

Decision Tree for Provision of In Person Learning among K-12 Students at Public and Private Schools during the COVID-19 Pandemic

Summary of October 16 changes:

- Under **COVID-19 Activity Level**, DOH clarified and made consistent across all three activity levels that health and education leaders should look at the trends in COVID-19 cases and hospitalizations and test positivity should ideally be lower than 5%.
- Under **Education Modality**, DOH clarified that in communities with Moderate COVID-19 Activity we recommend careful phasing in in-person learning, starting with elementary. Then, over time, if schools can demonstrate the ability to limit transmission in the school environment, schools should add in-person learning for middle and high school.
- Under **Extracurricular**, DOH created flexibility for schools and districts to cautiously phase in extra-curricular activities as they phase in in-person learning to create more parity between school-related and community related activities based on disease activity level. DOH continues to prioritize educational opportunities over extracurricular or other activities in the surrounding community.

Introduction

This framework can assist local health officers and school administrators in deciding whether to resume in-person instruction for public and private K-12 schools during the COVID-19 pandemic. This tool is added to the Department of Health's (DOHs) [K-12 Fall Health and Safety Guidance](#). Both will be updated as the COVID-19 pandemic evolves and additional scientific information is available.

School administrators face challenging decisions about how to operate their schools during a pandemic, and should consult with their local health officer, local elected leaders, teachers, school staff, families, and other stakeholders to weigh the risks and benefits of various locations and modes of education based on local COVID-19 activity. In particular, health officers and school administrators should engage staff and families of students at risk for severe COVID-19. In addition, they should engage the families of students with disabilities, English language learners, students living in poverty, students of color and young students to determine how to best meet the health and education needs of these students and the community.

While DOH encourages local health officers and school administrators to work together to choose the best setting(s) for their students, school administrators are ultimately responsible to establish appropriate education services. The local health officer should advise the school administrator and the school community on the level of COVID-19 activity, the community's access to testing, and the health department's capacity to respond to cases or outbreaks in schools with time investigations and contact tracing.

Local health officers are responsible for controlling the spread of communicable disease like COVID-19 in the community. County-level COVID-19 activity is measured by the number of cases per 100,000 people over a 14-day period, along with other key health indicators such as the percentage of positive tests and trends in cases or hospitalizations. The local health officer should inform the school administrator of significant changes in indicators. You can also find county and statewide indicators on [Washington's Risk Assessment Dashboard](#) (cases per 100K over 14 days and percentage of positive tests) and [Department](#)

of Health’s [COVID-19 Dashboard](#) (epidemiologic curves for cases and hospitalizations). The local health jurisdiction may further disaggregate these indicators, or use other data to guide recommendations for in-person learning.

If a local health officer determines that the opening of a school or the continuation of in-person learning poses an imminent public health threat to the community, they have the legal power and duty to direct or order an interruption of in-person learning ([WAC 246-110-020](#)). School administrators must cooperate with investigations, directives, and orders made by the local health officer ([WAC 246-101-420](#)).

Background

To help develop this guidance, DOH reviewed the experiences of countries that resumed some degree of in-person instruction this year. These countries generally had low and decreasing community rates of COVID-19 cases. Table 1 shows that the incidence rates in several countries that resumed in-person instruction were below 35 cases per 1,000,000 population, per day. As of July 23, 2020, Washington State had an incidence rate almost three times higher at 92 cases per 1,000,000 population, per day. In addition, the rate of COVID-19 in Washington slightly increased during the prior 20 days, whereas the trend in the rate of COVID-19 decreased in most other countries in the 20 days before reopening schools.

Table 1: School Re-Openings: Country Comparisons on Key Metrics Compared to Current U.S. Data

	Date of Reopening	Daily Cases (7-day average)	Daily Cases Per Million Population	Test Positive Rate (%) (7-day average)	Estimated Cases Per 100,000 Population Per 14 days
United States	—	65,750.4	198.6	8.3	278.0
Washington	—	711	92.9	5.6	130.1
Belgium	5/18/2020	291.3	25.1	2.1	35.1
Denmark	4/15/2020	205.7	35.5	6.2	49.7
France	5/11/2020	1,110.9	17.0	1.1	23.8
Germany	5/4/2020	1,140.3	13.6	2.4	19.0
Greece	6/1/2020	5.6	0.5	0.1	0.7
Israel	5/3/2020	126.7	14.6	1.4	20.4
Japan	4/24/2020	439	3.5	8.7	4.9
South Korea	6/8/2020	44.4	0.9	0.3	1.3
New Zealand	5/14/2020	1.1	0.2	0	0.3
Norway	4/20/2020	93.3	17.2	3.8	24.1
Switzerland	5/11/2020	57.1	6.6	1.3	9.2
Taiwan	2/25/2020	1.1	0.0	0.2	0
Vietnam	5/18/2020	4.6	0.0	0	0

This table was adapted from the Kaiser Family Foundation “What Do We Know About Children and Coronavirus Transmission?” website accessed on August 2, 2020 at: <https://www.kff.org/coronavirus-covid-19/issue-brief/what-do-we-know-about-children-and-coronavirus-transmission/>

NOTES: U.S. estimates calculated based on most recent data. France positivity rate from May 24. Vietnam positivity rate from April 29. Data represent 7-day average, as of re-opening date (unless other date noted).

SOURCES: COVID-19 data from: Department of Health [COVID-19 Data Dashboard](#) retrieved August for data

In addition to having lower and decreasing community rates of disease, these countries took a very cautious approach to resuming in-person instruction. Most countries first resumed in-person instruction for a portion of their students, and many implemented health and safety measures like physical distancing, frequent hand washing, use of face coverings, and frequent environmental cleaning to reduce the spread of COVID-19 in the schools.¹

There is limited data on the health impacts of resuming in-person learning when community incidence rates are as high as the current rates in the United States. With limited data, states are taking a wide range of approaches. The Oregon Health Authority recommends in-person instruction for K-3 students if rates are less than 60 cases per 100,000 over a 14-day period, and test positivity is <5%². The Minnesota Department of Health uses a staggered approach for K-12 students beginning at 100 cases per 100,000 population over 14 days, using local epidemiological information and the health and safety provisions of the school, to move from in-person elementary and hybrid secondary, through hybrid elementary and distance-learning for secondary, to fully distance-learning at 500 cases per 100,000. Once school has opened, they tailor the learning model based on the presence of cases in the school community³.

The decision to resume in-person learning is complex and requires weighing both the risks and benefits. When choosing thresholds to resume in-person learning, DOH considered both the health risks of COVID-19 to students, school staff, and the surrounding community; as well as the benefits of in-person school to children and their families.

Health risks of COVID-19 to students, school staff, and the community

The risk of COVID-19 entering schools depends on the level of COVID-19 spread in the community. At this time, any degree of in-person instruction presents some risk of infection to students and staff. It is hard to predict the number of infections that might occur under different in-person models and levels of transmission in the community.

The full spectrum of illness due to COVID-19 is not fully understood. While children generally have mild COVID-19 disease, serious infections have occurred⁴. Teachers and school staff are at risk for more serious disease, especially older adults and those with [certain underlying health conditions](#). Students and staff that acquire COVID-19 at school can transmit to others in the school setting as well as to their households and the community. DOH recommends comprehensive and strict [health and safety measures \(PDF\)](#) to minimize the risk of transmission within schools.

¹ Summary of School Re-Opening Models and Implementation Approaches During the COVID 19 Pandemic. July 6, 2020. Available at: <https://globalhealth.washington.edu/sites/default/files/COVID-19%20Schools%20Summary%20%28updated%29.pdf>

² Ready schools, safe learners: Guidance for school year. Version 3.0.1 July 29, 2020. Available at: https://www.oregon.gov/ode/students-and-family/healthsafety/Documents/Ready%20Schools%20Safe%20Learners%202020-21%20Guidance.pdf?utm_medium=email&utm_source=govdelivery

³ Safe Learning Plan for 2020-2021: A Localized Data-Driven Approach. Accessed August 1, 2020 at: https://mn.gov/covid19/assets/safe-learning-plan_tcm1148-442202.pdf

⁴ Götzinger F, Santiago-García B, Noguera-Julián A, et al. COVID-19 in children and adolescents in Europe: a multinational, multicentre cohort study. *Lancet Child Adolesc Health* 2020. Available at: <https://www.thelancet.com/action/showPdf?pii=S2352-4642%2820%2930177-2>.

Benefits of school for children

In-person learning has a broad range of benefits for our children. In addition to educational instruction, schools support the development of social and emotional skills; create a safe environment for learning; address nutritional, behavioral health and other special needs; and facilitate physical activity⁵. The absence of in-person learning may be particularly harmful for children living in poverty, children of color, English language learners, children with diagnosed disabilities, and young children, and can further widen inequities in our society⁶.

The decision tree on the following page can assist local health officials and school administrators in determining the degree of in-person learning that is advisable in their school. It can also help ensure the school is able to implement comprehensive health and safety measures, and respond swiftly if a person with confirmed COVID-19 is identified in the school environment. DOH favors a cautious, phased-in approach to resuming in-person instruction that starts with staff, small groups of our youngest learners, and students who are unable to learn or receive critical services asynchronously. Over time, schools can add additional students to in-person models. In-person learning should be prioritized for elementary school students because they may be less likely to spread COVID-19 than older children⁷, have more difficulty learning asynchronously, and may otherwise need to be in a childcare setting if their parent(s) work. While important to a child's growth and development, DOH prioritizes educational opportunities over extra-curricular activities in schools or other activities in the surrounding community.

More COVID-19 Information and Resources

Stay up-to-date on the [current COVID-19 situation in Washington](#), [Governor Inslee's proclamations](#), [symptoms](#), [how it spreads](#), and [how and when people should get tested](#). See our [Frequently Asked Questions](#) for more information.

A person's race/ethnicity or nationality does not, itself, put them at greater risk of COVID-19. However, data are revealing that communities of color are being disproportionately impacted by COVID-19- this is due to the effects of racism, and in particular, structural racism, that leaves some groups with fewer opportunities to protect themselves and their communities. [Stigma will not help to fight the illness](#). Share accurate information with others to keep rumors and misinformation from spreading.

- [WA State Department of Health 2019 Novel Coronavirus Outbreak \(COVID-19\)](#)
- [WA State Coronavirus Response \(COVID-19\)](#)
- [Find Your Local Health Department or District](#)
- [CDC Coronavirus \(COVID-19\)](#)
- [Stigma Reduction Resources](#)

Have more questions about COVID-19? Call our hotline: **1-800-525-0127**, Monday – Friday, 6 a.m. to 10 p.m., Weekends: 8 a.m. to 6 p.m. For interpretative services, **press #** when they answer and **say your language**. For questions about your own health, COVID-19 testing, or testing results, please contact a health care provider.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email civil.rights@doh.wa.gov.

⁵ CDC. The Importance of Reopening America's Schools this Fall. Accessed August 1, 2020 at <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/reopening-schools.html>

⁶ Levinson M, Phil D, Cevik M, Lipsitch M. Reopening Primary Schools during the Pandemic. *New Eng J Med* 2020.

⁷ Park YJ, Choe YJ, Park O, Park SY, Kim YM, Kim J, et al. Contact tracing during coronavirus disease outbreak, South Korea, 2020. *Emerg Infect Dis* 2020. Available at: <https://doi.org/10.3201/eid2610.201315>

Decision Tree for Provision of in Person Learning among Public and Private K-12 Students during COVID-19

Should your community provide in person learning and for whom? For School Administrators, Local Health Officers, and Community Stakeholders

The risk of COVID-19 being introduced into the school depends on the level of COVID-19 spread in the community and the health and safety measures taken by schools. Consider the following educational modalities based on community transmission and other health and education risks and benefits.

COVID-19 Activity Level	Education Modality*	Extracurricular**
HIGH >75 cases/100K/14 days Other considerations: <ul style="list-style-type: none"> Trend in cases or hospitalizations Test positivity, ideally <5% Other health and education risks and benefits to children and their families 	Strongly recommend distance learning with the option for limited in-person learning in small groups, or cohorts, of students for the highest need students, such as students with disabilities, students living homeless, those farthest from educational justice, and younger learners.	Strongly recommend canceling or postponing most in person extra-curricular activities, including sports, performances, clubs, events, etc. with the option to allow extracurricular activities in small groups of 6 or fewer students.
MODERATE 25–75 cases/100K/14 days Other considerations: <ul style="list-style-type: none"> Trend in cases or hospitalizations Test positivity, ideally <5% Other health and education risks and benefits to children and their families 	Recommend careful phasing in of in-person learning, starting with elementary students. Over time, if schools can demonstrate the ability to limit transmission in the school environment, add in-person learning for middle and high school students.	Consider cautious phasing in of low then moderate risk in person extra-curricular activities. Activities that can be done online, should continue in that format.
LOW <25 cases/100K/14 days Other considerations: <ul style="list-style-type: none"> Trend in cases or hospitalizations Test positivity, ideally <5% 	Encourage full-time in person learning for all elementary students and hybrid learning for middle and high school. Over time, if physical space allows, add full-time in-person learning for middle and high school.	Consider low, moderate, or high risk in-person extra-curricular activities.

When any in-person



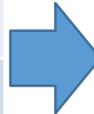
Can the school(s) implement recommended COVID-19 health and safety measures? School Administrators and Staff

The risk of COVID-19 spreading in schools depends on the ability of the school to implement [DOH's K-12 health and safety measures](#), and LNI employer safety requirements

Does the school have the plans, staff, space, and supplies to do the following?

✓	Protect staff and students at higher risk for severe COVID-19 while ensuring access to learning
✓	Transport or facilitate drop-off and pick-up of students
✓	Group students (required in elementary, recommended for middle and high school)
✓	Practice physical distancing of ≥6 feet among students and staff.
✓	Promote frequent hand washing or sanitizing
✓	Promote and ensure face covering use among students and staff
✓	Increase cleaning and disinfection
✓	Improve ventilation
<i>Are all staff trained on health and safety practices?</i>	

When all YES



Is the school and health system ready to monitor for and respond to suspected and confirmed cases of COVID-19? Schools and Local Public Health

COVID-19 cases in the school should be expected. The risk of COVID-19 spreading in schools depends on the ability to quickly identify and respond to suspected and confirmed cases and the level of community transmission.

✓	Can <u>the school</u> ensure monitoring of symptoms and history of exposure among students and staff? (attestation acceptable)
✓	Is <u>the school</u> prepared to manage students and/or staff who get sick onsite?
✓	Does <u>the school</u> have letters drafted to inform families and staff about confirmed cases or outbreaks?
✓	Is there adequate access to testing in the community <u>health</u> system for ill students and staff?
✓	Is there capacity in your <u>local health department</u> to investigate confirmed COVID-19 cases, quarantine their close contacts and assess whether transmission is occurring in the school?
✓	Can <u>local public health</u> monitor the level of community spread to determine when a change in education modality is needed?

When all YES



Begin Learning Model and Monitor

*Staff may work in school at any COVID-19 activity level if the school follows DOH and LNI health and safety guidance
 **Where possible do extracurricular activities outdoors, wear face coverings, and maintain physical distance of 6 feet.