Safe Re-Opening District Handbook

Addendum 2 - January 20, 2021

Addendum 2 January 20, 2021

Section 1.a Personal Protection Equipment Requirements – Face Coverings
Exceptions to wearing face masks

- Staff and students who request exception from wearing face masks as allowed by the WA Department of Health and outlined in Snohomish School District Safe Re-Opening Schools 2020 – 2021 Handbook, page 3, may be required to provide a medical doctor's note stating that the individual qualifies for the exception. The note may be asked by the building administrator or direct supervisor before granting the exception.

- Accommodations to wearing face masks are as stated in the Snohomish School District Safe Re-Opening Handbook, page 4.

- Job Description Risk Assessment for PPE Requirements. Refer to the attached matrix of job classification and risk level for PPE Requirements. Refer to Employer Health & Safety Requirements for School Scenarios, September 30, 2020 from WA Dept of Labor & Industries, Washington Dept. of Health and OSPI.
  INSERT MATRIX HERE

Section 2. – Staff and Student Screening

- Qualtrics attestation process will be used for all staff and students as practical. Refer to the specific training video and talking points for Qualtrics use.

- To verify whether staff and student / guardian has completed the attestation please note the following reporting.

  1. The following reports can be automatically sent via email:
     2 separate reports for the teachers' use:
     (a) Completed attestations of each classroom of students, "approved" and "not approved" to come to school.
     (b) "No Response" report of their students who have not completed the attestation as of the email distribution time.

  2. 3 separate reports for office staff use at your option:
     (a) All student attestations
     (b) All staff attestations
     (c) "No Response" report including all staff and all students

- The Qualtrics system can send out automatic emails with attached csv files (Excel) reports to your teachers and office staff based on the sample templates.

- Regarding the Excel formatted student reports please note:
    1. Completed student attestation status reports of “approved” or “not approved” to come to school or “no response”, which can be sent directly to the teachers, is restricted data. Teachers will only see their classroom students listed under “Advisor”, which is the teacher’s name.

    2. The Excel attachments can be sorted by the information in each column but are not formatted. That means that some columns must be expanded in order to make the data visible.

    3. The automatic emails can only be automatically distributed on the hour per Qualtrics, such as 7:00am, 8:00am, 9:00am. Principals would need to specify at what hour the emails should be sent.

    4. Building staff who have access to the Qualtrics dashboard can get “live” information of all staff and student status.

Section 3, District Cleaning and Disinfection Protocol

Isolation Room Disinfection – Once a probable positive individual has been taken to the Isolation Room and sent home, Maintenance and Custodial Services will as soon as possible begin the disinfection process in the Isolation Room. In conjunction with the building disinfection process already established, mobile UV-C equipment will be dispatched, as available, to assist in the speed of disinfection. This plan will also include any restroom facilities used by the probable positive individual. The team for disinfection may include maintenance staff, on-site and / or offsite custodial staff.

Classroom Disinfection after the school nurse identifies a probable positive individual
Classrooms or offices will cordon off areas where a staff or student with probable or confirmed COVID-19 illness was present until the area and equipment is cleaned and sanitized. (extract from September 30, 2020 L&I, DOH. OSPI document page 19). Students will be relocated to a temporary classroom space. Spaces may include empty classroom, stage, or music room. Upon the vacating of the classroom, the space will be aired out and sit for 24 hours or as long as practical within the 24-hour period and then disinfected. The team for disinfection may include maintenance staff, on-site and / or offsite custodial staff.

ATTACHMENTS:

Tools to Prepare for Provision of In-Person Learning among K-12 Students at Public and Private Schools during the COVID-19 Pandemic Washington Department of Health, December 16, 2020

Vaccination Frequently Asked Questions

Washington's COVID-19 Vaccine Phases

Questions and Answers for Restarting in Person, December 2, 2020

Safe Re-Opening District Handbook

Addendum 1 - October 29, 2020

Addendum 1 October 29, 2020

1.a Personal protection Equipment Requirements – Face Coverings

Cloth Face Coverings or Masks

Acceptable accommodation for negligible and low transmission risks

Per the September 30, 2020 Employer Health and Safety requirements for School Scenarios issued jointly by the WA Dept of health, WA Dept of Labor and Industries and OSPI, an acceptable face covering accommodation for negligible and low transmission risks, is a face shield that includes a cloth extension attached to the entire edge of the shield. Negligible and low transmission risks include general classroom settings when 6 feet physical distancing is maintained. Refer to page 9 of the attached September 30, 2020 document.

Office Administrative Assistants conditions for face coverings

According to the WA Dept of Labor and Industries Coronavirus (COVID-19) Common Questions Regarding Worker Face Coverings and Mask Requirements, (attached), office workers do not have to wear a face covering if they are considered to be working alone. Examples of working alone include:

"A lone worker inside a cubicle with 4 walls (one with an opening for an entryway) that are high enough to block the breathing zone of anyone walking by, and whose work cavity will not require anyone to come inside the cubicle."

Further clarification is provided in the September 30, 2020 Employer Health and Safety requirements for School Scenarios, page 14, cubicle walls can include Plexiglas.

Attachments:

1. WA Dept of Labor and Industries Coronavirus (COVID-19) Common Questions Regarding Worker Face Coverings and Mask Requirements

2. Employer Health & Safety Requirements for School Scenarios, OSPI, WA DOH, WA L&I

1.d Cohorting

Groups or Cohorts should maintain their cohorting during the school day through the following activities:

- Arrival and building entrance to classrooms
- Snack time or breakfast
- Recesses
- Lunch
- Bathroom use to the extent possible
- Dismissal and building exit to transportation

Students within a cohort should have assigned seating in the classroom and at lunchtime. This practice will assist if there is need for contact tracing.

Shared Items

Use of shared objects (e.g., gym or physical education equipment, art supplies, toys, games) should be limited when possible, or cleaned and disinfected between use. These items at a minimum should limited to a cohort or classroom as a shared item.

Discourage sharing of items that are difficult to clean or disinfect such as electronic devices, pens and pencils, classroom stapler, whiteboard markers and erasers, books, games, art supplies (e.g., markers, crayons, scissors), and other learning aids. Soft and porous materials, such as area rugs and seating, may be removed to reduce the challenges with cleaning and disinfecting them.

Keep each student's belongings separated from others' and in individually labeled containers, cubbies, or areas.

Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (e.g., assigning each student their own art supplies, equipment) or limit use of supplies and equipment to one group of students at a time and clean and disinfect between use.

1.f Ventilation

HVAC systems filters were upgraded with new filters that meet higher ratings per new standards per the American Society of Heating Refrigeration and Air Conditioning Engineers.

Portable Classrooms:

- All filters have been replaced with upgraded filtration
- The heating system cannot be controlled for maximizing outside fresh air
- Therefore, room box fans are supplied when desired to increase outside air by opening the window.
- When the window is closed, portable air purifiers are provided to purify the air when the box fan is not running
- The box fan and the portable air purifier are to run as one or the other but not simultaneously.

1.g COVID-19 Supervisor Duties and Responsibilities

The COVID-19 Supervisor is assigned to each facility and reports to the building administrator or supervisor. The COVID-19 Supervisor and the building administrator communication is in the overall building management of safe school practices Therefore, on-going issues resolution should begin with communication between the COVID-19 Supervisor and the school administrator.

2. Staff and Student Screening

The district has acquired an online email / text message system for completing the attestation process before coming to school.

- As of the date of this document, the system is made available to staff only.
- The temporary system will be abandoned once the system is rolled-out to families.
- Once the attestation is completed by staff and families, the school will need to verify the disposition of staff and students upon arrival at the building.
- Students or staff who did not complete the attestation prior to arriving at school will be required to complete at the school before entering the classroom or office work space.
- A link through a QR Code will be available at the school for staff or students to use their smart phone to complete the attestation.
- A separate instructional video and supporting document is distributed to staff and will be later to families.
- Therefore, the description of the process will not be covered here.
- Under Section 4, Trainings, is a copy of the instruction materials, attached.

3. District Cleaning and Disinfection Protocol

Playground Cleaning

Outdoor areas, like playgrounds in schools, generally require normal routine cleaning. Disinfection of outside playgrounds is not necessary or recommended except in cases of biohazard contamination. Students should be given time to wash their hands both before and after outdoor play. Social distancing of students should be maintained, and appropriate staff present at all times for supervision.

4. Trainings

The following training material talking points are included in this addendum.

Attachments:

1. Face Coverings, Physical Distancing & Hand Hygiene – Handwashing
2. Ventilation
3. Disinfecting and Cleaning
4. Daily Symptom Checker
5. Daily Symptom Checker Dashboard
6. COVID-19 Supervisor, Response and Contact Tracing

5. Staff and Student COVID-19 Diagnosis, Symptomatic and Close Contact Tracing

The following narrative replaces the previous September 18, 2020 Version 2.0 Section 5 information regarding response to positive cases and contact tracing.

Staff member or student has a confirmed, positive test for COVID-19

1. Confirm that Director of Communications knows name of person who tested positive.
2. Principal/administrator should meet with person who tested positive to determine any potential close contacts.
    - Close contact is defined as being within 6-feet for 15 or more cumulative minutes (over 24-hour period) of person (masked or unmasked) who tested positive 48 hours from date of positive test (if no symptoms) or 48 hours from symptom onset.
    - Work with COVID-19 supervisor to complete template and send to Director of Communications.
    - Note: If 48 hours window is over a weekend, when there was no school or said individual was not in the building, there is no further action needed by the school, building or school district.
3. Hold confidential meeting with each person listed on the close contact template.
    - Script of meeting - "I want you to know that your name and contact information have been provided to the Snohomish Health District as a potential close contact of someone who has tested positive. I'd like to ask that you please go home now. You can expect to hear by phone from the Snohomish Health District within the coming day. If you have been deemed a close contact, the Snohomish Health District will note you should quarantine for 14 days from the date you last had contact with the person who tested positive. Those specific details and dates will be communicated to you by the Snohomish Health District."
    - Do not expect your school or the Snohomish Health District to provide you with the name of a student or staff member who has tested positive for COVID-19. This is protected personal health information under the Health Insurance Portability and Accountability Act (HIPAA). If you get a call that you or your child has been identified as a close contact of a confirmed case, public health staff will do their best to answer your questions. However, contact traces are required to adhere to medical privacy law and are therefore instructed not to share the name of the person who tested positive. Public health and school officials also are not providing detailed information that could identify individuals. We understand that parents may want to ask whether the case was a student or staff member, what grade they teach or are in, what classrooms they spent time in, etc. However, not all details will be shared because this can jeopardize the privacy of individual cases. If you know the identity of someone who has COVID-19 through personal channels, do not share that information publicly. There are a number of precautions in place to reduce the risk of spreading illness and to

respond quickly when there is a case. Identifying ill students or staff on a public platform does not add to disease control efforts and is likely to raise a number of problems rather than solving them. A friend or colleague may tell you in confidence that they or their child has tested positive. Please keep that confidential.

- If someone was not contacted by the Snohomish Health District and should have been (name was on the template), please communicate that to the Director of Communications so there can be follow up with the Snohomish Health District.

4. Person who has tested positive and close contacts should communicate the date of their return to their principal/administrator.

<u>Person Who Tested Positive</u>

- Person who tested positive must quarantine for 10 days from the date of their test (if no symptoms) or from the date of symptoms onset.
- If after 10-day quarantine, symptoms or fever persist, person who tested positive can return when there is no fever and symptoms are improving.
- Note: A negative test is not required to end the quarantine period. The Snohomish Health District has noted that a positive result can remain in a person's DNA for many days to even months. The date of quarantine is dependent on the first positive test.
- Any people who live with the person who tested positive's home must quarantine for 24 days (the 10 days of the person who tested positive) plus an additional 14 days. Unless:
    - A person living in the household tests positive. If that is the case, that specific person will quarantine for their 10 days.
    - If a person living in the household doesn't test or tests negative, they continue to quarantine the 24 days.

<u>Close Contact</u>

- Close contacts of persons who tested positive must quarantine for 14 days.
- Others in the household are urged to quarantine if one person is a close contact. If a parent, sibling, or someone else where a student lives with has been identified as a close contact of a COVID-19 case, the preferred plan is to keep everyone in the household home and monitor for symptoms during the quarantine period.
- Close contacts do not need to be tested unless they become symptomatic or they want to be tested. If during the 14-day quarantine period the close contact develops symptoms, the person should immediately seek testing.
    - If the test comes back negative, person fulfills the remainder of the 14-day quarantine period.
    - If the test comes back positive, the person quarantines for 10 days from their test and that person's potential close contacts are communicated to the Snohomish Health District.

5. Refer person who tested positive or close contacts to work directly with Human Resources regarding their leave.
    - Contact is Dawn Persha - Classified
    - Contact is Kelly Anderson - Certificated

Additional Close Contact Information

- Close contacts should expect to hear from the Snohomish Health District within the day of the template being submitted.
    - The Snohomish Health District does an extensive interview of the person who tested positive (asks about work, school, church, etc. contacts). The information provided on the district supplied template is matched with the information collected through the interview and only close contacts are contacted by the Snohomish Health District.
- Close contacts may never contract the virus. Additionally, it can possibly take the 14-day quarantine period for a close contact to develop symptoms.
    - If during the 14-day quarantine period the close contact develops symptoms, the person should immediately seek testing.
        - If the test comes back negative, person fulfills the remainder of the 14-day quarantine period.
        - If the test comes back positive, the person quarantines for 10 days from their test and that person's potential close contacts are communicated to the Snohomish Health District.
    - If no symptoms develop during the 14-day quarantine period, the quarantine period has been completed.
- Close contacts of close contacts are NOT close contacts. If you are not contacted by public health, and if no one in your household has been ill or identified as a close contact, you do not need to quarantine or isolate.

Privacy Information

- All information regarding a person who has tested positive or has been determined to be a close contact is CONFIDENTIAL PROTECTED INFORMATION. DO NOT SHARE.
- Do not expect your school or the Snohomish Health District to provide the name of a student or staff member who has tested positive for COVID-19. This is protected personal health information under the Health Insurance Portability and Accountability Act (HIPAA).
- Public health and schools also are not providing detailed information that could identify individuals.
- Contact tracers are required to adhere to privacy requirements. They will do their best to answer questions but won't divulge others' personal health information.
- If you know the identity of someone who has COVID-19 through personal channels, do not share that information publicly. Identifying ill students or staff on a public platform does not add to disease control efforts and is likely to raise problems rather than solve them.

Attachments:

1. Flow Chart - Return to School Guidance Following a Positive Symptom Screen for COVID-19 and No Exposure – WA Dept of Health
2. School and COVID – What to Expect – Snohomish Health District October 16, 2020

Safe Re-Opening District Handbook

September 18, 2020 - Version 2

SAFE RE-OPENING SCHOOLS 2020 – 2021
HANDBOOK
September 18, 2020 – Version 2.0

TABLE OF CONTENTS **Page No.**

SAFE RE-OPENING SCHOOLS 2020 – 2021
HANDBOOK
SEPTEMBER 18, 2020 – Version 2.0

INTRODUCTION

The purpose of this handbook is to provide the district a single location for information outlining practices, processes, and strategies to prevent and mitigate the spread of the COVD-19 virus during this pandemic time.

The material within this handbook contains excerpts from the Centers for Disease Control and Prevention (CDC), Washington State Department of Health, Office of the Superintendent of Public Instruction (OSPI), Snohomish Health District and the Washington Department of Labor and Industries. Not all excerpts are noted with the source location. A few website locations are provided for added reading.

The use of this handbook is intended for all administrators, teachers and staff as a personal and collective resource. The handbook provides strategies for implementation based on relevance to the specific school. This handbook establishes expectation of practices and behavior for daily conduct by all district employees and students. The handbook is also a resource for schools to inform families and students when students are present at school.

This document is intended to be a dynamic tool as conditions, information and research changes. It is also intended to incorporate new procedures and ideas as they are considered for district wide implementation.

To report health safety concerns and related issues contact your designated COVID-19 Supervisor (see 1.g for description of duties) or your building administrator.

We value your comments and desire to incorporate information we may have overlooked.

1.a Personal Protection Equipment Requirements - Face Coverings

Cloth Face Coverings or Masks

- Cloth face coverings are required to be worn in the Snohomish School District by amended Order 20-03.1, July 24, 2020 of the State of WA Department of Health, unless otherwise noted in the exceptions.

- Face coverings are required as a simple barrier to help prevent the spread of respiratory droplets from traveling into the air and onto other people when the person wearing the mask talks, coughs, sneezes, or raises their voice.

- Face coverings should have two or more layers, fit over the nose and mouth and fit snuggly against the sides of your face without gaps. (CDC "How to Select, Wear, and Clean Your Mask")

- Wearing cloth face coverings is required for all staff and students in all public spaces where others are or will be present such as classrooms, offices, hallways, entryways and bathrooms, except where specific exceptions are made based on age, development, or disability.

    - Examples of allowed exceptions:
        - Students and staff with certain respiratory conditions such as severe asthma or other breathing difficulties.
        - Students and staff with a disability, special educational or healthcare needs, including intellectual and developmental disabilities, mental health conditions, and sensory concerns or tactile sensitivity.
        - Students and staff who are deaf or hard of hearing, or those who care for or interact with a person who is hearing impaired.
        - Those advised by a medical, legal, or behavioral health professional that wearing a face covering may pose a risk to that person.
        - See the Washington State Department of Health Guidance on Cloth Face Coverings and CDC Recommendation Regarding the use of Cloth Face Coverings for more information.

- Disposable face coverings for staff will be provided for staff and students if they do not have their own.

- In the above exceptions when a cloth face covering cannot be worn, students and staff may use a clear face covering or face shield with a drape as an alternative to a cloth face covering. If used, face shields should extend below the chin, to the ears and have no gap at the forehead.

- Younger students must be supervised when wearing a face covering or face shield. These students may need help with their masks and getting used to wearing them.

- Continue practicing physical distancing while wearing cloth face coverings.

  Question: Can face shields be worn in place of cloth face masks? *Yes, in certain circumstances. L&I has updated their guidance to allow staff to wear face shields when a face covering reduces the effectiveness of instruction, (for example, during speech therapy, demonstrating enunciation, or language instruction). This is determined by the educator leading the instruction. For all other activities (staff meetings, hallway monitoring, playground or cafeteria monitoring, etc.) staff must wear a cloth face covering unless they fit into one of the exemption categories."*

- Students and staff may remove face coverings to eat and drink and when they go outdoors when they can be physically distanced.

- If students need a "mask break" take them outside or to a large, well ventilated room where there is sufficient space to ensure more than six feet of physical distance.

https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/Secretary_of_Health_Order_20-03_Statewide_Face_Coverings.pdf

Physical Barriers and Guides

- Using physical barriers and guides such as sneeze guards and partitions in lieu of a face covering should only be considered in areas where it is difficult for individuals to remain at least six feet apart and is only a solution for teacher – student assessment situations and office personnel proximity.

- For office personnel seating proximity, when six feet spacing is not possible mask should be worn when there is staff movement in and around the workstations in the same side of the seated staff person.

1.b - Physical Distancing

- Physical distancing (also known as social distancing) is defined by keeping a minimum of 6 feet physical space separation or distance between individuals and is one of the keys to help limit transmission of SARS CoV-2, the virus that causes COVID-19.

- Physically distancing is combined with the State requirement of wearing a face covering.

- Student face covering or a desk plexiglass screen does not take the place of physically distancing.

- In the classroom, when students are seated, there will be a 6 feet physical distance between each student and the teacher. Furniture may need to be removed in order to accommodate the spacing.

- Turn desks and tables to face in the same direction (rather than facing each other), or have students sit on only one side of tables, spaced apart.

- Reduce the number of students at tables, lab benches, or other workstations to increase physical distance

- Practice physical distancing as much as possible for some movements and tasks that may be difficult to achieve. These may include passing in the hallway or as a teacher moves around the classroom.

Strategies for implementation:

- Hold classes outside as weather allows

- Practice orderly movements for students entering and leaving the classroom with 6 feet physical distancing

- Create queues of physically distanced students when entering and leaving the school building

- Reduce the number of students in the halls. Stagger the release of classes, restroom breaks, recess, and other common travel times. Consider allowing students to bring belongings to the classroom and store them in a personal cubby or container to reduce the use of lockers

- Eliminate or limit areas of congregating. Close communal use or shared spaces such as staff lounges or limit the number of staff and rearrange furniture so that they are six feet apart.

- Cancel activities where multiple classrooms interact.

- Limit the number of students in the restrooms at a time

- Place tape, cones, paint or other markers to signal six feet in areas where students may be waiting in line

- Mark traffic flow and designate entrances and exits to minimize face to face contact

- Stagger arrival and/or dismissal times. These approaches can limit the amount of close contact between students in high-traffic situations.

- Limit the use of locker rooms to handwashing and restroom use only. Showers should not be used due to potential spread of aerosolized droplets. Consider eliminating requirements to change clothes for PE. If use of locker rooms for changing is necessary, maximize ventilation and use tape, spots, or cones to signal 6 feet of distance for students who need to change. Stagger entry to the changing area and use these facilities as appropriate with members of the same group/cohort. Make sure to limit occupancy of the locker rooms to avoid crowding.

- Cancel in person activities that are considered high risk. These activities include choir, playing of instruments involving breath, contact sports, or other activities that require students to remove face coverings and/or be in close contact with one another. These activities may contribute to transmission of COVID-19.

- Cancel in person field trips, assemblies, and other large gatherings. Cancel in-person activities and events such as field trips, student assemblies, special performances, STEAM fairs, school-wide parent meetings, or spirit nights.

- Limit cross-school transfer for special programs. For example, if students arrive from multiple schools for special programs (e.g., music, robotics, and academic clubs), 8 consider using distance learning to deliver the instruction or temporarily offer duplicate programs in the participating schools.

1.c - Hand Hygiene - Washing and Hand Sanitizer

- Hand washing and sanitizing is a critical behavior to the prevention and mitigation of the spread of COVID-19 and other viruses such as the common cold.

- Time needs to be allocated for washing hands for the following situations:
  - Arriving at school
  - Before meals or snacks
  - After outside activities
  - After going to the bathroom
  - After sneezing or blowing their nose
  - Before leaving school
- Handwashing should be done frequently with soap and water for at least 20 seconds. If soap and water are not readily available, hand sanitizer that contains at least 60% alcohol can be used (preferably fragrance free).

- If the sink and or paper towel dispenser is not touchless, practice the following process to keep washed hands from potentially being contaminated.

  - Draw down a small amount of paper towel from the dispenser but do not tear off
  - Turn on water faucet and wash hands thoroughly as prescribed
  - Pull off the paper towel
  - Turn off the faucet keeping the paper towel between the hand and faucet
  - Draw down more paper towel to dry hands keeping the first paper towel between the lever and the hand
  - Discard the first paper towel and pull off the new paper towel
  - Use the paper towel to dry hands and to open the bathroom door (if needed)
  - Toss the used paper towel into a trash bin on the way out of the restroom

- Encourage staff and students to cover coughs and sneezes with a tissue. Used tissues should be thrown in the trash and hands washed immediately with soap and water for at least 20 seconds or use of hand sanitizer as described above.

- Supervise use of alcohol- based hand sanitizer by younger children.

- Staff and students should not touch their eyes, nose, and mouth with unwashed hands.

1.d - Cohorting

- Cohorting is a strategy to limit contact between groups or cohorts of students and staff as part of the efforts to limit transmission of SARS CoV-2, the virus that causes COVID-19.

- Cohorting strategies work by keeping groups of students with dedicated staff who remain together throughout the day, at recess and lunch time. These groups should remain consistent from day to day and should not be combined or mixed. Staying in small groups limits the amount of contact between individuals. Reducing the mixing of students, teachers and staff through groups:

    - Decreases the opportunities for exposure or transmission of COVID at school.
    - Makes contact tracing easier in the event of a positive case.
    - Simplifies the testing, quarantine and isolation to a single cohort

- Ideally, the students and staff within a cohort will only have physical proximity with others in the same cohort.

  (Excerpts from WA Department of Health and CDC Preparing K-12 School Administrators for a Safe Return to School in Fall 2020 Preparing for a Safe Return to School)

Strategies to implement:

1. Keep a classroom together during school day as much as possible. Limit co-mingling with other classrooms.

2. Block scheduling for secondary schools. For passing periods, consideration should be given to stagger the times, one-way hallways/stairwells, use of outside walkways whenever possible, and avoid students gathering in close proximity.

3. Students should be assigned seating in classrooms which is consistent and recorded.

4. Smaller and consistent cohorts during recess. Stagger recess times during the day to facilitate smaller groups during recess.

5. Lunch should be eaten in consistent cohort groups and in spaces that students and staff occupy on a consistent basis.

6. Limit sharing of devices, toys, manipulatives or other classroom teaching aids. Assign items to a student or small group of students within the classroom.

7. Rotate teachers to classrooms instead of students moving around the building to different teachers.

8. Assemble students in cohorts/classes prior to entering the school at the beginning of the day. Maximize use of the number of entry points in the morning to limit cohort sizes entering the same entry. Students should report directly to point of entry upon arrival on campus.

9. Releasing students at staggered times in cohorts to buses and parental transportation at the end of the day.

1.e - Student Drop-off and Pick-up Zones

- With more attention to student transportation and the need for physical distancing, more space will be required for parental student drop-off and pick-up.

- Develop a system for dropping off and picking up students that keeps families at least six feet from each other and reduces their need to enter the school. This may include staggering drop-off and pick-up times for various groups, one-way traffic flows, greeting students at their vehicle, or placing distancing markers on walkways.

- Each school has a different configuration for designated bus and auto lanes, access to local streets and parking areas. Therefore, improving conditions for student pick-up and drop-off will be implemented by school based on the following strategies for consideration to implement.

- In many cases, infrastructure reconfiguration and capital improvements cannot be implemented without significant capital investment.

Strategies to implement

1. Times
    a. Consider stagger times of pick up and drop off to minimize the number of students entering the building at same time. i.e. buses at one time and parent drop off at another or stagger by grade level or homeroom.

    b. No early drop off. Drop off times will need to be enforced. This is to avoid unsupervised students on campus. Students should report directly to their entry point.

2. Traffic Flow
    a. There will be an expected increase in parent drop off and traffic flow. Therefore, extra supervision in those areas will be needed to enforce physical distancing and encourage continuous flow through parking area.

    b. Schools should review their current parent/drop off areas and seek to maximize wait time capacity in these areas.

    c. All drivers dropping off students should remain in cars unless there is need for physical assistance with their student. If they need to get out of the car social distancing must be practiced and a mask be worn.

3. If limited lane length for student pick-up queuing
    a. At schools where drives are short in length, for student pick-up, consider all cars queuing in two lanes and holding in groups until all students are in their

guardians' cars. Groups of cars are then released together. This can be paired with release of students by cohorts and staggered release times.

b. Lanes are assigned based on whether cars are turning left or right onto the street.

c. All drivers to remain in cars unless there is a need for physical assistance with their student.

d. This procedure requires direct supervision of traffic queueing and release. (This procedure has been effective in urban locations where on-site infrastructure was limited.)

4. Consider switching bus and auto drop-off and pick-up zones
    a. Evaluate on-site opportunities to increase auto traffic queuing lane lengths. Verify bus turns are adequate for the length of the buses in the new locations.

5. Entry Points
    a. Identify a number and wide variety of entry points into the building and have students enter either by grade level, homeroom, etc. Students do not enter building unless through supervised checkpoint.

    b. Entry points staffed by adults who will check off screening process.

    c. Students should directly report to the entry point once they leave bus or private vehicle.

6. Utilize Covered Play Areas
    a. Utilize covered play areas where they adjacent to drives and sidewalks as student queuing and staging areas for dismissal.

    b. Mark the asphalt and sidewalks with 6 feet physical distancing locations.

    c. Assign students to locations for pick up on site in order to spread out traffic and reduce bottlenecks.

7. Bus waiting areas
    a. Reduce or eliminate on site bus waiting zones once the bus has unloaded students at the beginning of the day.

    b. Utilize the space for any auto overflow as may be needed.

1.f – Ventilation

- Good ventilation combined with filtration helps to create a safer school environment. Therefore, facilities will have the following enhancements to improve indoor air quality in anticipation of students returning to the classroom. The following actions are currently being implemented.

- **Filtration:**
    - All school HVAC filters were replaced earlier this summer
    - Schools will be upgraded to the recommended higher filtration standard filters, (American Society of Heating Refrigeration and Air Conditioning Engineers)

- **Ventilation:**
    - According to health experts, good positive ventilation with outside air will help dilute the concentration of any aerosol contaminants.
    - HVAC units are reset to allow maximum outside air into the building as the equipment allows.
    - Each night the buildings will be flushed out and replaced with fresh air.
    - Open windows will help with fresh air input.
    - The higher outside air ratio may affect room temperatures when the weather is colder.
    - As the temperature drops, the outside air may be modulated to maintain room temperature comfort.
    - Portable classrooms have pre-engineered package heating and cooling units. Modifications are either not possible or minimal.
    - Each portable classroom in use will receive a box fan to aide in positive outside air circulation.
    - Each portable classroom in use will receive a portable room air purifier

1.g COVID-19 Supervisor Duties and Responsibilities

- A COVID-19 Supervisor is to be named for each facility in the district per the requirements of the Snohomish Health District. The COVID-19 Supervisor monitors the health of employees and students in the district and enforces the COVID-19 safety plan as described in this handbook.

- The following is a description of the duties and responsibilities of the COVID-19 Supervisor:

    1. Receive, oversee and distribute personal protection equipment (PPE) and health safety supplies for the building occupants. Certain items will be stocked by the custodian.

    2. Act as contact to the Custodial Services Department for requests of PPE and health safety supplies.

    3. Monitor Health of Employees:
        a. Track staff and students that are quarantined due to potential or actual COVID-19 exposure through the on-line attestation application.
        b. Place students who become symptomatic at school into the Isolation Room and contact student's guardians to come pick-up the student.
        c. Assist in the daily screening of staff and students who did not complete the on-line attestation app prior to coming to school.

    4. Enforce the Safe Re-Opening Schools 2020-2021 Handbook and other health safety practices:
        a. Observe and communicate staff and student compliance to health safety practices.
        b. Inform building administration of compliance issues for their action to non-compliance with health safety practices.
        c. Assist with staff and student training as requested by building administration
        d. Assist in placement of health safety signage within the building and at entries
        e. Provide input to the building administration and Director of Facilities / School Safety regarding additions or modifications to the handbook.

    5. Act as the building liaison to the SSD Director of Communications and the Snohomish Health District (SHD) after the district is notified of a staff or student testing positive.
        a. SHD initially notifies the Director of Communications as the district single point contact.

b. The Director of Communications will notify the building COVID-19 Supervisor for any follow up communication between the district and SCHD regarding the case.
c. Follow up duties may include:
    i. Provide case information about date and time of onsite attendance.
    ii. Provide a list of employees, students and visitors that were on site within a specific time period.
    iii. Provide list of close contacts
    iv. Assist in sending families exposure letter from SHD
    v. Assist in a SCHD site visit if needed.
    vi. Assist in on site testing event if deemed necessary.

d. If the positive case's health care provider contacts the school building directly, the COVID-19 Supervisor will contact the building administration and the Director of Communications immediately.

e. The Director of Communications will contact the SHD to determine or verify that the SHD has been informed of the case.

2. – Staff and Student Screening

- The district is in the process of determining a self-screening / attestation digital system.
- The process if approved will require parents or students and staff to daily respond to electronic notifications regarding symptoms and / or exposures to others who may have tested positive for COVID-19.
- Until the permanent system is deployed staff will use the following temporary screening process.
- As of the date of this handbook version, the permanent solution is still under review.
- Prior to students on campus there will be an update and training on the permanent process.

Temporary Staff Screening Process

1. Entry will be through the front, main entrance.
2. Each morning staff are required to stop at the designated administrative assistant's station or separate station established for screening and check-in.
3. Staff will sign in on a log and respond to the questions on the log spreadsheet
4. The staff person will take your temperature (must be under 100.4) and attest to good health prior to entering further.
5. Masks and/or face shields will be required while in the building.
6. Follow the requirements of this handbook during the workday.

Temporary Student Screening Process

1. Student's parent will be required to fill out a screening questionnaire log sheet before going to school.
2. The completed form can be handed to the bus driver when the student boards the bus. The bus driver will hand to the staff person meeting the bus on behalf of the student.
3. Parent will be required to take student's temperature and confirm student does not have a temperature prior to student leaving for school.
4. Student temperature must be under 100.4 degrees for admittance. The clinical definition of a fever is 100.4. This is the standard in student admittance.
5. If all questions are answered 'no', student admittance is approved.
6. If a question is answered 'yes', then student is to stay home.
7. Students will bring completed questionnaire to school.
8. Completed questionnaire will be provided to district staff member meeting student at the school.

9. Students will wear an approved mask per state requirement, unless there is an exemption related to health issues or a young age.
10. Admittance is not allowed if student will not wear a mask except as noted for health or age exemption.

3. - District Cleaning and Disinfecting Protocol

Introduction: Custodial Services currently performs all recommended building cleaning measures. This document will describe the routine and supplemental cleaning protocol for the current COVID-19 requirements of cleaning and disinfection. Included in the protocol is the responsibilities of school staff to assist in the efforts. Custodial Services has sufficient stock of cleaning and disinfecting supplies for re-opening.

District Facilities Cleaning and Disinfection Protocol
Purpose: To describe the district plan for cleaning buildings and to prevent the spread of disease.

Objective: Provide a clean environment and mitigate the spread of disease to staff, students, volunteers and community members through frequent, effective and safe cleaning and disinfecting protocols in district buildings.

Scope: Applies to all schools, offices, programs, auxiliary service buildings.

Procedures: There are four modes of cleaning which apply to various circumstances and staff:

1. **Routine cleaning** is performed on a regularly scheduled basis by district custodial staff, or substitute custodians as needed, assigned to that building or area. Routine cleaning includes daily cleaning in the building, disinfection of all restrooms, scheduled sweeping of all floors, sanitizing of cafeteria tables, emptying trash and other building-based tasks.

2. **Supplemental cleaning** is performed by regular custodial staff, substitute custodial staff as needed, and school district staff responsible to perform cleaning in addition to routine cleaning. Supplemental cleaning is focused on cleaning and disinfecting high touch surfaces, specifically for the purpose of preventing spread of disease.

3. **Personal area** cleaning is performed by all employees in their personal workspace, which may include their desk, telephone, keyboard, chair or any other work-station items they use in preforming their duties. This cleaning is individualized, using district supplied cleaning products and equipment.

4. **Emergency cleaning** is performed by contracted services on an emergency basis, which cannot be promptly, effectively and safely handled by district staff, in response to a specific, identified incidence of potential disease contamination.

High Touch Surfaces Disinfection:

Surfaces include the following *(not all apply in every building)*:

Routine high touch items:

- Restroom stalls, dispensers, grab bars
- Cafeteria tables
- Toilets, sinks and faucets
- Drinking Fountains

Supplemental high touch items:

- Door handles, knobs (including exterior doors), push plates, panic bars
- Elevator buttons
- Handrails
- Vending machines
- Cleared Counter tops/Flat surfaces
- Student desks and chairs
- Light switches
- Copier, printer and fax control buttons
- Front desk and lobby surfaces

Personal area cleaning: (All Staff)

- Staff / individual desks
- Computer keyboards and mouse
- Phones and headsets
- Chair arms
- Remote controls
- Cabinet and file drawer handles
- Personal room microwave, refrigerator, and other personal appliances
- Personal coffee machines

Supplemental Cleaning - Planned Effort:

Objective: The objective of the supplemental cleaning plan is to accomplish the work as defined above. The supplemental cleaning checklists below presents daily tasks that are needed to accomplish the objective. This will only be possible with the cooperation and assistance from district staff.

The time requirements are based on best estimates. As Custodial Services gain additional experience, adjustments will occur as needed to effectively and safely accomplish the stated objective.

Implementation of Supplemental Cleaning: The supplemental cleaning plan will be implemented at the direction of the Operations Executive Director or Custodial Supervisor in response to threats to health, pandemic, and as directed by County or State health authorities.

Supplemental Cleaning Daily Checklists
District non-custodial Supplemental Cleaning checklist:

- School district staff and students will be responsible for assisting in maintaining their personal areas. This includes the following:
- Keeping counter tops and flat surfaces clear of clutter, prepared for daily disinfection. ***Due to time constraints, areas not prepped for disinfection will be bypassed***
- Picking up debris and food around desks, daily.
- Wiping/cleaning debris removal desks and chairs, daily.
- Putting chairs up at the end of day.
- Garbage and recycling bins placed outside the classroom for emptying at the end of the day.

Your building custodian will assist with refills of disinfectant. Please develop a refill plan with your bldg. morning custodians for daily refill of disinfectant bottles. If you find yourself sensitive to your disinfectant, please contact our office and we can provide an alternative disinfectant. Office number: 360-563-3545

Morning/ Mid-day Custodian Classroom Supplemental Cleaning Checklist:

- Works with teachers and staff on replenishing disinfectant and supplies.
- Checks restrooms periodically during shift and cleans and disinfects touch points and addresses problems immediately.
- Routinely cleans and disinfects building touch points and flat surfaces.
- Refills hand sanitizer and PPE dispensers.
- Cleans and disposes garbage around lunch schedule.
- Responsible for addressing classroom spills and messes as soon as possible and may include spot cleaning the carpet during recess.
- We have reallocated custodial hours for supplemental disinfecting.

Mid-day/Evening Custodian Classroom Supplemental Cleaning Checklist:

- Custodians will dispose of ALL garbage and recycling daily.
- Restrooms will be cleaned, sanitized and disinfected daily.
- All classrooms will be vacuumed a minimum of 2 times a week or on a needed basis.
- Sanitize & disinfection of all building high touch surfaces, flat surfaces, student desks and chairs, done daily.
- Custodians will put chairs down after disinfecting and will proceed with disinfecting the desktops.

Emergency cleaning: The emergency cleaning plan will be implemented at the direction of the Operations Executive Director or Custodial Supervisor in response to a known infection located at or attributed to a school or location or when directed by County or State health authorities.

Summary: The overriding purpose for these processes is to protect the health of school district staff, our students and the public. Implementation of the four modes of cleaning procedures must be done to maintain healthy environments. Clear, timely communication and cooperation of all parties will result in the best outcomes for our students, staff and community.

4. - TRAININGS

- The purpose of this section is not to provide scripts or format for the necessary safety trainings.
- Instead the section provides a listing of the recommended trainings and allow administration to determine the format and the best method of training for staff and families.
- As of the writing of this version, a plan and schedule are being developed for trainings including supporting resources such as videos.

Teachers & Staff

When only staff and small groups of students are on campus:

1. Brief overview of Covid-19 including symptoms and promoting behaviors that reduce the spread
2. Building COVID-19 Supervisor and their role
3. Proper Use of PPE including wearing of cloth face coverings or masks
4. Physical Distancing
5. Hand Hygiene
6. Staff Screening (both temporary and when on-line system is available)
7. Cleaning and Disinfecting their personal area
8. Own mental health, coping, and resilience

When students are returning for in person classes (In addition to the topics above):

1. Modified classroom layouts
2. Lunch procedures
3. Recess
4. Bathroom and physical distancing
5. Cohorts and Grouping
6. Use of shared objects
7. Screening students (if they are involved)
8. Working with students of disabilities (provided by Special Services)
9. Procedure for dealing with student that develops symptoms of COVID-19 at school
10. Parent Access

Families and Students

1. Brief overview of COVID-19 including symptoms and promoting behaviors that reduce the spread
2. Proper use of PPE including wearing of cloth face coverings or masks
3. Physical distancing, cohorting and grouping
4. Hand hygiene
5. Lunch procedures

6. Recess procedures
7. Parental Access
8. Screening using on-line system
9. Mental health, coping and resilience

5. - Staff/Student COVID-19 Diagnosis, Symptomatic or Close Contact Plan

Introduction:

- Currently, the Snohomish Health District takes the lead in processing of positive cases including contact tracing and notifications to school districts.

- The following is the current Snohomish Health District process as lead in responses to COVID-19 cases.

- Please refer to Snohomish Health District documents at the end of this section:

    - School COVID-19 Case Response Flow Chart
    - Daily COVID-19 Screening Protocols – this document includes several screening scenarios
    - COVID-19 Intervention Table by Test Status, Exposure History & Clinical Status

COVID-19 Positive Case Steps with Snohomish Health District (SHD):

If the Snohomish School District (SSD) is notified before the SHD receives notification of a positive case:

1. The building COVID-19 Supervisor notifies the SSD Director of Communications.
2. The COVID-19 Supervisor compiles a list of close contacts.
3. The COVID-19 Supervisor with the Director of Communications contacts SHD for instructions on sending contact list.
4. SHD will conduct case investigation and notify close contacts with instructions.
5. The SHD starts the contact tracing investigation with the positive contact case.

If the SHD is notified before the SSD receives notification of a positive case:

1. The SHD contacts SSD single point contact - Director of Communications, Kristin Foley.
2. The SHD will provide the Director of Communications with instructions and recommendations on next steps for the district, based on the specifics of the case and contacts.
3. The Director of Communications will immediately advise the school COVID-19 Supervisor and the Superintendent's office
4. The Director of Communications notifies the Operations Department to begin any disinfection required at the facility.

5. Next steps may include:
    a. Quarantining an individual or individuals.
    b. Quarantining a class.
    c. Quarantining a school.
    d. Closing a class for disinfection.
    e. Closing a portion or all of a school for disinfection.
6. Disinfection of involved spaces within the school or support facility based on SCHD recommendation.
7. SHD will determine when the positive case is safe to return to school.

Health condition and patient identity are protected information under federal HIPAA guidelines.

Staff or student arrives at school with symptoms or develops symptoms of COVID-19 while at school:

1. Identify an isolation room in each building. Ideally, the isolation space should have several rooms with doors that can close and windows that vent to the outside with a private bathroom. Supervision of person should be from a distance of at least six feet away. Schools should avoid making the isolation space part of the nurse's office or cot room.
2. If any staff or stduent is symptomatic on -site, the building COVID-19 Supervisor should be notified immediately. If not available, notify school adminstrator.
3. The ill person should proceed directly to the pre-identified isolation room. If the ill person is a staff member, notify the COVID-19 Supervisor or administrator and immediately go home or wait in the isolation room for someone to pick them up.
4. Staff caring for the ill person should use appropriate medical PPE.
5. The ill person should wear a cloth face covering or mask.
6. After the ill person leaves, notify Custodial Services staff.
7. The isolation room should be aired out, cleaned and disinfected. Disinfect all high touch areas between the room and bathroom. Disinfect the room the ill person was in prior to going to the isolation room.

8. Provide instructions to students and families who are excluded from school due to illness.

Staff or Student subsequently gets tested for COVID-19

1. If testing is positive, follow SHD guidelines and recommendations
2. If testing for COVID-19 is negative, stay home until 24 hours after fever resolves and symptoms are improving.
3. If testing for COVID-19 is not performed, stay home for at least 10 days after symptom onset and at least 24 hours after fever has resolved and symptoms have improved.

Close Contact with a Positive COVID-19 individual

1. Stay home or if at school, immediately go home.
2. If a person believes they have had close contact to someone with COVID-19, but they are not sick, they should watch their health for COVID-19 symptoms. This should last for 14 days after the last day they were in close contact with the person sick with COVID-19. They should not go to work, childcare, school, or public places for 14 days. If a person develops symptoms of COVID-19 during their quarantine, they should seek testing for COVID-19. If they test positive for COVID-19, they should follow the guidance listed in the SHD documents. Consider testing at day 10 even if no symptoms are present. However, a negative test after exposure does not shorten the 14-day quarantine period.

Safe Re-Opening District Handbook

Addendum and Supporting Documents

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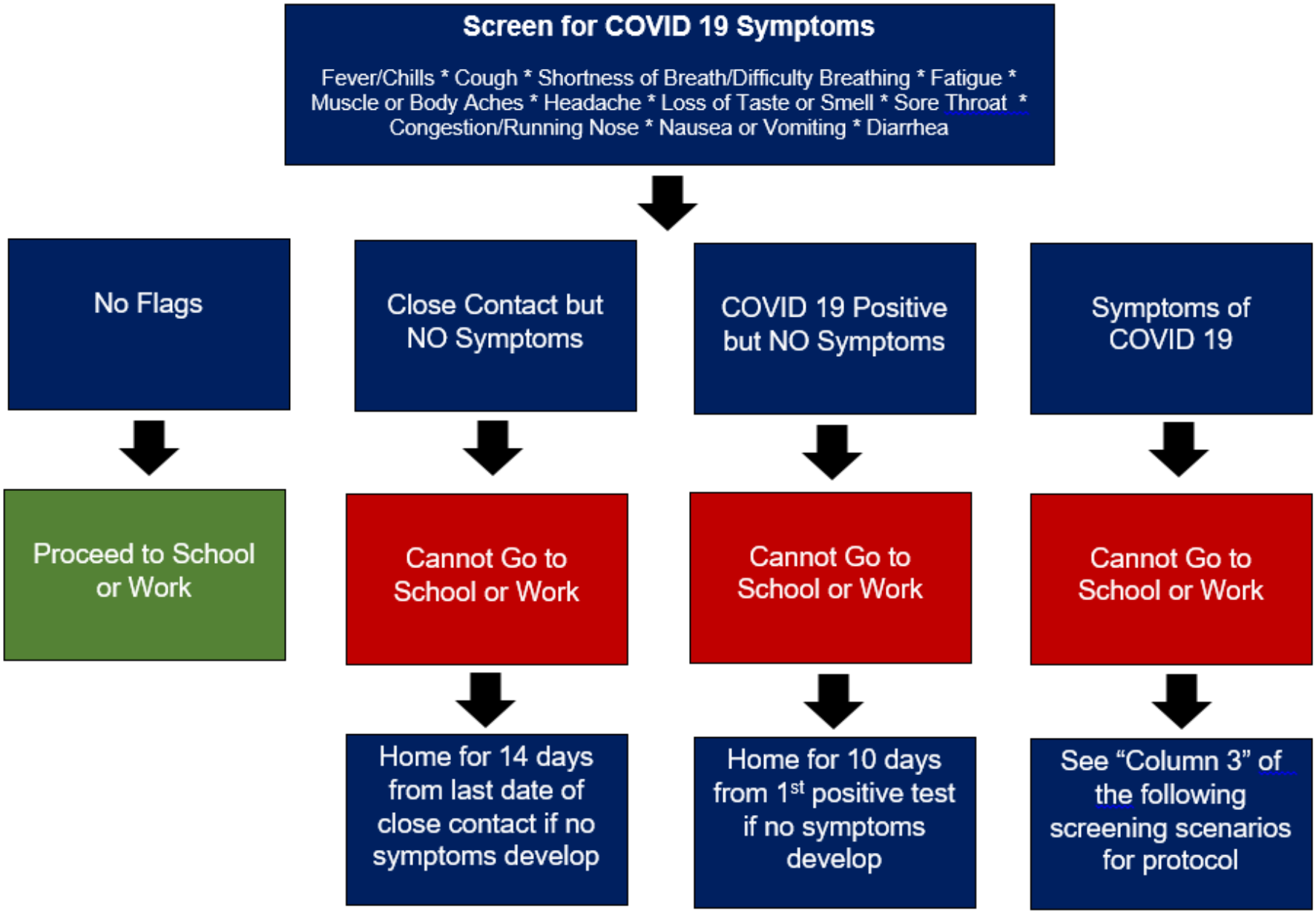
2020

Daily COVID-19 Screening Protocols

SNOHOMISH HEALTH DISTRICT



A "Close Contact" is less than 6 feet away for at least 15 minutes from a confirmed or probable COVID 19 positive person.

Positive Screening Scenarios

Positive Screening Protocol: On Arrival with Immediate Transportation

Who	Close contact, no symptoms Staff or Student shares they were in close contact (exposed) to someone with COVID-19 within the last 2 weeks but has NO symptoms.	COVID-19 diagnosis, no symptoms Staff or Student shares that they were diagnosed with COVID-19 less than 10 days ago but has NO symptoms.	1 or more COVID-19 symptoms Staff or Student presents with at least 1 of the following COVID-19 symptoms: Fever or chills; cough; shortness of breath/difficulty breathing; Fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.
Staff Member or Student When student has a designated individual (e.g., parent or guardian) present to immediately support child to get home or to medical care safely.	☐ Immediately go home. ☐ Can return to school once it has been 14 days since last close contact if they do not develop symptoms. ☐ Cleaning/disinfecting protocol. ☐ Student documentation: symptoms, interventions, disposition. ☐ Staff documentation per District HR guidelines. ☐ Contact Snohomish Health District.	☐ Immediately go home. ☐ Can return to school once it has been 10 days since their positive COVID-19 test, if they did not subsequently develop symptoms. ☐ Assess any exposure that may have occurred while on site. ☐ Close affected rooms for 24 hours and then initiate cleaning/disinfecting protocol. ☐ Student documentation: symptoms, intervention, disposition. ☐ Staff documentation per District HR guidelines. ☐ Contact Snohomish Health District.	☐ Immediately go home. ☐ To return to school after a **positive** COVID-19 test: ▪ At least 24 hours have passed since recovery – defined as no fever without the use of medications and improvement in respiratory signs like cough and shortness of breath; **AND** At least 10 days have passed since signs first showed up. ☐ To return to school after a **negative** COVID-19 test: ▪ Until 24 hours after fever resolves and symptoms are improving. ☐ To return to school if **no COVID-19 test** is performed: ▪ At least 10 days after symptom onset **AND** at least 24 hours after fever has resolved and symptoms improved. ☐ Clean and disinfect student area. At the discretion of nurse or admin, evaluate need to further close room for 24 hrs (Is there other COVID activity in the school? Were there multiple mild symptoms vs one? Etc.). ☐ Student documentation: symptoms, intervention, disposition.

			☐ Staff documentation per District HR guidelines.

Positive Screening Protocol: On Arrival Without Immediate Transportation

Who	Close contact, no symptoms Student shares they were in close contact (exposed) to someone with COVID-19 within the last 2 weeks but has NO symptoms.	COVID-19 diagnosis, no symptoms Student shares they were diagnosed with COVID-19 less than 10 days ago but has NO symptoms.	1 or more COVID-19 symptoms Student presents with at least 1 of the following COVID-19 symptoms: Fever or chills; cough; shortness of breath/difficulty breathing; Fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.
Student When student **DOES NOT** have a designated individual (e.g., parent or guardian) present to immediately support child to get home or to medical care safely.	☐ If available, student should be in a disposable mask. If not, a cloth face covering. ☐ Isolate student in designated area with supervision by an adult wearing a disposable face mask and face shield standing at least 6 feet away. ☐ Enact plan to safely send student home as quickly as possible. ☐ Can return to school once it has been 14 days since last close contact if they do not develop symptoms. ☐ Close affected rooms for 24 hours or as long as possible and then initiate cleaning/disinfecting protocol. ☐ Student documentation: symptoms, interventions, disposition. ☐ Contact Snohomish Health District.	☐ If available, student should be in a disposable mask. If not, a cloth face covering. ☐ Isolate student in designated area with supervision by an adult wearing a disposable face mask and face shield standing at least 6 feet away. ☐ Enact plan to safely send student home as quickly as possible. Cannot be school transportation. ☐ Can return to school once it has been 10 days since their first positive COVID-19 test, if they did not subsequently develop symptoms since their positive test. ☐ Close affected rooms for 24 hours and then initiate cleaning/disinfecting protocol. ☐ Student documentation: symptoms, intervention, disposition.	☐ If available, student should be in a disposable mask. If not, a cloth face covering. ☐ Isolate student in designated area with supervision by an adult wearing a disposable face mask and face shield standing at least 6 feet away. ☐ Enact plan to safely send student home as quickly as possible. Cannot be school transportation. ☐ To return to school after a **positive** COVID-19 test result: ▪ At least 24 hours have passed since recovery – defined as no fever without the use of medications and improvement in respiratory signs like cough and shortness of breath; **AND** At least 10 days have passed since signs first showed up. ☐ To return to school after a **negative** COVID-19 test result: ▪ Until 24 hours after fever resolves ad symptoms are improving. ☐ To return to school if **no COVID-19 test** is performed:

		☐ Contact Snohomish Health District.	▪ At least 10 days after symptom onset **AND** at least 24 hours after fever has resolved and symptoms improved. ☐ Clean and disinfect student waiting area. At the discretion of nurse or admin, evaluate need to further close room(s) for 24 hrs (Is there other COVID activity in the school? Were there multiple mild symptoms vs one? Etc.). ☐ Student documentation: symptoms, intervention, disposition.

Positive Screening Protocol: During the School Day

	Close contact, no symptoms	COVID-19 diagnosis, no symptoms	1 or more COVID-19 symptoms
Who	Student shares they were in close contact (exposed) to someone with COVID-19 while contagious within the last 2 weeks but has NO symptoms.	Student shares they were diagnosed with COVID-19 less than 10 days ago but has NO symptoms.	Student presents with at least 1 of the following COVID-19 symptoms: Fever or chills; cough; shortness of breath/difficulty breathing; Fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.
Student	☐ If available, student should be in a disposable mask. If not, a cloth face covering. ☐ Isolate student in designated area with supervision by an adult wearing a disposable face mask and face shield standing at least 6 feet away. ☐ Enact plan to safely send student home as quickly as possible.	☐ If available, student should be in a disposable mask. If not, a cloth face covering. ☐ Isolate student in designated area with supervision by an adult wearing a disposable face mask and face shield standing at least 6 feet away. ☐ Enact plan to safely send student home as quickly as possible. Cannot be school transportation. ☐ Can return to school once it has been 10 days since their first positive COVID-19 test, if they	☐ If available, student should be in a disposable mask. If not, a cloth face covering. ☐ Isolate student in designated area with supervision by an adult wearing a disposable face mask and face shield standing at least 6 feet away. ☐ Enact plan to safely send student home as quickly as possible. Cannot be school transportation. ☐ To return to school after a **positive** COVID-19 test result: ▪ At least 24 hours have passed since recovery – defined as no fever without the use of medications and improvement in respiratory signs

	☐ Can return to school once it has been 14 days since last close contact if they do not develop symptoms. ☐ Close affected rooms for 24 hours or as long as possible and then initiate cleaning/disinfecting protocol. ☐ Student documentation: symptoms, interventions, disposition. ☐ Contact Snohomish Health District.	did not subsequently develop symptoms since their positive test. ☐ Close affected rooms for 24 hours, or as long as possible, and then initiate cleaning/disinfecting protocol. ☐ Student documentation: symptoms, intervention, disposition. ☐ Contact Snohomish Health District.	like cough and shortness of breath; **AND** At least 10 days have passed since signs first showed up. ☐ To return to school after a **negative** COVID-19 test result: ▪ Until 24 hours after fever resolves and symptoms are improving. ☐ To return to school if **no COVID-19 test** is performed: ▪ At least 10 days after symptom onset **AND** at least 24 hours after fever has resolved and symptoms improved. ☐ Clean and disinfect student area. At the discretion of nurse or admin, evaluate need to further close room(s) for 24 hrs (Is there other COVID activity in the school? Were there multiple mild symptoms vs one? Etc.). ☐ Student documentation: symptoms, intervention, disposition.

Positive Screening Protocol: During the School Day

Who	Close contact, no symptoms	COVID-19 diagnosis, no symptoms	1 or more COVID-19 symptoms
	Staff member shares they were in close contact (exposed) to someone with COVID-19 while contagious within the last 2 weeks but has NO symptoms.	Staff member shares they were diagnosed with COVID-19 less than 10 days ago but has NO symptoms.	Staff member presents with at least 1 of the following COVID-19 symptoms: Fever or chills; cough; shortness of breath/difficulty breathing; Fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.
Staff	☐ Immediately go home. ☐ Can return to school once it has been 14 days since last close contact if they do not develop symptoms.	☐ Immediately go home. ☐ Can return to school once it has been 10 days since their first positive COVID-19 test, if they	☐ Immediately go home. ▪ If not well enough, isolate staff in designated area with a disposable face mask and provide support to get home or to medical care.

	☐ Close affected rooms for 24 hours, or as long as possible, and then initiate cleaning/disinfecting protocol. ☐ Staff documentation per District HR guidelines. ☐ Contact Snohomish Health District.	did not subsequently develop symptoms since their positive test. ☐ Close affected rooms for 24 hours, or as long as possible, and then initiate cleaning/disinfecting protocol. ☐ Staff documentation per District HR guidelines. ☐ Contact Snohomish Health District.	☐ To return to school after a **positive** COVID-19 test result: ▪ At least 24 hours have passed since recovery – defined as no fever without the use of medications and improvement in respiratory signs like cough and shortness of breath; **AND** At least 10 days have passed since signs first showed up. ☐ To return to school after a **negative** COVID-19 test result: ▪ Until 24 hours after fever resolves ad symptoms are improving. ☐ To return to school if **no COVID-19 test** is performed: ▪ At least 10 days after symptom onset **AND** at least 24 hours after fever has resolved and symptoms improved. ☐ Clean and disinfect staff area. At the discretion of nurse or admin, evaluate need to further close room for 24 hrs (Is there other COVID activity in the school? Were there multiple mild symptoms vs one? Etc.). ☐ Staff documentation per District HR guidelines.

Positive Screening Protocol: Multiple Family Members

	Close contact, no symptoms	COVID-19 diagnosis, no symptoms	1 or more COVID-19 symptoms
Who	Staff member and children or siblings shares that one or more within the family group were in close contact (exposed) to someone with COVID-19 while contagious within the last 2 weeks but has NO symptoms.	Staff member and children or siblings shares that one or more within the family group were diagnosed with COVID-19 less than 10 days ago but has NO symptoms.	Staff member and children or siblings shares that one or more within the family group presents with at least 1 of the following COVID-19 symptoms: Fever or chills; cough; shortness of breath/difficulty breathing; Fatigue; muscle or body aches; headache; new loss of taste or smell; sore throat; congestion or runny nose; nausea or vomiting; diarrhea.

Multiple Family Members (e.g., district staff member with 1 or more children I the district; siblings)	☐ Enact plan to safely send family members home as quickly as possible. ☐ Can return to school once it has been 14 days since last close contact if they do not develop symptoms. ☐ Close affected rooms for 24 hours, or as long as possible, and then initiate cleaning/disinfecting protocol. ☐ Student documentation: symptoms, interventions, disposition. ☐ Staff documentation per District HR guidelines. ☐ Contact Snohomish Health District.	☐ Immediately go home. ☐ Can return to school once it has been 14 days since the last member of the household cleared their quarantine period. Contact the Snohomish Health District if assistance is needed in determining a safe return date. ☐ Close affected rooms for 24 hours, or as long as possible, and then initiate cleaning/disinfecting protocol. ☐ Staff documentation per District HR guidelines. ☐ Contact Snohomish Health District.	☐ Symptomatic person should immediately go home. ▪ If not well enough, isolate staff/children in designated area with a disposable face mask and provide support to get home or to medical care. ☐ To return to school after a **positive** COVID-19 test result: ▪ At least 24 hours have passed since recovery – defined as no fever without the use of medications and improvement in respiratory signs like cough and shortness of breath; **AND** At least 10 days have passed since signs first showed up. ☐ To return to school after a **negative** COVID-19 test result: ▪ Until 24 hours after fever resolves ad symptoms are improving. ☐ To return to school if **no COVID-19 test** is performed: ▪ At least 10 days after symptom onset **AND** at least 24 hours after fever has resolved and symptoms improved. ☐ Clean and disinfect affected areas. At the discretion of nurse or admin, evaluate need to further close room(s) for 24 hrs (Is there other COVID activity in the school? Were there multiple mild symptoms vs one? Etc.). ☐ Staff documentation per District HR guidelines.

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School COVID-19 Case Response Flow Chart

Staff or student receives positive COVID-19 result

Staff or student tested for COVID-19

Staff or student exhibiting signs/symptoms of COVID-19 at school

School/District will compile list of close contacts. Send families exposure letter from SHD.

Contact the Snohomish Health District for instructions on sending contact list.

Snohomish Health District will conduct case investigation and notify close contacts with instructions. Will maintain ongoing communication with School and/or District.

Positive Test

Negative Test

Staff or student should be isolated and return home as soon as possible.

See “Daily Screening Protocol” document on snohd.org for further guidance.

No signs/symptoms but close contact to a positive COVID-19 case requires 14-day quarantine

No signs/symptoms and no close contact may return to work/school

Signs/symptoms but no close contact can return to school 24 hours after fever resolves and symptoms are improving.

For questions contact the Snohomish Health District School Team at schools@snohd.org or (425) 339-8634

Updated December 16, 2020
DOH 821-120

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

Summary of December 16 changes:

- The Department of Health (DOH) revised the metrics to inform local decisions around the provision of in-person learning and the risk of transmission of COVID-19 in school environments. These revisions were based on emerging research and data gathered by state and national officials.
- These changes include revisions to the COVID-19 incidence rates to consider when making decisions about who to prioritize in-person learning for and further clarification that local leaders should consider test positivity and trends in cases and hospitalizations to inform decisions around in person learning.
- DOH defined a maximum 'small group' size of 15 for learning when disease activity is high and defined our 'youngest learners'.
- DOH moved away from a 'decision tree.' This toolkit now includes two checklists that ensure readiness to implement all required DOH Health and Safety Measures and LNI requirements, and a matrix that summarizes our recommendations for the provision of in-person learning based on the community's metrics. The introduction and background sections were updated to reflect the rationale for the changes.

Introduction

This framework can assist local health officers in guiding and school administrators in deciding whether to resume, expand, or reduce 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 continue to 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 they should consult with their local health officer, local elected leaders, teachers, school staff, families, and other stakeholders. DOH recommends that school administrators weigh the risks and benefits to students, families, staff, and their communities when deciding which mode of education to use. They should consider rates and trends in COVID-19 cases and hospitalizations and test positivity in their community along with other health and education risks and benefits to children and their families. In making these difficult decisions, school administrators should also engage staff and families of students at risk for severe COVID-19, families of students with disabilities, English language learners, students living in poverty, students of color, and families of 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 evaluate the public health considerations regarding in-person learning during the COVID-19 pandemic, school

administrators are ultimately responsible for establishing 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 timely 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 key health indicators including the number of cases per 100,000 people over a 14-day period, the percentage of positive tests, trends in cases or hospitalizations, and other measures, such as outbreaks and age-specific impacts. The local health officer should ensure information on key indicators is available to inform school administrators and the public. 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.

School administrators must cooperate with investigations, directives, and orders made by the local health officer (WAC 246-101-420). 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).

Background

To inform the first version of this guidance published this summer, DOH reviewed the experiences of countries that resumed some degree of in-person instruction this spring. These countries generally had low and decreasing community rates of COVID-19 cases. The incidence rates in several countries that successfully resumed in-person instruction were below 50 cases per 100,000 population per 2 weeks. [1]

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.[2]

Based on these data, DOH previously recommended cautiously phasing in in-person learning when county incidence rates fell below around 75 cases per 100,000 population per 2 week period. With rates above this threshold, schools could consider bringing back students with special needs and the youngest learners. In all cases, schools must implement the COVID-19 safety and prevention measures recommended by DOH.

Early experience and learning from the United States

This fall, most schools across the country and some schools in Washington resumed some degree of in-person learning. While no national entity is rigorously studying data from across the country, a team of

[1] 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/

[2] 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

researchers and students at Brown, MIT, Harvard, Massachusetts General and other institutions have enrolled over 5,000 schools with more than 3.9 million students participating in in-person learning to voluntarily share their data on the number of COVID-19 cases and outbreaks in their school.[3] Case rates for COVID-19 among students and staff trend similarly to the surrounding community rate, , meaning when community rates increase, so do staff and student rates. with student rates typically lower than community rates. During the period of August 31 to November 22, 2020, these data show that the proportion of students and staff with confirmed COVID-19 was 0.22% and 0.42% respectively. During the period of November 9-22, among schools providing either full or hybrid in person learning, 5.4% of all schools reported an outbreak involving five or more cases and 1.5% of schools reported an outbreak involving 10 or more cases.

States have taken a range of approaches. California allows in-person learning when counties have fewer than 98 cases per 100,000 over 14 days.[4] Oregon recently updated their school metrics, and now recommends in-person instruction when counties have fewer than 50 cases per 100,000 population over 14 days. When counties have between 50 and 100 cases, Oregon recommends phasing in of onsite or hybrid learning, starting with elementary students. Counties must switch to comprehensive distance learning with limited in-person instruction when they exceed 200 cases per 100,000 population over 14 days.[5] Massachusetts prioritizes in-person learning for all students if feasible when COVID-19 rates are less than 140 cases per 100,000 population over 14 days (in this range, hybrid models are allowed only if necessary to meet health and safety requirements); when COVID-19 case rates are higher than this, Massachusetts recommends hybrid learning that maximizes in person learning for high needs students.[6] Arizona recommends in person learning at or below 20 cases per 100,000 population over 14 days, hybrid learning between 20 and 200 cases per 100,000 population of 14 days, and primarily remote learning at 200 cases per 100,000 over 14 days.[7] West Virginia shifts to primarily remote learning at 210 cases per 100,000 population over 14 days.[8] Colorado encourages in-person learning when there are

[3]Accessed from https://covidschooldashboard.com/ on November 18, 2020

[4] Blueprint for a Safer Economy website. California Department of Public Health. Accessed on November 19, 2020. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID19CountyMonitoringOverview.aspx

[5] General Metrics for Returning to In-Person Instruction Through the On-Site or Hybrid Model. Oregon Department of Education website accessed November 17, 2020. https://www.oregon.gov/ode/students-and-family/healthsafety/Documents/Following%20the%20Metrics%20Visual.pdf

[6] Updates to Guidance on Interpreting DPH COVID-19 Health Metrics website accessed on November 17, 2020. https://www.doe.mass.edu/covid19/on-desktop/interpreting-dph-metrics.html#iii

[7] Safely Returning to In Person Instruction, Arizona Department of Health Services. Accessed November 19, 2020. https://www.azdhs.gov/documents/preparedness/epidemiology-disease-control/infectious-disease-epidemiology/novel-coronavirus/covid-19-safely-return-to-in-person-instruction.pdf

[8] West Virginia School Reentry Metrics and Protocols website. West Virginia Department of Education. Accessed November 19, 20202 https://wvde.us/school-reentry-metrics-protocols/

State	Rates of COVID-19 Cases per 100,000 population over 14 days*		
	In-Person Learning	Hybrid, Phased, or Transitional	Remote Learning for most or older students
Arizona	<20	20-200	>200
California	≤98		>98
Colorado	<75	75-350**	>350**
Massachusetts	<140	≥140	
Minnesota	<100	100-500	>500
Oregon	<50	50-200	>200
Washington	<50	50-350	>350
West Virginia	<210		≥210

Table 1: *State Metrics for Learning Modality among States*

*some states have daily or weekly case rates for metrics. Above are adapted to the approximate rate per 100K per 14 days. States may also have additional metrics.

** Colorado suggests in-person for K-5 at moderate and high levels, with the option to provide hybrid or distance learning. At the high level, in-person remains an option for middle school.

fewer than 75 cases per 100,000 population over 14 days. It suggests in-person learning up to 350 cases per 100,000 over 14 days with the option to provide hybrid or distance learning. Above 350 cases per 100,000 over 14 days, Colorado suggests in-person learning for K-5 with the option to provide hybrid and distance learning, the option of in-person, hybrid, or remote learning for middle school, and hybrid or remote learning for high school.[9] Minnesota 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 a school has opened, they tailor the learning model based on the presence of cases in the school community.[10]

Early experience and learning in Washington state

In Washington state, the majority of public school districts are providing some in-person learning, however, most of Washington's 1.1 million public school students have been learning remotely. According to data from the Office of the Superintendent of Public Instruction (OSPI) and the Association of Educational Service Districts (AESD), as of October, 91% of Washington public school students live in districts that are providing some level of in-person learning. However, in most districts, in-person learning is limited to small group instruction of the youngest elementary students or students with special needs.

According to data from OSPI and AESD, as of October, 115 school districts were providing in-person learning to more than half of their students. These 115 school districts serve approximately 11% of Washington's public school students. In contrast, about 90% of Washington's 73,000 private school students are in full or hybrid in-person learning. Similar to national data, Washington state outbreak data also show that, while cases and outbreaks do occur in schools, recognition of transmission of COVID-19 has been limited in the school setting.

[9] COVID-19 Risk dial. State of Colorado website. Accessed December 13, 2020. https://covid19.colorado.gov/covid-19-dial
[10] 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

Local public health has reported a total of 88 K-12 school outbreaks to DOH since the start of the pandemic through December 12, 2020; 84 of which have occurred since August 1, 2020.

A total of 266 cases have been linked to the 84 outbreaks. Among these cases, 48% were among children. Cases were distributed evenly across child age groups. The age distribution of cases appears in Table 2.

While COVID-19 does get introduced into school environments, the health and safety measures being taken within schools seem to be limiting the spread of the infection in the school. The number of school outbreaks is larger in counties with higher community transmission, however the size of outbreaks is, on average, small (Table 3). Half of the outbreaks in K-12 schools have 3 or fewer cases linked. Among outbreaks since August 1, 15 involve five or more cases, 2 of those involve ten or more cases. The two largest outbreaks each have 11 cases linked to them and occurred in private schools.

Age in years	Percent of Cases linked to K-12 Outbreaks
5-9	17%
10-14	16%
15-19	15%
20-39	15%
40-59	29%
60+	8%

Table 2: *Age distribution of cases linked to K-12 outbreaks in Washington reported Aug 1, 2020 through December 12, 2020.*

Table 3: Rates of COVID-19 cases per 100, 000 population over 2 weeks and K-12 school outbreaks in Washington reported Aug 1, 2020 through December 1, 2020.

Rates of COVID-19 cases per 100K/14 days	All Outbreaks		Smaller Outbreaks (Less than 5 cases)		Larger Outbreaks (More than 5 cases)	
	N	%	N	%	N	%
Low (<50)	5	6	5	8	0	0
Moderate (50-349)	65	82	52	81	13	87
High (>350)	9	12	7	11	2	13

It is important to note that the experience of hybrid or in person learning in Washington schools has occurred in the setting of relatively low community transmission rates compared to other states. As community transmission rises, more cases will likely be introduced into schools. In addition, because children are less often symptomatic, some cases have likely gone unrecognized.

In addition to experiences in Washington and the United States, a recent literature review by the University of Washington and models from the Institute for Disease Modeling (IDM) suggests that the risk of transmission in K-12 schools depends on the incidence of COVID-19 infections in the community as well as school-based countermeasures.[11,12] A follow up report from IDM found that risks could be

[11] University of Washington. Summary of Evidence Related to Schools during the COVID-19 Pandemic Updated October 19, 2020. Accessed November 29, 2020. Available at https://depts.washington.edu/pandemicalliance/wordpress/wp-content/uploads/2020/10/COVID-19-Schools-Summary_2020_10_19.pdf

[12] Institute for Disease Modeling. Schools are not islands: we must mitigate community transmission

significantly mitigated through hybrid school schedules or via a phased-in approach that brings back K-5 first.[13] A third modeling study found that *when R effective is already at 1* in the surrounding community (meaning, disease levels are stable and not increasing or each person who has COVID-19 on average, infects one other person), reopening schools will not significantly increase community-wide transmission, provided sufficient school-based interventions are implemented, such as masking, physical distancing, and screening students and staff for symptoms. The use of hybrid scheduling further reduces the infection rate.[14]

Summary and Recommendations

Taken together, the science and early experience of schools in Washington state and across the nation suggest that rigorous health and safety measures can limit transmission of COVID-19 in the school environment. DOH recommends comprehensive and strict health and safety measures (PDF) to minimize the risk of transmission within schools, and Proclamation 20-09.3 requires schools to implement them. These measures include all five of CDC's key mitigation strategies.[15] Checklists that summarize these requirements follow on the next page.

Given this, DOH recommends continued, cautious in-person learning can occur at community COVID-19 rates higher than established in the initial versions of this framework. The updated case rates in this version reflect DOH's best estimate of appropriate parameters given these findings.

- **High COVID-19 activity:** At this level, DOH recommends in person learning for pre-K through grade 5. Schools should prioritize the youngest learners—pre-K, Kindergarten, and grades 1-3—and those with the highest needs (from any grade), such as students with disabilities, students living homeless, or those farthest from educational justice, using small group instruction of 15 or fewer students and strict cohorting due to the level of community transmission. Then phase in grades 4-5, similarly in small groups.
- **Moderate COVID-19 activity:** At this activity level, DOH recommends careful phasing in of in-person learning starting with any elementary students not already in-person and middle school students. Then over time, adding high school after middle school and when rates drop below 200 cases per 100,000 over 14 days.

Low COVID-19 activity: At this activity level, DOH recommends the provision of in-person learning for all students, prioritizing full time in-person learning for elementary students. If space allows, full time in-person learning can be added for middle and high school students.

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to reopen schools. Accessed November 29, 2020. Available at https://covid.idmod.org/data/Schools_are_not_islands_we_must_mitigate_community_transmission_to_reopen_schools.pdf

[13] Institute for Disease Modeling. Maximizing education while minimizing risk: priorities and pitfalls for reducing risks in schools. Accessed November 29, 2020. Available at https://covid.idmod.org/data/Maximizing_education_while_minimizing_COVID_risk.pdf

[14] Institute for Disease Modeling. Testing the Waters: is it time to go back to school. Accessed November 29, 2020. Available at https://covid.idmod.org/data/Testing_the_waters_time_to_go_back_to_school.pdf

[15] Centers for Disease Control and Prevention. Indicators for School Decision-Making website. Accessed December 15, 2020. Available at https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/indicators.html

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.

Are all staff trained on health and safety practices?

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

Begin Learning Model and Monitor

The decision to resume or expand in-person learning is complex and requires weighing both risks and benefits to children, staff, their families, and the broader community. With regards to COVID-19, DOH recommends that local leaders consider COVID-19 activity level (i.e., case rates, percent test positivity, trends, etc.) as well as the educational, social and emotional benefits of in-person learning for students. When recommending guiding metrics 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. These metrics are not intended to serve as a hard thresholds but as a primary consideration in determining for whom to provide in-person learning.

For whom should your community provide in person learning?

For School Administrators, Local Health Officers, and Community Stakeholders

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

COVID-19 Activity	HIGH **>350 cases/100K/14 days** Test positivity >10% Trends in cases and hospitalizations	MODERATE **~50-350 cases/100K /14 days** Test positivity 5-10% Trends in cases and hospitalizations	LOW **<50 cases/100K/14 days** Test positivity <5% Trends in cases and hospitalizations
Education Modality	**Phase in in-person learning in groups of 15 or fewer students for pre-K through grade 5 and those with highest needs.** Prioritize Pre-K through grade 3, and students in any grade with disabilities, students living homeless, or those farthest from educational justice. If schools can demonstrate the ability to limit transmission in the school environment, add grades 4-5.	**Phase in in-person learning.** Prioritize Elementary (pre-K - 5) if they are not already receiving in-person learning, and Middle School. If schools can demonstrate the ability to limit transmission in the school environment, add more high school students when case rates are below about 200/100K/14 days.	**Provide in-person learning for all students.**
Extra-curricular Activities	Cancel or postpone most in-person extra-curricular activities except those allowed under Safe Start and Governor's proclamations on COVID-19.	Extra-curricular activities must follow K-12, applicable Safe Start protocols and Governor's proclamations on COVID-19.	Extra-curricular activities must follow K-12, applicable Safe Start protocols and Governor's proclamations on COVID-19.
Transition	**Across all COVID-19 Activity Levels:** • When trends in cases and hospitalizations are flat or decreasing, and the school can demonstrate the ability to limit transmission in the school environment, expand access to in-person learning • When trends are increasing, pause expansion of additional in-person learning and maintain access to in-person learning for those who have it. Schools are not required to reduce in-person learning or revert to remote learning based on metrics if the school can demonstrate the ability to limit transmission in the school environment. • Consider other health and education risks and benefits to children and their families At any COVID-19 level, transition temporarily to full distance learning for 14 days when school meets criteria in DOH's K-12 Health and Safety Guidance (p 16) or on recommendation of the local health officer.		

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

The risk of COVID-19 entering schools depends on the mitigation measures in place at the school and 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 not possible to predict the number of infections that might occur under different in-person models and levels of transmission in the community with certainty, but higher levels of community transmission will generally result in a higher risk of COVID-19 being introduced into the school environment. **DOH recommends and Governor's Proclamation 20-09.3 requires comprehensive and strict health and safety measures (PDF) to minimize the risk of transmission within schools.**

The full spectrum of illness due to COVID-19 is not fully understood. While children generally have mild COVID-19 disease, serious infections have occurred[16]. 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 their contacts in the community.

Beyond COVID-19 infections, the pandemic has brought other health concerns. Recent data from the CDC show the proportion of emergency department visits related to mental health crises has increased for young children and adolescents since the pandemic started. From this March through October, while the overall number of children's mental health–related ED visits decreased, the proportion of all ED visits for children's mental health–related concerns increased, reaching levels substantially higher beginning in late-March to October 2020 than those during the same period during 2019.[17]

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 activity[18]. 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 society[19].

A narrative review of multiple studies made recommendations for addressing child and adolescent mental health during the pandemic. It noted the importance of face-to-face learning and recommended

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[16] 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. https://www.thelancet.com/action/showPdf?pii=S2352-4642%2820%2930177-2.

[17] Leeb RT, Bitsko RH, Radhakrishnan L, Martinez P, Njai R, Holland KM. Mental Health–Related Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic — United States, January 1–October 17, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1675–1680. DOI: http://dx.doi.org/10.15585/mmwr.mm6945a3external icon

[18] 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

[19] Levinson M, Phil D, Cevik M, Lipsitch M. Reopening Primary Schools during the Pandemic. *New Eng J Med* 2020. https://www.nejm.org/doi/full/10.1056/NEJMms2024920

school reentry policies consider strict social distancing and hygiene measures, keeping in mind the importance of in-person learning for children in the school set-up.[20]

Following a review of school re-openings in multiple countries during COVID-19, a group of public health and education experts at Harvard, recommended that primary school be deemed essential.[19]Because of the critical role, schools play in children's physical, developmental, and mental health, CDC recently recommended that K-12 schools should be the last settings to close after all other mitigation measures have been employed and the first to reopen when they can do so safely.[21]

Conclusion

This framework can assist local health officers in guiding and school administrators in deciding whether to begin, expand, or reduce in-person instruction for public and private K-12 schools during the COVID-19 pandemic. 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.

In-person learning should be prioritized for elementary school students because they may be less likely to spread COVID-19 than older children[22], have more difficulty learning asynchronously, and may otherwise need to be in a childcare setting if their parent(s) or primary caregiver(s) work. DOH favors a cautious, phased-in approach to resuming in-person instruction, especially at high rates of disease. DOH recommends that schools start with staff, small groups of our youngest learners (pre-Kindergarten, Kindergarten, and grades 13), and students who are unable to learn or receive critical services asynchronously. Over time, schools can add additional students to in-person models.

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

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[20] Singh, S., Roy, D., Sinha, K., Parveen, S., Sharma, G., & Joshi, G. (2020). Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations. *Psychiatry research*, *293*, 113429. https://doi.org/10.1016/j.psychres.2020.113429

[21] Honein MA, Christie A, Rose DA, et al. Summary of Guidance for Public Health Strategies to Address High Levels of Community Transmission of SARS-CoV-2 and Related Deaths, December 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1860-1867. DOI: http://dx.doi.org/10.15585/mmwr.mm6949e2

[22] 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. https://doi.org/10.3201/eid2610.201315

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.

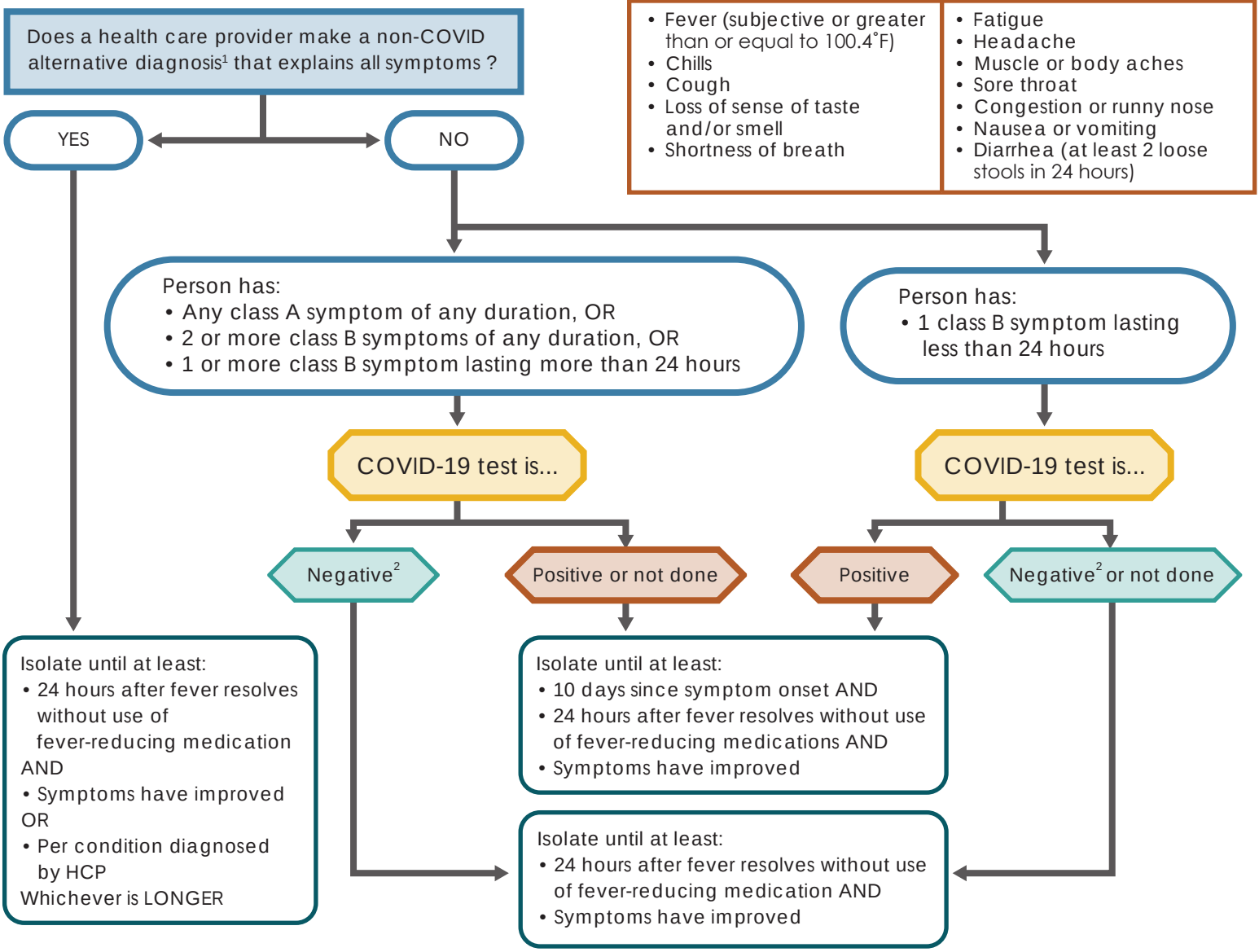
EVALUATION AND MANAGEMENT OF PERSONS WITH NEW UNEXPLAINED SYMPTOMS OF COVID-19 AND NO KNOWN EXPOSURE TO COVID-19

This guidance can be used by staff in schools, childcare facilities, and non-health care workplaces to make decisions about excluding ill persons and readmitting them. Health care providers can also use it to guide evaluation and testing decision-making for ill persons from these settings.

- If testing is available, anyone with symptoms consistent with COVID-19 should be tested.
- Ill persons should be sent home.
- Facilities with testing resources may initiate COVID-19 testing before sending the ill person home and use test results in conjunction with the diagram below to guide isolation recommendations.
- Public health recommendations from the local health jurisdiction supersedes this guidance and should be sought in the context of a COVID-19 outbreak.
- Ill persons should consider seeking evaluation by a health care provider.
- Critical infrastructure essential workers should not work if having symptoms of COVID-19; consult with local public health for any questions.

***Symptoms* consistent with COVID-19**

Class A Symptoms	Class B Symptoms
• Fever (subjective or greater than or equal to 100.4˚F) • Chills • Cough • Loss of sense of taste and/or smell • Shortness of breath	• Fatigue • Headache • Muscle or body aches • Sore throat • Congestion or runny nose • Nausea or vomiting • Diarrhea (at least 2 loose stools in 24 hours)



Visit DOH.WA.GOV/Coronavirus for more information.

[1]Examples of alternative diagnosis made by health care provider include childhood rash illness, acute otitis media, or a lab confirmed diagnosis such as strep throat or non-COVID-19 viral pathogen. If testing for other viral pathogens, strongly recommend testing for COVID-19 as well.

[2]In symptomatic persons and when community transmission rate is moderate-high, a negative rapid test should ideally be confirmed with a PCR test performed in a clinical laboratory. For community COVID-19 rate, see State of Washington COVID-19 Risk Assessment Dashboard.

EVALUATION AND MANAGEMENT OF PERSONS WITH NEW UNEXPLAINED SYMPTOMS OF COVID-19 AND SUSPECTED OR KNOWN EXPOSURE TO COVID-19

This guidance can be used by staff in schools, childcare facilities, and non-health care workplaces to make decisions about excluding ill persons and readmitting them. Health care providers can also use it to guide evaluation and testing decision-making for ill persons from these settings.

- Persons without symptoms who have an exposure to COVID-19 should be quarantined at home away from others until 14 days after last contact to COVID-19. They should not be at school, childcare or work until the quarantine ends (exception to quarantine may be made for critical infrastructure essential workers, however they should not work if having symptoms consistent with COVID-19; consult with local public health for any questions.
- Persons with exposure to COVID-19 and symptoms consistent with COVID-19 should isolate at home away from others.
- If testing is available, anyone with symptoms consistent with COVID-19 should be tested.

See the list of symptoms consistent with COVID-19 and the table below for recommendations for isolation or quarantine for ill persons who had close contact with a person with COVID-19 in the 14 days prior to symptom onset.

***Symptoms* consistent with COVID-19**

Class A Symptoms	Class B Symptoms
• Fever (subjective or greater than or equal to 100.4˚F) • Chills • Cough • Loss of sense of taste and/or smell • Shortness of breath	• Fatigue • Headache • Muscle or body aches • Sore throat • Congestion or runny nose • Nausea or vomiting • Diarrhea (at least 2 loose stools in 24 hours)

COVID-19 test result	Recommendation
Positive	Isolate until at least: • 10 days since symptom onset (longer for those who are severely ill or severely immunocompromised), AND • 24 hours after fever resolves without use of fever-reducing medications, AND • Symptoms have improved
Negative	Quarantine at home away from others until: • 14 days after last exposure OR Isolate until at least: • 10 days since symptom onset (longer for those who are severely ill or severely immunocompromised), AND • 24 hours after fever resolves without use of fever-reducing medications, AND • Symptoms have improved Whichever is LONGER
No test performed	Isolate until at least: • 10 days since symptom onset (longer for those who are severely ill or severely immunocompromised), AND • 24 hours after fever resolves without use of fever-reducing medications, AND • Symptoms have improved

Visit DOH.WA.GOV/Coronavirus for more information.

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

Washington State Department of Health

DOH 420-287 November 2020

School and COVID - What to Expect

While preventive efforts like face coverings, handwashing, screening for symptoms, distancing, and good ventilation can greatly reduce the likelihood of spreading COVID, the risk cannot be entirely eliminated in settings like schools where people are together in person.

It can be scary for students, parents or staff to hear that there may have been a case at school. Here are a few things to know about how schools and public health are working together to help keep students, staff and families healthy.

If there is a confirmed case at school ...

- Snohomish Health District has a team dedicated to responding to COVID in schools or child care. Disease investigators contact the person who has tested positive and the team works with the school or child care provider.
- Close contacts of the case are identified and provided via a secure portal to the Health District. Trained contact tracers reach out to everyone who has been identified.
  - Close contact = 15 minutes within six feet of someone infectious.
  - Close contacts are notified directly via phone call by public health staff.
- If you are not contacted by public health, and if no one in your household has been ill or identified as a close contact, your child does not need to quarantine or isolate.

If a child is sick but has not tested positive...

- Anyone with symptoms, even mild ones, should stay home. Symptoms could include cough, sore throat, fever, chills, fatigue, nausea, diarrhea, vomiting, or loss of taste or smell. One symptom is enough to stay home.
- A student with symptoms at school is to be sent home. Until they can be picked up, they'll be distanced from others.
- Public health recommends anyone with symptoms get tested.

If a child is a close contact of a confirmed case...

- A public health order requires close contacts to quarantine. The quarantine period is 14 days from most recent contact. No one who is a close contact should be at school or child care during that time.
- Others in the household of a close contact should quarantine, as well, and monitor for symptoms.
- If school officials are informed a close contact has come to school during the quarantine period, they may ask them to return home, or to isolate in a designated room until a parent or guardian can pick them up.

More on other Side/page

School and COVID - What to Expect

Timelines for return to school after illness or exposure*

Negative test results and not a close contact
Return to school once symptoms have improved and no fever for at least 24 hours.

Close contact of a confirmed case
Stay home for the full 14-day quarantine period, regardless of symptoms or test results.

Symptoms but not tested
Remain home for at least 10 days after symptoms started AND at least 24 hours after fever is gone and symptoms improve.

**These timelines apply to students and staff. At this time, a doctor's note is not adequate for a student or staff member to return to school.*

A note on privacy

- Do not expect your school or the Health District to provide the name of a student or staff member who has tested positive for COVID-19. This is protected personal health information under the Health Insurance Portability and Accountability Act (HIPAA).
- Public health and schools also are not providing detailed information that could identify individuals.
- Contact tracers are required to adhere to privacy requirements. They will do their best to answer questions, but won't divulge others' personal health information.
- If you know the identity of someone who has COVID through personal channels, do not share that information publicly. Identifying ill students or staff on a public platform does not add to disease control efforts, and is likely to raise problems rather than solve them.

Stay up-to-date on COVID-19: www.snohd.org/covid

Exact timelines and guidance may change over time. This document was created October 12, 2020.

SNOHOMISH HEALTH DISTRICT
WWW.SNOHD.ORG

More on other Side/page

Washington Office of Superintendent of PUBLIC INSTRUCTION

Washington State Department of Health

Washington State Department of Labor & Industries

EMPLOYER HEALTH & SAFETY REQUIREMENTS FOR SCHOOL SCENARIOS

September 30, 2020

Developed by:

- The Office of Superintendent of Public Instruction
- The Department of Health
- The Department of Labor & Industries
- Local School District Superintendents
- School Labor Representatives

ABOUT THIS GUIDANCE

The following set of rules and guidance for school staff health and safety was developed by representatives from the Office of Superintendent of Public Instruction (OSPI), the Department of Health (DOH), the Department of Labor & Industries (L&I), local superintendents, and labor organizations.

Questions related to personal protective equipment (PPE) or other employment-related requirements should be directed to L&I, questions about health requirements should be directed to DOH, and questions about K–12 education requirements should be directed to OSPI.

Key Points

This guidance clarifies and builds out the worksite safety guidance embedded in the June reopening guidance (*Reopening Washington Schools 2020: District Planning Guide*).

The key points are as follows:

- The overall health risk for the typical K–12 in-person instructional setting is classified as low risk. There are other scenarios in the school setting where the risk level may be higher or lower.
- In low risk situations, staff may wear a cloth face covering.
- In medium risk situations, L&I's long-standing guidance allows for several different protection options, including a face shield with a cloth face mask, a surgical-style mask, a hobby dust mask, a KN95 mask, or a KN90 mask.
- For high risk or extremely high risk situations, an N95 respirator or equivalent should be used. If an employer cannot reasonably obtain an N95 or equivalent, they may use a face shield **plus** an FDA-approved surgical mask, procedural mask, or a KN95 mask until a respirator can be obtained.
- N95 respirators or equivalent protection are only required in high risk or extremely high risk situations.

For all risk levels, different face covering and respirator options are included in L&I's *Which Mask for Which Task?* document.

TABLE OF CONTENTS

INTRODUCTION

This document provides general guidance to protect employees in common school scenarios under existing conditions. The guidance is intended to aid local school districts and safety officers as they develop required COVID-19 safety plans and procedures. The guidance does not replace local decisions based on specific conditions.

When schools reopen for in-person instruction, they must protect their employees. Required protections may differ based on the specific job duties and occupations. For guidance related to the health and safety requirements for students, please refer to materials developed by the Department of Health, including:

- Fall Guidance, K–12
- Decision Tree, K–12

This document focuses on required PPE, assuming other required safeguards such as cleaning and hygiene, and engineering or administrative controls, are present. It is intended to aid school districts for planning purposes only.

Please also consider recently updated guidance from the U.S. Centers for Disease Control and Prevention (CDC):

- Strategies for Protecting K–12 School Staff from COVID-19
- What is known about the signs and symptoms, burden, and transmission of SARS-COV-2 among children?
- Preparing K–12 School Administrators for a Safe Return to School in Fall 2020

GENERAL REQUIREMENTS

As described in the *Reopening Washington Schools 2020: District Planning Guide*, school districts, like all businesses, have a general obligation to keep a safe and healthy worksite in accordance with state and federal law and safety and health rules for a variety of workplace hazards. An employer's obligations include developing an Accident Prevention Plan (APP), including a Job Hazard Analysis that also includes worker protections from COVID-19, a known workplace hazard.

School districts must comply with the following COVID-19 worksite-specific safety practices as outlined in the Governor's "Stay Home, Stay Healthy" Proclamation 20-25, and in accordance with L&I's *General Requirements and Prevention Ideas for Workplaces* and DOH's Workplace and Employer Resources and Recommendations.

K–12 employers must specifically ensure operations follow the main L&I COVID-19 requirements to protect workers, including:

1. Educate workers in the language they understand best about coronavirus, how to prevent transmission, and the employer's COVID-19 policies.
2. Limit capacity in indoor spaces to ensure 6 feet of distance can be kept between all staff, students, and others.
3. Maintaining a minimum 6-foot separation is required between all employees, students, and others to the maximum extent feasible. When strict physical distancing is not feasible for a specific task, and takes more than 10 minutes in an hour, the employer is required to provide additional prevention measures, such as use of barriers, masks, or respirators that provide a higher level of protection than a cloth face covering, minimize the number of staff or students in the enclosed areas, and stagger breaks, recesses, and work shift starts.
4. Provide (at no cost to employees) and require the wearing of PPE, such as gloves, goggles, face shields, and face masks as appropriate or required for the work activity being performed. Cloth face coverings must be worn by every employee not working alone on the job site unless their exposure dictates a higher level of protection under L&I safety and health rules and guidance.
    a. Exceptions to this requirement for cloth face coverings include:
        i. when working alone in an office, vehicle, or at a job site;
        ii. if the individual is deaf or hard of hearing and is communicating with someone who relies on language cues such as facial markers and expression and mouth movements as a part of communication;
        iii. if the individual has a medical condition or disability that makes wearing a facial covering inappropriate; or
        iv. when the job has no in-person interaction.
    b. For additional details, please refer to:
        i. L&I's *Washington Coronavirus Hazard Considerations for Employers (except COVID-19 care in hospitals and clinics) Face Coverings, Masks, and Respirator Choices* document.
        ii. L&I's *Which Mask for Which Task?* document.
        iii. Cloth face coverings are described in Department of Health guidance.
5. Ensure frequent and adequate hand washing with adequate maintenance of supplies. Use disposable gloves where safe and applicable to prevent transmission on tools or other items that are shared.

6. Increase the frequency of facility cleaning schedules that includes cleaning and sanitizing with a particular emphasis on commonly touched surfaces – which shall be no less stringent or frequent than what is required by the Department of Health's fall guidance for K–12 schools.
7. Screen employees, students, and any other individual who will be at the school facility for more than 15 minutes, for signs/symptoms of COVID-19 at start of every shift.
8. Make sure sick employees and students stay home or immediately go home if they feel or appear sick.
9. Cordon off any areas where an employee or student with probable or confirmed COVID-19 illness worked, touched surfaces, etc. until the area and equipment is cleaned and sanitized. Follow the cleaning and sanitizing guidelines established by the Department of Health in their fall K–12 guidance.

A site-specific COVID-19 supervisor shall be designated by the employer at each school and other worksite to monitor the health of employees and enforce the COVID-19 job site safety plan.

SCENARIOS FOR SCHOOL SETTINGS

The following scenarios are intended as general guidance to aid local school districts and safety officers as they develop required COVID-19 safety plans and procedures. Specific conditions of each work site must be considered when determining workplace protections required for workers. However, these general guidelines should be beneficial for planning and anticipating needed PPE supplies.

Each scenario assumes:

- The activity is conducted indoors, if not otherwise specified. In general, working outdoors reduces potential exposure to airborne pathogens.
- People who are required to wear a cloth face covering are, indeed, wearing a cloth face covering during any interaction. While protections outlined below are required for workers, they are predicated on the assumption that virus transmission is reduced when non-workers also wear at least a cloth face covering.
- No known positive case of COVID-19 exists in the workplace. When a positive case is identified, that person is immediately removed from the worksite, and the locations where the person had been are cordoned off and sanitized before workers return to the area.
- Exposure time exceeds 15 minutes. In general, longer periods of potential exposure increase the likelihood that a worker is infected. For reference, the June reopening guidance exempts individuals who are on campus less than 15 minutes.
- All required protections – including PPE – are provided by the employer. These workplace protections work together to protect workers. No single protection is sufficient by itself.
- Required disinfection occurs before work areas are shared. For example, if a school employee moves from one classroom to another, all shared equipment is sanitized before the next employee arrives.
- Additional controls are not present. Where additional barriers, ventilation, distance or other controls are provided, minimum requirements may be reduced further. Consultative services from the Department of Labor & Industries Division of Occupational Safety and Health are available for districts with specific questions.

In the *Washington Coronavirus Hazard Considerations for Employers (except COVID-19 care in hospitals & clinics)*, minimum requirements for face coverings, masks, and respirators are identified based on transmission level. For each scenario below, a risk level is identified, indicating required PPE and some alternatives. Additional alternatives, or combinations of controls and PPE may also be identified through consultation services.

The summary tables on pages 8–11 provide basic PPE requirements in each scenario. However, all additional conditions identified immediately above must also be considered when applying the minimum PPE guidelines summarized in the tables.

SUMMARY OF PPE REQUIREMENTS FOR SCHOOL-SPECIFIC SCENARIOS

Examples of Work Conditions by Transmission Risk Level

Negligible Transmission Risk	Low Transmission Risk	Medium Transmission Risk	High Transmission Risk	Extremely High Transmission Risk
Health Status of the People Around You:				
Healthy/Asymptomatic (No COVID-19 Symptoms)	**Healthy/Asymptomatic (No COVID-19 Symptoms)**	**Healthy/Asymptomatic (No COVID-19 Symptoms)**	**Healthy/Asymptomatic (No COVID-19 Symptoms)**	**Probable or Known COVID-19 Source or Direct Human Mouth, Nose, or Eye Interactions**
Worksite with controlled and low public interaction, where at least 6 feet of distance is always maintained and only broken in passing once or twice a day. *For example, when working alone in a classroom or office.*	Work inside a structure/office where number present allows for at least 6 feet of distance to be **easily maintained fulltime and only broken intermittently**, in passing, up to several times a day. *For example, in the general instructional setting, in office settings with 6 feet of distance, or in food service with 6 feet of distance.*	Work inside a structure/office where at least 6 feet of distance is **mostly maintained, but with job tasks that require sustained several minutes of 6-foot distance broken several times a day** without sneeze guards or other mitigations. *For example, in an individual/small group instructional setting with 6 feet of distance or in transportation settings with 6 feet of distance mostly maintained.*	Work in close quarters, such as a multiple-occupancy permit-required confined space or inside a room with 10 or more people **where at least 6 feet of distance is not maintained, and includes job tasks requiring sustained close-together** (less than 3 feet apart) work for more than 10 minutes in an hour multiple times a day. *For example, in different in-person educational settings with sustained close contact.*	Healthcare work involving face-to-face close proximity or potential for coughing or sneezing while working with healthy or asymptomatic people. Potential for droplets of biological material or fluids to become airborne within the breathing zone of the employee. Examples include tonometry during eye exams, visual examination of the oral and nasal cavities, visual examination of the eyes, swab sampling in the mouth or nose. *For example, in a health or isolation room.*

Minimum Required Mask or Respiratory Protection for Employees Without Additional Engineering Controls or PPE

Negligible Transmission Risk	Low Transmission Risk	Medium Transmission Risk	High Transmission Risk	Extremely High Transmission Risk
Health Status of the People Around You:				
Healthy/Asymptomatic (No COVID-19 Symptoms)	**Healthy/Asymptomatic (No COVID-19 Symptoms)**	**Healthy/Asymptomatic (No COVID-19 Symptoms)**	**Healthy/Asymptomatic (No COVID-19 Symptoms)**	**Probable or Known COVID-19 Source or Direct Human Mouth, Nose, or Eye Interactions**
Reusable cloth face covering that fully covers mouth and nose except when working alone in room, vehicle, or on job site. Job has no in-person interaction. A face shield that includes a cloth extension attached to the entire edge of the shield is an acceptable accommodation.	Reusable cloth face covering that fully covers the mouth and nose. A face shield that includes a cloth extension attached to the entire edge of the shield is an acceptable accommodation.	Face shield with a cloth face covering. **-OR-** Non-cloth disposables: dust mask, KN95 or other non-approved foreign-system NIOSH-style filtering facepiece respirators, or non-FDA approved procedure masks.	Elastomeric half- or full-face respirator with particulate filters **** **-OR-** Powered-air purifying respirator (PAPR) with particulate filter. (Tight-fitting respirators must be fit-tested and the wearer must be clean-shaven. No fit-testing is required for loose fitting systems.) **-OR-** Industrial use N95, R95 or P95 or foreign-system non-NIOSH approved filtering facepiece respirator (or other particulate respirator****). **-OR-** Face shield plus an FDA-approved KN95 mask, surgical mask, dust mask, or procedural mask (if a respirator cannot be reasonably obtained).	FDA-approved surgical mask or healthcare N95 filtering facepiece respirator**** **-OR-** Elastomeric respirator with particulate filters. **-OR-** Face shield plus an FDA-approved KN95 mask, surgical mask, dust mask, or procedural mask (if a respirator cannot be reasonably obtained). Tight-fitting respirators must be fit-tested and the wearer must be clean-shaven. Powered-air purifying respirator (PAPR) with particulate filter may be used; no fit testing is required for loose-fitting models. When feasible, people with COVID-19 should also wear an FDA-approved surgical N95 or surgical mask.

**Use a face shield combined with the minimum face covering to lower the risk category where the work or job task allows.*

*For all risk levels, different face covering and respirator options are included in L&I's *Which Mask for Which Task?* document.

Staff-Only Face Coverings Required in School-Specific Scenarios

Scenario	Negligible Transmission Risk	Low Transmission Risk	Medium Transmission Risk	High Transmission Risk	Extremely High Transmission Risk
In Classroom or Office Working Alone	X – when "working alone," a mask is not required				
General Group Instructional Setting		X – with 6 feet of distance easily maintained			
Individual/Small Group Instructional Support Setting			X – with 6 feet of distance	X – without 6 feet of distance, sustained close contact*	
Office Settings—School and Non-School-Based	X – when "working alone," a mask is not required	X – with easily maintained 6 feet of distance		X – if near health/isolation room, sustained close contact*	
Transportation (Driver and Staff)			X – with 6 feet of distance mostly maintained	X – without 6 feet of distance, sustained close contact	
Food Service		X – with easily maintained 6 feet of distance	X – with 6 feet of distance mostly maintained		
Health/Isolation Room*					X – whether nurse or other staff*
Band	X – wind instruments permitted only if entirely remote, with no other human	X – for percussion and string instruments only with easily maintained 6 feet of distance			

Scenario	Negligible Transmission Risk	Low Transmission Risk	Medium Transmission Risk	High Transmission Risk	Extremely High Transmission Risk
	outside the household present				
Choir	*Remote only with no other human outside the household present; otherwise not permitted at this time. See DOH Guidance to determine when small or large group choir may be resumed.*				
Physical Education (Outdoor)		X – with easily maintained 6 feet of distance; no strenuous activity; cloth face covering worn at all times			
Physical Education (Indoor)			X – with 6 feet of distance mostly maintained; no strenuous activity; cloth face covering worn at all times		
Distribution Centers		X – with 6 feet of distance easily maintained	X – without 6 feet of distancing		

***Additional PPE is required as indicated.**

If an employer cannot reasonably obtain a NIOSH-approved N95 or equivalent for their employees who perform work tasks (not including aerosolizing procedures) that require one, they may utilize a face shield and an approved KN95 mask, dust mask, or procedural mask until a respirator can be obtained. The employer must show that they are attempting to procure the appropriate the PPE (for example, through a standing order that cannot be filled).

1. General Instructional Settings

General instructional settings are the most common settings in schools. This is a typical 900-square-foot classroom with a planned number of students present, allowing for 6 feet of physical distancing and additional recommended health and safety measures as outlined by the Department of Health.

School employees working from their classroom workstation with students present would be at low risk level, where at least 6 feet of distance is **easily maintained full time** and only **broken intermittently**, in passing, up to several times a day.

This low risk environment requires:

- Reusable cloth face coverings that fully covers the mouth and nose.
- Tools are not shared or are sanitized between different users.

However, there are some situations that may require a different level of protection, depending on specific job tasks. For example, school employees working from their classroom workstation with no one else (students or staff) present are considered to be "working alone" and, therefore, not required to wear a cloth face covering.

When leaving the classroom or if being joined by any other person, employees must wear a cloth face covering or face shield that includes a cloth extension attached to the entire edge of the shield.

Where possible, a cohort model is used to reduce potential exposure. According to the CDC's guidance Preparing K–12 School Administrators for a Safe Return to School in Fall 2020, updated August 24, 2020:

Cohorting is a new term for a strategy that schools may use to limit contact between students and staff as part of their efforts to limit transmission of SARS-CoV-2 (the virus that causes COVID-19). These strategies work by keeping groups of students – and sometimes staff – together over the course of a pre-determined period of time. Ideally, the students and staff within a cohort will only have physical proximity with others in the same cohort.

This practice may help prevent the spread of COVID-19 by limiting cross-over of students and school employees to the extent possible, thus:

- Decreasing opportunities for exposure or transmission of SARS-CoV-2
- Reducing contact with shared surfaces
- Facilitating more efficient contact tracing in the event of a positive case
- Allowing for targeted testing, quarantine, and/or isolation of a single cohort instead of school-wide measures in the event of a positive case or cluster of cases

Cohorting strategies are common practice in many elementary schools across the United States. Many elementary school students have the same school employees and classmates during the entire school year. Implementation of this strategy varies, depending on setting and resources. For example, schools may:

- Keep cohorts together in one classroom, and have employees rotate between rooms.
- Alternate cohorts by days or weeks, with cohorts assigned to specific days or weeks.

- Adopt a hybrid approach, with some cohorts assigned to in-person learning and others assigned to remote learning.

Evidence of the impact of cohorting on the spread of COVID-19 is limited. Some evidence from other viral disease outbreaks and school reopenings in international settings suggests that cohorting may be an important tool for mitigating the spread of COVID-19. However, it is essential to note that those studies were conducted in very different contexts, in communities with lower transmission levels.

2. Individual/Small Group Instructional Support Setting

Individual instructional settings include situations when work occurs inside a classroom or office where at least 6 feet of distance **is mostly maintained,** but with job tasks that **require sustained** several minutes of 6-foot distance broken several times a day without sneeze guards or other mitigations. Examples may include:

- Working with students with disabilities or other students needing one-to-one support
- Speech language, behavioral support, or articulation therapy

A school employee working in an individual or small group instructional support setting would generally be considered medium transmission risk.

Medium transmission risk requires:

- A minimum of 6 feet of distance is maintained in most interactions.
- Students wear at least a cloth face covering.
- Employees wear at least a face shield with a cloth face covering **OR** non-cloth disposable dust mask, KN95 or other non-approved, foreign-system NIOSH-style filtering facepiece respirator, or non-FDA approved procedure mask.

When working in close proximity with someone who may not be able to consistently wear at least a cloth face covering, best practices also include:

- Wearing a disposable gown that is discarded after each close interaction.
- Frequent hand washing and reminders to not touch face.

In addition, and while it is likely the exception, there may be job tasks that require sustained close contact with students. For those job tasks, a school employee may be considered high transmission risk where at least 6 feet of distance **is not maintained,** and includes tasks **requiring sustained** close-together (less than 3 feet apart) work for more than 10 minutes in an hour multiple times a day.

In these situations:

- School employees wear at least industrial use N95, R95, or P95 or foreign-system non-NIOSH approved filtering facepiece respirator (or other particulate respirator********). If an employer cannot reasonably obtain an approved filtering facepiece respirator, then a face shield **plus** an FDA-approved KN95 mask, dust mask, or procedural mask is an acceptable alternative.
- Respirator use that is required must comply with existing respirator rules, including medical surveillance, fit testing, training, and a written program. Written Respiratory Protection Program templates can be found on L&I's website.

3. Office Settings – School and Non-School Based

Like other office settings, school and non-school-based office settings could include situations where workers are "working alone" and also potential interactions with students and other staff on a daily basis. Non-school-based office settings *may* include short interactions with families and students for specific staff, but primarily the settings would only include other staff members working in the same school buildings.

When a worker in a school-based office setting is expected to interact with others but maintains distance, it would be considered a negligible transmission risk, requiring at least a cloth face covering. This may include situations where more than one worker is in an office space without petitions or doors, or students or other staff may enter the space.

Where an office worker is working alone, with no expectation of human interaction, a cloth face covering is not required. A person is considered to be working alone when they're isolated from interaction with other people and have little or no expectation of in-person interruption. How often a worker is able to work alone throughout the day may vary.

Examples of working alone include:

- A person by themselves inside an office with four walls and a door.
- A lone worker inside a cubicle with four walls (one with an opening for an entryway) that are high enough to block the breathing zone of anyone walking by, and whose work activity will not require anyone to come inside of the cubicle. Cubicle walls or other barriers may include plexi-glass or other non-porous materials.

Staff working in an office with students present would be at low risk level, where a distance of at least 6 feet is **easily maintained fulltime** and only broken intermittently in passing up to several times a day.

It would require:

- A reusable cloth face covering that fully covers the mouth and nose.
- Tools are not shared or are sanitized between different users.

Office staff who are working with students in the health or isolation room where known or suspected cases of COVID-19 may be present, and where at least 6 feet of distance is maintained may be considered high transmission risk, requiring at least Industrial use N95, R95 or P95 or foreign-system non-NIOSH approved filtering facepiece respirator (or other particulate respirator****) or surgical mask. If an employer cannot reasonably obtain an N95 or equivalent, they may use a face shield **plus** an FDA-approved surgical mask, procedural mask, or a KN95 mask.

If their duties include working directly (within 3 feet) with these students, particularly students not able to wear a mask, a respirator is required. See section 6, Health/Isolation Room minimum requirements.

When working in close proximity with someone who may not be able to consistently wear at least a cloth face covering, best practices may also include:

- Wearing a disposable gown that is discarded after each close interaction.
- Frequent hand washing and reminders to not touch face.

4. Transportation

Student transportation may include many different sizes of buses and numbers of students. Students boarding the bus may be screened prior to boarding to take temperatures and observe symptoms. (If screening is done, it is performed by additional staff at the pick-up spot.) Windows should remain open to increase ventilation whenever possible.

A driver or other staff working to transport students would be considered medium transmission risk, requiring they:

- Wear non-cloth disposables, such as dust masks, KN95 or other non-approved foreign-system NIOSH-style filtering facepiece respirators, or non-FDA approved procedure masks

-OR-

- Wear a face shield with a cloth face covering.

Also, consider leaving seats open near the driver to reduce exposure.

A driver or other staff working to transport students, including students with disabilities or other students that may require the driver or staff to be in close proximity, where at least 6 feet of distance **is not maintained,** and includes job tasks **requiring sustained** close-together (less than 3 feet apart) work for more than 10 minutes in an hour multiple times a day would be considered high transmission risk, requiring at least Industrial use N95, R95, or P95 or foreign-system non-NIOSH approved filtering facepiece respirator (or other particulate respirator********). If an employer cannot reasonably obtain an approved filtering facepiece respirator, then a face shield **plus** an FDA-approved KN95 mask, dust mask, or procedural mask is an acceptable alternative.

When working in close proximity with someone who may not be able to consistently wear at least a cloth face covering, best practices may also include:

- Wearing a disposable gown that is changed between each close interaction.
- Frequent hand washing and reminders not to touch face.

Frequent cleaning procedures for commonly touched surfaces on the bus is also required. Follow CDC guidelines, including:

- Clean and disinfect frequently touched surfaces on school buses at least daily or between use as much as possible.
- Develop a schedule for increased frequency of routine cleaning and disinfection.
- If transport vehicles (e.g., buses) are used by the school, drivers should practice all safety actions and protocols as indicated for other staff (e.g., hand hygiene, cloth face coverings). To clean and disinfect school buses or other transport vehicles, see guidance for bus transit operators.
    - Develop a schedule for increased, routine cleaning and disinfection.
    - Ensure safe and correct use and storage of cleaning and disinfection products, including storing products securely away from children. Use products that meet EPA disinfection criteria.
    - Avoid using cleaning products near children and ensure there is adequate ventilation to prevent children or themselves from inhaling toxic fumes.

When considering spacing of students while being transported, 6 feet of distancing is not required. Follow DOH's K–12 Fall Guidance, including:

- Keep riders as far apart as possible on the bus. Consider how to reduce occupancy and increase space on the bus through scheduling (e.g., through staggered arrivals/departures, A/B scheduling) or add buses where possible.
- Require assigned seating.
- If possible, seat students with household members or members of their school group/cohort.
- Maximize outside air and keep windows open as much as possible.
- Encourage walking or biking where safe or being driven by caregivers when feasible.
- Require riders and staff members to wear a cloth face covering or acceptable alternative.
- Encourage students to wash or sanitize hands when they leave their home or classroom immediately before boarding the bus.
- Clean and disinfect frequently touched surfaces, including the tops and backs of seats, using an EPA-registered product and following manufacturers' instructions.

Additional Resources

- National Association of Pupil Transportation
- Transit Operators Guidance (CDC)
- List of Disinfectants for Use Against SARS-CoV-2 (Environmental Protection Agency)
- Resources for School Bus Personnel (American Federation of Teachers)

5. Food Service

In addition to other applicable food handling and safety requirements, school personnel preparing, serving, delivering, and cleaning up after service for students must be provided appropriate PPE to meet the conditions of their work. Several different approaches to food service in schools may be used.

Wherever possible, schools should have students bring their own meals or serve individually plated meals in classrooms instead of in a communal dining hall or cafeteria to reduce staff interaction, while ensuring the safety of children with food allergies.

In addition, schools should:

- Use disposable food service items (e.g., utensils, dishes). If disposable items are not feasible or desirable, ensure that all non-disposable food service items are handled with gloves and washed with dish soap and hot water or in a dishwasher. Individuals should wash their hands after removing their gloves or after directly handling used food service items.

- If food is offered, use pre-packaged boxes or bags for each student instead of a buffet or family-style meal. Avoid sharing food and utensils and ensure the safety of children with food allergies.

In areas where food service workers are in a common, indoor kitchen, where at least 6 feet of distance **is mostly maintained,** but with job tasks that **require sustained** several minutes of 6-foot distance broken several times a day without sneeze guards or other mitigations would be considered medium transmission risk, requiring:

- Non-cloth disposables: dust mask, KN95 or other non-approved foreign-system NIOSH-style filtering facepiece respirators, or non-FDA approved procedure masks.

-OR-

- A face shield with a cloth face covering.
- Tools are shared and sanitized between different users.

In areas where food service workers are in a common, indoor kitchen, where number present allows for at least 6-foot distance to be **easily maintained full time** and only broken intermittently, in passing, up to several times a day would be considered low transmission risk, requiring:

- A reusable cloth face covering that fully covers the mouth and nose.
- Tools are not shared or are sanitized between different users.

Workers delivering meals are encouraged to place them outside the classroom or eating space, and pick up leftover food/packaging there, as well. Staff delivering pre-packaged meals or retrieving debris after meals, but remaining outside the eating area or classroom, where at least 6-foot distance is **easily maintained fulltime** and only broken intermittently, in passing, up to several times a day are considered low transmission risk, requiring:

- A reusable cloth face covering that fully covers the mouth and nose.
- Tools are not shared or are sanitized between different users.
- A face shield that includes a cloth extension attached to the entire edge of the shield is an acceptable accommodation.

Food service workers serving students or cleaning after a meal, gathered in a cafeteria, whether in a cohort group or not, where at least 6-foot distance **is mostly maintained,** but with job tasks that **require sustained** several minutes of 6-foot distance broken several times a day without sneeze guards or other mitigations would be considered medium transmission risk, requiring:

- Non-cloth disposables: dust mask, KN95 or other non-approved foreign-system NIOSH-style filtering facepiece respirators, or non-FDA approved procedure masks.

-OR-

- A face shield with a cloth face covering.

In addition, follow Department of Health guidelines for schools, including:

- Limit gatherings and potential mixing of classes or groups in the cafeteria or other communal spaces.
- If using the cafeteria, have students sit with their class or group and ensure physical distance between students in a group or cohort and between groups.
- Stagger mealtimes in lunchroom or dining hall. Arrange and direct the flow of students to reduce crowding such as at handwashing sinks, food vending areas, etc.
- Space students as far apart as you can at the table. Make sure tables are at least 6 feet apart. Individually plate food for each student.
- To reduce the spread of germs, staff (not students) should handle utensils and serve food.

- Clean and sanitize tables before and after each group eats. Use a washable plastic tablecloth for wooden tables.

Schools could also review the CDC's guidance for bars and restaurants for additional food service safety guidance.

6. Health/Isolation Room

Each school facility is required to plan for temporarily isolating any staff or student who appears symptomatic or indicates a fever, cough, shortness of breath, fatigue, muscle aches, or new loss of taste or smell. Refer to the CDC guidance about protecting school staff to ensure that personnel managing sick employees or students are appropriately protected from exposure. See also What Healthcare Personnel Should Know About Caring for Patients with Confirmed or Possible COVID-19 Infection.

- Only designated, trained staff should interact with people showing symptoms of COVID-19. At least one designated, trained staff member should be available at all times in case there is a need to isolate a symptomatic employee or student.
- When providing care for anyone with suspected or confirmed SARS-CoV-2 infection, personnel who need to be within 6 feet of a sick colleague or student must be provided appropriate PPE (including gloves, a gown, a face shield or goggles, and an N95 or equivalent or higher-level respirator or a surgical facemask and face shield if a respirator is not available), and follow Standard and Transmission-Based Precautions.

If respirators are needed, they must be used in the context of a comprehensive respiratory protection program that includes medical exams, fit testing, and training in accordance with Washington Administrative Code 296-842 – Respirators.

Staff serving in these roles would be considered an extremely high transmission risk, requiring:

- FDA-approved surgical mask or healthcare N95 filtering facepiece respirator******** or elastomeric respirator with particulate filters. Tight-fitting respirators must be fit-tested and the wearer must be clean-shaven. Powered-air purifying respirator (PAPR) with particulate filter may be used; no fit testing is required for loose-fitting models. When feasible, clients with COVID-19 should also wear an FDA-approved surgical N95 or surgical mask.
    - If an employer cannot reasonably obtain an approved filtering facepiece respirator, then a face shield **plus** an FDA-approved KN95 mask, dust mask, or procedural mask is an acceptable alternative.
- Add face shield to surgical masks or eye goggles to half-face disposable respirators and non-permeable disposable upper body coverings; use powered-air purifying respirator (PAPR) system, elastomeric full-face respirators with particulate filters or higher protection.

However, if the interaction with ill students involves students without masks, particularly for very close contact (3 feet), or if there is an additional reason for concern (aerosol-generating procedure or performing physical assistance would be the most likely), a surgical mask would not be sufficient. If staff are simply watching over the students and can generally maintain physical distancing, then surgical masks are sufficient.

In addition, staff are required to cordon off any areas where an employee or student with probable or confirmed COVID-19 illness was present until the area and equipment is cleaned and sanitized. Follow the cleaning guidelines set by the CDC to clean and sanitize.

School nurses circulating in multiple school settings must follow these guidelines for each school setting in which they work. In addition, follow guidelines required for cleaning vehicles prior to traveling between work locations.

This document does NOT substitute nursing judgment and acknowledges that courses of action may be modified on a case-by-case basis.

Additional Resources

- Guidance for Healthcare Personnel on the Use of PPE in Schools During COVID-19 (National School Nurses Association)
- Special Considerations – School nurses/health professionals (CDC)

7. Band & Choir

Continuing the full range of academic activities is important to maintain student learning. However, singing or playing wind and brass instruments, when done by a person with COVID-19, can generate respiratory droplets and aerosols that contain the virus. As shown by recent events, such activities may contribute to virus spread, whether or not that person is symptomatic.

To reduce potential exposure from these activities:

- Band is limited to percussion and stringed instruments only, with physical distancing and at least a cloth face covering to be worn at all times; and
- Choir is permitted only in a remote setting, when no other people outside the immediate household are present. Otherwise, choir is not permitted at this time. See DOH's guidance to determine when small or large group choir may be resumed.

In addition, students and staff are encouraged to rehearse alone or remotely, whenever possible, and:

- Limit exchange (or sharing) of any instruments, parts, music sheets, or any other items.
- Sanitize between users.
- Maintain at least 6 feet of distance between participants.

Band practice should occur outdoors whenever possible. If indoors, increase the distance between staff and students and increase ventilation, including opening windows. Staff are required to wear at least a cloth face covering. No instrument should be played that requires removal of at least a cloth face covering.

Additional Resources

- High SARS-CoV-2 Attack Rate Following Exposure at a Choir Practice (Skagit County, Washington, March 2020)
- Safer Singing During the SARS-COV-2 Pandemic: What We Know and What We Don't (Naunheim et al., 2020)

8. Physical Education

Whenever possible, physical education should occur outdoors, within class cohorts. Outdoor locations for fitness training and team sports are preferred to indoor locations and should be utilized to the greatest extent possible to allow for maximum fresh air circulation and social distancing. Outdoor temporary structures may be used. Outdoor temporary structures should have no more than two walls to provide appropriate ventilation.

Limit exercise so that it is not strenuous to allow students and staff to continue to wear at least a cloth face covering and maintain at least 6 feet of distance. Clean and disinfect all exercise equipment and tools between users.

If indoors, increase the distance between staff and students during exercise and follow DOH guidelines, avoid strenuous activity so that a cloth face covering is worn by all participants at all times. Keep doors and windows open where possible and utilize fans to improve ventilation. Adjust mechanical ventilation systems to bring in as much outside air as possible. Increase filters to MERV 13 if the HVAC can accommodate.

Use class cohorts to reduce possible transmission outside the cohort. Clean and disinfect all exercise equipment and tools between users. In addition, schools should:

- Modify or adjust cardio equipment, free weight areas, weight training equipment, and classrooms to maintain at least 6 feet of distance between students, coaching staff, and athletic trainers.
- Where specialized equipment is used such as weighs, balls, or rackets, they must be disinfected between each use.
- Consider limiting locker room access to the restroom area only, prohibiting the use of shower and changing areas.
- Consider closing water stations and water fountains if students have alternative water access.
- Encourage staff and students to bring their own water bottles to minimize use and touching of water fountains or consider installing no-touch activation methods for water fountains.
- Students and staff must wash their hands or use hand sanitizer before and after each exercise session.
- Mark group exercise areas with floor markings to show the physical distancing requirements for participants, when practical, and sanitize thoroughly before and after use. Adequate time must be provided between classes in order for the facility to properly sanitize after each class.

Staff, whether working with a cohort or not, where at least 6 feet of distance **is mostly maintained,** but with job tasks that **require sustained** several minutes of 6-foot distance broken several times a day without sneeze guards or other mitigations, are considered medium transmission risk, requiring:

- Non-cloth disposables: dust mask, KN95 or other non-approved foreign-system NIOSH-style filtering facepiece respirators, or non-FDA approved procedure masks.

-OR-

- A face shield with a cloth face covering.

Additional Resources

- COVID-19 Reopening Guidance for Businesses and Workers (Governor Inslee's Office)
- Phase 2 and 3 Indoor Fitness and Training COVID-19 Reopening Requirements – Update (Governor Inslee's Office)
- Indoor Fitness and Training – Proclamations 20–25 (August 3, 2020 Memo by Governor Inslee)
- Fitness Frequently Asked Questions (Governor Inslee's Office)

9. Distribution Centers (Food Service, Technology, etc.)

Distribution centers used to prepare and distribute items such as meals, student learning packets, or technology have generally been held outside with few or no students present. Interaction is limited between employees and the public, with the public remaining in their vehicles to access services and supplies.

The following guidance should be followed when school employees are outside and are working together to prepare and package meals and materials:

1. In a large area where at least 6 feet of distance is **easily maintained fulltime** and only broken intermittently, in passing, up to several times a day and tools are not shared or are sanitized between different users would be considered low transmission risk, requiring:
    - A reusable cloth face covering that fully covers the mouth and nose.
    - Writing utensils or other tools are not shared or are sanitized between users.
    - A face shield that includes a cloth extension attached to the entire edge of the shield is an acceptable accommodation.

2. In a large area where at least 6 feet of distance is **mostly maintained,** but with job tasks that require several minutes of 6-foot distance broken several times a day and tools are shared and sanitized between different users would be considered medium transmission risk, requiring:
    - Non-cloth disposables: dust mask, KN95 or other non-approved foreign-system NIOSH-style filtering facepiece respirators, or non-FDA approved procedure masks.

    -OR-

    - A face shield with a cloth face covering.

For school employees working together to distribute meals and materials where they are outside and have limited interaction with members of the public only such as reaching through a car window and/or placing items into a car trunk, where at least 6 feet of distance is **easily maintained fulltime** and only broken intermittently, in passing, up to several times a day and tools are not shared or are sanitized between users would be considered low transmission risk, requiring:

- A reusable cloth face covering that fully covers the mouth and nose.
- Writing utensils or other tools are not shared or are sanitized between users.
- A face shield that includes a cloth extension attached to the entire edge of the shield is an acceptable accommodation.

Additional Resources

- Preparing K–12 School Administrators for a Safe Return to School in Fall 2020 (CDC)

WA DEPT of LABOR and INDUSTRIES Coronavirus (COVID-19) Common Questions Regarding Worker Face Coverings and Mask Requirements

These common questions and answers are to help with implementation of Governor Jay Inslee's orders and L&I regulatory policy related to COVID-19 and the use of face coverings, masks and respirators. This information is being updated as new questions come in.

Businesses and workers should also use the following guidance documents for additional information on required face coverings and mask use based on the level of risk for various job tasks:

- Which Mask for Which Task? (F414-168-000)
- Washington Coronavirus Hazard Considerations for Employers (except COVID-19 care in hospitals & clinics)

What does it mean to be "working alone"?

Someone is considered to be working alone when they're isolated from interaction with other people and have little or no expectation of in-person interruption. How often a worker is able to work alone throughout the day may vary.

Examples of working alone include:

- A lone worker inside the enclosed cab of a crane or other heavy equipment, vehicle, or harvester.
- A person by themselves inside an office with 4 walls and a door.
- A lone worker inside of a cubicle with 4 walls (one with an opening for an entryway) that are high enough to block the breathing zone of anyone walking by, and whose work activity will not require anyone to come inside of the cubicle.
- A worker by themselves outside in an agricultural field, the woods, or other open area with no anticipated contact with others.

Do fire, police, 911 dispatchers, and the like need to wear a cloth face covering while working at the desk during emergency calls?

Barriers and ventilation should be set up in the call center to provide effective separation between workstations and supervisor locations. Dispatchers do not need to wear masks while sitting in separated workstations or communicating on emergency calls.

Coverings/masks must be used when with other people, in accordance to the L&I guidance chart.

What about police? Should they wear (or not wear) cloth face coverings in a car alone, on the beat, and other situations?

As a general rule, cloth face coverings should be worn when not working alone. When interacting with the public, masks should be worn, but other public safety concerns may necessitate removing the mask for improved communication or to avoid the mask being a hazard. An individual alone in a car is permitted to not wear a facial covering. Two officers in a car is likely medium risk and a covering must be worn; other situations may need to be evaluated. Masks or face coverings are required when law enforcement officers are in a station house or other administrative building with frequent in-person interactions.

What are the requirements for workers with medical and disability issues that prevent the use of a cloth face covering or mask?

Employees with a medical or disability issue, who are requesting accommodation, must provide their employer with an accommodation statement from their medical professional specifying that a face covering or mask should not be worn due to their present health condition. Employers cannot just allow the employee to work without a mask with no other mitigations or accommodations.

Employers should assess any negative impacts that face coverings might have on employees with disabilities and make accommodations per the Americans with Disabilities Act (ADA). For example, workers communicating with people who are deaf or hard of hearing may need to temporarily unmask while staying at least 6 feet away or behind a physical barrier in order to allow for lip reading.

What COVID-19 protections are required for a speaker at a news conference, and witnesses in court trials?

Reporters, on-camera anchors/talent, speakers on camera, and witnesses at court trials may remove their cloth facial covering or mask for the time they are speaking only. A shared podium, witness stand, or equipment should not be touched without being sanitized after each person has used it. All people involved must maintain at least 6 feet of physical distancing from each other. All other workers, including camera operators, production staff, and courtroom staff, must wear masks or face coverings while not working alone.

Do workers have to wear cloth face coverings when interacting with clients while they're behind a Plexiglas barrier and are safe-distanced?

Yes. While the use of barriers is encouraged, it does not remove the requirement that workers have to wear a face covering or mask. The requirement for workers to wear face coverings or better is based on whether they're working alone.

Do workers working alone in 6-foot-high cubicles need to wear cloth face coverings?

If the cubicle has 4 walls and a door opening, and the worker can maintain social distancing, they are considered to be "working alone." With that, they do not have to wear a cloth face covering or better while in their cubicle. When workers leave their cubicles, they need to put the face covering on.

Is a barista working at a drive-through coffee stand considered working alone?

If a drive-through worker is the only person in the stand, they only have to wear a cloth face covering or better while they are interacting with customers.

Do delivery drivers working for companies such as UPS and FedEx need to wear masks?

Delivery drivers must wear masks when they may come within 6 feet of another person. No mask is required while a delivery driver is in their vehicle alone.

Do vendors delivering goods to a store need to wear a mask?

Under Governor Inslee's Safe Start directive, at a minimum all workers are required to wear a cloth facial covering unless they are working alone or are exempt because of medical reasons. Vendors entering a store to deliver supplies or stock shelves must wear a face mask while interacting with others in the store, unless they are working completely alone.

Does wearing a mask create a build-up of carbon dioxide for the person wearing it?

No. That's a myth. You can find more information at the Department of Health (DOH) web page Myths and Facts about Cloth Face Coverings.

Can workers traveling together in a vehicle be closer than 6 feet apart?

Workers traveling together in a vehicle should maintain 6 feet of social distance; however, transporting multiple workers in vehicles for up to 1 hour per trip would be a considered a medium-transmission risk **when all of the following conditions are met**:

- Workers must be seated with at least 3-foot separation. This is measured between breathing zones, the space within about 12 inches of their mouths and noses. For example, it is okay for a worker's feet to extend under the seat of another worker as long as they are not breathing the same air.
- Ventilation must be operated at full force, drawing in outside air, or all windows that can be opened should be fully open to provide as much fresh air as possible.
- Vehicles must be cleaned between trips, focusing on high-touch surfaces around seating positions.

- No more than 2 workers (including the driver) are allowed in a compact car. Up to 4 workers (including the driver) are allowed in larger sedans and work trucks with 2 rows of seats.
- Up to 6 – 7 workers are allowed in passenger vans if the minimum 3-foot distancing can be accomplished. It is possible that the design of the vehicle or its seating systems may not allow passenger vans to carry this many people.

Workers in the medium-risk category must wear non-cloth disposables, which include dust masks; KN95 or other non-approved, foreign system, NIOSH-style filtering face-piece respirators; or non-FDA-approved procedure masks.

Using a vehicle for higher occupancy will be considered a high-transmission risk, and workers are required to wear respiratory protection. Businesses must comply with Washington Administrative Code 296-842 Respiratory Protection, which includes medical surveillance, fit testing, training, and a written program.

Can cloth face coverings or masks be removed during lunch?

Yes, but social distancing needs to be maintained.

Can cloth face coverings be laundered at home?

Yes, cloth face coverings can and should be routinely laundered at home.

Are face shields an acceptable substitute for masks or cloth face coverings?

No. Face shields provide good droplet protection for the wearer, but the purpose of using a cloth face covering or mask is to protect others. Because people can be infected and actively transmitting the virus without knowing it, coverings stop the virus at the source — the mouth and nose — from getting into the air. It prevents workers from passing the virus to other workers and customers.

Does an employer have to inform employees about COVID-19 hazards and the possibility of it being in the workplace?

Yes. If the employer is aware there is an above-normal risk of COVID-19 in their workplace, they need to inform employees of the heightened risk. A general statement will suffice.

Do firefighters have to wear masks while sleeping at the station?

No. Beds need to be 6 feet from each other, and if only bunk beds are used, the bottom bunk should be occupied.

Is a face shield with cloth covering the side and bottom edges an acceptable accommodation for workers who have a medical exemption to wearing a mask or cloth face covering?

Yes. A face shield that includes a cloth extension attached to the entire edge of the shield is an acceptable accommodation.

Are there guidelines about cloth weight for face coverings used in low- or negligible-risk settings?

No. There are no official guidelines regarding cloth weight for face masks used in low-risk settings.

What are employer requirements for providing masks?

Employers must provide employees masks free of charge. The employer must immediately replace your mask if you request it, or if it becomes contaminated, wet, dirty, damaged, or when recommended by the manufacturer.

Heat Stress and Face Coverings

Can wearing a mask while I am working and it is hot out cause me to overheat?

No, a face covering alone will not cause a person to overheat. Studies have shown that filtering facepieces such as an N95 respirator do not cause additional physiological stress to most wearers and do not contribute to heat stress. Cloth face coverings and procedural masks are typically not as restrictive as wearing an N95 mask, and so are of even less concern regarding overheating of the wearer.

When can a face shield substitute for coverings/masks for outside heat exposed workers?

While working alone.

Can workers lower their mask below the chin occasionally throughout the day while working, and what steps should workers take to stay safe?

Yes, while working alone and during cool-down breaks, as long as appropriate distance from other people is maintained.

At what temperature above 80 degrees is it appropriate to remove facial coverings and masks when exposed to the hazard of heat stress?

It is not appropriate to remove facial coverings based on the temperature. Removing facial coverings is not an effective way of reducing body temperature. Regular protective measures to

control heat stress must be implemented, such as drinking plenty of water, frequent breaks in a cool area, and scheduling work during cooler parts of the day.

Disposable medical masks seem to be better tolerated for outside workers in heat. Are these better than cloth masks during heat?

Cloth face coverings are the minimum that is required for low-transmission-risk work. If the worker prefers to use disposable medical masks, that is acceptable.

Customer Mask Use

What are the minimum requirements for a business to comply with the customer mask order?

The business must post prominent customer mask policy signage at entrances, and they **should** be in the language of their main customer base (for example, English, Korean, English and Spanish, and so forth).

The business should take steps to engage customers to ensure face coverings are worn to protect workers and other customers, but avoid creating potentially violent situations.

- Include customer masking policy and procedures in COVID-19 worker safety programs.
- Designate a manager/supervisor to oversee the business's COVID-19 safety program at each facility.

Are employers required to post an employee at each entrance to check on customer masking?

No. However, each employer must decide if posting an employee at each entrance is needed to increase the effectiveness of their COVID-19 customer masking program.

Are public transportation businesses expected to enforce the customer mask order?

Yes. Public transportation providers are expected to display signs that inform riders they need to wear a face covering or mask. When riders do not wear face coverings or masks, the operator should inform the rider of the mask policy and ask that they comply. The transit business may have specific steps for operators to take, but operators should avoid actions potentially creating violent situations.

Questions?
If you have further questions regarding workplace safety, please call **1-800-4 BE SAFE** (**1-800-423-7233**).

Safe Re-Opening District Handbook

Vaccine Information

GUIDANCE SUMMARY
WA STATE COVID-19 VACCINE PRIORITIZATION GUIDANCE AND INTERIM ALLOCATION FRAMEWORK

The Washington State Department of Health has developed this guidance for COVID-19 vaccine allocation and prioritization to facilitate harmonized planning for distribution across Washington State. This guidance is the result of several months of engagement with expert groups and community partners to gather input and ideas. Given current information and federal guidance, we are providing guidance on Phase 1a and 1b that incorporates this input while staying aligned with the principles and criteria noted below. We are offering tentative ideas of populations that may be considered in future phases. The guidance will be updated to provide details on these other phases based on:

- New information from clinical trials
- New federal guidance and vaccine recommendations
- Ongoing feedback from impacted communities, partners, sectors, and industries

In this guidance, population groups overlap and there are individuals who fit into multiple categories. When this is the case, the higher phase should take precedence. Also, the order of the populations does not suggest any type of prioritization or risk stratification. In all circumstances, although reinfection appears uncommon during the initial 90 days after symptom onset, prior confirmation of COVID-19 infection will not exclude any individual from eligibility for COVID-19 vaccine and serologic testing is not being recommended prior to vaccination. Vaccines should be administered according to age groups for which the specific vaccine is authorized (e.g., Pfizer for 16 and over and Moderna for 18 and over).

GOAL: To reduce severe morbidity and mortality and negative societal impact due to the transmission of SARS-CoV-2

ETHICAL PRINCIPLES
- Maximum benefit
- Equal concern
- Mitigation of health inequities

PROCEDURAL PRINCIPLES
- Fairness
- Transparency
- Evidence-based

CRITERIA
- Risk of acquiring infection
- Risk of severe morbidity and mortality
- Risk of negative societal impact
- Risk of transmitting infection to others

Washington State Department of Health

Currently, we are limiting Phase 1 of the allocation framework to **Phase 1a** and **Phase 1b**. Phase 1a is eligible for vaccine as of December 31, 2020. Phase 1b Tier 1 is eligible as of January 18, 2021. We will continue to announce when new phases are eligible.

Phase 1a - Tier 1

Overarching Groups:

- **High-risk workers in health care settings** (clinical judgment should be applied to identify who is at greatest risk using the guidance below)
- **High-risk first responders** (clinical judgment should be applied to identify who is at greatest risk using the guidance below)
- **Residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance**

Phase 1a focuses on (a) high-risk workers in health care settings and high-risk first responders in order to protect our medical care response capacity and (b) residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance aiming to avoid hospitalizations, severe morbidity, and mortality. The table below identifies the desired objectives and guidance regarding what individuals would be prioritized for vaccine allocation in this phase. We provided recommendations that closely align with the Advisory Committee on Immunization Practices (ACIP) and initially include risk stratification given limited vaccine.

CDC provided initial COVID-19 vaccine supply projections for the first two months. Assuming Washington state receives approximately 2 percent of the total projections (Washington's approximate proportion of total U.S. population), our state was expected to receive between 150,000 to 350,000 doses in the first month and between 500,000 to 1 million doses in the second month (inclusive of second doses). Also note that many residents of long-term care facilities will be served via a federal pharmacy program that began in late December and draws down from the Washington state vaccine allotment. Given limited vaccine, sub-prioritization and sequencing of distribution to health care personnel was initially necessary. Furthermore, agencies have been encouraged to consider staggering vaccine schedules of teams to avoid potential clustering of worker absenteeism related to systemic reactions.

Beyond ACIP, this guidance was developed based on input and review by a number of experts including Washington advisory groups (Vaccine Advisory Committee, Disaster Medical Advisory Committee, COVID-19 Science Advisory Working Group, Association for Professionals in Infection Control), health care providers, and local health jurisdictions (including health officers).

PHASE 1A-1 OBJECTIVE	PHASE 1A-1 GUIDANCE
To protect those at highest risk of exposure, to maintain a functioning health	*In the context of limited vaccine, this guidance includes the following sub-prioritization considerations:* • Personnel without known infection in prior 90 days • Workers in sites where direct patient care is being frequently delivered to confirmed or suspected COVID-19 patients, including sites where suspected patients are directed for COVID testing and care

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Example setting: hospital sites managing suspected/confirmed COVID patients; emergency departments; urgent care; clinics (walk-in, respiratory); home; isolation and quarantine facility
Examples types of workers: health care workers; technicians; security; environmental, janitorial, and facility staff; non-remote translators; counselors; home health aides, caregivers, and companions

Workers frequently performing high-risk exposure procedures with suspected or confirmed COVID-19 patients

Example procedures: endotracheal or cough inducing intubation; cough induction or cough inducing procedure (e.g., nasogastric tube); bronchoscopy; suctioning; turning the patient to the prone position; disconnecting the patient from a ventilator; invasive dental procedures and exams; autopsies; respiratory specimen collection; cardiopulmonary resuscitation; upper endoscopy; laparoscopic surgery; placement of chest tubes for pneumothorax

Workers exposed to/handling potentially SARS-CoV-2 containing specimens
COVID-19 testing site staff at high risk of exposure to suspected COVID-19 patients
First responders at high risk of exposure to suspected or confirmed COVID-19 patients via high public exposure and procedures

Licensed emergency medical service frontline staff regardless of agency (e.g., fire, ambulance, hospital)
Emergency workers providing patient transport/ambulatory support regardless of agency
Personnel working in the field to provide oversight of these emergency medical service positions

Workers with elevated risk of acquisition/transmission with populations at higher risk of mortality or severe morbidity

Workers at long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance (e.g., healthcare, environmental facility management, counselors, dining staff, etc.)
Home health aides, care aides, caregivers, companions, etc.
Workers with patients undergoing chemotherapy, chronic renal disease, dialysis, etc.

Workers (including pharmacists and occupational health staff) administering vaccines to Phase 1a and 1b populations

- -
Residents and staff of long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance and are unable to reside independently in the community:

Example: skilled nursing facilities – facility engaged primarily in providing skilled nursing care and rehabilitation services for residents who require care because of injury, disability, or illness
Example: assisted living facilities – facility providing help with activities of daily living; residents often live in their own room or apartment within building/group of buildings
Examples of possible settings: adult family homes; group homes for people with disabilities (physical, developmental, intellectual); mental/behavioral health institutions; residential homeless shelters

Where sub-prioritization is needed, consider:

Skilled nursing facilities caring for the most medically vulnerable residents and of congregate nature so they face the joint risk factors of severe disease/mortality and transmission due to their living settings
After skilled nursing facilities, consider broadening to other facilities, including:

Assisted living facilities and adult family homes
Residential care communities
HUD 202 low-income senior housing
Intermediate care facilities for individuals with developmental disabilities

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	o State Veterans Homes

Phase 1a (Tier 1) Additional Guidance

- We specifically use the terminology “workers in health care settings” and not “health care workers” because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services). ACIP provides similar guidance regarding defining healthcare personnel.[1]
- Special attention should be paid to workers in health care settings who are at high risk of exposure and may have inconsistent or limited use of PPE as well as those working in settings with inadequate environmental controls for recommended air exchange.

Phase 1a - Tier 2 (after completion of Tier 1)

Overarching Group:

- **All other workers at risk in health care settings**

The definition of healthcare settings as defined by CDC refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long term acute care facilities, inpatient rehabilitation facilities, nursing homes and assisted living facilities, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, and others.

PHASE 1A-2 OBJECTIVE	PHASE 1A-2 GUIDANCE
To protect those at highest risk of exposure, to maintain a functioning health system, and to protect highly vulnerable populations	**All other workers at risk to COVID working in health care settings** • Workers who are at risk of acquisition or transmission of COVID because they are interacting in close proximity (less than 6 feet) with patients, co-workers, or specimens and are unable to remain socially distant (i.e., not include remote workers)

Phase 1a (Tier 2) Additional Guidance

- We specifically use the terminology “workers in health care settings” and not “health care workers” because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services).
- Across Washington, it is important that health care systems actively reach out to and provide access to COVID-19 vaccination for community-based health care workforce outside their systems and in their community. This includes other health care providers, school nurses, and behavioral health providers, etc., in order to compete this phase and ensure we have a protected healthcare system.

Phase 1b

Phase 1b phase generally includes people who are high to moderate risk against the four risk criteria:

- Risk of acquiring infection
- Risk of severe morbidity and mortality
- Risk of negative societal impact
- Risk of transmission to others

In addition, we have applied equity as a cross-cutting lens and considered situations when certain groups are disproportionately affected due to social factors and/or other systemic inequities to mitigate for these factors.

Summary:

Phase 1b Tiers (in order)	Groups
Tier 1	• All people 65 years and older • People 50 years and older in multigenerational households
Tier 2	• High-risk critical workers 50 years and older who work in certain congregate settings
Tier 3	• People 16 years and older with 2 or more co-morbidities or underlying conditions
Tier 4	• High risk critical workers under age 50 in certain congregate settings (as noted above in Tier 2) • People (residents, staff, volunteers) in congregate living settings (e.g., correction facilities, prisons, jails, detention centers; group homes for people with disabilities) and people experiencing homelessness that access services or live in congregate settings (e.g., shelters, temporary housing)

Phase 1b - Tier 1

Overarching Groups:

- **All people 65 years and older**
- **People 50 years and older in multi-generational households**

The first tier focuses on protecting those who are driving hospitalization and face high rates of severe morbidity and mortality in order to reduce the burden on hospitals that keeps us in an emergency state. We also want to recognize that there are older adults and elders who may be vulnerable and unable to live independently similar to those in community-based, congregate care settings (Phase 1a) but their families care for them at home. In addition, we recognize that many families - especially those disproportionately affected by COVID - live in multi-generational homes that put the older

adults and elders in the household at significantly higher risk for acquiring infection. Because these individuals are among disproportionately affected groups, they are also at risk for higher rates of severe morbidity and mortality.

PHASE 1B-1 OBJECTIVE	PHASE 1B-1 GUIDANCE
To prevent hospitalization and rates of severe morbidity and mortality	**All people 65 years and older** (about half of whom have co-morbidities that increase risk for severe outcomes if infected with COVID)
To prevent acquiring infection, hospitalization, and rates of severe morbidity and mortality	**People 50 years and older in a multigenerational (2 or more generations) household** These individuals would be at risk either due to: • Vulnerability – specifically, an older adult or elder who cannot live independently *and* is being cared for by a relative or in-home caregiver or being cared for by someone who works outside the home • Risk of exposure – specifically, an older adult or elder who is living with and taking care of kinship (along the lines of a grandparent with a grandchild) • This group does not include an older adult who is able to live independently and is taking care of the individual's kinship/children

Phase 1b - Tier 2

Overarching Groups:

- **High-risk critical workers 50 years and older who work in certain congregate settings**

Phase 1b – Tier 2 includes specific high-risk essential workers groups[1] age 50 and older who work in certain congregate settings. Occupational risk factors for COVID include setting (time inside vs. outside), proximity (to co-workers and/or customers), type of contact (physical, surface), duration, daily number of contacts, capability to assess possible infection (screening), consistent access to/ability to use protection, cleaning (frequency), and barriers to healthcare access. The course of the pandemic in Washington state indicates that specific groups of workers operating in congregate settings—such as, agricultural workers, food processing, incarceration facilities, and child care workers — have experienced significantly elevated rates of infection given the nature of their working and/or living conditions. In addition, the working and living conditions contribute to transmission at work and in the community. We have also selected an age range that represents about half of the workers in these groups whose age is associated with higher rates of hospitalization, morbidity and mortality.

Phase 1b – Tier 2 also includes workers in child care settings and K-12 educators and staff during in-person schooling or childcare. Child care includes programs that are permitted to operate under DOH guidance for child care/youth development/day camps. Not only do they face the risks noted above

[1] See Washington Essential Critical Infrastructure Workers for most up-to-date list of essential worker groups

(note: there is growing evidence that older kids have higher risk of transmission) but remote care and education is also associated with very high risk of negative societal impact. There is strong evidence regarding the negative impact remote schooling is having on K-12 students regarding educational advancement and access to meals and support services for children, which disproportionately affects low-income families.

PHASE 1B-2 OBJECTIVE	PHASE 1B-2 GUIDANCE
To protect those who are at *high risk* of exposure and transmission given the nature of working and living conditions, to prevent hospitalizations and rates of severe morbidity and mortality, and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems	**Critical workers 50 years and older with significantly high risk of exposure and transmission in congregate settings** Congregate setting refers to an environment where individuals work and/or live in an enclosed space where they are interacting with a high volume of people (i.e., supermarket) over extended time and not able to consistently social distance (i.e., be more than 6 feet apart). This does not include all critical worker groups but just a subset outlined below. This subset is focused on workers who are working in a congregate/enclosed setting working within 6 feet of other workers over an extended time (>3 hours in 24 hour day). Therefore, workers who are able to socially distance, work remotely or work off-site not in a congregate setting would not be included. Specific groups and guidance are outlined below: • *Congregate agriculture* – specifically those who work and/or live in a congregate setting interacting with a high volume of co-workers (vs. animals) over extended periods of time (i.e., >3 hours in 24 hour day). Relevant roles are more likely to include crop selection, production and packaging vs. equipment maintenance • *Congregate food processing* – specifically those who work and/or live in a congregate setting interacting with high volume of co-workers (vs. animals) over extended periods of time (i.e., >3 hours in 24 hour day) • *Workers in congregate grocery stores or food banks* - specifically those who work in a congregate setting interacting with high volume of co-workers over extended periods of time (i.e., >3 hours in 24 hour day). We encourage considering prioritizing retail stores of higher density/volume vs. where people are more able to be socially distant (e.g., wineries, coffee shops). • *Congregate staff in correction facilities, prisons, jails, detention facilities, and court facilities* – specifically those who are interacting with high volume of individuals in a congregate interior setting over extended periods of time (i.e., >3 hours in 24 hour day). We encourage considering the spectrum of staff (e.g., facility management, security, counselors) who fit this exposure criteria. • *Congregate public transit* - specifically those who work in an enclosed (vs. outdoor) congregate setting interacting with high volume of co-workers or general public over extended periods of time (i.e., >3 hours in 24 hour day) to facilitate the transport of people. Settings may include bus, train, ferry, airport, and other high density transportation settings – or lower density settings where individuals are tightly constricted over an extended time, specifically taxies, limos and private vehicles over 4 people). Not include those who can work remotely or in office where can practice being socially distant. • *Firefighters, law enforcement and social workers responding to public health and safety* - specifically those who work in a congregate setting interacting with high volume of co-workers or general public over extended periods of time (i.e., >3 hours in 24 hour day). Not including administrators or those who can work remotely.

Same as above and to reduce the negative societal impact on families and children (that disproportionately affects low-income families)	**Workers 50 years and older years of age in child care settings** **K-12 educators and staff 50 years and older who are working at the school (i.e., not remote workers)** • This category should consider the full spectrum of workers including administrators, environmental services staff, maintenance workers, school bus drivers, paraeducators, and all of who are essential to child care and education. • Specifically, this group includes those who face substantially high risk of exposure given work conditions because they are operating in a congregate setting interacting with co-workers or youth over extended periods of time. • Childcare includes early learning and child care programs that are permitted to operate under DOH guidance for child care, youth development, and day camps. • Attention should be given to the specific programs that reach children with special health care needs, individual educational plans, and technological gaps. • This group should not include those who are working remotely or in a role where they can practice being socially distant.

Phase 1b - Tier 3

Overarching Groups:

- **People 16 years and older with 2 or more co-morbidities or underlying conditions**

Phase 1b – Tier 3 includes people who have certain medical conditions that put them at increased risk for severe illness if infected with COVID leading to increased hospitalization, morbidity and mortality. The list of conditions is based upon research by CDC that is posted at the following site: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html. It is a living document that may be updated as science evolves.

PHASE 1B-3 OBJECTIVE	PHASE 1B-3 GUIDANCE
To prevent hospitalization and rates of severe morbidity and mortality	**People 16 years and older with 2 or more co-morbidities or underlying conditions** (See CDC's list of the conditions that put people at increased risk of severe illness from COVID-19.)

Phase 1b - Tier 4

Overarching Groups:

- **High risk critical workers under age 50 in certain congregate settings (as noted above in Tier 2)**
- **People (residents, staff, volunteers) in congregate living settings (e.g., correction facilities, prisons, jails, detention centers; group homes for people with disabilities) and people experiencing homelessness that access services or live in congregate settings (e.g., shelters, temporary housing)**

Phase 1b – Tier 4 includes two other high risk groups: (1) essential workers from the same groups as Tier 2 but under age 50 and (2) people in congregate living settings where there is a high risk of exposure and transmission. Exposure risk is due to factors such as setting (time inside vs. outside), proximity (to co-workers and/or customers), type of contact (physical, surface), duration, daily number of contacts, capability to assess possible infection (screening), consistent access to/ability to use protection, cleaning (frequency), barriers to healthcare access, etc.

PHASE 1B-4 OBJECTIVE	PHASE 1B-4 GUIDANCE
To prevent hospitalization and rates of severe morbidity and mortality, including in settings that increase potential exposure - and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems	**Critical workers under age 50 with significantly high risk of exposure and transmission in congregate settings.** See Phase 1b – Tier 2 for description of congregate settings to be considered. **Residents and staff in group homes for individuals with disabilities, including serious mental illness, development and intellectual disabilities, and physical disabilities as well as residential substance use disorder facilities not already covered in Phase 1** **People in prisons, jails, detention centers, and similar congregate facilities who work in such settings not already covered in Phase 1** **People experiencing homelessness that access services or live in congregate settings (e.g., temporary housing, shelters)** **People living or residing in domestic violence shelters**

INTERIM COVID-19 Vaccine Allocation Phase Quick Reference

PHASE 1A

TIER 1

- High-risk workers in health care settings
- High-risk first responders
- Long-term care facility residents

TIER 2

- All other workers at risk in health care settings

PHASE 1B

TIER 1

- All people 65 years and older
- People 50 years and older living in multigenerational households

TIER 2

- High-risk critical workers 50 years and older who work in certain congregate settings:
  - Agriculture; food processing; grocery stores; K-12 (teachers and school staff); childcare; corrections, prisons, jails, or detention facilities; public transit; fire; law enforcement

TIER 3

- People 16 years and older with 2 or more comorbidities or underlying conditions

TIER 4

- High-risk critical workers under 50 years who work in certain congregate settings (as noted above in Tier 2)
- People, staff, and volunteers in congregate living settings:
  - Correctional facilities; group homes for people with disabilities; people experiencing homelessness that live in or access services in congregate settings

PHASE 2*

- Critical workers in other settings who are in industries essential to the functioning of society and are at risk of exposure not already covered in Phase 1
- People 16 years and older with 1 comorbidity or underlying condition not already covered in Phase 1
- People with disabilities that prevent them from adopting protective measures

PHASE 3*

- Workers in industries and occupations essential to the functioning of society and at increased risk of exposure not included in Phase 1 or 2
- Young adults/children under 16 years (if vaccine is authorized for children under 16 years)

PHASE 4*

- Everyone residing in Washington State who did not have access to vaccine in previous phases

*Future phases are still tentative and will be finalized based on clinical trial data, federal guidance, vaccine supply projections, and ongoing community input.

Certain population groups have been prioritized with an aim to mitigate health inequities recognizing that specific populations are disproportionately impacted by COVID-19 due to external social factors and systemic inequities. Examples of populations disproportionately affected due to such factors include:

- People of color
- People with limited English proficiency
- People in shared housing, crowded housing, and multi-generational homes
- People in poverty and low-wage earners
- People with disabilities that are connected to underlying health conditions that may put a person at higher risk for COVID-19
- People with access barriers to healthcare

Washington State has also developed a social vulnerability index which includes social determinants of health factors to identify highest vulnerability areas. This will be one of several inputs informing vaccine allocation decisions to ensure equitable allocation.

NOTE Immigration status and health insurance status do not impact an individual's eligibility.

EQUITY IS A CROSS-CUTTING FOCUS

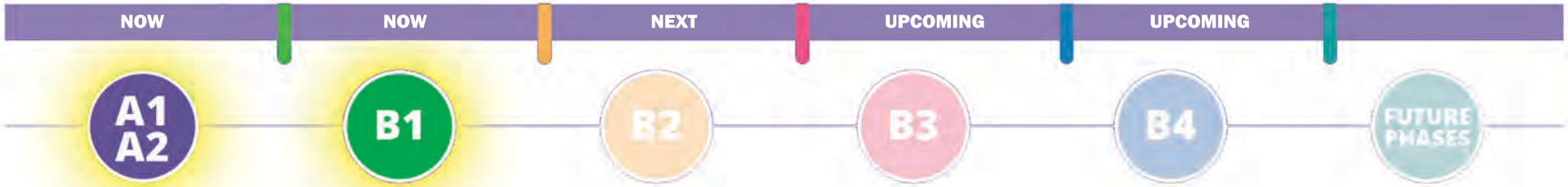
Updated January 17, 2020

SNOHOMISH COUNTY'S COVID-19 VACCINE PHASES

Who is in Phase 1 for vaccination?

Timing between phases will vary. There are currently no firm dates for when future phases will start.

Find more information about COVID vaccine at www.snohd.org/covidvaccine



A1 A2

- High-risk healthcare workers in health care settings
- High-risk first responders
- Long-term care facility residents

B1

- All people **65 years or older**
- People **50 years or older** in multigenerational households

B2

- High-risk critical workers **50 years or older** who work in certain congregate settings: Agriculture; food processing; grocery stores; K-12 (teachers and school staff); childcare; corrections; prisons, jails or detention centers; public transit; fire; law enforcement

B3

- People **16 years or older** with 2 or more co-morbidities or underlying conditions

B4

- High-risk critical workers **under 50 years** who work in certain congregate settings (as noted in B2)
- People, staff, and volunteers in congregate living settings: Correctional facilities; group homes for people with disabilities; people experiencing homelessness that live in or access services in congregate settings

FUTURE PHASES

- Information on who is eligible for Phases 2, 3 and 4 coming soon.

FOCUS ON EQUITY: This approach prioritizes population groups that have been disproportionately impacted by COVID-19 due to external social factors and systemic inequities.

Each group will become eligible for the vaccine one at a time and will continue to be eligible throughout the vaccine distribution. The timelines represented here are estimates and subject to change.

SNOHOMISH HEALTH DISTRICT
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Adapted from the Washington State Department of Health. Updated January 19, 2021

COVID-19 Vaccine Distribution and Prioritization: Frequently Asked Questions

SNOHOMISH HEALTH DISTRICT
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1) Can I get a vaccine now?

For most people, not yet. While there are COVID-19 vaccines arriving and being administered in Snohomish County, we do not have enough to offer it to everyone just yet. Until there is enough vaccine for everyone who wants it, we are following state and federal guidance to help make those tough decisions on who gets the vaccine first. Even if we had an adequate supply of vaccine to cover the entire population, capacity to administer vaccines is also limited. These scarce resources (vaccine, administration capacity) must be allocated over time in a manner to achieve the most benefit for society (greatest good for the greatest number).

Right now we are in Phase 1a, which is focused on high-risk workers in healthcare settings and first responders, as well as residents and staff of long-term care facilities. We will soon open up vaccinations for all other workers in health care settings, once high-risk workers are vaccinated. This phase represents more than 40,000 people in Snohomish County, so it will take time.

After the vaccination of high-risk workers in health care settings are completed, Phase 1a expands to include all other workers in healthcare settings.

More information about the next phases will be provided as it is available. We encourage you to visit www.snohd.org/covidvaccine for updates.

2) Who is in the next phase?

Snohomish County is currently in Phase 1a. After all or most of the people within Phase 1a who want to be vaccinated have been vaccinated, we can advance to Phase 1b.

Phase 1b, as currently adopted by the Washington State Department of Health, has four tiers:

- B1
  - All people 70 years and older
  - People 50 years and older who live in multigenerational households
- B2
  - High-risk critical workers 50 years and older who work in congregate settings: agriculture; food processing; grocery stores; K-12 (teachers and school staff); child care; corrections, prisons, jails, or detention facilities (staff); public transit; fire; law enforcement
- B3
  - People 16 years or older with 2 or more co-morbidities or underlying conditions that have been linked to higher risks of severe COVID infections or complications.
- B4
  - High-risk critical workers in congregate settings under 50 years old
  - People, staff, and volunteers of all ages in congregate living settings: correctional facilities; group homes for people with disabilities; shelters for people experiencing homelessness.

COVID-19 Vaccine Frequently Asked Questions

SNOHOMISH HEALTH DISTRICT
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1) How effective is the COVID-19 vaccine?

There are multiple COVID vaccines at various stages of the development, approval and distribution process. The clinical trials for the Pfizer vaccine showed a 95% efficacy rate and 94% with the Moderna vaccine in preventing symptomatic COVID. That means the rate of catching COVID in vaccinated participants was only 5-6% of the rate seen in those who received placebo. There is still a small chance of infection post-vaccination. Masks and social distancing will be with us for some time to come.

Research is still being done to measure the impact on transmission—whether someone vaccinated can pass the infection on to someone else. Virtually all vaccines both protect against getting the disease and reducing transmission, and it is our hope that these vaccines follow that pattern. As with other vaccines, the more people who get immunized, the greater the community-wide protection against the disease.

2) Is the vaccine safe?

While the COVID vaccine is new, the clinical trials and vetting vaccines go through are not. The speed of the vaccine development process may make people wary, but there have been multiple layers of safety and quality assurance. As was the case for other vaccines in the past, oversight and review of the COVID vaccine authorization process by the FDA and CDC was led by panels of independent experts. Washington was also a member of the Western States Pact, which created the Scientific Safety Review Workgroup for another layer of scrutiny and expert review to this process. Learn more at www.snohd.org/covidvaccine.

3) What are the side effects from the vaccine?

Side effects that have been reported with the COVID-19 vaccine include:

- Pain, redness or swelling at the site of injection
- Fatigue
- Fever
- Headache
- Muscle or joint pain
- Chills
- Nausea
- Swollen lymph nodes

One or more of these side effects are to be expected in up to 1-in-4 people after the first dose and 1-in-2 after the second dose. They generally occur the day after vaccination and are normal signs that the vaccine is working. You can take fever or pain relievers like acetaminophen or ibuprofen if needed or apply a cool compress to the injection site. Contact your healthcare provider if you are concerned or if the symptoms don't go away within two days (48 hours).

COVID-19 Vaccine Frequently Asked Questions

SNOHOMISH HEALTH DISTRICT
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4) What adverse reactions were reported for the vaccine?

There is a remote chance that the vaccine could cause a severe allergic reaction. This was not observed during the clinical trials, but has been observed in rare cases since the vaccine has been implemented outside research studies. Those kind of reactions would usually occur within a few minutes to one hour after getting a dose of the vaccine. Signs of a severe allergic reaction can include:

- difficulty breathing
- swelling of your face and throat
- a fast heartbeat
- itching
- hives
- dizziness and weakness.

If you have a severe allergic reaction, and are not still at the vaccine clinic, seek medical attention or call 911 immediately. The CDC has also created V-safe, a platform for people to share information on their side effects and reactions. All vaccine recipients are encouraged to sign up for this system to provide additional information about the vaccine's side effects as vaccination is implemented. Learn more at www.cdc.gov/vsafe.

5) Will the vaccine give me COVID?

No. The vaccine does not contain SARS-CoV-2 and cannot give you COVID-19.

6) How many doses do I need?

There will likely be multiple potential COVID vaccines rolling out within the next year, so be sure to check with your medical provider on the vaccine for specific instructions. The Pfizer vaccine requires two (2) doses, with the second dose given 17-21 days after the first one. The Moderna vaccine also requires two (2) doses, with the second dose given 28 days after the first one. It's important to make sure you get both doses of the same vaccine brand in order for the vaccine to be most effective.

7) Who will get the vaccine first?

Vaccines will be given out in planned phases. The first phase will be for workers in high-risk healthcare settings and high-risk first responders in order to protect our medical and emergency care capabilities. The first phase will also include residents and staff at nursing homes, assisted living facilities, and other community-based congregate living settings where most of the individuals receiving care are over 65 years of age.

8) How were the phases decided? Can I get vaccinated sooner?

Snohomish County's framework for the phased approach to COVID-19 vaccination is aligned with the Washington State Department of Health (DOH) and the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP). It is important that the framework is consistent

across the state and between counties to ensure that the roll-out of the vaccine is efficient, understandable, and equitable.

While we have received inquiries from organizations, employers or individuals that are interested in being vaccinated earlier in the framework, we do not anticipate adjusting the phases locally in such a way that they would vary from what is adopted by the state Department of Health..

9) How do I know if a message or email offering vaccination options is legitimate?

There are, unfortunately, already scams circulating related to COVID-19 vaccine. Know how to spot vaccine scams. Remember that there are no pre-payments required to "get in line" for vaccination, you cannot pay for early access, vaccines are not available for purchase online, and vaccines must be administered by licensed medical professionals. Most people are expected to be vaccinated by their regular healthcare provider. Turn to your doctor, clinic, or other reliable sources if you are uncertain whether a message or email about COVID vaccine is legitimate. If you receive a vaccination-related communication from someone other than your health care provider, health insurance provider, or employer, you have reason to be suspicious.

You can check back at www.snohd.org/covidvaccine for additional tools to find reliable vaccination options in Snohomish County. These will be added as they become available. You can also reach the Snohomish Health District COVID call center at 425-339-5278 from 8:30 a.m. to 4:30 p.m. on weekdays.

10) When will I get vaccinated?

For most Snohomish County residents, the vaccine is expected to be administered through the existing healthcare system. Connecting to a primary care provider will help to have a smooth pathway to being vaccinated when your turn comes further down the line. If you are not already connected to primary care, now is a good time to work on finding a primary care provider.

If you do not have a primary care provider, are struggling to access healthcare, or do not have insurance, there are resources available. Find information about insurance at www.hca.wa.gov or www.wahealthplanfinder.org. You can also call 2-1-1 for help connecting with health and human services in the community.

Those eligible for Phase 1a should be contacted by their employer or agency. Check www.snohd.org/covidvaccine for updates.

11) Who should get the vaccine?

The FDA has authorized the Pfizer vaccine for individuals 16 years of age or older and the Moderna vaccine for those 18 years of age or older. Tell your vaccine provider about all of your medical conditions. You should not get the vaccine if you have had a severe allergic reaction after a previous dose of the same vaccine or a severe allergic reaction to any ingredient of this vaccine.

COVID-19 Vaccine Frequently Asked Questions

SNOHOMISH HEALTH DISTRICT
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12) If I had COVID, should I still get vaccinated?

Yes, when you are eligible to get the vaccine, it is recommended that you do so. We are still learning about COVID. While reinfection appears to be rare so far, it is possible to get COVID more than once. If you currently have COVID, wait until after your isolation period is done to get vaccinated. Talk with your healthcare provider for additional guidance.

13) Do I get to choose which vaccine I get?

Right now, only the Pfizer and Moderna vaccines have been authorized for distribution. As we learn more from the clinical trials, there may be a vaccine that is more appropriate for you than another. We encourage you to talk with your healthcare provider to know what is recommended for your circumstances.

14) Once I get the vaccine, can I stop wearing a mask?

The vaccine looks to be very effective, but it's not perfect. Even after you are vaccinated, you will need to avoid gatherings, wear a face covering and keep your distance when around people outside your household. This isn't forever, just for now.

15) How soon can we get back to pre-pandemic activities?

The COVID vaccine is a big step on the path out of this pandemic, but it is not an instant solution. If all goes smoothly, it will likely take 9-12 months to fully vaccinate most of the population. That's another 9-12 months of fighting COVID with the same measures we're relying on now. Wear a mask. Avoid gatherings. Stay home if you're sick. Keep your distance and wash your hands. We can't let our guard down until public health and medical professionals agree it is safe to do so.

16) How does the vaccine work?

The Pfizer and Moderna vaccines aremessenger RNA vaccines, also known as mRNA vaccines. These are a new type of vaccine to protect against infectious diseases, but they have been known and researched for decades.

To trigger an immune response, many vaccines put a weakened or inactivated germ into our bodies. Not mRNA vaccines. Instead, they teach our cells how to make a protein from the virus—or even just a piece of that protein—that triggers an immune response inside our bodies. That immune response, which produces antibodies, is what protects us from getting infected if the real virus enters our bodies later.

COVID-19 Vaccine Frequently Asked Questions

SNOHOMISH HEALTH DISTRICT
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17) What is in the vaccine??

You may see some rumors about ingredients listed online or in social media. These are generally myths. The ingredients in the Pfizer and Moderna vaccines are pretty typical for a vaccine. They contain the active ingredient of mRNA along with other ingredients like fat, salts, and sugars that protect the active ingredient, help them work better in the body, and protect the vaccine during freezing. See this Q&A webpage from the Children's Hospital of Philadelphia for more information about ingredients.

COVID-19 Vaccine Distribution and Prioritization: Frequently Asked Questions

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3) When does the next phase or tier start?

We do not have a firm date for when Phase 1b will begin in Snohomish County. There are roughly 40,000 people within Phase 1a to vaccinate. The goal is to move to Phase 1b as soon as possible, and work is ongoing to expand vaccination options and access in Snohomish County.

If you believe you are in Phase 1b, please hold off calling for an appointment until Phase 1b goes into effect. Our vaccine providers are currently busy taking calls for and scheduling Phase 1a vaccinations. It is important that we all let them focus on those in order to continue on to Phase 1b as quickly as we can.

4) What are the underlying conditions or co-morbidities eligible for vaccination under Phase 1b3?

Adults with certain underlying medical conditions are at increased risk for severe illness from the virus that causes COVID-19. Severe illness from COVID-19 is defined as hospitalization, admission to the ICU, intubation or mechanical ventilation, or death.

Those over 16 who have two or more of the following would be eligible under Phase 1b3:

- Asthma (moderate-to-severe)
- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Cystic fibrosis
- Down Syndrome
- Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Hypertension or high blood pressure
- Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines
- Immunocompromised state (weakened immune system) from solid organ transplant
- Neurologic conditions, such as dementia
- Liver disease
- Obesity (body mass index [BMI] of 30 kg/m2 or higher)
- Pulmonary fibrosis (having damaged or scarred lung tissues)
- Pregnancy
- Sickle cell disease
- Smoking
- Thalassemia (a type of blood disorder)
- Type 1 and 2 diabetes

For more information about these conditions, please see the CDC's website.

COVID-19 Vaccine Distribution and Prioritization: Frequently Asked Questions

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5) What if I share a household with someone who is high-risk; can I get the vaccine when they do?

Not yet, unless you are eligible under the same phase or tier. If you share a household with someone who is high-risk based on age, underlying health conditions, or the nature of their work and exposure risk, it's important to maintain all health measures for yourself and to get vaccinated when your turn comes in the phased approach.

If the person you live with gets vaccinated before you do, this will help reduce the risk of them catching or spreading the virus. However, to keep your household member and yourself healthy, it's still vital to take steps like handwashing, cleaning and sanitizing, and avoiding large gatherings or any gatherings that are indoors or unmasked.

Those who are older than 50 and live in multigenerational households (currently defined as two or more generations in the same household) will be eligible for vaccination in the first tier of Phase 1b (Phase 1b1).

6) How and where do I get vaccinated?

There are multiple options for getting vaccinated against COVID-19 in Snohomish County, and we expect those options and access to expand in the coming weeks and months.

1. Once you become eligible, check with your primary healthcare provider, clinic or local pharmacy on their vaccination process.

2. If you are eligible under Phase 1a, your employer may provide vaccination if they are an approved COVID vaccine provider. They also may partner with a pharmacy or medical provider on vaccination clinics, or provide a voucher for you to get vaccinated by one of the other COVID vaccine providers in our county.

    a. If you are an employer and staff are eligible under Phase 1a, visit www.snohd.org/covidvaccinevoucher for more information on vouchers or to submit a request.

    b. If you are an employee who is eligible in the first phase, please talk to your employer. You can share the www.snohd.org/covidvaccinevoucher link with them for information.

3. Several vaccination sites are under development by the Snohomish County Vaccine Taskforce. These sites are meant to enhance vaccination efforts and supplement the existing healthcare system. Vaccination at these sites is by appointment only. If multiple people in the same household are eligible and being vaccinated at the same time, they each need individual appointments. Information on who is eligible for vaccination and what vaccination sites are available will be updated online as that information emerges.

    The Washington State Department of Health will soon be launching an online tool to determine what phase you will be in. Visit www.snohd.org/covidvaccine or www.covidvaccinewa.org for updates.

COVID-19 Vaccine Distribution and Prioritization: Frequently Asked Questions

SNOHOMISH HEALTH DISTRICT
WWW.SNOHD.ORG

Snohomish County

7) Do I need insurance?

According to the CDC, vaccine doses purchased with taxpayer dollars will be given at no cost in the United States. However, vaccine providers may charge an administration fee for giving the shot to someone. For those without insurance, the vaccine still is provided at no cost. Vaccine providers can get the administration fee for uninsured patients reimbursed by the Health Resources and Services Administration's Provider Relief Fund.

Those who have health insurance should have their insurance information with them when they make an appointment and when they show up for vaccination. Vaccine providers may not bill patients for any portion of the vaccine administration fee that is not covered by insurance.

8) How long will it take to vaccinate enough people so that we can resume more pre-pandemic activities?

Like any new process, it will take time for the vaccine distribution and administration to ramp up to the point where we can vaccinate everyone in Snohomish County who wants to be vaccinated. This is why it will likely take many months for the benefits of vaccine to be seen at a population-wide level. Most estimates suggest that 70-80% of the population would need to be vaccinated, and we hope to reach those levels within about 6-9 months. We haven't really been here before, so estimates on how long it will take for society to open up and life to normalize are more educated guesses than predictions.

However, vaccines are just one part of the equation. The new Healthy Washington: Roadmap to Recovery provides a framework for regions to safely ease some restrictions while also maintaining crucial hospital capacity. Throughout the vaccination process, we must keep up with existing health measures, including masking, physical distancing, and avoiding social gatherings with people you don't live with. These preventive measures can help achieve the decline transmission levels so further economic recovery can happen.

9) Is the COVID vaccine mandatory?

Washington is not currently considering any mandates for the vaccine, but employers could require it. The Snohomish Health District recommends that all people who qualify get vaccinated unless they have a specific medical condition that indicates otherwise. The vaccine will help protect you from becoming ill with COVID-19. We encourage you to review trustworthy credible sources of information to help you make the best choice for you.

10) Why is it taking so long to get all of the vaccines out?

We know everyone is looking forward to it being their turn to getting the vaccine, and everyone is working as fast as possible to make that happen. Most vaccination campaigns that occur under non-emergency conditions take at least a year to plan and several years to reach good coverage. Considering multiple vaccines were developed and manufactured within a year of the virus being identified in this country, and we already have thousands of people vaccinated here in Snohomish County, the timeline is pretty remarkable.

An entire personal and public health care system is having to reframe staffing, space, materials and other resources to implement this. Enough vaccine needs to be distributed to providers, and there needs to be enough providers available to administer the vaccine. Logistics such as scheduling, locations, staffing, and managing records for things like second-dose follow-up take time to put in place and require resources and staffing to implement. This is all on top of a pandemic that has already significantly strained the systems, simultaneously working to test those potentially exposed, prevent outbreaks from happening, and treat those infected.

Planning for and standing up large-scale vaccination sites are also quite different from testing sites. There is an approval process for administering vaccines, requiring specially trained personnel to perform the vaccination. Specific storage and supply requirements need to be factored into site selection. Information needs to be verified for the patient to ensure they are both eligible for the phase and a candidate for the vaccine being provided based on medical history. After being vaccinated, individuals must be observed for a period of time to watch for possible reactions. Immunization records need to be provided to the individual, which includes the lot number for the specific vial the vaccine is being drawn from. Those records also need to be entered into the statewide immunization registry.

In the coming weeks and months, we expect the COVID vaccine distribution and administration process will become much smoother and the pace of vaccination will increase significantly.

11) I hear stories about vaccines being wasted or expiring. Is that happening here in Snohomish County?

We have not received any reports of vaccine wasting locally, nor are there concerns at this time about vaccines expiring in Snohomish County before they can be used.

12) Other counties or states are vaccinating different people/groups first. How was the prioritization in Snohomish County determined?

Our goal is to harmonize with the Washington State Department of Health's phase allocation direction. These have been adapted from thoroughly researched and highly detailed work conducted by vaccine, public health, and ethics experts with the National Academy of Medicine and the Centers for Disease Control and Prevention. DOH also conducted surveys among consumers and other key stakeholders in Washington State that it incorporated into the development of their framework. For more information on their process, contact covidvaccine@doh.wa.gov.

As the process moves along, it will be important to consider a county's population and workforce characteristics. Some counties or regions are known for being healthcare or medical hubs, meaning it will take longer to vaccinate Phase 1a individuals. Others have much smaller communities and the ability to reach more vaccine coverage in a shorter period of time.

COVID-19 Vaccine Distribution and Prioritization: Frequently Asked Questions

SNOHOMISH HEALTH DISTRICT
WWW.SNOHD.ORG

Snohomish County

13) I have heard about people getting vaccines that aren't currently eligible. How is that possible?

This occasionally happens if there are no-shows or more people vaccinated than anticipated. For instance, the Moderna vaccine comes in a vial that holds enough for 10 doses. Once it reaches a particular temperature or has been opened, it needs to be used within six hours. To avoid vaccine waste, it may be reasonable to vaccinate what we call "sub-eligible" candidates with residual vaccine from vials that would otherwise have to be discarded if not used within a few hours. These sub-eligible candidates are usually close to eligible based on their work duties and/or site of employment. Beyond that, the Health District has not endorsed vaccination of ineligible or sub-eligible individuals.

Safe Re-Opening District Handbook

District Staff Training,
Q&A & Talking Points

FACE COVERINGS, PHYSICAL DISTANCING, COHORTING & HANDWASHING

FACE COVERINGS

All students, staff, volunteers, or guests are required to wear cloth face covering at school when indoors.

HOW TO WEAR YOUR FACE COVERING

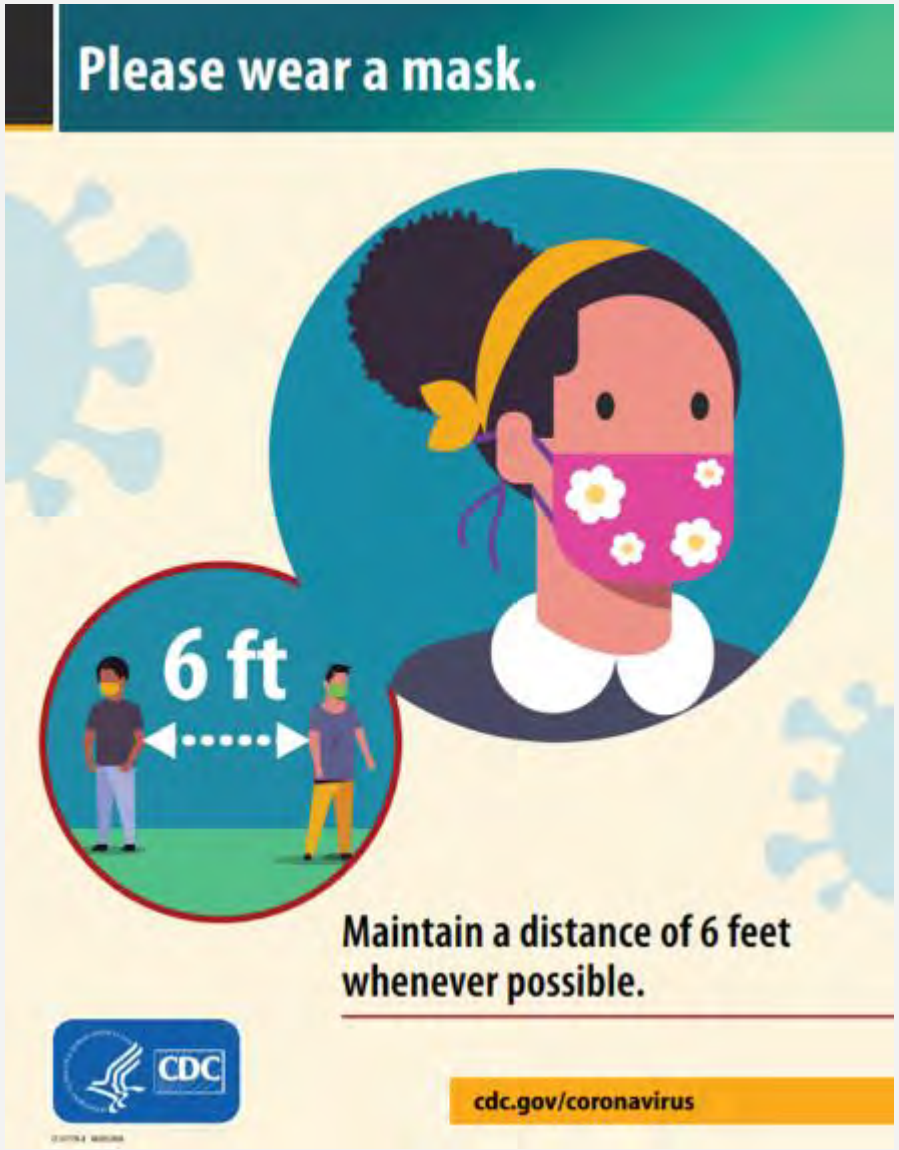
- Wear a face covering to protect others.
- Wear a cloth face covering that covers your nose and mouth to help protect others in case you're infected with COVID-19 but don't have symptoms.
- Wear a face covering in public settings when around people who don't live in your household, especially when it may be difficult for you to stay six-feet apart.
- Wear a face covering correctly for maximum protection.
- **Don't** put the face covering around your neck or up on your forehead.
- **Don't** touch the face covering, and, if you do, wash your hands or use hand sanitizer to disinfect.

EXCEPTIONS

- **Exceptions must be validated by medical professional who provides documentation for condition that excludes individual from wearing cloth face covering**.
  - Respiratory conditions – severe asthma, or breathing difficulties.
  - Disability, special education or healthcare need, mental health conditions, sensory concerns.
  - Deaf or hard of hearing and those who care or interact with deaf or hard of hearing student.
  - Advised by medical, legal or behavioral health professional that wearing a face covering may pose a risk to that person
- For exceptions, may use clear face covering or a face shield.

FACE COVERINGS

- Schools will provide disposable masks for those who don't have them.
- Students and staff will continue practicing physical distancing while wearing masks.
- Supervise younger children wearing face coverings or shields.
- For informational videos on how to properly wear a face covering, visit **www.sno.wednet.edu/reopening/facecoverings**



FACE COVERINGS

- General instruction scenario is considered low-transmission risk when students and teachers are wearing cloth face covering and physically distancing.
- Students may remove their face covering to eat and drink and when they can be physically distanced outside at six-feet or greater.
- Students needing a "mask break" may be taken them outside or to a large, well ventilated room where there is sufficient space to ensure more than six feet of physical distance between people.

TEACHER AND STAFF GUIDANCE

Can face shields be worn in place of cloth face masks?

- Yes, in certain circumstances. L&I has updated their guidance to allow staff to wear face shields when a face covering reduces the effectiveness of instruction, (for example, during speech therapy, demonstrating enunciation, or language instruction). This is determined by the educator leading the instruction. For all other activities (staff meetings, hallway monitoring, playground or cafeteria monitoring, etc.) staff must wear a cloth face covering unless they fit into one of the exemption categories.

PHYSICAL DISTANCING

- Physically distancing is six-feet minimum spacing or separation between individuals.
- Social distancing helps to limit transmission when combined with proper face covering.
- Face covering or desk Plexiglas screen does not substitute for physical distancing.
- Student desks are separated six-feet between student and teacher, center to center.
- Desks should face the same direction as much as possible.
- When social distancing is difficult for passing in hallways and moving around student desks, people should maintain social distancing as much as practical in these situations.
- Create queues with floor markers spaced for physical distancing.
- Create one-way directional student traffic patterns in the hallways and entries with floor markings.

COHORTING

We will create cohorts or smaller groups of students with dedicated staff who will remain together throughout the day, at recess and time. These groups will remain consistent from day to day and should not be combined or mixed.

Cohorts are to:

- Remain consistent
- Ease the contact tracing process
- Simplify testing and possible quarantine

COHORTING

- Keep cohorts with dedicated staff and separate from other cohorts during:
  - Arrival and building entry
  - Mask breaks
  - Lunch
  - Recess
  - Release and building exit
- Assign classroom and lunchroom seating within cohorts
- Limit sharing of devices, toys, manipulatives or other classroom teaching aids.

HANDWASHING

Hands should be washed:

- Before arriving at school
- Before meals or snacks
- After outside activities
- After going to the bathroom
- After sneezing or blowing their nose
- Before leaving school

Children and adults should not to touch their eyes, nose, and mouth with unwashed hands.

Cover coughs or sneezes with a tissue, throw the tissue in the trash, and clean hands with soap and water or hand gel.

HANDWASHING

- Hand washing for at least 20 seconds thoroughly scrubbing with soap and water
- Hand sanitizer with at least 60% alcohol is alternative to hand washing thoroughly spreading and rubbing over hands.
- Use of hand sanitizer by younger children should be supervised by an adult.
- Keep hands away from the front of the face covering, nose eyes, and mouth to prevent contamination.

REMINDER

All of us have a role to play to help **stop the spread** of germs. Through face coverings, physical distancing, cohorting and handwashing we can help prevent the spread of respiratory viruses such as COVID-19.

COVID-19 – SUPERVISORS, RESPONSE & CONTACT TRACING

COVID-19 SUPERVISORS

According to the Washington State Department of Health, the Washington Office of Superintendent of Public Instruction (OSPI), and the Department of Labor and Industries a site-specific COVID-19 supervisor shall be designated by the employer at each school and other worksites to monitor the health of employees and enforce the COVID-19 safety plan.

COVID-19 SUPERVISORS

Job duties and role of the COVID-19 site supervisors

- Stay up to date with current information from Washington State Department of Health, the Washington Office of Superintendent of Public Instruction (OSPI), Snohomish Health District and the Department of Labor and Industries along with information that is distributed by the Snohomish School District.
- In collaboration with the custodial department makes requests for and receives additional personal protective equipment.
- Monitor the health of employees and track staff and students who may be quarantined or not able to come to school due to COVID-19 related reasons.
- Place students who become symptomatic at school into the isolation room, monitor them, and contact the student's parent/guardian.
- Assist in the daily screening of staff and students who did not complete the daily self-attestation prior to coming to school.
- Work with school administrators.
- Act as the site liaison to the district's director of communications after the district is notified of a confirmed positive COVID-19 case.

CONTACT TRACING

What can you expect in terms of contact tracing for close contacts?

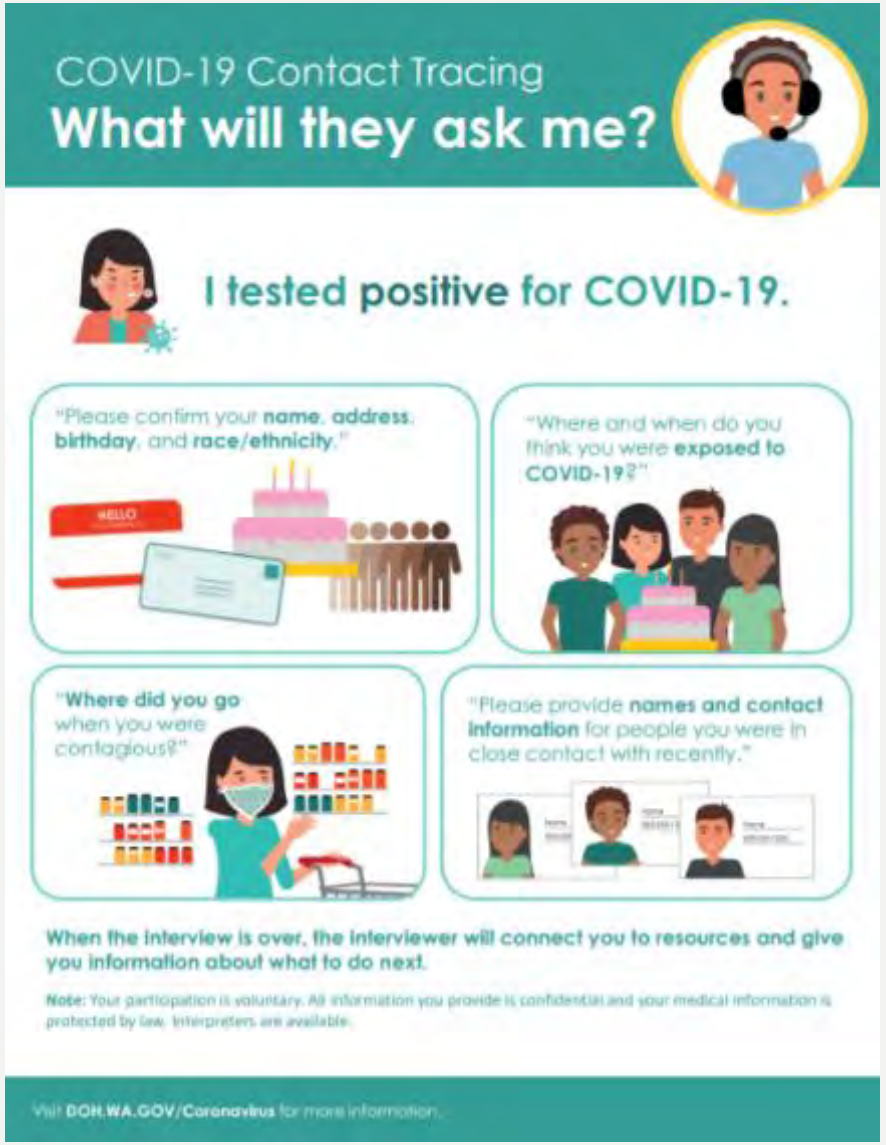
What to expect should a school or worksite have an individual with a confirmed case?

CONTACT TRACING

The Snohomish Health District has a specific team dedicated to responding to COVID-19 cases in schools.

What if there's a confirmed case of COVID-19 among a staff member or student?

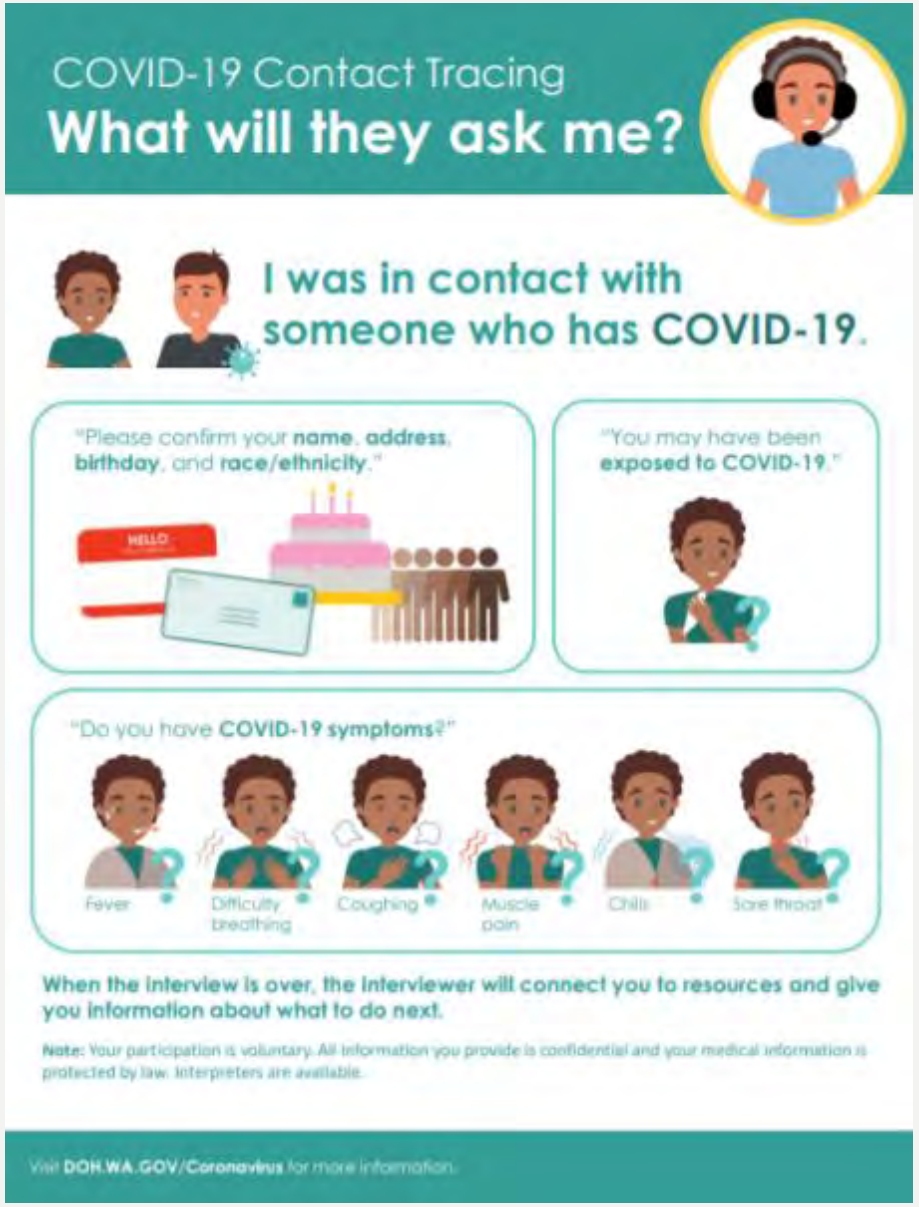
- The Snohomish Health District will contact and interview the person who tested positive.
- The Snohomish Health District work with the district to identify any close contacts of the person who tested positive.



CLOSE CONTACTS

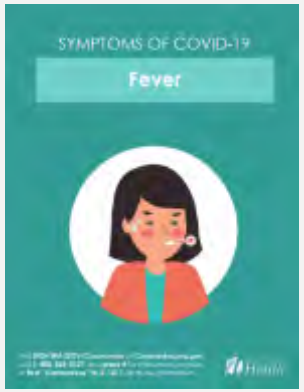
The Snohomish Health District has defined close contacts as:

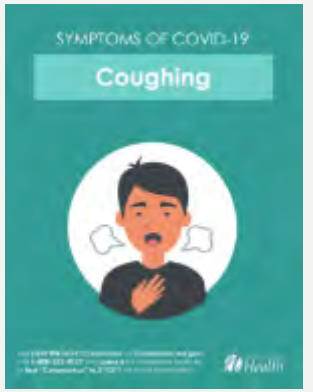
- Any person who was within six feet of the positive person for longer than 15 (cumulative) minutes.
- The close contact window is 48 hours from the date of symptom onset or the date of the test (if asymptomatic)
- If a staff member or student is a close contact of a confirmed case they will be contacted directly from the Snohomish Health District and will be required to quarantine for 14 days from their most recent contact with the positive person.
- The Snohomish Health District will provide the start and end date of the quarantine period.
- It is suggested that others who are within the same household are urged to quarantine at the same time.

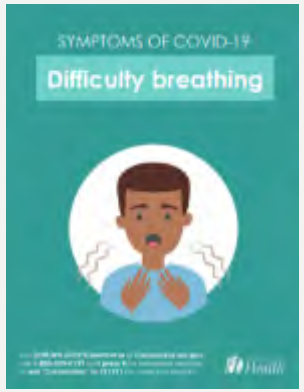


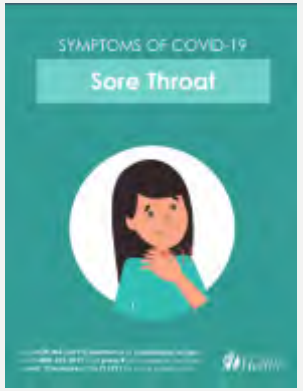
CONFIRMED CASE

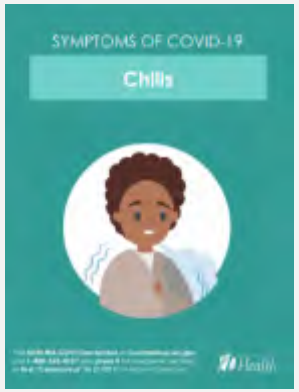
If there is a confirmed case of COVID-19 at a school, a team of individuals from across the district (COVID-19 supervisor, principal, communications, custodial, maintenance, administration, etc.) to enact a safety plan.

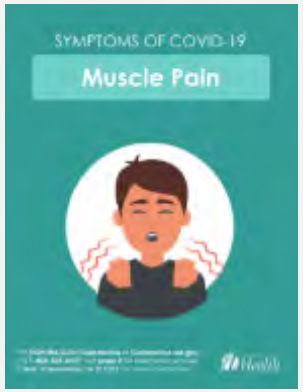


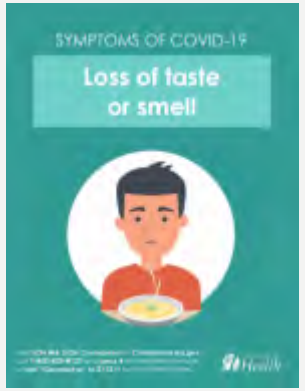












PRIVACY

- Do not expect your school or the Snohomish Health District to provide the name of a student or staff member who has tested positive for COVID-19. This is protected personal health information under the Health Insurance Portability and Accountability Act (HIPAA).
- Public health and schools also are not providing detailed information that could identify individuals.
- Contact tracers are required to adhere to privacy requirements. They will do their best to answer questions, but won't divulge others' personal health information.
- If you know the identity of someone who has COVID-19 through personal channels, do not share that information publicly. Identifying ill students or staff on a public platform does not add to disease control efforts, and is likely to raise problems rather than solve them.

REMINDERS

- Each school and worksite within the district has an identified COVID-19 supervisor. If you do not know who this person is, ask your direct supervisor or building administrator.
- COVID-19 supervisors are responsible for requesting and receiving additional personal protective equipment, monitoring and tracking the health of employees and students within the building, and also working with the director of communications should a building or worksite have a positive COVID-19 case.

REMINDERS

- The Snohomish Health District has a dedicated team to work with schools for close contacts and positive cases.
- Our district liaison to the health district is Kristin Foley, Director of Communications.
- Information regarding staff or student close contact or confirmed case is protected by HIPAA.
- Direct questions or concerns to your building administrator or specific-site COVID-19 supervisor.

RESPONSE HANDBOOK

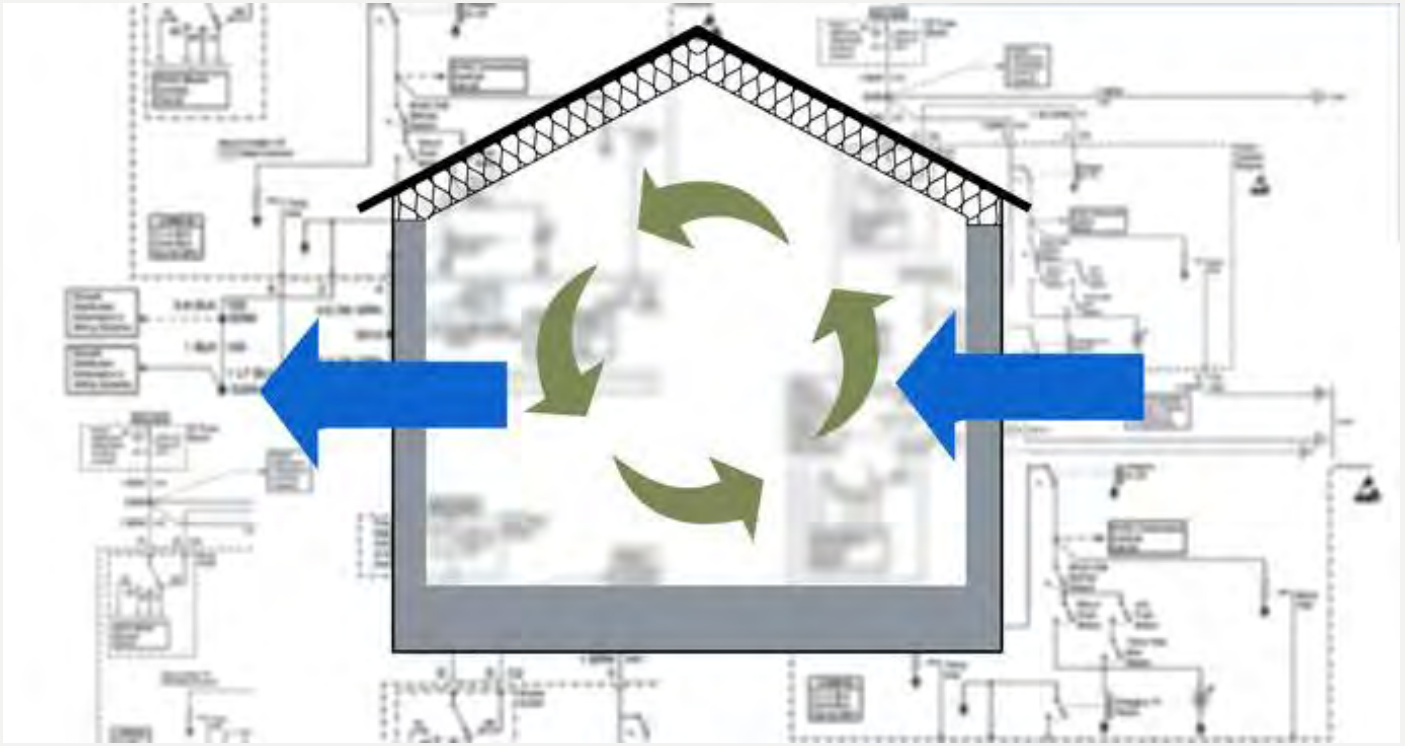
To prepare for the potential of a student or staff showing symptoms while at school, the Snohomish School District has a response plan in place that includes communication with staff, families, and the Snohomish Health District. For a copy of the district's Safe Re-Opening Schools 2020 Handbook please visit www.sno.wednet.edu/reopening/responsehandbook.

VENTILATION, DISINFECTION & CLEANING

AIR QUALITY

Good ventilation of outside fresh air, combined with good air filtration, provides good indoor air quality.

What have we done in the Snohomish School District to provide good indoor air quality?



FILTRATION & VENTILATION

Filtration

- The HVAC air filters have all been replaced.
- The quality of the filtration has been upgraded to meet new standards.
- Portable air purifiers have been provided in places where needed such as the isolation rooms.

Fresh Air and Ventilation

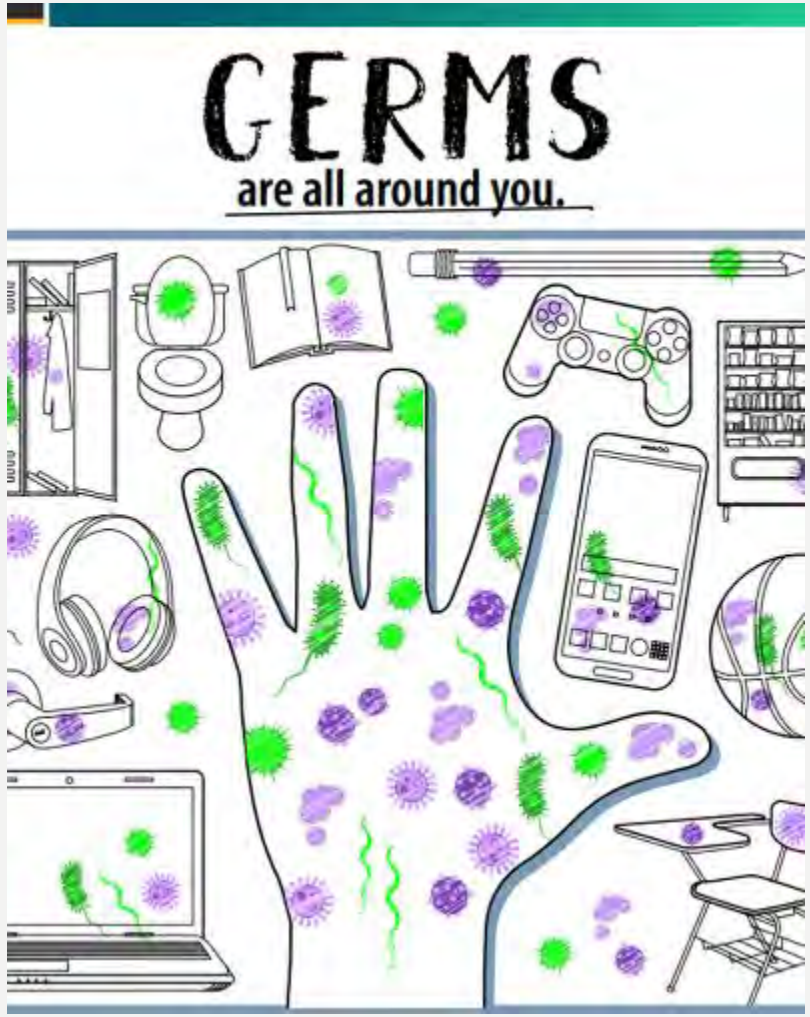
- Increased the amount of fresh air supplied by the ventilation system.
- Performing two-hour building flush-out overnight.
- Upgrading building heating and cooling controls where needed to improve the amount of outside fresh air.

Portable classrooms

- All filters have been replaced with upgraded filtration.
- The heating system cannot be controlled for maximizing outside fresh air.
- Therefore, room box fans are supplied when desired to open the window to increase outside air.
- Portable air purifiers provided to purify the air when the box fan is not running.
- The box fan and the portable air purifier are to run or the other but not simultaneously.

DISINFECTION & CLEANING

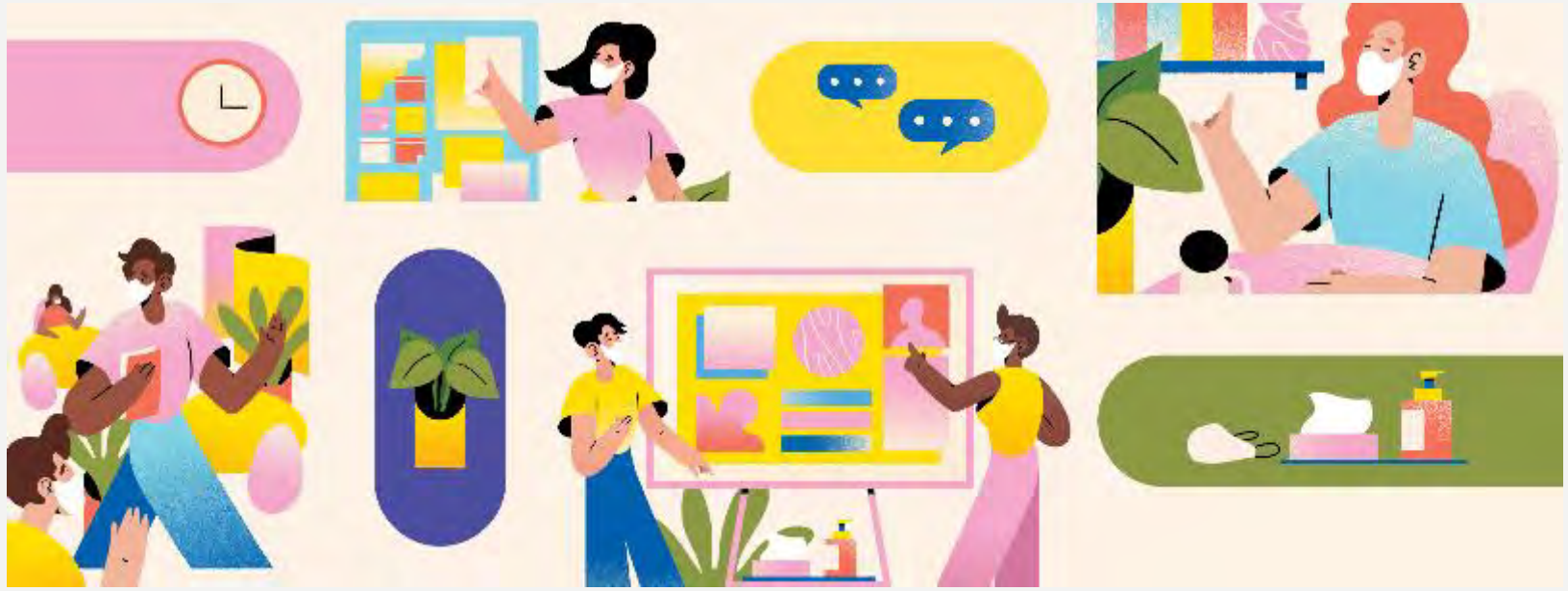
- We are committed to maintaining a safe work and teaching environment.
- In the following training we will cover:
  - How to disinfect your personal work space.
  - An overview of the custodial disinfection plan for schools.
  - How each of us can contribute to the safety of our staff, students and community while at our workplace.



DISINFECTION & CLEANING

What is your personal work space?

- Desk
- Computer, including screen, keyboard, mouse, speakers, etc.
- Phone and/or handset
- Chair
- Personal devices used by you
- Plexiglass shield



DISINFECTION & CLEANING

How to clean your personal work space

- Appropriate personal protective equipment (PPE) - Usually gloves plus a mask if needed.
- Ensure adequate ventilation.
- Disinfect when students are not present for a minimum of 15 minutes.
- Follow directions on cannister, bottle, or can.
- If possible spray onto towel or rag and wipe on surfaces.
- The disinfected surface should remain wet. Allow to air dry.
- Rinse/wipe with water if cleaning food prep area.
- **All disinfection and most cleaning products must be kept out of the reach of children.**

PLEXIGLASS

- Do not use alcohol-based cleaners.
- Mild soap and water is recommended.
- Use non-abrasive towel or cloth.
- Quaternary ammonium- or hydrogen peroxide-based cleaners can be used for disinfection.
- Possible products safe for plexiglass include Clorox wipes, Envy spray, Lysol wipes, Virex, Purell wipes, Oxivir, Renown spray and Final Step 512. Please request assistance from custodial staff if you don't have one of these products.

DISINFECTION & CLEANING

- **All disinfection and most cleaning products must be kept out of the reach of children.**
- Safety data sheets (SDS) are available in your building and can be requested from the custodial office.
- Baby wipes are available upon request. These may be used by students and will greatly assist in the cleaning and disinfection process.

CUSTODIAL PROTOCOLS

Custodians will continue to do their routine work on a regularly scheduled basis, including cleaning, disinfection, sweeping, restocking, cafeteria, trash, vacuuming, and recycling

- Restrooms
  - Thorough cleaning and disinfection of restrooms 2x day.
  - Including all sinks, touchpoints, toilets, and dispensers. Floors mopped once a day.
  - Cleaning logs on bathrooms for verification
- Staff are encouraged to use staff restrooms as much as possible.

- High-touch areas will be disinfected multiple times a day including:
  - Sinks
  - Light switches
  - Faucets
  - Tables
  - Drinking fountains
  - Door handles
  - Crash bars
  - Push plates
  - Handrails
  - Vending machines (if operational)
  - Elevator buttons
  - Front desk and lobby surfaces

CUSTODIAL PROTOCOLS

All classrooms will be cleaned and disinfected each night.

- Teachers personal spaces will be the teacher's responsibility.
- Classroom touchpoints
  - Switches
  - Door handles
  - Crash bars
  - Sinks

- Counters (must be clear of all objects)
- Desks (must be cleared off with chairs should be on desks unless previous arrangements have been made with principal and custodial staff)
- Student chairs
- Garbage and recycling
- Vacuuming as needed with complete vacuuming once a week

CUSTODIAL SERVICES PLACARDS

- Most classrooms and offices have been given custodial services placards. These are for staff to place on their doors to show that someone has occupied the room.
- This helps the custodial team from duplicating cleaning in areas that have already been cleaned.
- Please contact your COVID-19 supervisor if you need your placard to be replaced.

HERE TO HELP

- This is a team effort.
- To facilitate cleaning and disinfection please keep counters and tables clear of objects when they are not being actively used.
- Staff are encouraged to use staff restrooms whenever possible.
- Baby wipes are safe for all of us to use including students. Baby wipes require no PPE. Please talk to your COVID-19 supervisor if you would like a package of baby wipes.
- Remember to mask up, maintain physical distance and wash your hands!

Daily Symptom Check

The Daily Symptom Check

- Each morning parents, faculty and staff will receive an email.
- Parent with multiple students in the district, will receive one email per student

Hello Jane,

Please take a moment to complete the daily symptom check. You must complete this symptom check every day in order to be present at the school.

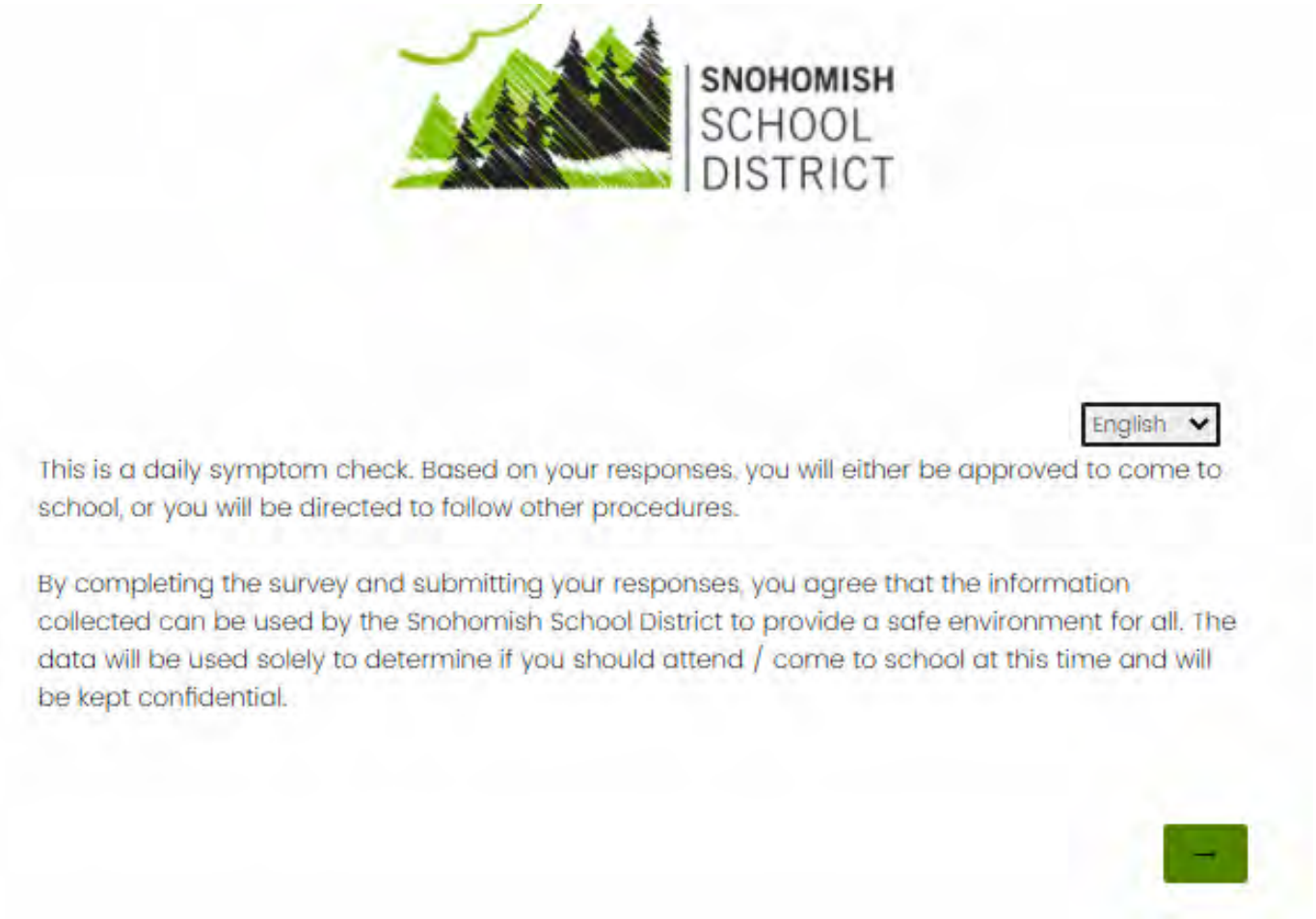
Please click here to take the Daily Symptom Check.

Or copy and paste the URL below into your Internet browser:
"https://snohomishsd.sjc1.qualtrics.com/jfe/form/SV_eYhMhEcoV2S9ClL?RID=CGC_BRFmA38fcTNH4Is&Q_CHL=email"

If you have any questions, or need assistance, please contact your school/work site directly.
Thank you.

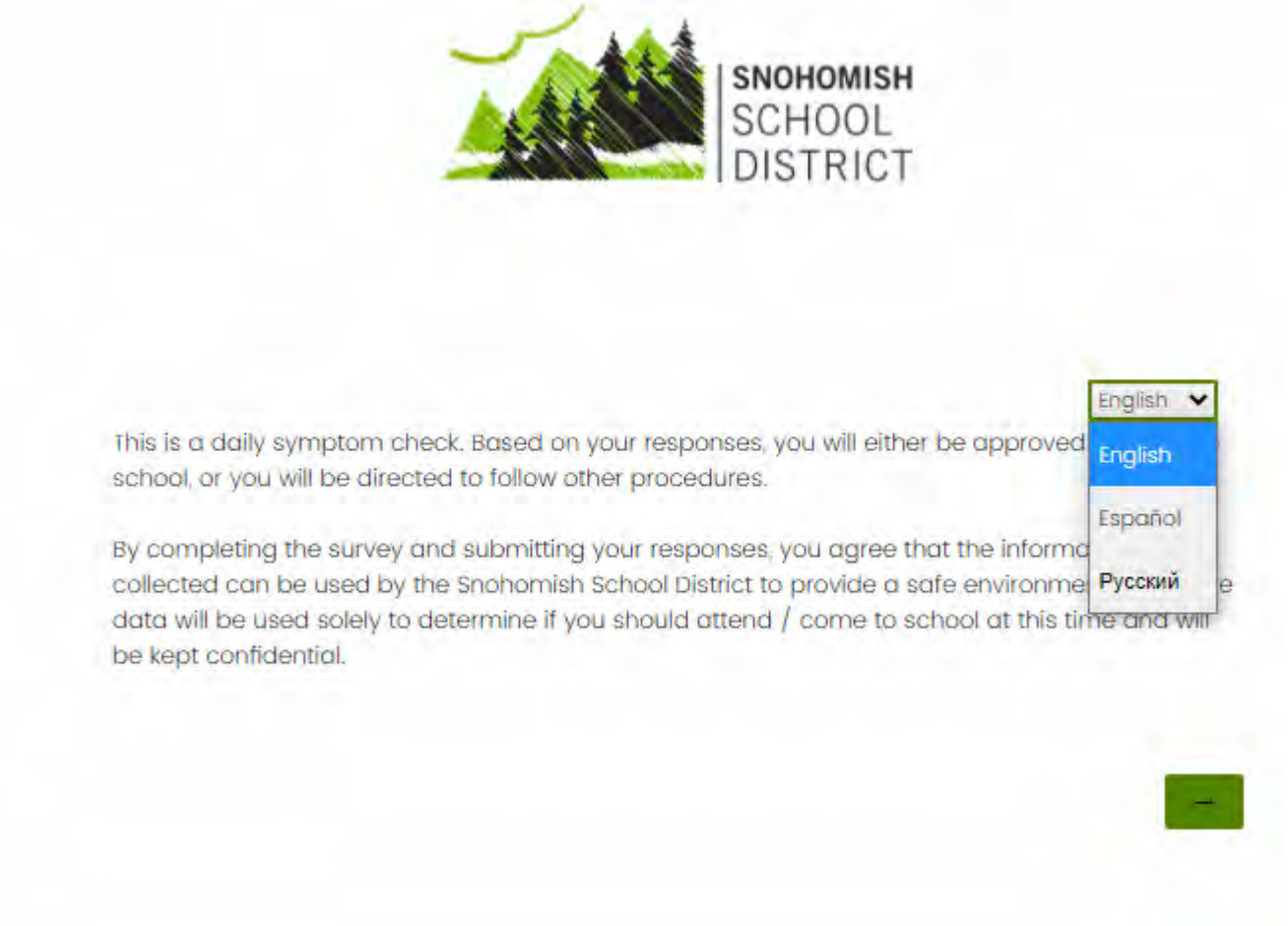
The Daily Symptom Check

- Selecting the link will open a browser window
- No separate app needs to be downloaded



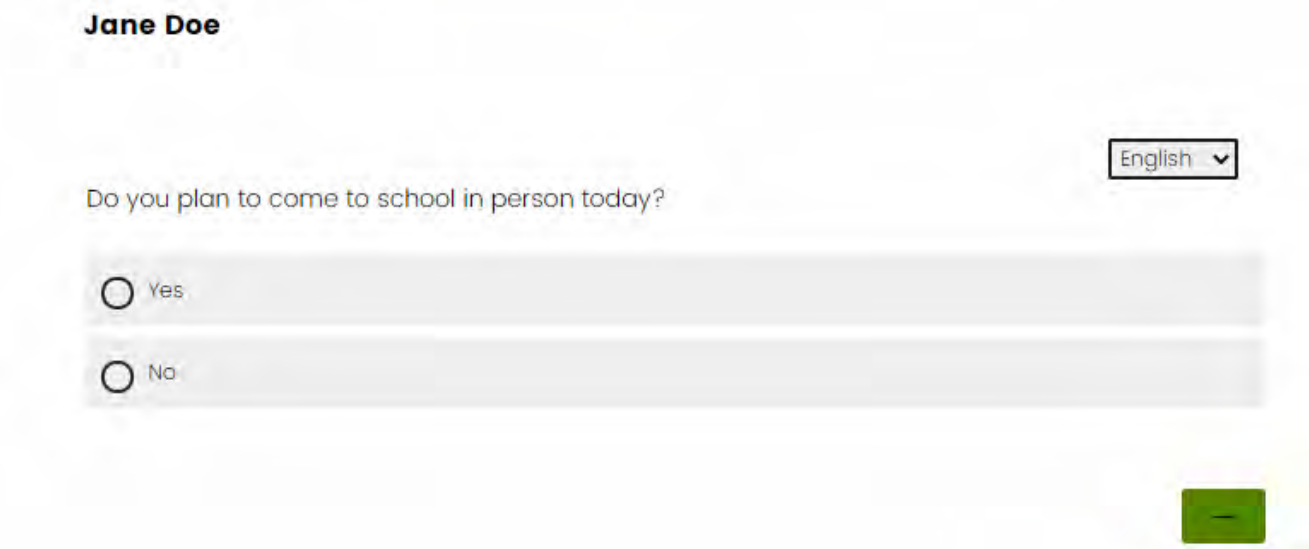
The Daily Symptom Check

- The languages English, Spanish or Russian are available



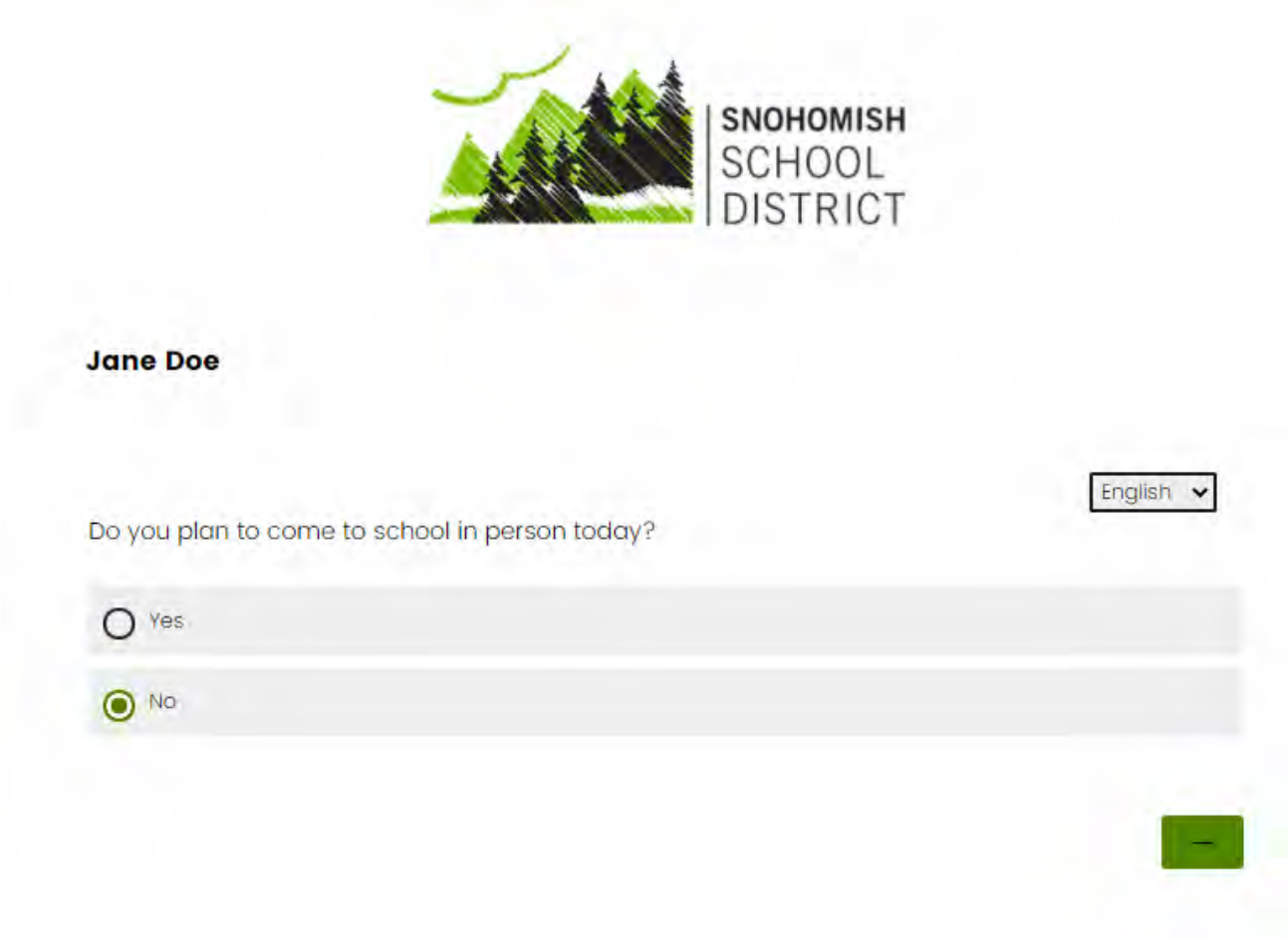
The Daily Symptom Check

- The name of the person who the attestation is for is already included when using the emailed link
- When using the QR code, an email address as well as the name needs to be entered



The Daily Symptom Check

- You will be asked, if you plan on coming to school today



The Daily Symptom Check

- If you select “NO”, you will not be certified to come to school today and the survey will end at this point.
- If you later decide you need to come to school, you can click the link on this notification to update your attestation

SNOHOMISH SCHOOL DISTRICT

Jane Doe

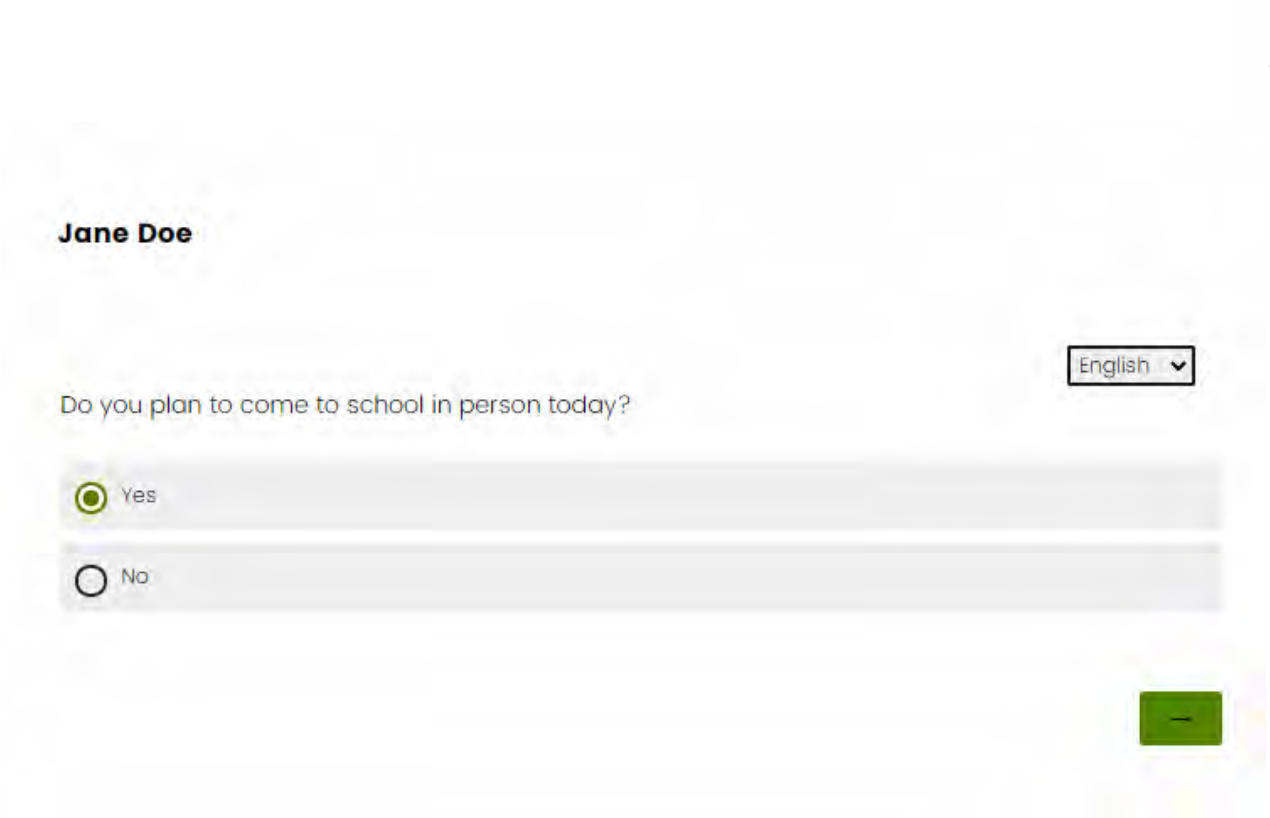
Thank you for your response. If you are ill please follow standard procedures for reporting an absence.

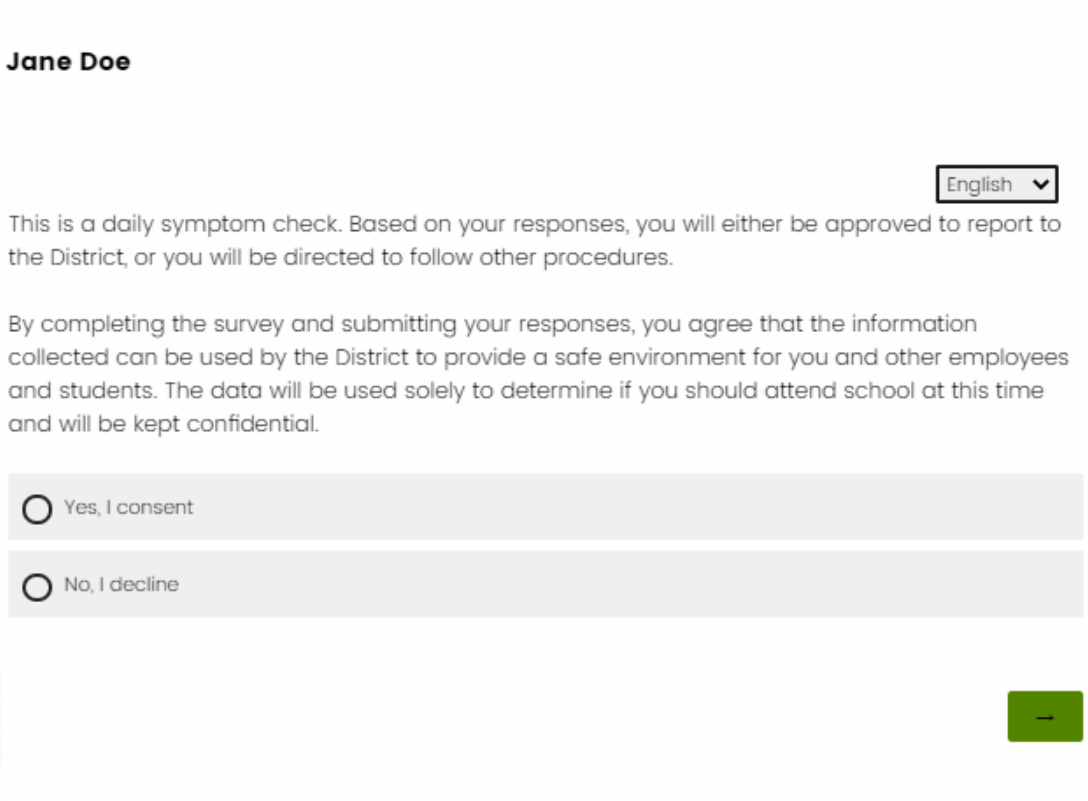
Status: NOT AT SCHOOL TODAY
Date/Time: Tuesday, October 27th 5:02 PM

If you need to attend school later today, please use this link to complete the survey and be cleared to enter.

The Daily Symptom Check

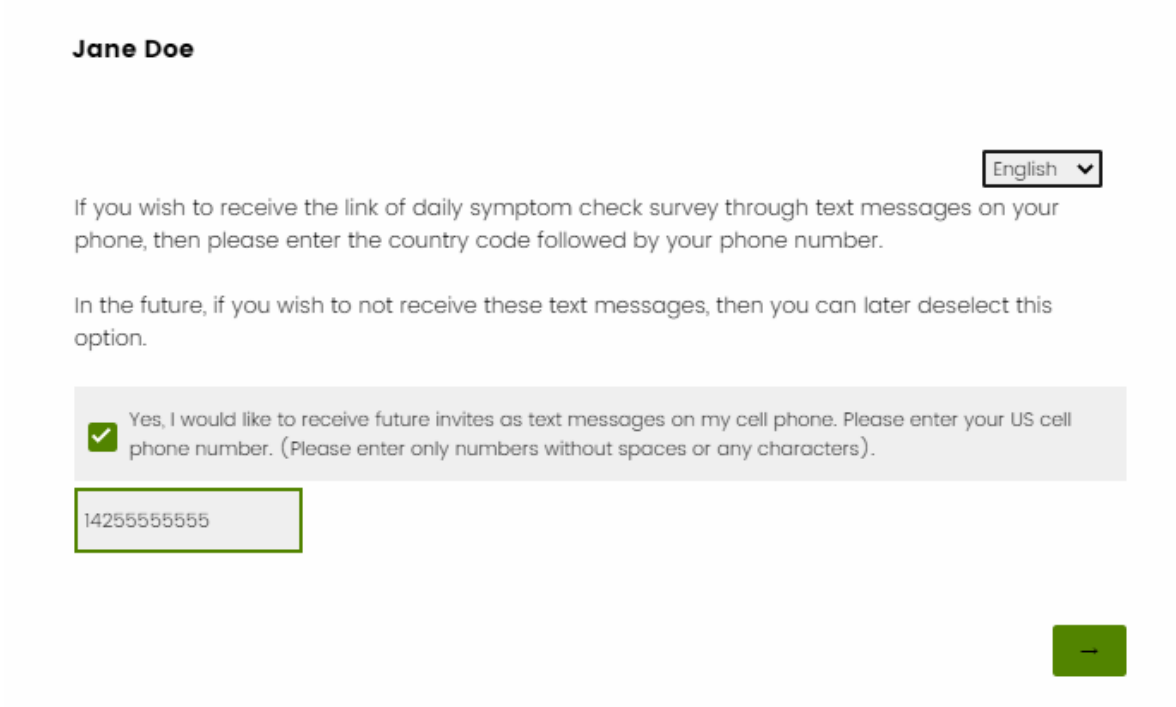
- If you select “yes”, you will be asked to give your consent.
- This answer will stay on file and you won’t have to consent again.





The Daily Symptom Check

- Next, there is the opportunity to provide a cell phone number in order to receive the daily symptom check via text message in the future.
- Note that this will be in addition to the daily email and that the entered number can be updated every time you take the survey

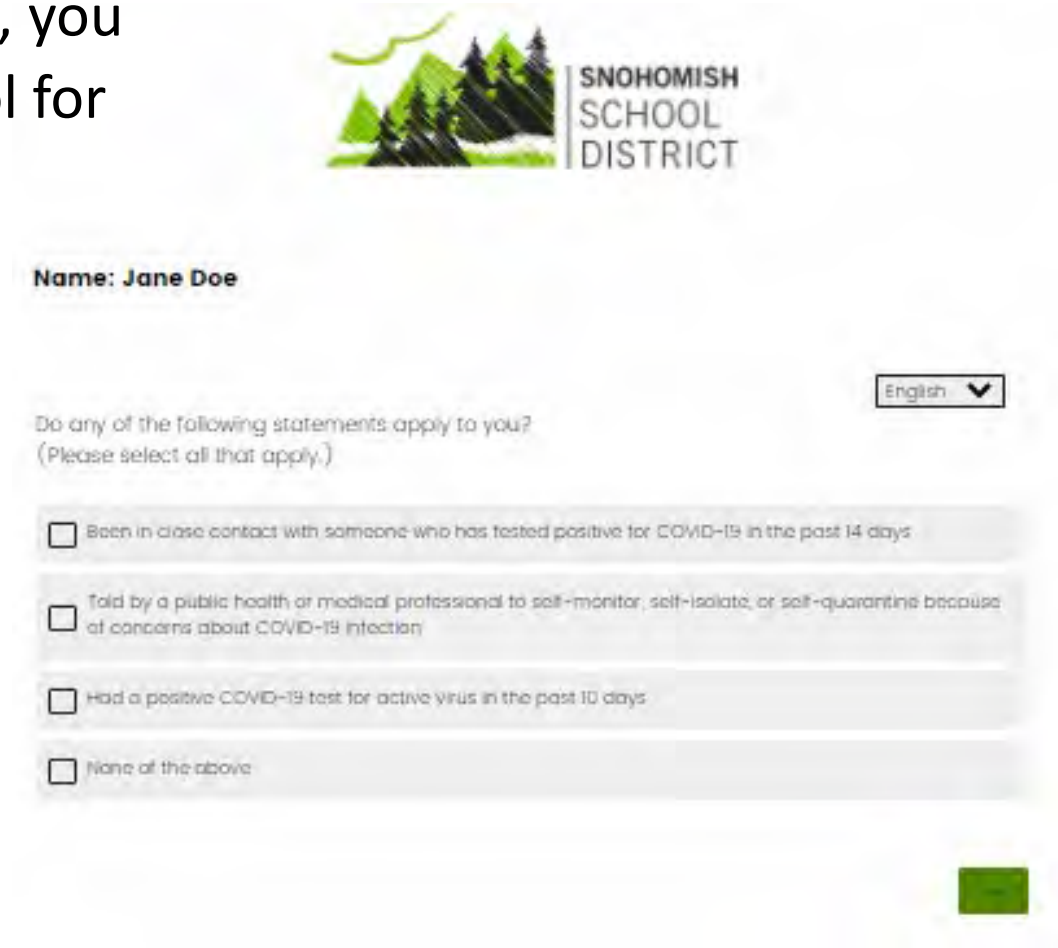


The Daily Symptom Check

- A list of symptoms will be presented
- If you are experiencing any of these, you will be asked to stay at home and possibly contact your health care provider
- If you are symptom fee, you will be asked about a potential COVID -19 exposure

The Daily Symptom Check

- If you have not had any exposure, you will be certified to come to school for that day.



The Daily Symptom Check

SNOHOMISH SCHOOL DISTRICT

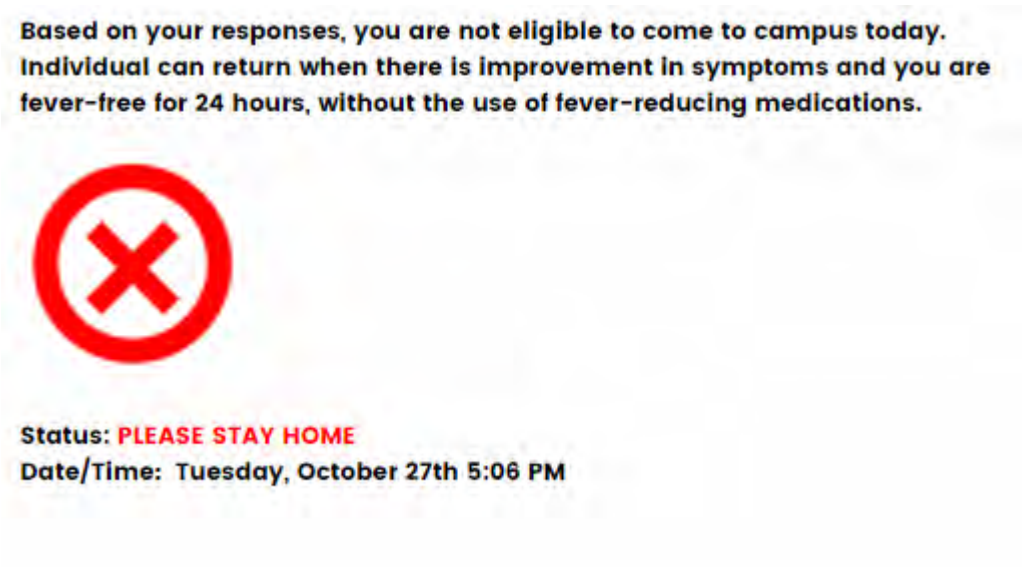
Jane Doe

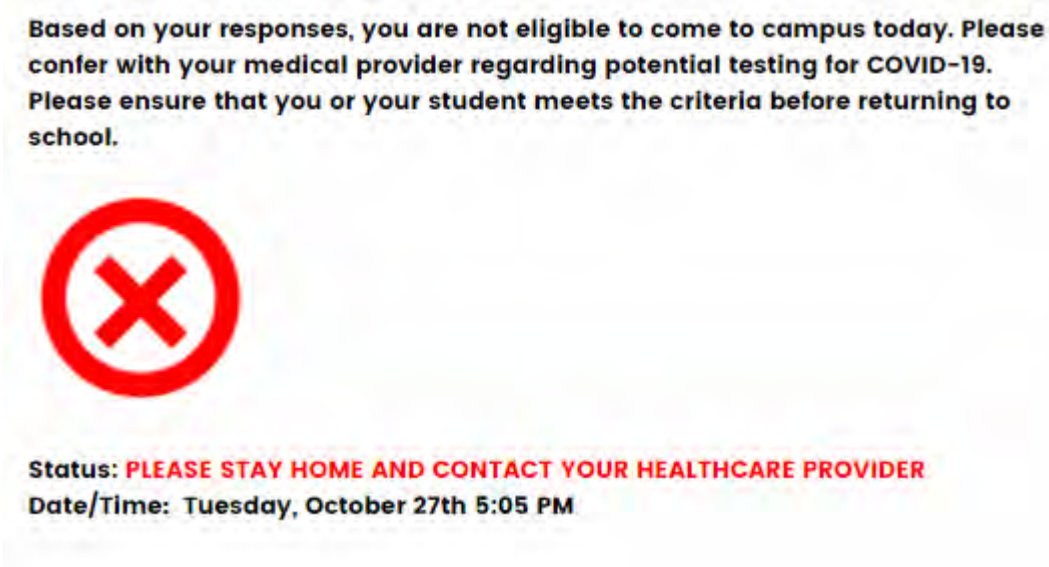
Based on your responses, you are eligible to come to school today.

Status: APPROVED
Date/Time: Tuesday, October 27th 4:36 PM

The Daily Symptom Check

- If you had any symptoms or exposure, you won't be certified to come to school.
- Depending on the answers, one of the messages below will be received.





The Daily Symptom Check

- The attestation result will also be sent to you via email
- Please take a screenshot or have the email available on your mobile device in order to present it when you get to school or your building
- If you won’t be able to do so, help will be available upon your arrival at your school.

Daily Symptom Check Dashboard

Daily Symptom Check Dashboard User Roles

Daily Symptom Check Dashboard - User Roles

Building-Health Role:

- Principals
- Assistant Principals
- Nurses
- Covid-19 Supervisors

This role can see student-, staff-, and visitor attestations for the building including checked symptoms.

Daily Symptom Check Dashboard - User Roles

Building-Gatekeeper Role:

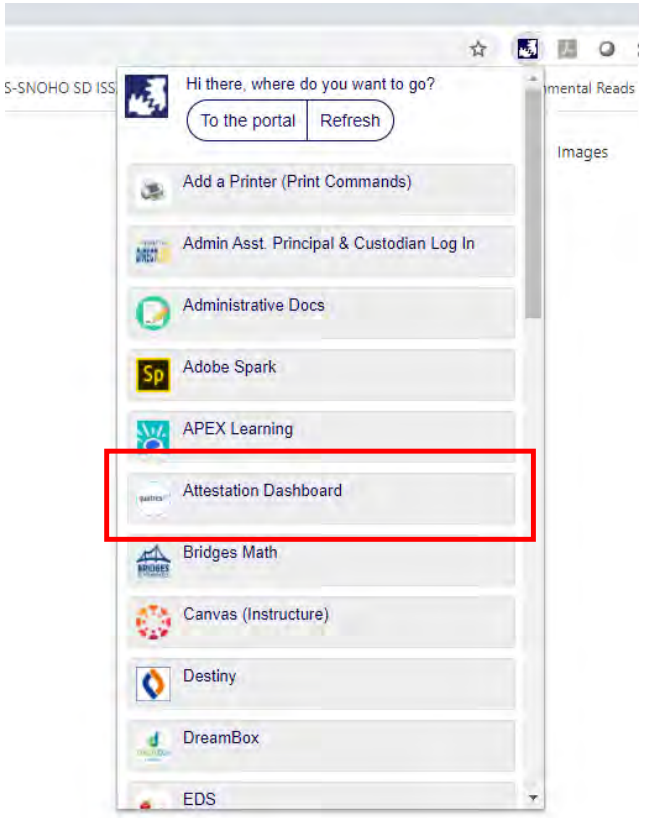
- All who have Building-Health role
- Admin Assistants
- Main Office Secretaries

This role can see student-, staff-, and visitor attestations for the building as “Certified”, “Not Certified”, “Not Coming to School” or “Not Responded”

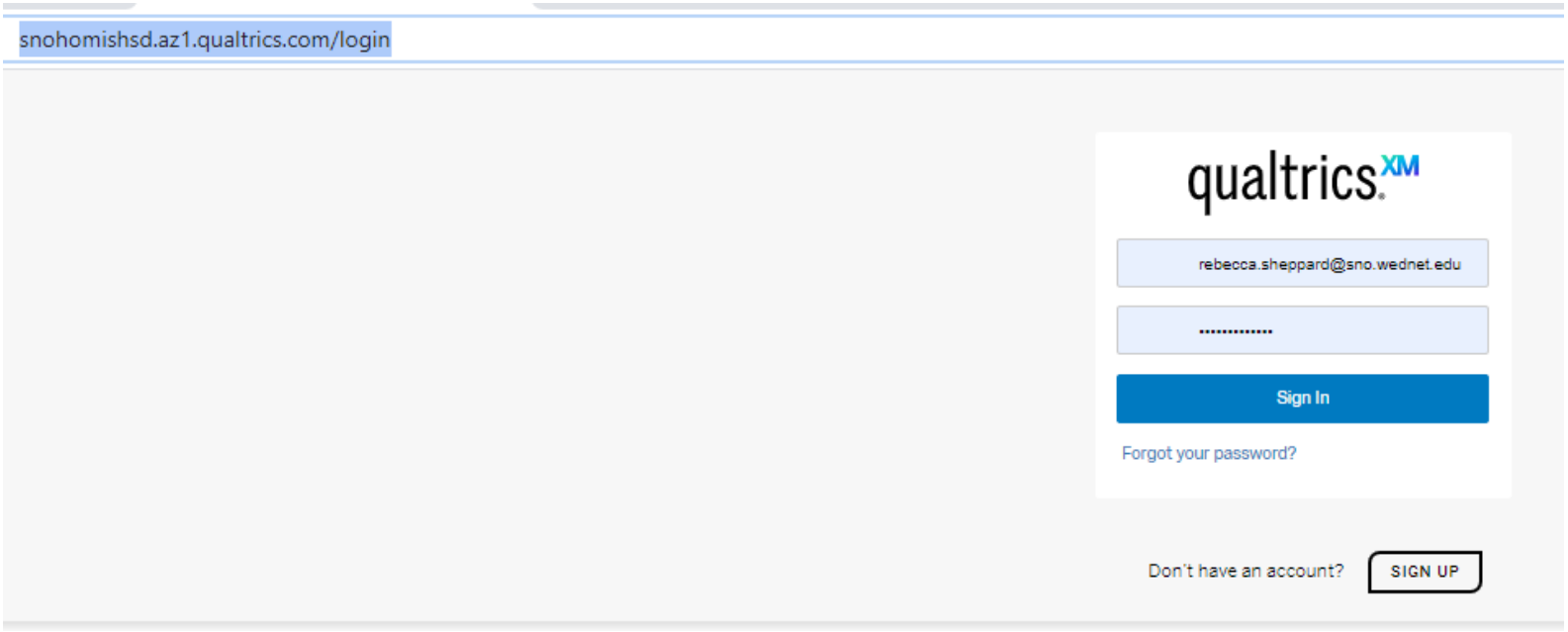
Daily Symptom Check Dashboard Login

SNOHOMISH SCHOOL DISTRICT

- Go to HelloID and select “Attestation Dashboard”

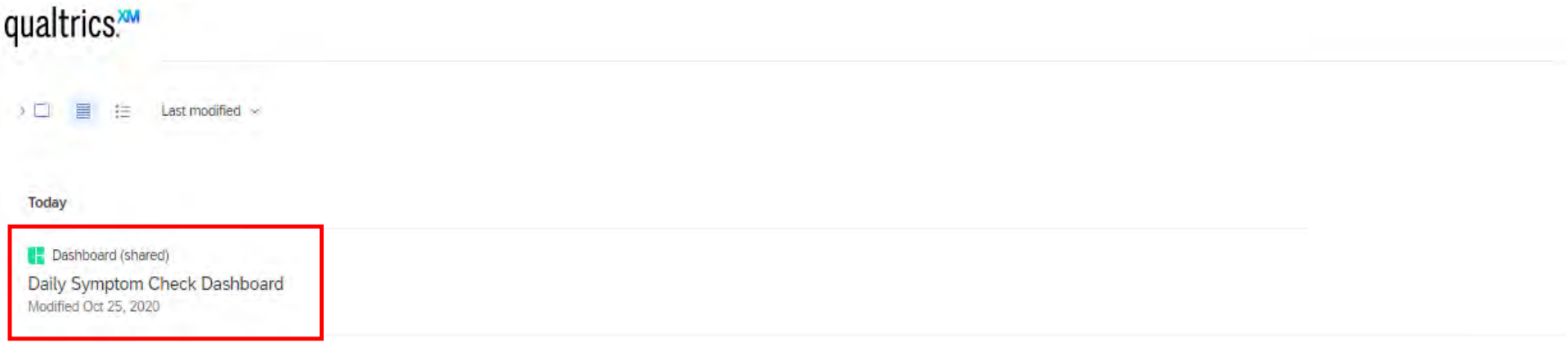


- Enter your login credentials



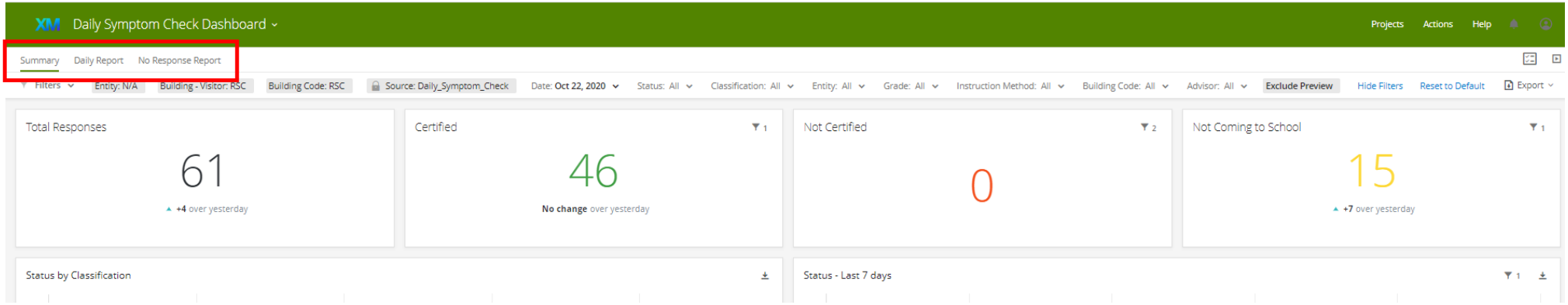
SNOHOMISH SCHOOL DISTRICT

- Click on “Daily Symptom Check Dashboard”



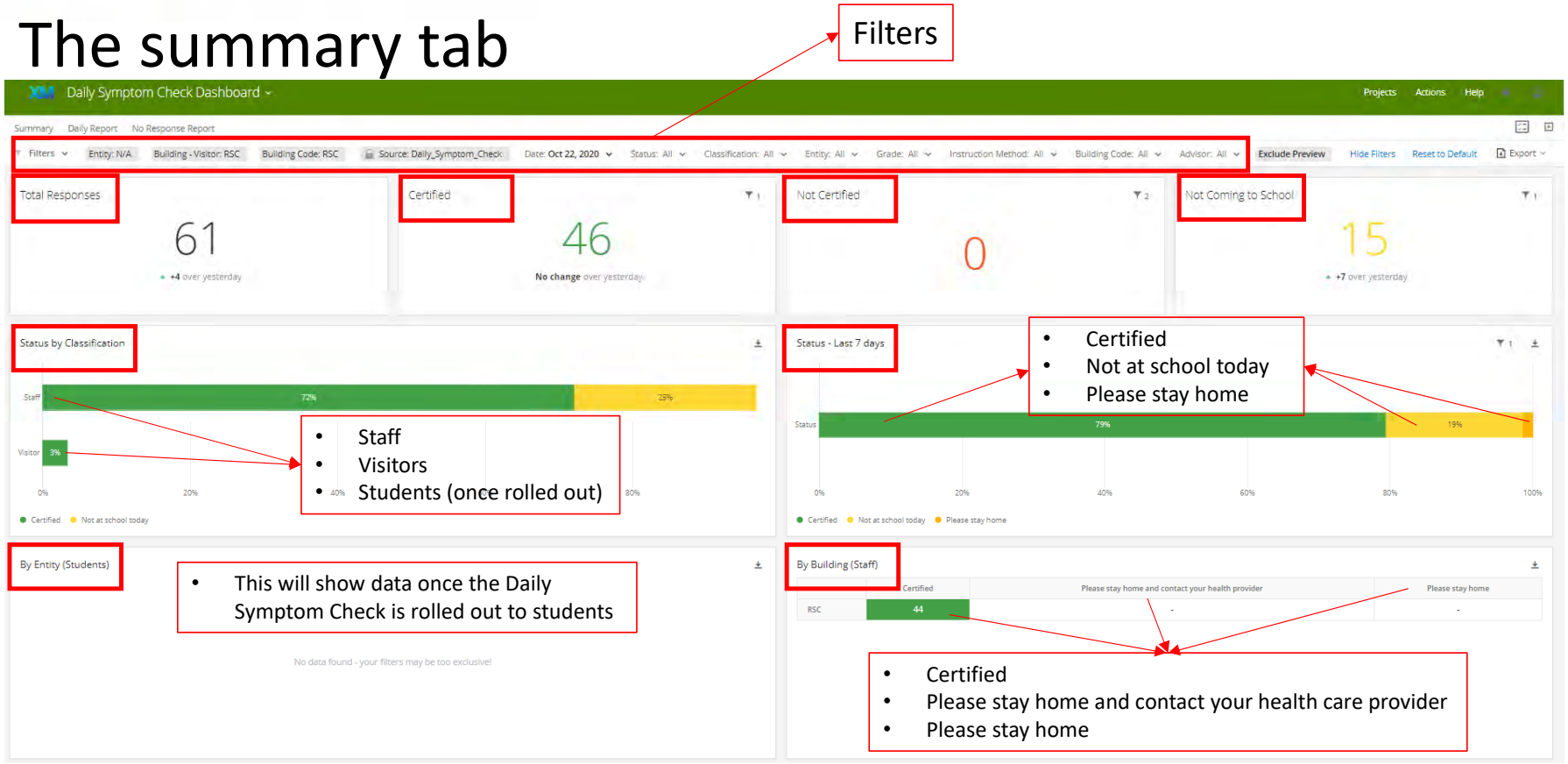
Daily Symptom Check Dashboard Tabs

- There are four tabs for Administrators, nurses and Covid-19 supervisors
- There three tabs for office staff
  - Summary
  - Daily Report
  - Health Report – not for office staff and or teachers
  - No Response Report

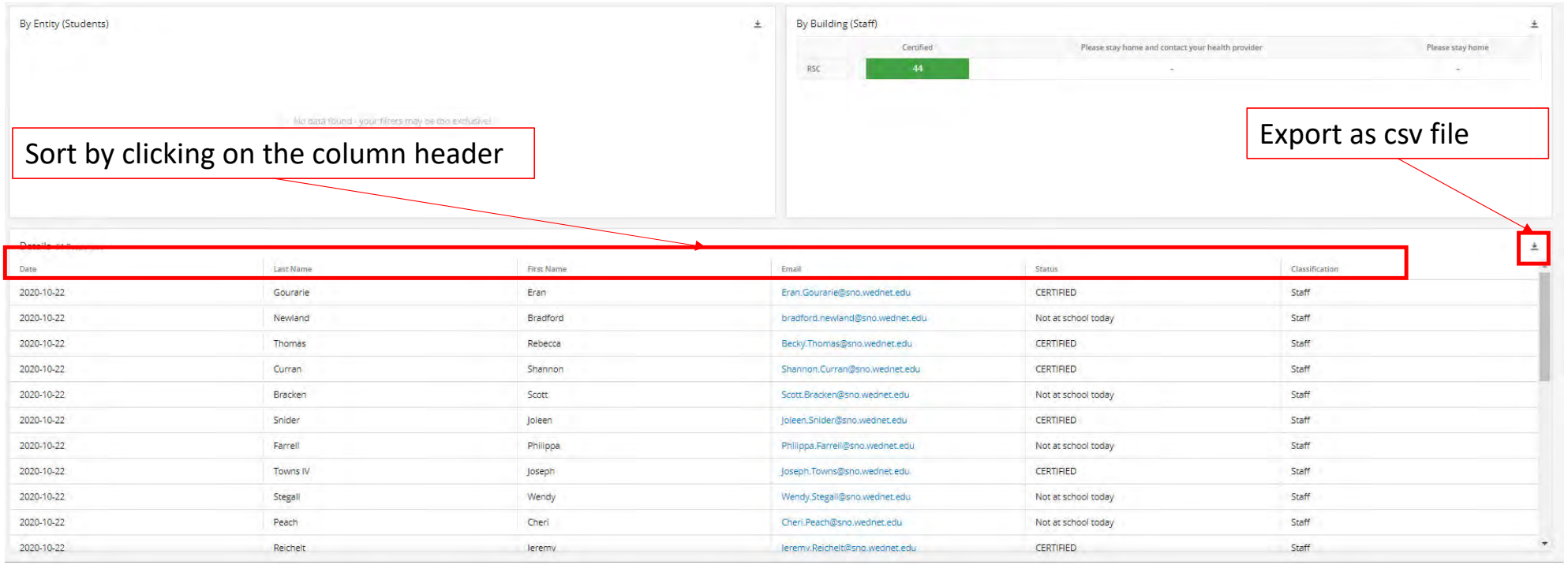


SNOHOMISH SCHOOL DISTRICT

The summary tab

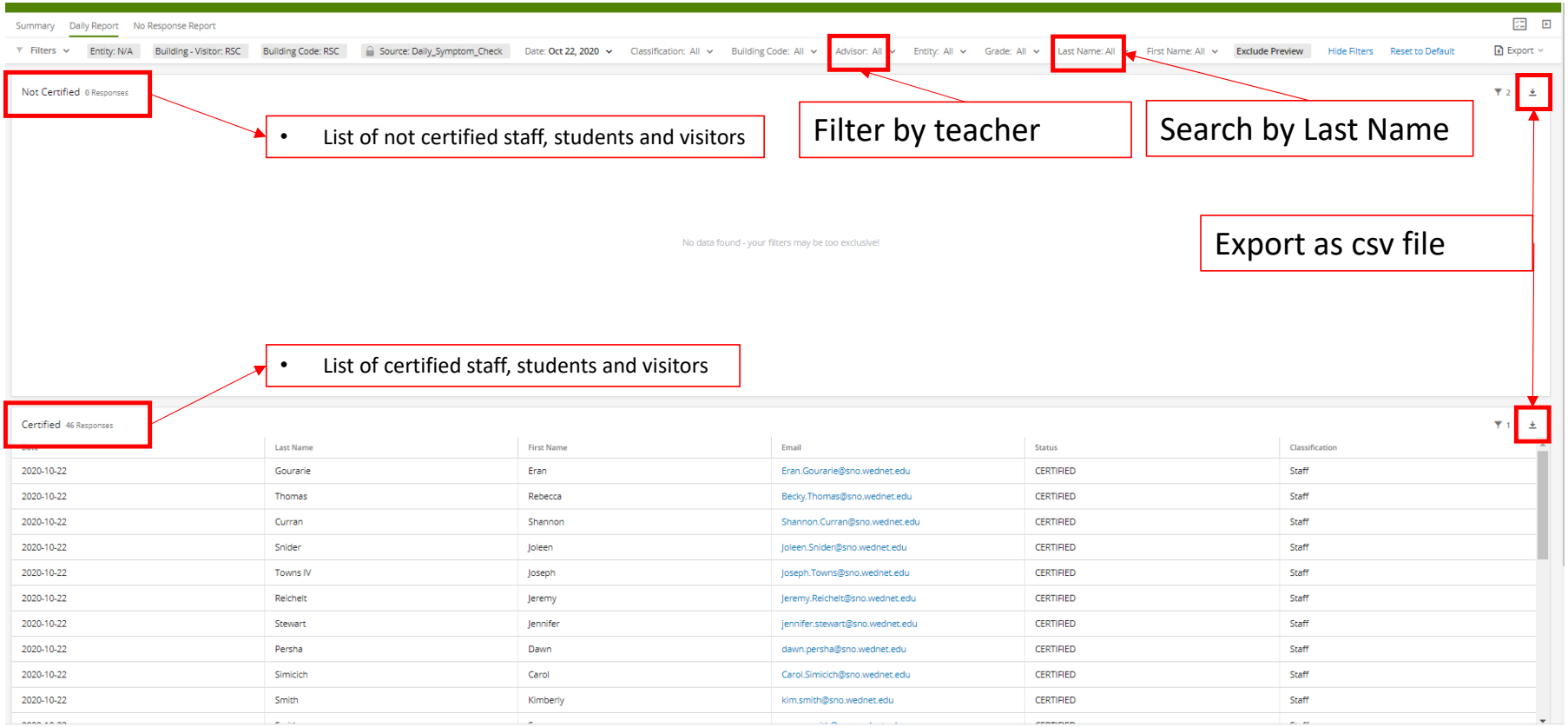


The summary tab – continued – please scroll down on your browser



SNOHOMISH SCHOOL DISTRICT

The Daily Report tab



- List of not certified staff, students and visitors

Filter by teacher

Search by Last Name

Export as csv file

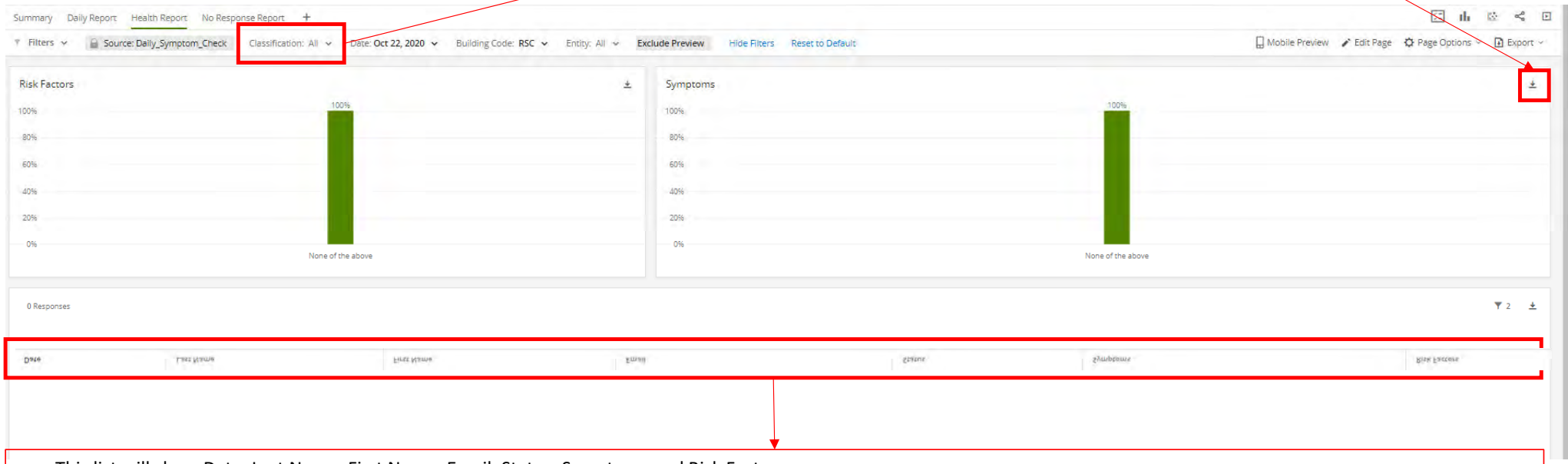
- List of certified staff, students and visitors

SNOHOMISH SCHOOL DISTRICT

The Health Report tab

You can filter students, staff and visitors

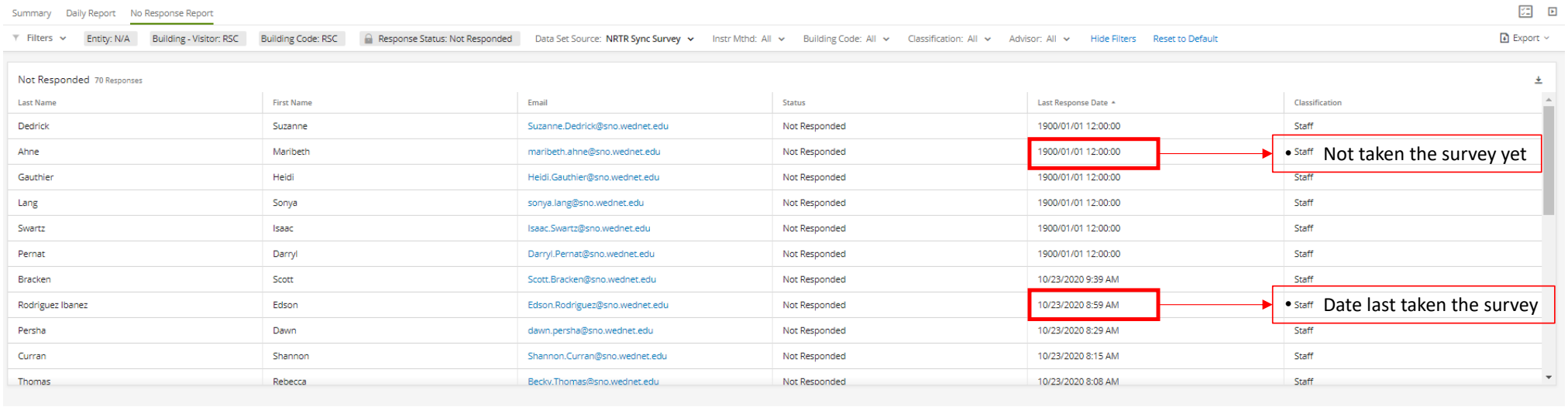
Export as csv file



- This list will show Date, Last Name, First Name, Email, Status, Symptoms and Risk Factors

SNOHOMISH SCHOOL DISTRICT

The No Response Report tab



Last Name	First Name	Email	Status	Last Response Date	Classification
Dedrick	Suzanne	Suzanne.Dedrick@sno.wednet.edu	Not Responded	1900/01/01 12:00:00	Staff
Ahne	Maribeth	maribeth.ahne@sno.wednet.edu	Not Responded	1900/01/01 12:00:00	Staff
Gauthier	Heidi	Heidi.Gauthier@sno.wednet.edu	Not Responded	1900/01/01 12:00:00	Staff
Lang	Sonya	sonya.lang@sno.wednet.edu	Not Responded	1900/01/01 12:00:00	Staff
Swartz	Isaac	Isaac.Swartz@sno.wednet.edu	Not Responded	1900/01/01 12:00:00	Staff
Pernat	Darryl	Darryl.Pernat@sno.wednet.edu	Not Responded	1900/01/01 12:00:00	Staff
Bracken	Scott	Scott.Bracken@sno.wednet.edu	Not Responded	10/23/2020 9:39 AM	Staff
Rodriguez Ibanez	Edson	Edson.Rodriguez@sno.wednet.edu	Not Responded	10/23/2020 8:59 AM	Staff
Persha	Dawn	dawn.persha@sno.wednet.edu	Not Responded	10/23/2020 8:29 AM	Staff
Curran	Shannon	Shannon.Curran@sno.wednet.edu	Not Responded	10/23/2020 8:15 AM	Staff
Thomas	Rebecca	Becky.Thomas@sno.wednet.edu	Not Responded	10/23/2020 8:08 AM	Staff

Questions about the dashboard?

Please contact Rebecca Sheppard

rebecca.sheppard@sno.wednet.edu
360-563-7261

Frequently Asked Questions (FAQ) for Safe Schools Practices Re-Opening in Person
Staff and Parents
December 9, 2020

Worksite Supervisor and Health and Safety

1. What is a COVID-19 Supervisor and what do they do at each school? The COVID - !9 Supervisor is the person at the school who keeps up inventory of personal protection equipment and maintains compliance to the safe schools practices in collaboration with the school principal.
   What training have these individual received? Most are the school nurses and have been trained in the district's safe schools practices. There is a weekly COVID-19 Supervisors meeting in which the supervisors meet with the Director of Facilities and School Safety to answer questions and share information.

2. Where is the district's plan for health and safety protocols related to COVID? It can be found on the district website, https://www.sno.wednet.edu/Domain/3164
   Principals and COVID-19 Supervisors have hard copy as well.

3. What is the plan for providing a space for isolating staff and students who present with possible COVID symptoms? Isolation rooms have been identified and set up to isolate symptomatic staff and students while awaiting their ride home.

4. What is the plan for cordoning off areas and deep cleaning those areas when a student or staff member with probable or confirmed COVID-19 illness has worked/touched surfaces? Custodial Services is following state and local health agency guidance for supplemental cleaning. Spaces will be locked and isolated for 24 hours, if practical, prior to the start of supplemental cleaning. Refer to Section 3, District Cleaning and Disinfection Protocol pages 17 through 20 and the attachments Facility Cleaning Procedure Following Positive Case and COVID-19 Case Cleaning Procedures for cleaning and disinfection processes.
   https://www.sno.wednet.edu/Domain/3164

5. What is the District's most recent plan for attestation with students and staff? The district is using the Qualtrics online email or mobile phone text attestation system. The Qualtrics online attestation system will be made available to families to complete student attestation before arriving at school. The video instruction and training can be found at:
   https://www.youtube.com/watch?v=olbz7WbGen4

Enforcement of health and safety protocols

6. How will expectations for wearing face coverings be enforced for students, staff, and visitors? For students who are not exempt from the face covering requirement, schools should take steps to educate the student on safety compliance, implement positive behavior interventions, and, when appropriate, consult with the student's parent or guardian. The

director supervisor for staff will follow up with expectations for face coverings. Visitors at this time are not allowed. Should they be allowed in the future it would be the responsibility of school administration.

7. Will volunteers be allowed in the buildings? In the classrooms? With students? No

8. What is the plan for training staff (including intermittent staff (substitutes or itinerant) on the new health and safety protocols? There are currently four different video trainings that can be assigned to these staff for training along with review of the SSD handbook.
   The videos can be accessed through the following links:
   Face coverings, physical distancing, cohorts and hand hygiene:
   https://www.youtube.com/watch?v=9VkX6MuY9oI
   Covid-19 Supervisor, Response and Contact Tracing:
   https://www.youtube.com/watch?v=-D5V7pJPBiw
   Attestation:
   https://www.youtube.com/watch?v=olbz7WbGen4
   Ventilation and Cleaning:
   https://www.youtube.com/watch?v=pCobf26qRSs

   Other links to resources can be found on the district website:
   https://www.sno.wednet.edu/Domain/3049

9. How will the district ensure staff safety regarding students who will not wear masks? Masks are required to be worn by students unless they are exempt.

PPE – Staff, students and visitors:

10. What is the plan for these classes/services regarding communicating with employees and families about risk? What is being communicated to families around health and safety, risk and requirements? Further discussion needed.

11. How will the district communicate with students' families who need special accommodations due to not being able to wear a mask about the PPE requirements that will be followed by staff? (It is important that students who may be triggered by the additional protective measures are aware that they will be followed). A plan to communicate with families is forthcoming.
    How do we communicate that people are following the rules, when the rules seem different (i.e. when a custodian is wearing alternative approved PPE how is that explained to other staff and families while keeping the custodian's rights.)? Staff can check in with the Principal or COVID-19 supervisor if they have concerns at the same time understanding that privacy protected information cannot be shared.

12. Will the District be providing masks for all students? Masks will be provided on an as needed basis to students who do not have them, forget them, or may need a replacement during the school day.

13. What supports will the District provide to increase student access to PPE when needed? Staff/students can make requests to COVID supervisors and/or Principals.

Capacity for Social Distancing (6 feet)- Transitions: Lunch breaks, recess, other classes/services

14. How does the district plan to meet this for all employees and students? What is the plan for physical distancing during transitions, recess, lunch, hand washing, bathroom breaks, filling of water bottles, drop off and pick up and transportation? As a general rule students and employees should be distanced six feet apart. However, there will be incremental, small amount of times that students and staff will be within six feet. Students and staff will not be closer than six feet for more than 15 minutes at a time.

15. How has cohorting been designed and prepared to reduce the amount of cross contact between students and staff? Currently at the elementary level a cohort has been defined as a grade level. Secondary level cohorting is being discussed currently.

16. Has the district provided signage and spacing markers to help students, staff, and visitors maintain proper social distancing? Yes buildings have been given large round distancing stickers for main office areas, one way arrows, a large sandwich board sign, safe distancing strips, wash your hands signs, fight the spread signs, rolls of tape for interior and exterior, Velcro dots for classroom floors to mark desks, and other items they have individually requested.

17. How will students and staff be provided lunch? Breaks? If so, where will these take place? How will people know where to go and when? How does the district plan to meet these transition periods for all employees and students? See response to question 32 & 33.

18. How have typical communal areas/tools been signed and arranged to provide for at least 6 feet of distancing between employees and students? Seats in lunch room have been spaced 6 feet apart using desks and/or tables and students will be assigned seating.

19. What regulations will be in place regarding student desk/table arrangement, alternate seating (i.e. carpet time, moving of students) and directions (s) students are facing? Desks will be spaced 6 feet apart and marked on the ground with students all facing the same direction when possible.

20. In spaces such as school offices, that may have less than 6 feet of social distancing how has the district provided mitigation strategies and what are they? In some cases staff have been moved to alternate locations and in others plexi glass has been hung from the ceiling or framed and secured to the countertop.

Cleaning, Ventilation, Water, Hygiene

21. Is there sufficient staff to do the required cleaning before opening and on an ongoing basis once school returns? There is sufficient staff to do the required cleaning and disinfection before opening and once school returns to fulltime / hybrid models.
    What is the regular cleaning schedule? The regular cleaning schedule is outlined in Section 3 of the Re-Opening Handbook which can be accessed here.
    https://www.sno.wednet.edu/Domain/3164
    Has it been communicated with all staff? The training modules with the principal will provide info.

22. How will individual personal hygiene be handled and provided for? Hand hygiene will need to be planned into the day. The Re-Opening handbook and module 1 of the video training with your principal will provide further discussion.
    What about in locations such as portables or where there are limited sinks access? Hand hygiene includes proper hand washing or hand sanitizer use. Portable hand wash stations have been purchased for distributing to elementaries for use near portables.

23. What plans are in place for high touch surfaces? supplies needed? training of staff? Schedule of disinfection? Allowable / not allowable manipulatives, supplies? Protocols on sharing items? Please refer to Section 3 of the district Safe Re-Opening handbook and module 4 of the video training regarding cleaning and disinfecting plans. Supplies have been or will be provide to each classroom for disinfection. Custodial staff have had refresher training prior to the start of the school year. Regarding manipulatives and sharing of items, please note the health district guidance states to limit the sharing of classroom items. Items that should not be used include wooden toys and blocks, stuffed animals / toys, include fabrics of any kind. Items that are shared should be cleaned with soap and water first to remove visible soiling and then disinfected thoroughly by wetting down all surfaces with approved district supplied disinfectant. All disinfectant should be done when students are not present and with good ventilation.

24. How will desks (inside and out) and shared materials/tools be cleaned between groups of students? Elementary and secondary desks will be cleaned once after hours. Between groups of students (such as between periods) in the daytime will need to be done by classroom staff. Each classroom will be provided disinfection chemicals with 30 second contact time for use. Further discussion needed.

25. What steps have been taken to provide additional materials/tools to reduce the need for sharing and sanitizing? Each classroom has or will be supplied with disinfecting tools and chemicals. For replenishing supplies, please contact the building COVID-19 Supervisor.

26. What plans are in place to address bathrooms? Please refer to the Safe Reopening Handbook, section 3. Floor markings will indicate distancing and capacity.
    Cohorts, transitions, cleaning and sanitation, supervision? More discussion is needed.

27. What plans are in place to address ventilation? Refer to Section 1f of the Safe Reopening handbook addendum 1, October 29, 2020 and the handbook, version 2.0 September 18, 2020 and module 4 of the video trainings with your principal.
    What about in rooms with no outside access (window or doors)? Rooms without outside access will receive the same degree of maximized fresh air. Rooms of potential contamination condition receive portable air purifiers that have HEPA filters and air exchange of 500 sf in 30 minutes.

28. What standard are you planning to meet regarding % of fresh air coming into the buildings? Health agency guidance is to maximize the amount of fresh air in the supply to spaces. The plan is to achieve maximum fresh air intake up to 100% if weather temperatures permit and modulate percentages when temperatures drop such that the heating units cannot keep up.

29. What plans are in place to address water fountains? Per health agency guidance, water fountains including classroom bubblers will be turned off or closed.

Daily Health Screenings

30. If the district is planning on using an attestation form, who will be responsible for checking to make sure that it has been completed? The district has moved to online attestation. The principal will be responsible for determining staff assignments for verifying attestation has been completed.
    How will in-person screening occur if they fail to complete it? Refer to the principal's screening process. Those individuals who do not complete the attestation process will be required to be screened at the school in a designated space prior to entering the classroom or workspace. Location in the building will be determined with the principal.

31. When will students & staff be screened? When general ed students return, families will use the same Qualtrics online system currently be used by staff.
    How will staff and students be checked into the building to make sure screening has taken place? Principal will provide process for verification of the completion of attestation.

32. What will the screening protocol be for students who show up after their scheduled start time? The same online attestation system will be utilized. It is anticipated that late arrivals check in at the office for verification of completed attestation before going to the classroom.

If the attestation has not been completed before arriving, the student will be screened by the COVID-19 Supervisor or designated staff member before proceeding to the classroom.

33. How will the District ensure staff privacy & meet requirements of HIPPA during screening and with record keeping? HIPPA requirements will be adhered through the attestation process. Record keeping will be through the Qualtrics system which has levels of limited access for confidentiality and privacy based on roles of personnel accessing the information. Will you create a dashboard like Central Valley or Moses Lake? Not familiar with the two referenced districts dashboards. Qualtrics comes with a dashboard. At this time, the district will not have a district wide positive case count on the district website for public information.

34. Where will the students go once they have been screened? Refer to the principal's student entry process.

35. How will you limit possible exposure prior to screening occurring? Students must be wearing face coverings, physically distanced and organized in cohorts.

36. Who will complete the screening? (what will deem them qualified?) COVID – 19 Supervisors will be involved in the process for students who need to be screened at the school due to not completing the attestation prior to coming to school.
What safety measures will be in place for screeners? All measures as required in the Safe Reopening handbook including wearing appropriate PPE for both staff and student.

37. What is the plan for when someone shows signs of or reports they have been exposed to COVID-19? (students / staff). A student describing or showing signs at school will be directed to the Isolation Room by the COVID-19 Supervisor and parent called to take student home. Staff should notify the principal and leave if able to drive home. If not able to drive home, staff should go to the Isolation Room until someone comes to pick them up. Regarding exposure, refer to Module 2, COVID-19 – Supervisors, Response and Contact Tracing as well as the Safe Reopening handbook addendum 1 and Version 2.0. Refer to Addendum No. 1 dated October 29, 2020, page 5 through page 8 and attachments from WA Department of Health and Snohomish Health District.

38. What is the plan in each building for separate spaces for COVID related-symptoms/illness and regular health room needs (first aid, medication, etc)? COVID related illness will be taken to the Isolation Room which is a different space from the regular health room in each school.

39. What self-monitoring / self-isolation protocols are being considered? Through the attestation screening and contact tracing process, staff and students are to stay home until such that they can return per the protocols associated with the illness.

40. How will the district ensure there is enough nursing staff to cover all the needs in each building, given this new health-intensive situation? Three additional FTE nurses are to be hired.

41. How will the district address staffing need proactively to prepare for when nurses call in sick or must quarantine? The district will work through substitutes or reassignments as needed. The district is in the process of hiring additional nurses for providing fulltime school nurses. Additionally, the COVID-19 supervisors are developing a back up plan in the event that the nurse or COVID-19 supervisor is out sick for the day. Nurses from other buildings will be made available to support the affected building shortfall.

Limiting Exposure – Notice of Exposure

42. What processes will be followed to notify staff and students when there may be exposure to an individual with a positive test results while following privacy protocols? (see CDC guidance). Close contacts to a positive case will be notified by the Health district. Staff will be given a brief notification that a positive case was in the building, with no further detail, in compliance with HIPAA law.
    How will the union be notified of positive test results impacting worksites? Information will be provided on a building specific basis only. A communication to the building is as follows: *"An individual in our school community has tested positive for COVID-19. We are working closely with the Snohomish Health District to respond and protect the health of others. All individuals who are at risk of being a close contact have already been contacted. Remember, the best way to prevent the spread of COVID-19 is by staying home when ill, wearing face coverings, physical distancing, avoiding large gatherings, and practicing good health hygiene habits. Be sure to wash your hands frequently with soap and water, cover your coughs and sneezes, and avoid contact with people who have signs of illness. Get plenty of rest, exercise, and eat a healthy diet."*

43. How else will the district address the need to limit cross-mixing students and staff as much as possible? (use of cohorts/groups at elem. & secondary? Transportation patterns? Alternating schedules?). Defining cohorts, traffic patterns, scheduling for student release, loading buses has been on-going with principals utilizing safe practices guidance and protocol requirements. Module 5 of staff training will be walk throughs in the building with the school principals to identify the implementation of these safe practices.