

Tina Brock

From: Shawn Frederick <sfrederick@snohd.org>
Sent: Friday, September 25, 2020 3:02 PM
To: Tina Brock
Cc: Linda Carl
Subject: [External!] City Council Meeting Follow-up
Attachments: DOH-BHimpactsCOVID.pdf; Schools_SHD Framework 20200910.pdf; Updated Recommendation for School_Sep 10.pdf; DecisionTree-K12schools FINAL 20200805.pdf

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Hi Tina,

I hope you are well. I wanted to follow up with the Mayor and City Council on a few topics that were discussed during the meeting:

Suicide in the time of COVID-19: The questions was whether there has been an increase in suicides as a result of COVID-19. While official suicide data often lags, I've attached a study from DOH along with several references below:

The most recent often-quoted study

<https://wellbeingtrust.org/news/annual-deaths-due-to-alcohol-drugs-or-suicide-exceeded-150000-according-to-the-most-recent-data-and-could-get-worse-due-to-covid-19/>

Preventing suicide in the context of the COVID-19 pandemic

<https://onlinelibrary.wiley.com/doi/full/10.1002/wps.20767>

COVID-19 is Likely to Lead to an Increase in Suicides

<https://blogs.scientificamerican.com/observations/covid-19-is-likely-to-lead-to-an-increase-in-suicides/>

Schools: There was also a question regarding schools and re-opening. I've included guidance provided at the state and local levels to facilitate reopening gradually in serial increments spread 3 weeks apart over the coming months. See underlined portions of attached letter and table on p. 5 from statewide guidance.

Resuming the Safe Start Plan: Dr. Spitters and I had a call with the Secretary of Health and State Health Officers along with other LHJ administrators and Health Officers to discuss several topics one of those being the safe start plan. While there were no specific dates or timelines to move forward, the Secretary did voice concern over resuming prior to having more kids in school and potentially a timeline for vaccine distribution once one became available.

Hospital Capacity: Lastly, we continue to have good hospital capacity locally and monitor the status of the system routinely.

Please let me know if there are any additional questions.

Shawn

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Statewide High-Level Analysis of Forecasted Behavioral Health Impacts from COVID-19

SUMMARY

Purpose

This document provides a brief overview of the potential statewide, behavioral health impacts from COVID-19. The intent of this document is to communicate the potential impacts of the outbreak to response planners and behavioral health organizations, public and private, so they can adequately prepare.

Bottom Line Up Front

- The COVID-19 pandemic is considered a ‘natural disaster’ and as such, this document is heavily informed by research on disaster recovery and response.
- The behavioral health impacts from the COVID-19 outbreak and related government actions have to-date caused a surge in behavioral health symptoms across the state, which is a trend likely to continue. This surge will present differently based on the stage of the pandemic, the effectiveness of the overall response effort, and the populations being impacted. A second or third pandemic wave will dramatically change this forecast, as outlined in the scenarios that follow. This forecast will be updated monthly to reflect changes in baseline data.
- Ongoing behavioral health impacts in Washington will likely be seen in phases, peaking around 6-9 months post initial-outbreak.^{1,2} This will likely coincide with a potential second wave of infections, in a pattern consistent with previous pandemics.

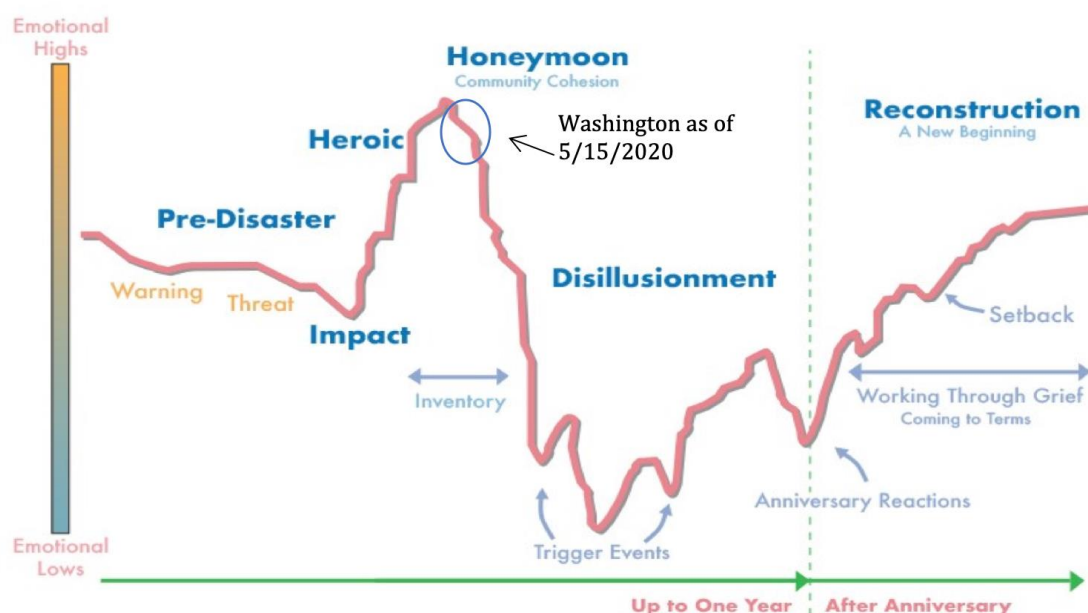
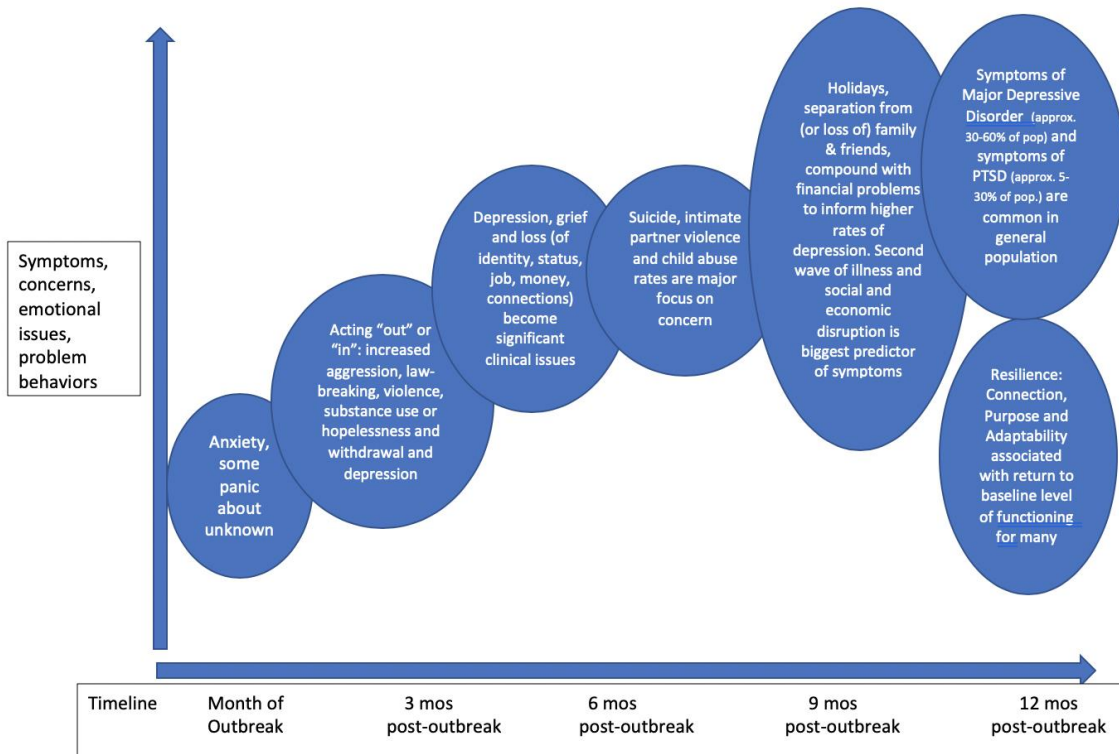


Figure 1. Reactions and Behavioral Symptoms in Disasters: SAMHSA
<https://www.samhsa.gov/dtac/recovering-disasters/phases-disaster>

Initial Forecast of Behavioral Health Symptoms (Without Additional Waves)



NOTE: Where people start on this chart is strongly predicted by their baseline level of functioning BEFORE the outbreak / pandemic

Figure 2.

- In Washington, the highest risk of suicide will likely occur between October and December 2020. This is consistent with known cycles of disaster response patterns. Seasonal affective disorder exacerbates mental health challenges at that time of year due to increased hours of darkness and inclement weather, as does the occurrence of winter holidays, which are often an emotionally and financially difficult time of year for many people.
- Outreach and support strategies need to be tailored based on the current phase of the incident and the target population. Resources exist to inform outreach and support strategies. Additional resources to support these efforts are currently under development.
- Efforts should focus on activating/augmenting existing community supports to increase social connections, which reduces behavioral health symptoms, and encouraging active coping skills among target audiences.
- An eventual return to baseline levels of functioning for **many** people should occur around 12-14 months post-initial outbreak, **assuming that the potential second wave of the pandemic is stabilized by that time, in terms of both social and economic disruptions, and a sense of the "new normal" is underway.**

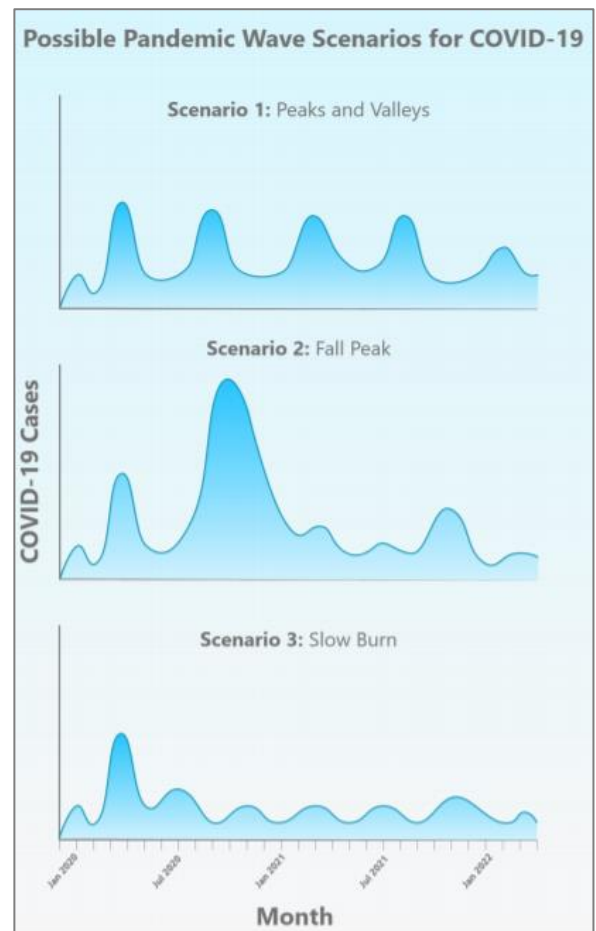
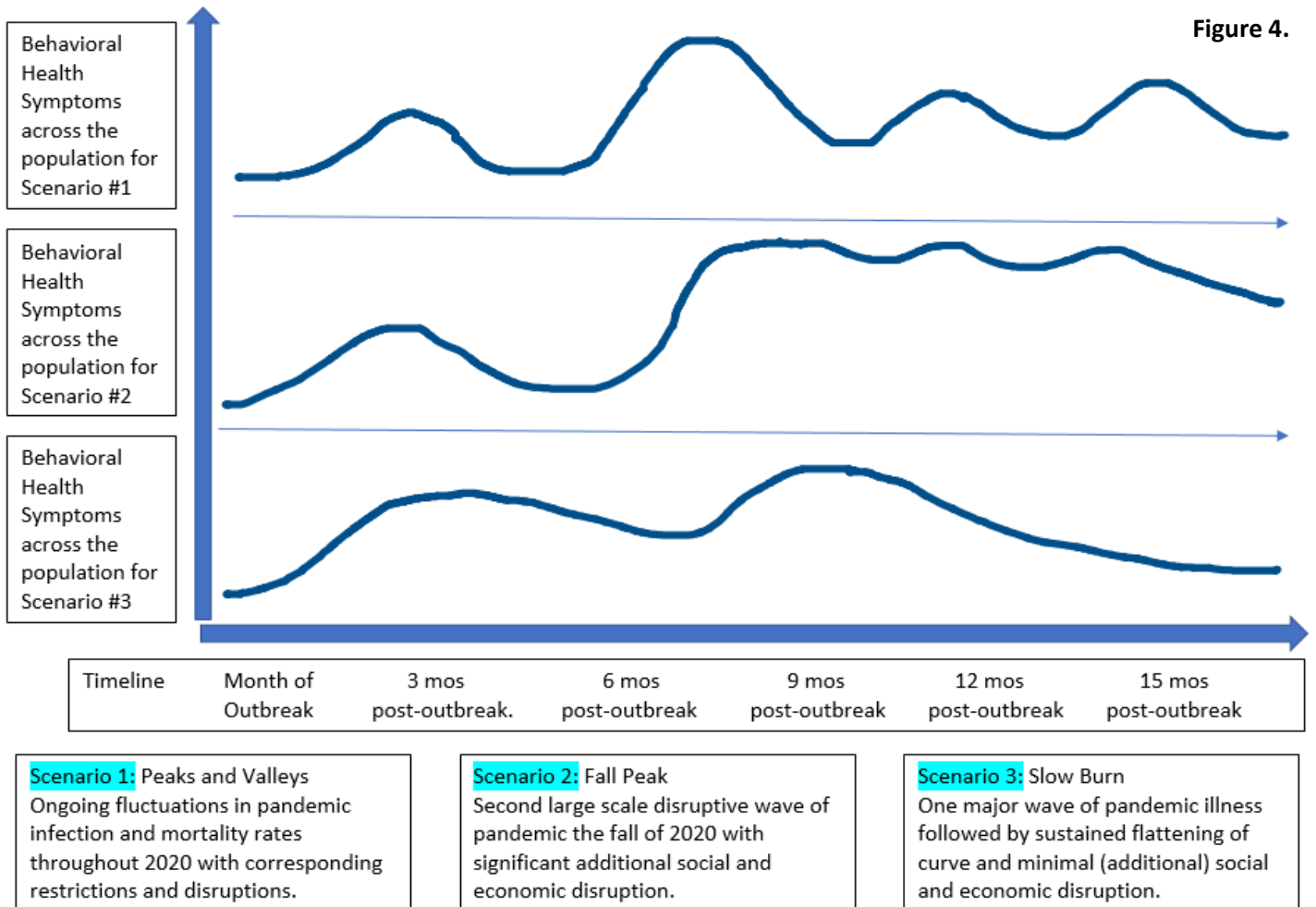


Figure 3.

- There are three different scenarios for the future of the COVID-19 pandemic as we move into summer and fall, some of which are consistent with what occurred during past influenza pandemics (see Figure 3).³ The behavioral health symptom projections that follow are based on the different scenarios and their corresponding behavioral health impacts.

Forecasted Behavioral Health Symptoms, Based on COVID-19 Wave Scenarios



Key Things to Know

What sort of impacts are we expecting?

- Approximately 650,000 Washingtonians were receiving treatment for behavioral health needs prior to the COVID19 outbreak.
- Approximately 700,000 Washingtonians have mental health concerns, but were NOT receiving services prior to the outbreak.
- Approximately 10% to 33% of individuals experience symptoms of acute stress (such as negative thoughts, sadness, intrusive dreams or memories, avoidance, insomnia or hypersomnia, headaches & stomach aches) within one month after the impact phase of a disaster or critical incident. In Washington, for the Puget Sound area specifically, that timeline begins mid-March 2020.^{4,5,6}
- While Only 4% to 6% of people typically develop symptoms of PTSD after a disaster (equivalent to 380,000 individuals in Washington), *this number can vary quite a bit depending on the type of disaster*, and is often higher amongst first responders and medical personnel if the disaster is more chronic, widespread, children are hurt or injured, and burnout is likely.^{5,6,6}

- Rates of PTSD have been much higher (10-35%) in some places more directly impacted by a critical incident (NYC on 9/11).⁷ We are anticipating that although rates of PTSD may not reach such critical levels in Washington State, **rates of depression are likely to be much higher (perhaps 30-60% of the general population, which is equivalent to 2.25 million to 4.5 million people in Washington State⁷) due to the chronic and ongoing social and economic disruption in people’s lives as a result of the COVID-19 pandemic.** This is a much higher rate than is typical after a ‘natural disaster’ where there is a single impact point in time.
- A significant number of COVID-19 positive individuals require critical care, a trend consistent across China (7-26% of cases), Italy (5-12%), and the United States (5-12%).⁸ Of those individual receiving critical care, up to 75% also require mechanical ventilation.^{9,10} Current literature reports the prevalence rate of PTSD in patients post-mechanical ventilation is 10% to 30%.^{11,12,13}
- For Washington State, where mortality rates are so strongly related to nursing homes, and the vast majority of people in the general population have not been directly threatened by the illness itself, behavioral health concerns are much more anchored in changes in lifestyle, fears about the unknown, financial worries, loss of income or livelihood, and loss of connection with others.
- **Impact of Unemployment:** Suicide rates are highly influenced by unemployment rates.^{14,15,16} For every percentage point increase in unemployment rates (i.e., 1%), there is a 1.6% increase in suicide rates.¹⁵ In Washington, approximately 1,283 people die from suicide annually. If unemployment rates increase by 5% (rates similar to the Great Recession in the late 2000’s), that means we will see approximately 103 additional people die by suicide.¹⁶ If unemployment increases by 20% (rates similar to the Great Depression in the 1930’s), that’s approximately 412 additional people who will die by suicide in Washington.
- **Approximately half of the individuals who experience a behavioral health diagnosis will develop a substance-related disorder, and vice versa.**¹⁷
 - As a result, we can expect substance-related symptoms and disorders to increase as behavioral health symptoms and disorders increase.
- During disasters, individuals may have difficulty accessing their prescribed medication, which could lead them to seek alternatives. Relatedly, quarantine policies mean that peer support groups for both substance-related disorders and behavioral health disorders are inaccessible via traditional means.
 - Healthcare providers should anticipate an increase in substance-use as a possible disaster reaction, and should suggest both healthy alternatives for coping, and sources of support.
- Based on population data for Washington, and known cycles of common psychological responses to disasters, **we can reasonably expect that between TWO to THREE MILLION Washingtonians will experience behavioral health symptoms over the next three to six months. Symptoms of depression will likely be the most common, followed by anxiety and acute stress.** These symptoms will likely be strong enough to cause significant distress or impairment for most people in this group.

What does this look like over time?

- **Behavioral health symptoms will likely present in phases:**^{1,2}
 - We can reasonably expect that behavioral health symptoms including anxiety, trouble sleeping, stomach aches, and headaches will be consistent in the general population in the summer months of 2020.
 - Behavioral symptoms associated with “acting out” (aggression, law breaking, significantly increased domestic child abuse, intimate partner violence, and substance use) or “acting in” (voluntary isolation, non-participation, blunted emotional expression) are likely to increase from three to six months post-outbreak. Weekly surveys of state law enforcement agencies indicate that domestic violence offenses were up 17%, while other select offenses were down

25% (see Figure 5).^{*18} However, these data only represent approximately 29% of law enforcement agencies and, based on data from previous disasters, it is likely that – even among reporting agencies – the true number of domestic violence cases is significantly higher.

- Depression rates and symptoms, along with suicides, are increasing dramatically at the current time with the potential of peaking in the fall and winter of 2020. For the general

population, this is due to a particularly hard combination of:

- The Disillusionment phase of disaster recovery (when people recognize that things will not be returning to the way they once were)
- The season (holidays as well as limited daily sunlight)
- Long term effects of financial losses or concerns on sense of hope
- A second wave of illness resulting in large-scale social and economic disruption
- An eventual return to premorbid baseline levels of functioning by February or March 2021 is anticipated for many people, depending on the level of disruption caused by the potential for a second wave of illness in the fall of 2020 or winter of 2021.^{1,2}
- In scenarios where multiple waves of pandemic occur (see scenarios 1 and 2 above), a “Trauma Cascade” is likely. For behavioral health, this means that the recurrence of a traumatic event (in this case, a second or third wave of significant illness and/or restriction) inhibits the natural ability of people to recover to baseline levels of functioning. Symptoms increase and are compounded rather than having an opportunity to be actively managed.

How do we begin preparing?

- Behavioral health systems, providers, and public messaging teams should be mindful of the following strategies to maximize the impact of their efforts:
 - Primary efforts for the next 3-6 months should be focused on activating community supports to increase social connections (and thus reducing behavioral health symptoms) and encouraging the development of ACTIVE coping skills amongst the general public to reduce symptoms of depression.
 - Communication about **preparation** necessary for multiple phases or waves of pandemic (the potential for additional school closures, social distancing measures, and restrictions in the fall) will help to reduce acute behavioral health symptoms for people when a second wave of illness occurs.
 - There should be a psychoeducational emphasis on the disaster response cycle so that people are informed about what they may expect, and they do not pathologize a normal response to an abnormal situation.
- The typical response to disaster is RESILIENCE, rather than disorder.^{1,4} Resiliency can be increased by:¹⁹

*The number of law enforcement agencies submitting offense counts varies from week to week: April 6-12 (n=84), April 13-19 (n=80), April 20-26 (n=78), April 27-May 3 (n=80); among the 85 agencies that submitted counts for at least one week, 74 agencies submitted counts for all four weeks. In addition to counts of domestic violence, law enforcement agencies were only asked to submit counts of the following (select) offenses: Murder, assault, robbery, burglary, theft, destruction of property, weapons offenses, and animal cruelty.

Domestic violence and other select offenses*, April 6 - May 3 (2020 vs. 2019)

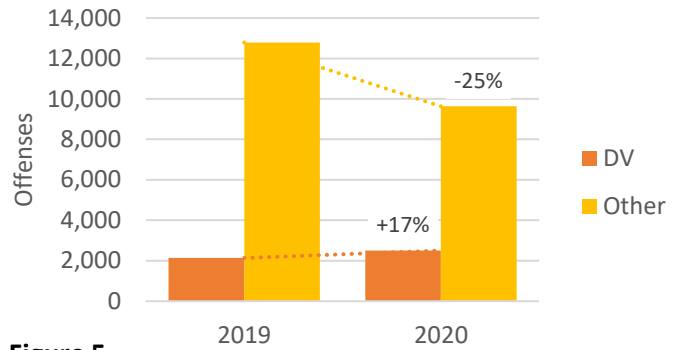


Figure 5.

- Focus on developing social CONNECTIONS big or small
- Reorienting and developing a sense of PURPOSE
- Becoming adaptive and psychologically FLEXIBLE
- Focusing on HOPE
- Resilience is something that can be intentionally taught, practiced, and developed for people across all age groups.
- Community support groups, lay volunteers, law enforcement, first responders, and all manner of social organizations and clubs are resources that can be developed to help reduce behavioral health symptoms for the general population, and should be leveraged to take pressure off depleted or unavailable professional medical and therapeutic resources throughout 2020.

Background Data and Analysis

Mental Illness, Behavioral Health Diagnoses, and Demographics

National prevalence rates for mental and behavioral health diagnoses^{20,21}

Generalized Anxiety Disorder = approximately 1% of adolescents, 2.9% adults (6.06 million nationally)

Panic Attacks = 11.2% of adults (23.40 million)

Panic Disorder = approximately 2-3% of adolescents and adults (4.18 million)

Mood Disorders = approximately 9.7% of adults²¹ (20.27 million)

Depression = 12.7% in WA, 41.1% of whom received mental health services²²

Annual suicide rates = approximately 17 per 100,000²³

Post-Traumatic Stress Disorder: 3.5% of adults nationally²⁰

Substance-Related Disorder prevalence

National prevalence rates for substance-related disorders^{20,21,24}

Alcohol Use Disorder = approximately 4.6% of adolescents, 8.5% of adults

Cannabis Use Disorder = approximately 2.3% of adolescents, 5% of young adults, and 0.8% of adults

Opioid Use Disorder = approximately 0.6% of adolescents, 1.1% of young adults, and 0.8% of adults

Population of WA: Approx. 7.5488 Million

Percentages with baseline Serious Mental Illness (2017 most recent):

Adults 18 and over = 5.3%²² (or 400,044 people)

Young adults from 18-25 = 6.2%²² (or 29,014)

Percentage of adults 18 and over with ANY mental illness who received treatment in Washington (2017 most recent) = 45.6% (approximately 650,000 people or 8% of the total population of WA)²²

Developed by Washington State Department of Health's Behavioral Health Strike Team, authored by: Kira Mauseth, Ph.D.; Stacy Cecchet, Ph.D., ABPP., Matt Brickell, Psy.D, and Tona McGuire, Ph.D.

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

Introduction

The purpose of this decision framework is to assist local health officers and school administrators in making decisions around resuming in-person instruction for public and private K-12 schools during the COVID-19 pandemic. This decision making tool is added to the Department of Health's (DOHs) [K-12 Fall Health and Safety Guidance](#) and both will be updated as the pandemic evolves and additional science becomes available.

School administrators are currently faced with challenging decisions around how to operate their schools this year in the midst of the pandemic. It is important for school administrators to consult with their local health officer, local elected leaders, teachers and other school staff, families and other stakeholders when considering the risks and benefits of different locations and modes of education in the context of COVID-19 activity in the community. 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 determine the best setting or mix of settings for their students, school administrators remain ultimately responsible for establishing the education services appropriate for their students. The local health officer should advise the school administrator and the school community regarding the level of COVID-19 activity, as well as the local community's access to testing, and the health department's capacity to respond to potential cases or outbreaks in schools with time investigations and contact tracing.

Local health officers remain responsible for controlling the spread of communicable disease. Toward that end, the local health officer will monitor COVID-19 activity in the community as measured by the number of cases per 100,000 population over 14 days for the county in combination with other key health indicators (such as the percentage of positive tests and the trend in cases or hospitalizations) and proactively inform the school administrator when there are significant changes. These indicators are available at the statewide and county level 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 have other data that inform their recommendations for schools and in-person learning during the pandemic.

All parties should remain aware that if a school's opening to or continued operation of in-person learning poses an imminent public health threat to the community in the estimation of the local health officer, then that local health officer has the legal power and duty to direct or order an interruption of

in-person learning ([WAC 246-110-020](#)). School administrators are obligated to cooperate with investigations, directives, and orders of the local health officer ([WAC 246-101-420](#)).

Background

In developing this guidance, DOH reviewed the experiences of other countries that resumed some degree of in-person educational instruction earlier this year. The countries that resumed in-person instruction generally had low and decreasing rates of COVID-19 cases in the community. Table 1 shows that the incidence rates in several countries that resumed in-person educational instruction were below 35 cases / 1,000,000 population / day. As of July 23, 2020, Washington State had an incidence rate that was almost three times higher at 92 cases / 1,000,000 population / 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 was decreasing 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 through July 23, 2020 and “Coronavirus Pandemic (COVID-19)”. Published online at [OurWorldInData.org](#). Retrieved on July 28, 2020. School reopening dates from: University of Washington, [Summary of School Re-Opening Models and Implementation Approaches During the COVID 19 Pandemic](#), July 6, 2020.

In addition to experiencing lower and decreasing community rates of disease, other countries took a very cautious approach to resuming in-person instruction. Most countries initially only resumed in-person learning for a portion of their students, and many implemented a variety of 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 schools if introduced.¹

Little data are available 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 to resuming in-person learning. The Oregon Health Authority recommends in-person instruction for K-3 students if rates are less than 60 cases per 100,000 over 14 days and test positivity is <5%² while the Minnesota Department of Health recommends in-person instruction for elementary students if rates are less than 500 cases / 100,000 population over 14 days³.

The decision to resume in-person learning is a complex decision that requires weighing both risks and benefits. When considering thresholds for resuming 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 being introduced into the school environment depends on the level of COVID-19 spread in the community. At this time, any degree of in-person instruction will present some risk of infection to students and school staff. It is difficult 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 completely understood currently. While children generally have mild COVID-19 disease, serious infections have occurred⁴. Teachers and other school staff are at risk for more serious disease, particularly older adults and those with [certain underlying health conditions](#). Students and staff that acquire COVID-19 in the school setting can lead to transmission in the school setting as well as in households and the community. DOH is recommending comprehensive and strict [health and safety measures](#) to minimize the risk of transmission within the school setting.

Benefits of school for children

In-person learning provides a broad range of benefits to our children. In addition to providing educational instruction, schools support the development of social and emotional skills; create a safe

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>.

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 is designed to assist local health officials and school administrators in determining the degree of in-person learning that is advisable in their school and ensuring that the school is able to implement comprehensive health and safety measures and is ready to respond swiftly if a person with confirmed COVID-19 is identified in the school environment. The Department of Health favors a slow, cautious, phased-in approach to resuming in-person instruction beginning 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) are working. While important to a child's growth and development, the Department also prioritizes educational opportunities over extra-curricular activities in the school setting and other discretionary 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"> Increasing trend in cases or hospitalizations Test positivity >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 all in person extra-curricular activities, including sports, performances, clubs, events, etc.
MODERATE 25–75 cases/100K/14 days Other considerations: <ul style="list-style-type: none"> Increasing trend in cases or hospitalizations Test positivity >5% Other health and education risks and benefits to children and their families 	Recommend distance learning as described above. In addition, consider expanding in person learning to elementary students. Over time, consider adding hybrid in person learning for middle or high school students if limited COVID transmission occurs in schools.	Strongly recommend canceling or postponing all in-person extra-curricular activities. Consider low risk activities when all students have some level of in person learning.
LOW <25 cases/100K/14 days	Encourage full-time in person learning for all elementary students and hybrid learning for middle and high school. Over time and if physical space allows, consider full-time in person learning for middle and high school.	Consider low and moderate risk in person extra-curricular activities.

When any in-person



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

For 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](#).

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

Are all staff trained on health and safety practices?

When all YES



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

For 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 in Person 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



September 10, 2020

Considerations to Inform Schools’ Planning for Return to In-Person Learning

Factors to consider when conducting planning to return students to hybrid and in-person learning should include, but may not necessarily be limited to, the following:

Factor	Agency Domain	Criteria to Proceed	Comment
Ensuring that the affected schools are able to fully implement COVID-19 health and safety measures	Schools	Yes	See DOH and OSPI guidelines
Ensuring that the affected schools are ready to monitor for and able to respond to suspected cases of COVID-19	Schools (pre-event) & Health District (during and post-event)	Yes	See DOH and OSPI guidelines
The level and trajectory of COVID-19 case and outbreak activity in the school or school district itself and in the community at large	Health District	Stable or improving	Primary metrics: <ul style="list-style-type: none"> • 14-day incidence stable or decreasing • <5% of tests positive countywide in past week and stable or decreasing • COVID-19 hospital census stable or decreasing and <10% of all licensed beds • ≥20% hospital surge capacity
The time elapsed since prior events (e.g., holidays) or modifications in staff or student onsite presence that may impact COVID-19 transmission	Schools	≥3 weeks	Time required to reliably detect a surge in COVID-19 activity following a possible exposure



Factor	Agency Domain	Criteria to Proceed	Comment
Findings from other settings in the county and region about the impact of return to in-person learning upon school and community transmission	Health District	No local or regional empiric data indicating a problem with pursuing the next step	Published data or guidance from other settings will be considered
Selecting between hybrid versus full-time in-person learning;	Schools	Must meet space, social distancing and other parameters set forth in DOH and OSPI guidance	Experience of others locally, regionally, or nationally may inform these choices as time progresses
The timeline along which a school's or district's administration can reasonably implement a transition to more in-person capacity	Schools		
The willingness of informed parents and guardians to send their students to in-person settings	School		
The ability to provide a stable learning environment and lasting return to in-person learning	School		



September 10, 2020

TO: Snohomish County Public K-12 Superintendents
Snohomish County Private School Administrators

SUBJECT: Updated Recommendations regarding Remote-vs-In-Person Learning

This letter provides updated Health District guidance on considerations for planning future hybrid and in-person learning in the light of ongoing moderate but declining COVID-19 transmission in Snohomish County. After peaking in late July at nearly 100 cases per 100,000 per 14 days, the incidence of newly reported COVID-19 cases has continued a sustained, five-week decline. For the most recent 14-day period (August 23 – September 5, 2020), the rate was 48.

Since that late July peak when the Health District recommended beginning the fall term via remote learning, circumstances have changed for the better. Not only do we now have over a month of declining COVID-19 rates in Snohomish County, but we also have a framework for proceeding forward in the Washington State Department of Health's (DOH's) [Decision Tree for In Person Learning](#). This guidance based on DOH's decision tree highlights general parameters and overarching considerations from a countywide disease control perspective. The Health District defers to you on how to best serve your students within that general framework and meeting statewide guidelines, recommendations and requirements cited below.

As a result of the improving situation and in accord with DOH's guidance, a reasonable next step is to begin planning for how to expand in-person learning to elementary school students, as well as to any remaining high needs students of any grade level who are not already receiving in-person educational or ancillary services. However, this is not a suggestion to immediately go to full, in-person attendance in all elementary school settings, nor is this a recommendation to proceed with plans for in-person learning by middle and high school students. Furthermore, given the level of COVID-19 activity in the county and the size of the school population, it is inevitable that cases will occur in students and school staff. We all must be prepared for and ready to respond to that in a systematic and sustainable fashion.

Factors to consider when conducting planning to return elementary school students to in-person learning may include, but may not necessarily be limited to, the following:

1. your ability to fully implement COVID-19 health and safety measures as set forth in guidance from [DOH](#) and the [Office of the Superintendent of Public Instruction](#) (OSPI);
2. your readiness to monitor for and ability to respond to suspected cases of COVID-19 as set forth in guidance from DOH and OSPI;
3. the level and trajectory of COVID-19 case and outbreak activity in the school or school district itself and in the community at large;
4. the time elapsed since prior events (e.g., holidays) or modifications in staff or student onsite presence that may impact COVID-19 transmission;
5. findings from other settings in the county and region about the impact of a return to in person learning upon COVID-19 transmission;
6. selecting between hybrid versus full-time in-person learning and accounting for maintenance of social distancing and other prevention measures in making that selection;
7. the timeline along which a school's or district's administration, students and families can be reasonably expected to implement a transition in the learning plan;



8. the willingness of parents, guardians, and staff to attend in person settings; and
9. the ability to provide a stable learning environment and lasting return to in person learning.

In summary, a reasonable approach for the time being is to wait for at least three weeks of observation following both the Labor Day holiday and the re-opening of schools in their current configuration. If at that time COVID-19 activity in the school and community remains stable or improving and a review of the considerations set forth above is favorable, then proceeding with incremental returns of elementary school students to in person learning at your discretion is acceptable to the Health District. I urge you to continue to allow adequate time (e.g., at least three weeks) between increments in order to detect untoward effects prior to making the next move in your planned sequence.

The Health District is addressing this issue with a focus on countywide COVID-19 rates as its key metric due to:

- the overall mobility of the population, including school staff, causing a convergence in area-specific risk of transmission across locations;
- DOH's and the Governor's Safe Start framework being metered at the county level; and
- valuing countywide equity in students' access to in-person learning.

Consequently, the Health District cautions against advancing more rapidly than recommended on the basis of having a lower local COVID-19 rate than the county as a whole. On the other hand, it is not within the Health District's domain or capacity to prescribe or imply a minimum rate at which the process should progress. Local conditions, resources, and other factors within your domain may indeed lead you to move slower than this framework allows for.

Aside from high-needs students in small (e.g., ≤ 5), cohorted groups attending middle and high school in person, this letter communicates no current recommendation or guidance for returning to in person learning by middle and high school students. The Health District finds that teenage students:

- have higher rates of COVID-19 than younger children;
- are probably more likely to spread COVID-19 if infected; and
- as a group, appear to face fewer challenges in remote learning.

Given these factors, the Health District recommends middle and high schools continue to operate remotely (aside from special- or high-needs students). If we are able to return elementary school students to in-person learning in a safe and stable manner and we remain in similar or better COVID-19 circumstances overall, then at that time the Health District will update these recommendations, addressing the addition of hybrid or in person learning for middle and high school students.

In line with DOH guidance, the Health District continues to recommend against in-person extracurricular activities until such time as all students have at least some access to in-person learning, and COVID-19 activity in the community is otherwise so permitting. Also please note that a re-escalation in COVID-19 activity in the county, or in a specific school or district, may lead to modification of these recommendations. If such occurs, the Health District will notify you.



If you have any questions regarding these recommendations, please contact schools@snohd.org.

Meanwhile, we at the Health District look forward to continuing to work with you and your school communities to implement DOH and OSPI guidance, monitor disease activity, and respond to suspected and confirmed cases of COVID-19 that occur in your schools. I also look forward to continuing our regular communication and collaboration as we navigate together through this difficult time and try to implement a successful transition to in-person learning in the midst of the COVID-19 pandemic.

Sincerely,



Christopher Spitters, MD, MPH
Health Officer

cc: Snohomish Health District Board of Health