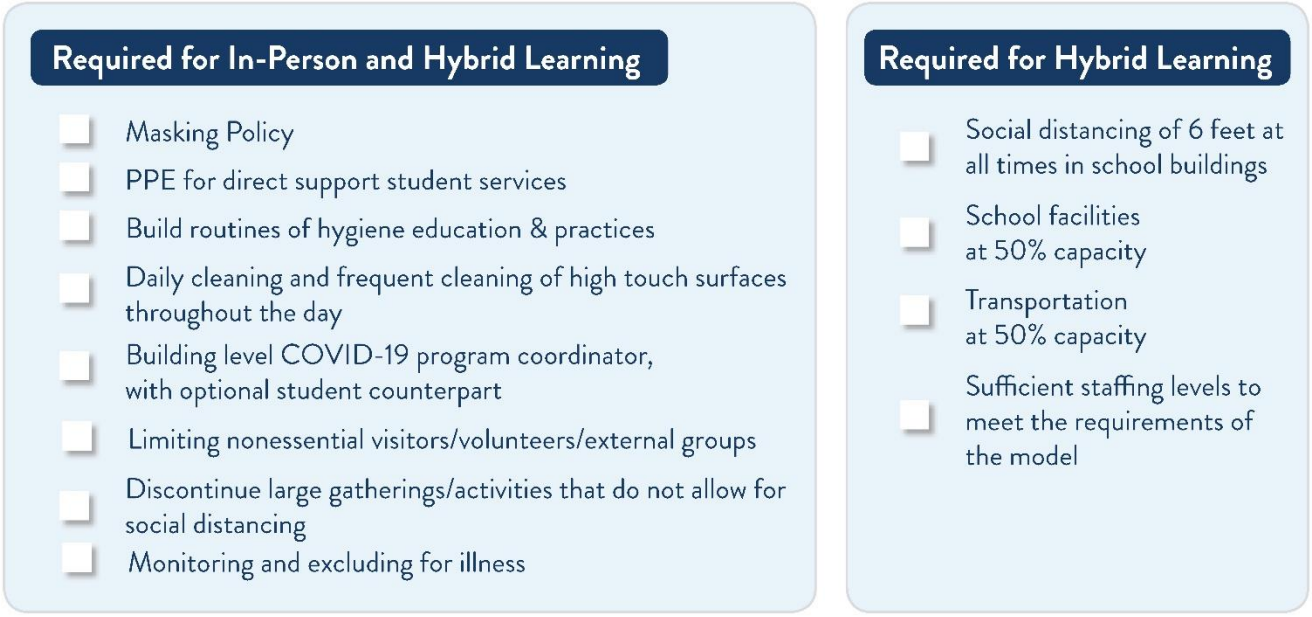
On July 30, 2020, superintendents and charter school leaders will receive an email from MDE with contact information and directions about how to schedule a consultation to support their learning model determination.

Superintendents and charter school leaders may also choose to consult with local public health officials regarding their learning model determinations.

Beginning August 24, 2020, school districts and charter schools will work with their Regional Support Teams to support implementation and ongoing evaluation of their learning model.

3. *Evaluate the ability to implement required and recommended health best practices to inform decision-making at the school or district level.*

It is important for school districts and charter schools to account for their level of preparedness and capacity to implement the required and recommended mitigation strategies outlined in MDH's 2020-2021 Planning Guide for Schools. All schools must implement the required health practices, which are considered the minimum level of implementation from which schools may not be less restrictive. As part of the learning model determination process, school districts and charter schools should carefully assess their preparations to ensure all required health practices are addressed to confirm they are prepared to operate with students learning in-person, regardless of whether they plan to operate a full in-person or hybrid learning model.



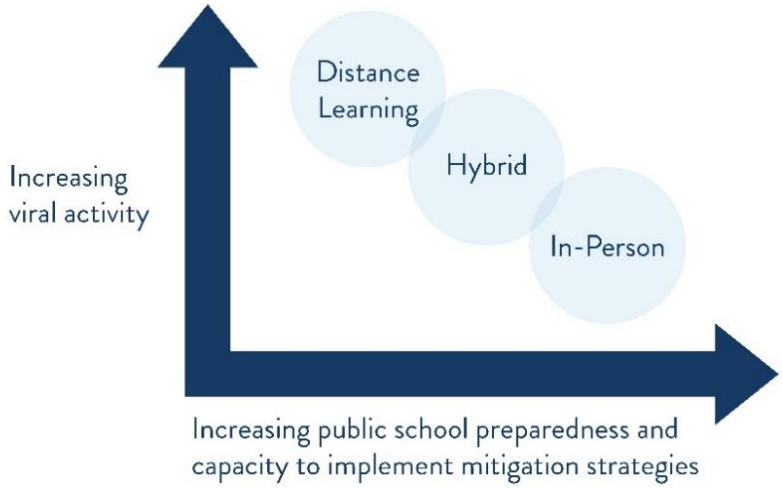
If a school district or charter school determines they are not able to successfully implement the required health practices for in-person or hybrid learning, they should implement distance learning for all students.

4. *Determine the learning model to begin the school year.*

After completing a thorough review of the base learning model in the context of the local epidemiology of COVID-19 and assessing preparedness to implement all required health practices, school districts and charter schools must make a determination of the learning model to begin the school year for each school. In making this determination, school districts and charter schools should use their current incident command team or advisory council consisting of school board members, bargaining units, staff, students and families. School districts and charter schools must report their learning model for each building to MDE before implementation. Additionally, the model(s) and plan, along with contingency plans for the other learning model scenarios, must be posted on the school district or charter school website. See the Communicating Plans with Students and Families section of this document.

Note: All school districts and charter schools must offer an equitable distance learning model to all families who choose not to attend in-person learning (whether as part of an in-person learning model or hybrid learning model) due to medical risks or other safety concerns. Families are not required to provide documentation of risks.

5. *Monitor the community and school-level impact of COVID-19 on a regular basis in consultation with public health to determine if adjustments are needed.*



After the initial selection of a learning model for school opening, the decision to shift to an alternative learning model should center on the impact of COVID-19 at the school level, while maintaining awareness of changes in viral activity in the community through continued review of the bi-weekly county-level case data (described under #1 above). School districts and charter schools considering making a change in their learning model for a school or entire district must do so first and foremost in the interest of safety for school staff and students. It is also important to respect the impact a shift in learning model will have on the school community. Making a change requires significant coordination and communication, even when well thought-out plans are in place, and therefore, any recommendation or decision to change learning models should not be taken lightly. With this in mind, school districts and charter schools may consider the general framework below to guide their decision-making.

As viral activity increases within a community or school (e.g., when there are increasing numbers of cases over a short period of time or clusters of cases are identified), the need to adjust to a learning model that reduces the number of people in a school building and requires more stringent mitigation strategies also increases. By contrast, schools using a distance or hybrid learning model that experience a declining level of viral activity in the school and/or surrounding community, as indicated by county-level case data, may consider cautiously shifting their learning models to increase the number of students learning in-person.

If a school district or charter school chooses to dial back to a more restrictive learning model than what is required by the Safe Learning Model Guidance, it must notify the education commissioner through the Learning Model Portal within 24 hours of beginning the new learning model.

If a school district or charter school is considering dialing forward to a less restrictive learning model than what is required under the Safe Learning Model Guidance, it must work with its Regional Support Team to consult with local public health officials, MDH or MDE as needed.

In making these determinations, school districts and charter schools should use their current incident command team or advisory council consisting of school board members, bargaining units, staff, students and families. If the learning model changes, the school district or charter school must update the learning model information on its website. See Communicating Plans with Students and Families section of this document.

The education commissioner retains statutory authority to order the transition from in-person instruction to a distance learning model if it is determined–after consultation with MDH–that in-person instruction is no longer safe due to concerns related to COVID-19.

Planning Scenarios for Moving Between Learning Models

It is not possible to account for every scenario that schools may encounter over the course of a school year. The scope and duration of transitions between learning models will depend on many factors, and will be made using the most up-to-date information about COVID-19 and the specific cases in the community during the consultative process. Included below are brief narrative descriptions of the general assumptions that would support each learning model, including the impact on the school community, staffing, the ability to trace and isolate close contacts, testing capacity, extracurricular activities, and staffing levels. The narratives are accompanied by planning scenarios, which can help inform a decision to shift between learning models.

These learning models apply to each individual school and recommendations based on health parameters vary by grade. This is because the risk of COVID-19 transmission is lower for younger students, and public health strategies, like consistent groupings or cohorting commonly practiced in elementary schools, are demonstrated to mitigate and prevent transmission. Further, in-person learning is more critical at younger ages due to child development.

Scenario 1: In-person learning for all students

Previously issued planning requirements and recommendations for Scenario 1 assume that minimal to moderate community spread is occurring, but the impact on the school community in terms of confirmed cases among students and staff is relatively small. Sporadic cases may be occurring, but in general, each confirmed case can be traced to a likely source of exposure and where all or most close contacts can be identified and excluded in the school setting. Staffing is assumed to be sufficient to continue in-person instruction. This planning scenario also assumes that contact tracing can be completed quickly and that all or most close contacts can be notified and excluded within 24 hours of being notified of the confirmed case. Most extracurricular activities may be held, provided they follow current public health guidance.

What situations under Scenario 1 may not necessitate a transition to a hybrid or distance learning model?

- Single, standalone cases are confirmed, but close contacts in the school setting can be quickly identified and are limited to individual classrooms or areas in the school. In this case, temporary distance learning could be implemented for the affected classroom(s) and space(s), rather than shifting the learning model for the entire school or school community.
- Multiple cases are identified, but can be linked to a specific classroom or individual activity with minimal impact or exposures to other classrooms/activities in the school setting. All close contacts can be quickly identified and are limited to individual classrooms and/or activities. In this case, temporary distance learning could be

implemented for the affected classrooms, rather than shifting the learning model for the entire school or school community.

- Multiple cases are identified, but are linked to a clear alternative exposure that is unrelated to the school setting and unlikely to be a source of exposure for the larger school community.
    - For example, social or household clusters where multiple people who attend the same school have become ill as a result of the social or household exposure.

Scenario 2: Hybrid model with strict social distancing and capacity limits

Previously issued planning requirements and recommendations outlined for Scenario 2 assume that moderate to substantial community spread is occurring, and there may be a higher degree of impact on the school community with multiple confirmed cases among students and staff. There may be higher numbers of confirmed cases over shorter periods of time, and/or clusters of cases identified within classrooms or the school community generally, however all or most close contacts can still be identified and excluded in the school setting. Staffing is assumed to be sufficient to continue in-person instruction, but measures, including overall capacity limits, are needed to allow for strict social distancing that further mitigates the risk of transmission. Testing capacity is generally assumed to be high enough that symptomatic individuals can access testing as needed from local clinics, and asymptomatic school staff and educators who are close contacts are prioritized in state testing guidance. Coursework and extracurricular activities with higher risk for transmission are modified to reduce risk or discontinued.

What situations may necessitate a transition to a hybrid learning model?

- The number of students and school staff who are absent or who are sent home with influenza- or COVID-19-like illness reaches approximately 5% of the total number of students and staff in a school within a single week.
- A significant community outbreak is occurring or has recently occurred (e.g., large community event or large local employer) that has the potential to impact staff, students and families served by the school community, but has not yet resulted in increased cases within the school setting.
    - Outbreaks in the community occurring in a setting that does not have a strong connection to the school (e.g., long-term care facility, local religious institution or correctional facility) are unlikely to result in a recommendation to shift to a hybrid learning model.

Scenario 3: Distance learning only

Previously issued planning requirements and recommendations outlined for Scenario 3 assume that substantial, uncontrolled community spread is occurring and/or there is a significant degree of impact on the school community, with multiple confirmed cases or large scale outbreaks occurring among students and staff. This planning scenario also accounts for situations where staffing may be impacted to the degree that a school is not able to offer in-person instruction. Extracurricular activities are discontinued. In general, implementation of a distance learning model should occur for a minimum of one incubation period (two weeks) when there is evidence of substantial, uncontrolled community transmission or significant levels of illness in the school setting.

What situations may necessitate a transition to a distance learning only model?

- A distance learning only model could be considered for short periods of time if confirmed cases are identified but contact tracing and notification of close contacts in the school setting cannot be completed within 24 to 36 hours. This short-term use of distance learning may allow schools to coordinate with local and state health officials to complete contact tracing and develop a clearer picture of the COVID-19 situation impacting the school while supporting continuity in learning.

- Multiple cases are identified within a short time period (e.g., several cases in one week or within a 14-day time period) that occur across multiple classrooms or activities, and a clear connection between cases or to a suspected or confirmed case of COVID-19 cannot be easily identified.
- A significant community outbreak is occurring or has recently occurred (e.g., large event or large local employer) and is impacting multiple staff, students and families served by the school community.
- Substantial, uncontrolled community transmission is occurring at the county, regional, or state level, and there are multiple confirmed cases of COVID-19 among students and/or staff.

Considerations for moving back to hybrid or in-person learning after a distance learning period

- After implementing a distance learning model due to high levels of viral transmission in the school or local geographic community, districts or schools should wait a minimum of two to three weeks before bringing any students back for in-person or hybrid learning. This timeframe is sufficient that most people in the school community who will develop symptoms of illness could be identified and self-quarantine, as appropriate.
- During the period of distance learning, a school district or charter school should consult with local public health officials, MDH and MDE if it is considering dialing forward to hybrid or in-person learning. This process will ensure that districts and schools are working with health officials to assess the level of viral activity occurring within the local community, as well as the impact on the school community, to determine whether the situation has improved to the point that hybrid or in-person learning may be appropriate.
- A school may consider using a hybrid learning model after a distance learning period was required due to high levels of viral transmission in the school or local geographic community. The hybrid model could be used as a bridge to safely move back toward the model of in-person learning for all students. For example, a school could operate using a hybrid learning model for two incubation periods (28 days) and carefully monitor for any additional clusters of confirmed cases of COVID-19 before transitioning back to a full in-person learning model.

Regional Support Teams

The Regional Support Teams are a partnership between local public health officials, MDE, MDH and regional service cooperatives to support school districts and charter schools in navigating the impacts of the COVID-19 pandemic on the 2020-21 school year.

Beginning August 24, 2020, school districts and charter schools will work with Regional Support Teams to consult regarding implementation and ongoing evaluation of their learning model.

In the interim, on July 30, 2020, superintendents and charter school leaders will receive an email from MDE with contact information and directions about how to schedule a consultation to support their learning model determination.

Team Structure

Regional Support Teams are structured in a way that allows efficient communication from the school and district level to the state level in the event of a confirmed case of COVID-19 in a school building.

As shown in the graphic on this page, the first step in this process is for a superintendent or charter school leader to contact their assigned service cooperative lead. The lead will then contact MDH and/or local public health officials to begin the response process, who will notify the Regional Support Team regarding appropriate next steps.

The Regional Support Teams are made up of rapid response staff, health consultants and testing event planners.

Rapid Response

- State lead to direct and oversee response to districts and schools:
    - Coordination across state supports and regional service cooperatives.
    - Works with State Testing Workgroup, oversees school testing event team.
        - 3-4 school testing staff who help execute events when local communities need support.
- Leads from regional service cooperatives (9):
    - Main point of contact for school districts and charter schools in region.
    - Shares updates and information between school districts/charter schools and local public health officials, MDH, MDE and other state partners.
    - Supports schools in completing contact tracing surveys.
    - Facilitates connections with local public health officials, MDH, MDE, and other state partners as needed.

Health Consultant

- MDH epidemiologists, assigned by region and paired with regional service cooperatives and local public health officials
- Connect with regional supports to help respond to health and epidemiology questions
- Supports state reporting and trends on COVID-19 and implications for schools
- Supports local and state health officials in tracking cases, testing events, and school closures

Distribution of Face Coverings

All students, staff, and other people present in school buildings and district offices or riding on school transportation vehicles are required to wear a face covering. Face coverings are meant to protect other people in case the wearer does not know they are infected. A face shield (a clear plastic barrier that covers the face) allows visibility of facial expressions and lip movements for speech perception and may be used as an alternative to a face covering in certain situations.

Face coverings should not be placed on anyone under age 2, anyone who has trouble breathing or is unconscious, anyone who is incapacitated or otherwise unable to remove the face covering without assistance, or anyone who cannot tolerate a face covering due to a developmental, medical or behavioral health condition.

Ideally, face coverings should be worn in combination with other infection control measures, including social distancing, but face coverings are especially important in settings where social distancing is difficult to maintain. As the Centers for Disease Control and Prevention (CDC) has explained, face coverings are most effective when they are worn by all individuals in public settings when around others outside of their households, because many people infected with COVID-19 do not show symptoms. Consistent with this guidance, Minnesota has strongly recommended widespread use of face coverings since April 2020. On July 22, 2020, Governor Walz signed Executive Order 20-81, requiring face coverings in all indoor public spaces in Minnesota, including K-12 school buildings.

Because this is such an important mitigation strategy, we are ensuring all public school students and staff have the face coverings they need for in-person and hybrid learning. The State of Minnesota will provide the following supplies to all public and private schools:

- Every K-12 student will receive one cloth face covering.
- Every school staff member will receive one cloth face covering.
- Every school will receive three disposable face masks per student.
- Every school will receive face shields for all licensed teachers and 50% of non-licensed staff.

Responding to Confirmed Cases of COVID-19

When a confirmed case of COVID-19 is identified in a school community, it is important for school districts and charter schools to work closely with local public health and MDH officials through the Regional Support Teams to identify whether the person who is ill was present on school grounds while infectious, and whether that resulted in any close contact exposures among students or staff. Because of the potential for asymptomatic and pre-symptomatic transmission of COVID-19, it is important that close contacts of students or staff with COVID-19 are quickly identified, informed of the need to quarantine at home, and encouraged to seek testing, even if they are not showing any symptoms. In general, testing of close contacts should not occur until either a person becomes symptomatic *or* at least 5 to 7 days have passed since their last exposure to the confirmed case to guard against a false negative test result, which can occur when a person is tested too early in the incubation period. Even if a close contact tests negative, they must remain in quarantine for a full 14 days, as some people develop infection at the end of their incubation period. The CDC does not recommend universal testing of all students and staff.

In addition to the identification and notification of close contacts, school districts and charter schools should consider the questions outlined below in consultation with health officials to determine whether additional mitigation strategies are needed to protect the school community.

- **How many cases are there, and are they close in time together, or spread out over several weeks?** Sporadic, single confirmed cases are not necessarily worrisome on their own, especially if students or staff did not attend school while infectious or the potential exposures in the school setting are limited (e.g., few classrooms or activities are impacted). Multiple cases that are identified closer together in time (e.g., within one week) could indicate that a significant, unidentified exposure occurred and/or that a higher level of transmission is occurring.
- **Are new cases traceable to the school community or are they likely the result of a different exposure (e.g., household exposure, travel)?** It is concerning to see cases that can be clearly traced back to an exposure within the school setting, as it may be an indication that transmission is occurring between members of the school community. Cases that can be traced back to a different exposure, such as a cluster of cases within a household or a likely exposure to a positive case while traveling, indicate that attendance in school was not the likely source of illness.
- **Where are the cases occurring, and do they have any common themes?** If cases seem to be concentrated based on a common trait such as a physical location (e.g., confined to one building within a school) or to a specific group within the school (e.g., a cluster of cases among food service workers), it may be possible to narrow down the exposure source and take more specific actions that do not necessarily require a change in the learning model used for the school or school system as a whole. Finding common themes among cases may also aid a school's efforts to modify practices to help prevent similar future exposures.
- **How many close contacts does each case have?** Cases that have limited numbers of close contacts in the school setting (e.g., few classrooms or activities are impacted) are less likely to result in a needed shift between learning models for the whole school. Cases that have many close contacts across multiple classrooms and activities, or potential exposures in common areas or at larger school-based gatherings/events where close contacts are not readily identifiable, may complicate the ability to identify all or most close contacts, and may have a larger impact on the school community as a whole.
- **Are students, parents, and staff forthcoming about close contacts?** When people are unwilling or unable to disclose their close contacts, it may be difficult to ensure that contact tracing can be effectively completed. When contact tracing cannot be fully completed, it is possible that exposed persons may not exclude for the recommended quarantine period of 14 days and could go on to develop symptoms of illness while in the school setting, thereby resulting in additional exposures.
- **Is there other significant COVID-19 transmission in the surrounding community (e.g., a cluster of cases at a large local employer) that will likely impact families and staff?** For example, in communities that are currently experiencing or have very recently (within the last 14 days) experienced an outbreak in a large local employer or

other setting where the families of many students and/or spouses of many staff work or visit, the nature of the community outbreak may increase the potential for community transmission in the school setting.
- **Are you able to maintain your current learning model based on staffing?** Staffing is a critical component of school operations. When adequate staffing to support an in-person or hybrid learning model cannot be achieved, it may be necessary for schools to transition to an alternative learning model.

COVID-19 Testing Process

While school communities execute significant strategies to prevent transmission of COVID-19, and as long as the virus continues to circulate in our communities, we must be diligent in monitoring and testing. This section is intended to provide an overview for pre-K and K-12 educational institutions to prepare for and execute needed COVID-19 testing for student, staff and other populations associated with their school.

Any school that may need to implement a COVID-19 testing strategy will work directly with their Regional Support Teams, following the process outlined in the Team Structure section above. This testing strategy provides a framework for schools and the state, but can vary based on the setting, number of close contacts, and circumstances. Each situation may look slightly different, and the Regional Support Team will guide school and district leaders through the necessary processes.

Routine universal testing is not recommended in schools. Testing should not be used as an entry or enrollment tool for programs for staff, students or families.

State Partnership and Strategy

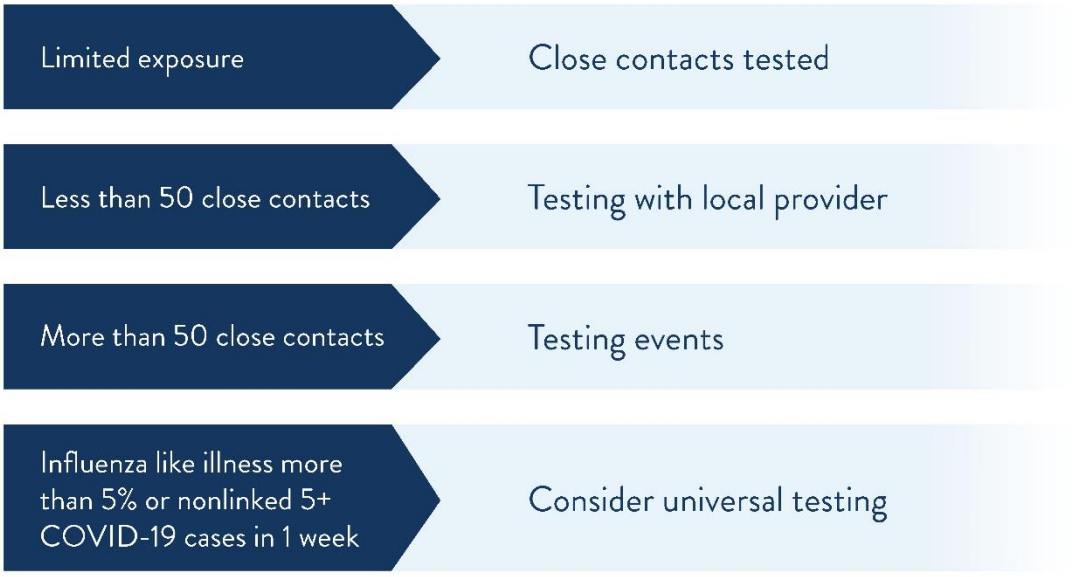
Access to testing and a community's ability to mitigate transmission and respond to COVID-19 exposure is a critical factor in a school or district's ability to provide in-person instruction. As such, the state has outlined a series of strategies that will support you.

- **Testing educators and school staff:** The state has a contract with a national saliva testing lab and will work with all insurers to ensure that all educators have access to a COVID-19 test from day one. This is a test that can be conducted at home and uses a courier for transport. This process ensures that in the case where an educator has close contact with a confirmed case and experiences any challenges getting tested in their community, there is a back-up option.
- **Comprehensive testing strategies:** The Regional Support Teams have a framework and strategy for how to plan for and respond to a potential COVID-19 exposure in our school communities. In all cases, the state has a structure and partnership with districts and charter schools to ensure that there is regular communication and consultation with public health experts. The comprehensive testing strategy includes:
    - State ensures school and settings are prioritized for COVID-19 testing when close contacts have been identified.
    - Regional Support Teams work with schools to ensure close contacts of an exposure are tested by local providers.
    - Testing events are used when 50+ close contacts and when local communities cannot execute their own testing events, the State Testing Workgroup steps in to execute.
    - School staff and students are prioritized in other available community testing events.

Testing Scenarios and Thresholds

If a known exposure occurs in a classroom (from staff or students), close contacts will be quarantined at home for 14 days. **Close contacts** are defined as someone who was within 6 feet of an infected person for at least 15 minutes starting from 48 hours before illness onset until the time the patient is isolated testing is recommended for all close contacts of confirmed COVID-19 cases.

Potential scenarios include:



- **Testing is recommended for close contacts** (by Regional Support Team):
  - Symptomatic students, children and staff
  - Asymptomatic close contacts—children and staff who are asymptomatic no sooner than 5 to 7 days after known exposure to confirmed case.
- **Testing with local providers:** In classrooms or programs with **less than 50 close contacts** (including children, students and staff) identified, the school community will notify families and they will seek out testing individually through an appointment with their clinic or access a testing site. Educators, school staff and asymptomatic individuals who have been identified as close contacts of a positive case in schools are a prioritized group in state testing guidance to health care providers. The liaison with MDE and MDH will remain partners with you and want to be notified if these close contacts are not being tested.
  - Here is draft language to use in communication with families: *Please contact your health care provider to see about getting them tested or visit the Find Testing Locations webpage to find a testing site near you. MDH recommends waiting to be tested until 5 to 7 days after known exposure, which is the optimal time period for the virus to be detected by a test.*
- **Testing event:** Based on the number of close contacts identified, a testing event should be considered if **more than 50 close contacts** (including staff, children and family community) are identified. Partnering with their Regional Support Team, districts will work with local health providers to execute these events first and bring in other state partners as needed. If local resources are limited and/or state-coordinated response is necessary, the State Testing Workgroup and school testing teams will plan with local communities to execute. If a testing event is indicated, it will not occur until at least 5 to7 days after a known exposure.
- **Universal testing:** A universal testing event could be recommended when substantial or ongoing transmission among students and staff is suspected to be occurring. Substantial transmission is defined as a threshold of 5% of total attendees (students and staff) have influenza-like illness or there are five or more non-linked laboratory confirmed cases in a single week. Non-linked cases are those that cannot be linked to another case at the school and do not have a clear link to a confirmed case outside of the school. Linked cases include people who are present in the same setting during the same time period (e.g., same classroom, school event, school-based extracurricular activity, or school transportation). As with testing events, if local communities are not able to execute such an event, the state will support the execution.

Meeting the Needs of Students and Families

Communicating Plans with Students and Families

School districts and charter schools must electronically post and communicate their contingency in-person learning, hybrid learning, and distance learning plans to students and their families no later than one week before the beginning of their respective 2020-21 school year. School districts and charter schools must make all attempts to provide such communications orally and written in languages spoken in their respective school district or charter school. The contingency plans must address, but not be limited to, communication pathways with students and families, community input on student and family needs, and other outreach opportunities. These elements are in addition to addressing core instruction, supports for all student groups, nutrition, school-age care, technology needs, and effective delivery of educational models to students in a distance learning or hybrid model setting.

The education commissioner may review whether a school district or charter school's plan adequately addresses technological disparities in access and learning. The commissioner may recommend changes and provide technical assistance to school district and charter school programming to address any such disparities, to assist in meeting the needs of their students, staff and communities.

For more information, see the "Communication with Students, Families and Staff" section of MDE's 2020-21 School Year Planning Guidance.

School-age Care

Equitable and affordable school-age child care programs are essential to support working families and provide enrichment and care for students. Over 100,000 students across the state rely on a school-based child care program as their trusted child care provider.

Care for school-aged children, especially those children of workers in critical sectors, will continue to be crucial for frontline workers to continue to confront the pandemic. The state will continue to work with child care providers, school-age programs, schools and all other child care settings to prioritize this need.

Executive Order 20-82 indicates that a school district or charter school that operates a hybrid or distance learning model "must provide school-aged care for Eligible Children at no cost during the time those children are not receiving instruction in the school building during regular school hours."

The school-age care for children of critical workers is intended for extreme circumstances in which no parent or guardian is at home, due to employment as a critical worker.

This school-age care must be provided for school-age children age 12 and under who are children of critical workers in Tier I of the critical worker list (See Appendix B for definitions). Children of Tier I workers only will be cared for at no cost during the typical school hours. For more information about providing school-age care, see the "School-age Care & Child Care Programs in Schools" section of MDE's 2020-21 School Year Planning Guidance.

Equitable Distance Learning Option

Executive Order 20-82 states that all school districts and charter schools must offer an equitable distance learning model to all families who choose not to attend in-person learning (whether as part of an in-person learning model or hybrid learning model) due to medical risks or other safety concerns. Families are not required to provide documentation of risks.

For more information about ensuring this model is available to families, see the "Meeting the Distance Learning Needs of Students" section of MDE's 2020-21 School Year Planning Guidance.

Ensuring Access to Services and Resources

Executive Order 20-82 outlines several areas that must consistently be addressed, even as schools transition through learning models:

- Regardless of learning model, the school district or charter school must continue to provide meals to students during the school day to the extent possible, using all waivers and flexibilities provided by the U.S. Department of Agriculture.
- School districts and charter schools that dial back in-person instruction, in cooperation with state agencies, are directed to support communities disproportionately impacted by distance learning and hybrid learning, including but not limited to, historically under-represented families and families experiencing homelessness. Where appropriate, school districts and charter schools should prioritize providing in-person instruction and services to students from the aforementioned groups. MDE will continue to provide additional guidance to school districts and charter schools about this.
- When providing in-person learning, a school district or charter school will continue to run its early childhood programs pursuant to MDH public health guidelines, including community education programs, and may charge fees on its normal sliding fee scale. A school district and charter school may also continue to provide before and after-school care and may charge fees on its normal sliding fee scale. Schools are not required to provide this care during previously scheduled breaks reflected on a school board-approved calendar.
- A school district or charter school that dials back in-person instruction must allow 2020-21 graduating seniors to complete any testing required to attain a state bilingual or multilingual seal under Minnesota Statutes, section 120.022(b), subdivision 1b.
- If a school district or charter school is providing instruction through a distance learning model, the education commissioner has the authority to expand in-school provision of necessary activities and programming that can be operationalized, in compliance with requirements and recommendations outlined in MDH's 2020-2021 Planning Guide for Schools. This expansion of in-school activities must be where those services cannot be provided through a distance learning model and those services are needed to access that student's distance learning instruction, provide supports or services schools can safely offer, and create opportunities for meaningful connections between students and teachers.
- MDE, in consultation with MDH, has established a protocol to allow for home visits by school staff to build and preserve relationships with students and their families for when a school district or charter school is providing instruction through a distance learning model. This should not be interpreted as a requirement or be used to replace services provided by counties or social services. For more information, see the "Home Visits" section of the 2020-21 Planning Guidance for Minnesota Public Schools.
- School districts and charter schools that dial back in-person instruction are encouraged to allow students to retain any technology provided to them through the remainder of the 2020-21 school year. School districts and charter schools should also continue to provide maintenance for this technology.

Tribal Consultation

Consistent with Tribal considerations, guidance from MDE, and the federal Every Student Succeeds Act (ESSA), all consultations, collaborations, and partnerships with Tribal Nations, American Indian Parent Committees, and Indigenous Education staff must continue. American Indian Education Aid Program Plans should be considered when creating contingency distance learning and hybrid learning plans.

For more information about Tribal Consultation and serving American Indian students, see MDE's 2020-21 School Year Planning Guidance.

Funding Supports

Education is a fundamental determinant of health because it cultivates life skills, knowledge and reasoning, social-emotional awareness and control, and community engagement, which serve people well over the course of a lifetime. Schools themselves function as tools and resources for public health intervention by addressing core needs of the safety, health and wellness of students, families and communities.

Coronavirus Relief Fund (CRF)

The Coronavirus Aid, Relief and Economic Security (CARES) Act requires that the payments from the Coronavirus Relief Fund only be used to cover expenses that:

1. are necessary expenditures incurred due to the public health emergency with respect to COVID-19;
2. were not accounted for in the budget most recently approved as of March 27, 2020 (the date of enactment of the CARES Act) for the state or government; and,
3. were incurred during the period that begins on July 1, 2020, and ends on December 30, 2020.

Funding would be allocated to public schools as follows:

- 60% allocated to schools by ADM (average daily membership)
- 40% allocated to schools by:
    - 40% by ADM
    - 60% by the number of historically underserved students each school supports

MDE will be requesting CRF funding to be allocated to school districts and charter schools to:

- Address the **necessary operating costs** associated with bringing children back into the classroom this fall, including, but not limited to:
    - Daily cleaning supplies and disinfectant sprayers.
    - Screening supplies, including no-touch thermometers.
    - Personal protective equipment (PPE), including face coverings.
    - Increased costs for transporting students at limited capacity.
    - Mental health supports.
- Support-related **student, family, and educator needs,** including, but not limited to:
    - Digital navigators: training for educators, students, or families on use of technology/digital literacy.
    - Technology devices and internet access.
    - Tutors or mentors to address learning loss: supporting whole school, small group, and individual needs.
    - Translation services.
    - School-age care.
    - Professional development focused on: Academic Response to Intervention (RtI); social emotional learning; competency-based learning; diversity, equity, and inclusion; and anti-bias practices.

Funding under this request will be available for eligible expenditures from July 1, 2020 to December 30, 2020.

Governor's Emergency Education Relief (GEER) Fund

GEER provides emergency support through grants to K-12 schools significantly impacted by COVID-19. These grants support the ability of schools to continue to meet the needs of students.

Minnesota received a $43 million award, and dedicated $38 million to K-12 support. Based on feedback from the range of communities across the state, we identified two key priorities for which these funds can be used:

- Expanding **technology capacity** to meet student learning needs, with particular attention to increasing broadband access, establishing wireless hotspots and purchasing devices, such as laptops or tablets, for students.
- Improving student-to-teacher ratios for **summer school programming** to at most six students per teacher.
- Grants to education-related entities providing **wrap-around services for children ages 0-8**.

Elementary and Secondary School Emergency Relief (ESSER) Fund

The core purpose of ESSER is to provide direct money to school districts to support areas impacted by the disruption from COVID-19, which includes both: 1) Continuing to provide educational services while schools are closed, such as remote learning; and, 2) Developing and implementing plans for the return-to-normal operations.

- ESSER funds are divided into two streams: a formula-based allocation and state-directed grants. Districts and charter schools were notified of their eligibility for one or both funding streams.
- The formula-based allocation to districts and charter schools is based on their allocations under Title I, Part A of the Elementary and Secondary Education Act (ESEA). These funds can be used for a wide range of expenses to meet local needs.
- The state-directed grants are used for summer school programming and to support schools, such as cooperatives, that did not receive funding under the Title I allocation model, such as cooperatives.

References

- CDC: Interim Guidance for Administrators of US K-12 Schools and Child Care Programs (www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/guidance-for-schools.html)
- CDC: Interim Considerations for K-12 School Administrators for SARS-CoV-2 Testing (www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-testing.html)
- Resolve to Save Lives Weekly Science Report: Reopening schools during the COVID-19 pandemic (preventepidemics.org/covid19/science/weekly-science-review/june-20-26-2020/)
- American Academy of Pediatrics COVID-19 Planning Considerations: Guidance for School Reopening (services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-planning-considerations-return-to-in-person-education-in-schools/)

Appendix A: Key terms

Close contact/close contact exposure: Close contact means someone you were within 6 feet of for more than 15 minutes. In the context of COVID-19, a close contact exposure means that an individual either lives with or was within 6 feet or more of a person with lab-confirmed COVID-19 for 15 minutes or longer while the ill person was infectious.

Community spread: Community spread means people have been infected with the virus within a local community, including some people who are not sure how or where they became infected.

Incubation period: The time from close contact exposure to development of symptoms. For COVID-19, the incubation period ranges 2-14 days.

Isolation: When someone who is infected (tested positive) with COVID-19 stays away from others, even in their own home. For COVID-19, the minimum isolation period is 10 days.

Outbreak: Two or more people with COVID-19 infection are discovered to be linked (e.g., they work in the same office space or attend the same classroom).

Quarantine: When someone who was in close contact with someone who has or is suspected to have COVID-19 stays away from others during the viral incubation period.

Transmission: When an illness spreads between people.

No to minimal community transmission: Individual cases or limited community spread; no evidence of exposure in large communal settings (e.g., schools, workplaces).

Minimal to moderate community transmission: Sustained transmission in the community with likelihood of exposure within communal settings (e.g., schools, workplaces) and potential for rapid increase in cases.

Substantial, controlled community transmission: High rate of cases that are associated with ongoing community transmission, including communal settings (e.g., schools, workplaces).

Substantial, uncontrolled community transmission: Large scale, uncontrolled transmission in the community, including communal settings (e.g., schools, workplaces).

Appendix B: Critical Worker Definitions

Employees in the sectors below are eligible to enroll their school-age child(ren) under age of 12 in school-age care if their school is implementing a distance or hybrid learning model.

This school-age care must be provided for district or school-enrolled school-age children age 12 and under who are children of critical workers in Tier I of the state critical worker list. Children of Tier I workers only will be cared for at no cost during the typical school hours.

HEALTHCARE / PUBLIC HEALTH

- Workers, including laboratory personnel, that perform critical clinical, biomedical and other research, development, and testing needed for COVID-19 or other diseases.
- Healthcare providers including, but not limited to, physicians; dentists; psychologists; mid-level practitioners; nurses; assistants and aids; infection control and quality assurance personnel; phlebotomists; pharmacists; physical, respiratory, speech and occupational therapists and assistants; social workers; optometrists; speech pathologists; chiropractors; diagnostic and therapeutic technicians; and radiology technologists.
- Workers required for effective clinical, command, infrastructure, support service, administrative, security, and intelligence operations across the direct patient care and full healthcare and public health spectrum. Personnel examples may include, but are not limited, to accounting, administrative, admitting and discharge, engineering, accrediting, certification, licensing, credentialing, epidemiological, source plasma and blood donation, food service, environmental services, housekeeping, medical records, information technology and operational technology, nutritionists, sanitarians, etc.
    - Emergency medical services workers.
    - Prehospital workers included but not limited to urgent care workers. o Inpatient & hospital workers (e.g. hospitals, critical access hospitals, long-term acute care hospitals, long-term care facilities including skilled nursing facilities, inpatient hospice, ambulatory surgical centers, etc.).
    - Outpatient care workers (e.g. end-stage-renal disease practitioners and staff, Federally Qualified Health Centers, Rural Health Clinics, community mental health clinics, organ transplant/procurement centers, and other ambulatory care settings/providers, comprehensive outpatient rehabilitation facilities, etc.).
    - Home care workers (e.g. home health care, at-home hospice, home dialysis, home infusion, etc.).
    - Workers at Long-term care facilities, residential and community-based providers (e.g. Programs of All-Inclusive Care for the Elderly (PACE), Intermediate Care Facilities for Individuals with Intellectual Disabilities, Psychiatric Residential Treatment Facilities, Religious Nonmedical Health Care Institutions, etc.).
    - Workplace safety workers (i.e., workers who anticipate, recognize, evaluate, and control workplace conditions that may cause workers' illness or injury).
- Workers needed to support transportation to and from healthcare facility and provider appointments.
- Workers needed to provide laundry services, food services, reprocessing of medical equipment, and waste management.
- Workers that manage health plans, billing, and health information and who cannot work remotely.
- Workers performing cybersecurity functions at healthcare and public health facilities and who cannot work remotely.
- Workers performing security, incident management, and emergency operations functions at or on behalf of healthcare entities including healthcare coalitions, who cannot practically work remotely.
- Vendors and suppliers (e.g. imaging, pharmacy, oxygen services, durable medical equipment, etc.).
- Workers at manufacturers (including biotechnology companies and those companies that have shifted production to medical supplies), materials and parts suppliers, technicians, logistics and warehouse operators, printers, packagers, distributors of medical products and equipment (including third party logistics providers, and those who test and repair), personal protective equipment (PPE), isolation barriers, medical gases, pharmaceuticals (including materials used in radioactive drugs), dietary supplements, commercial health

products, blood and blood products, vaccines, testing materials, laboratory supplies, cleaning, sanitizing, disinfecting or sterilization supplies (including dispensers), sanitary goods, personal care products, pest control products, and tissue and paper towel products.

- Donors of blood, bone marrow, blood stem cell, or plasma, and the workers of the organizations that operate and manage related activities.
- Pharmacy staff, including workers necessary to maintain uninterrupted prescription, and other workers for pharmacy operations.
- Workers in retail facilities specializing in medical good and supplies.
- Public health and environmental health workers, such as:
    - Workers specializing in environmental health that focus on implementing environmental controls, sanitary and infection control interventions, healthcare facility safety and emergency preparedness planning, engineered work practices, and developing guidance and protocols for appropriate PPE to prevent COVID-19 disease transmission.
    - Public health/ community health workers (including call center workers) who conduct community-based public health functions, conducting epidemiologic surveillance and compiling, analyzing, and communicating public health information, who cannot work remotely.
- Human services providers, especially for at risk populations such as:
    - Home delivered meal providers for older adults, people with disabilities, and others withchronic health conditions.
    - Home-maker services for frail, homebound, older adults.
    - Personal assistance services providers to support activities of daily living for older adults, people with disabilities, and others with chronic health conditions who live independently in the community with supports and services.
    - Home health providers who deliver health care services for older adults, people with disabilities, and others with chronic health conditions who live independently in the community with supports and services.
    - Workers who provide human services, including but not limited to social workers, nutritionists, case managers or case workers, crisis counselors, foster care case managers, adult protective services personnel, child protective personnel, domestic violence counselors, human trafficking prevention and recovery personnel, behavior specialists, substance abuse-related counselors, and peer support counselors.
- Government entities, and contractors that work in support of local, state, federal, tribal, and territorial public health and medical mission sets, including but not limited to supporting access to healthcare and associated payment functions, conducting public health functions, providing medical care, supporting emergency management, or other services necessary for supporting the COVID-19 response.
- Workers for providers and services supporting effective telehealth.
- Mortuary service providers, such as:
    - Workers performing mortuary funeral, cremation, burial, cemetery, and related services, including funeral homes, crematoriums, cemetery workers, and coffin makers.
    - Workers who coordinate with other organizations to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental and behavioral health services to the family members, responders, and survivors of an incident.

LAW ENFORCEMENT, PUBLIC SAFETY, AND OTHER FIRST RESPONDERS

- Public, private, and voluntary personnel (front-line and management, civilian and sworn) in emergency management, law enforcement, fire and rescue services, emergency medical services (EMS), and security, public and private hazardous material responders, air medical service providers (pilots and supporting technicians), corrections, and search and rescue personnel.
- Personnel involved in provisioning of access to emergency services, including the provisioning of real-time text, text-to-911, and dialing 911 via relay.

- Personnel that are involved in the emergency alert system (EAS) ((broadcasters, satellite radio and television, cable, and wireline video) and wireless emergency alerts (WEA).
- Workers at Independent System Operators and Regional Transmission Organizations, and Network Operations staff, engineers and technicians to manage the network or operate facilities.
- Workers at emergency communication center, public safety answering points, public safety communications centers, emergency operation centers, and 911 call centers.
- Fusion Center workers
- Workers, including contracted vendors, who maintain, manufacture, or supply equipment and services supporting law enforcement, fire, EMS, and response operations (to include electronic security and life safety security personnel).
- Workers and contracted vendors who maintain and provide services and supplies to public safety facilities, including emergency communication center, public safety answering points, public safety communications centers, emergency operation centers, fire and emergency medical services stations, police and law enforcement stations and facilities.
- Workers supporting the manufacturing, distribution, and maintenance of necessary safety equipment and uniforms for law enforcement and all public safety personnel.
- Workers supporting the operation of firearm, or ammunition product manufacturers, retailers, importers, distributors, and shooting ranges.
- Public agency workers responding to abuse and neglect of children, spouses, elders, and dependent adults.
- Workers who support weather disaster and natural hazard mitigation and prevention activities.
- Security staff to maintain building access control and physical security measures.

FOOD AND AGRICULTURE

- Workers enabling the sale of human food, animal food (includes pet food, animal feed, and raw materials and ingredients), pet supply, and beverage products at groceries, pharmacies, convenience stores, and other retail (including unattended and vending), including staff in retail customer support and information technology support necessary for on-line orders, pickup, and delivery.
- Restaurant and quick serve food operations, including dark kitchen and food prep centers, carryout, and delivery food workers.
- Food manufacturer workers and their supplier workers including those employed at food ingredient production and processing facilities; aquaculture and seafood harvesting facilities; slaughter and processing facilities for livestock, poultry, and seafood; animal food manufacturing and processing facilities; human food facilities producing by- products for animal food; industrial facilities producing coproducts for animal food; beverage production facilities; and the production of food packaging.
- Farmers, farm and ranch workers, and agribusiness support services, including workers involved in auction and sales; in food operations, including animal food, grain and oilseed storage, handling, processing, and distribution; in ingredient production, packaging, and distribution; in manufacturing, packaging, and distribution of veterinary drugs and biologics (e.g., vaccines); and in distribution and transport.
- Farmers, farm and ranch workers, and support service and supplier workers producing food supplies and other agricultural inputs for domestic consumption and export, to include those engaged in raising, cultivating, phytosanitation, harvesting, packing, storing, or distributing to storage or to market or to a transportation mode to market any agricultural or horticultural commodity for human or animal consumption.
- Workers at fuel ethanol facilities, biodiesel and renewable diesel facilities, and storage facilities.
- Workers and firms supporting the distribution of all human and animal food and beverage and ingredients used in these products, including warehouse workers, vendor-managed inventory controllers, and block chain managers.
- Workers supporting the sanitation and pest control of all human and animal food manufacturing processes and operations from wholesale to retail.
- Workers supporting greenhouses as well as the growth and distribution of plants and associated products for home gardens.

- Workers in cafeterias used to feed workers, particularly worker populations sheltered against COVID-19 and those designated as essential critical infrastructure workers.
- Workers in animal diagnostic and food testing laboratories.
- Government, private, and non-governmental organizations' workers essential for food assistance programs (including school lunch programs) and government payments.
- Workers of companies engaged in the production, storage, transport, and distribution of chemicals, drugs, biologics (e.g. vaccines), and other substances used by the human and agricultural food and agriculture industry, including seeds, pesticides, herbicides, fertilizers, minerals, enrichments, equipment, and other agricultural production aids.
- Animal agriculture workers to include those employed in veterinary health (including those involved in supporting emergency veterinary or livestock services); raising, caring for and management of animals for food, as well as pets; animal production operations; livestock markets; slaughter and packing plants, manufacturers, renderers, and associated regulatory and government workforce.
- Transportation workers supporting animal agricultural industries, including movement of animal medical and reproductive supplies and materials, animal biologics (e.g., vaccines), animal drugs, animal food ingredients, animal food and bedding, live animals, and deceased animals for disposal.
- Workers who support sawmills and the manufacture and distribution of fiber and forestry products, including, but not limited to timber, paper, and other wood and fiber products, as well as manufacture and distribution of products using agricultural commodities.
- Workers engaged in the manufacture and maintenance of equipment and other infrastructure necessary for agricultural production and distribution.

JUDICIAL BRANCH (ESSENTIAL SERVICES)

- Workers supporting the operations of the judicial system, including judges, lawyers, and others providing legal assistance.

MINNESOTA NATIONAL GUARD

- Members of the Minnesota National Guard who have been activated under an Executive Order.

EDUCATORS AND SCHOOL STAFF

- Educators supporting public preK-12 schools.
- Paraprofessionals and other school staff.
- Any school staff supporting school-age care programs for children of essential workers, or supporting food service programs in schools.

CHILD CARE AND SCHOOL-AGE CARE PROVIDERS

- Child care providers and other workers in child care centers, family child care, schools, and other facilities open and providing child care