

Email sent to many Oregon state leaders on August 17, 2020, By Nancy Willard, Embrace Civility.

Hi Drs. Sutton and Cieslak,

I would appreciate an interpretation of your findings that only one in five Oregonians with COVID-19 are being identified through diagnostic testing from the perspective of some other guidance that is being provided by OHA related to the opening of schools. The appropriateness of the metrics for school return both in general and for students who are at higher risk appear to be challenged by your findings.

This is the Ready Schools, Safe Students report: <https://www.oregon.gov/ode/students-and-family/healthsafety/Documents/Ready%20Schools%20Safe%20Learners%202020-21%20Guidance.pdf>

The metrics I am referring to are on pages 17 through 22. The data these metrics relied on is set forth on pages 22 through 24. Of significant concern to educators and family members is a section on pages 26 and 27.

Starting with the data from the report that appears to be accurate:

However, a July 13, 2020 study by the Institute for Disease Modeling, Bellevue, Washington demonstrated that unless community spread is reduced, reopening schools to in-person instruction, even with protective measures like physical distancing and face coverings, will cause significant growth of the epidemic. A June 2020 study by REL Mid-Atlantic noted that opening schools to in-person instruction, "...is likely to result in increased infection among children, teachers and support staff, although several of the mitigation strategies can substantially reduce the number of infections."

Obviously, there is a known risk of increased infections with the opening of schools. *Many other countries have re-opened schools. They re-opened schools cautiously and only when rates of new cases were low and when testing with quick turnaround was widely available to support isolation of individuals with COVID-19 and self-quarantine of close contacts.*

Country	Date	New cases per 100,000 per DAY	New cases per 100,000 per 7 days
Denmark	4/15/20	2.6	18.2
Germany	4/29/20	1.3	9.1
Netherlands	5/11/20	1.5	10.5
France	5/11/20	0.9	6.3
New Zealand	5/15/20	<0.1	<0.7
Australia	5/11/20	<0.1	<0.7
Oregon	5/25/20	0.8	5.6
Oregon	7/20/20	6.9	48.3

Obviously, other countries have done a much better job in controlling this virus. Please note the differences in the known rates. But also note that these countries had “testing with quick turnaround” that was “widely available.”

It is my understanding that in Oregon, many pediatricians are not testing children even if there is a suspicion of infection because of a lack of widely available tests. <http://www.portlandpediatric.com/articles/news/faq-covid19-testing>. Further, in some regions of the state, testing delays can be as long as several weeks. <https://www.opb.org/news/article/coronavirus-oregon-test-results-delay-covid-19/>

Also, having reviewed the underlying research, I have some significant concerns about the analysis of research in this section of the Metrics. This statement in particular:

We have strong evidence of transmission from children ages 10 to 19 years. Evidence of significant transmission from children ages 0 to 9 years is limited by the effect of school closures early in the pandemic. We have emerging evidence of high secondary attack rates in young children in the absence of physical distancing and masking. New data suggests that children under 10 years old get the virus at lower rates, get less sick when they get COVID-19 (Bi et. al.) and seem to spread the virus less than older children or adults (Park et. al.). One study suggested that the youngest children (5 years old or less) had more viral shedding (Heald-Sargent et. al.) but it is not known how this affects transmission to others. A study from Australia (Macartney et. al.) indicated that transmission of COVID-19 in school settings with effective public health measures in place and lower levels of spread in the community may be less than what is seen for influenza and other respiratory illnesses. It is critical that the safety of staff are considered for any in-person instruction plans, because staff are at a significantly higher risk of

both infection and potentially severe disease due to age and other risk factors according to the CDC.

The Bi article is from China. [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(20\)30287-5/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30287-5/fulltext) This study involved data collected from January to mid February, 2020. This study found that children were as likely to be infected as adults, but were less likely to show symptoms — from which one could surmise are less likely to be tested, even though infected. What the researchers considered to be a key aspect of the data was that children may be an important target for interventions to reduce transmissions, even though they do not get sick. This most important aspect of the findings appear to have been left out of the OHA analysis.

The Park study is from South Korea, with data collected from January to May, which was at the time schools were being closed. https://wwwnc.cdc.gov/eid/article/26/10/20-1315_article As we know, South Korea responded very vigorously to address the concerns of this virus. The study did find a lower rate of infections among children 0 to 9, but noted that this was specifically at the time of school closures and predicted that children would have higher rates of transmission when school closures ended. The study also specifically noted that “children who attend day care or school also are at high risk for transmitting respiratory viruses to household members. These important aspects of the findings were also left out of the OHA analysis.

Dr. Heald-Sargent’s research did indeed find that Infected children have at least as much of the coronavirus in their noses and throats as infected adults. https://jamanetwork.com/journals/jamapediatrics/fullarticle/2768952?utm_source=undefined&utm_campaign=content-shareicons&utm_content=article_engagement&utm_medium=social&utm_term=073020#.XyNylmjnx-k.email

In fact, this study found that children younger than age 5 may host up to 100 times as much of the virus in the upper respiratory tract as adults. “It definitely shows that kids do have levels of virus similar to and maybe even higher than adults,” Heald-Sargent said. “It wouldn’t be surprising if they were able to shed” the virus and spread it to others. <https://www.chicagotribune.com/coronavirus/ct-nw-nyt-coronavirus-children-lurie-childrens-hospital-study-20200731-enq5fjcxzbtvceqombbuekfka-story.html>. These important findings were minimized by the OHA analysis.

Further, there is research evidence on how this affects transmission to others. A study from Italy at around the same time. I do not have the link to the actual study. But a news report written by a retired professor at Harvard Medical School and School of Public Health reported as follows:

The researchers found that although young children had a somewhat lower risk of infection than adults and were less likely to become ill, children age 14 and younger transmit the virus more efficiently to other children and adults than adults themselves. Their risk of transmitting Covid-19 was 22.4 percent—more than twice that of adults aged 30 to 49, whose rate of contagiousness was about 11 percent. “Although childhood contacts were less likely to become cases,” they wrote, “children were more likely to infect household members.” <https://www.forbes.com/sites/williamhaseltine/2020/07/31/new-evidence-suggests-young-children-spread-covid-19-more-efficiently-than-adults/#6500486919fd>. So, yes, indeed, there is clear research evidence of the fact that children are very effective in transmitting the virus — and this research was totally ignored in the OHA analysis

The Maccartney study is from Australia. Please note from the above chart the level of transmission in Australia. The research did find that COVID-19 transmission in schools was considerably less than that seen for other respiratory viruses, such as influenza. However, it should be noted that this study was conducted between January and April — which is summer

in Australia. <https://www.sciencedaily.com/releases/2020/08/200804100225.htm>. The researchers also noted: "However, it is important to view these findings in the context of the NSW outbreak. Higher rates of transmission may occur in areas with higher levels of virus transmission in the community or with less rigorous public health and community response." OHA appears to have used these findings to support the idea that it is safe to open schools.

Now we come to your data. https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a4.htm?s_cid=mm6932a4_w#T1_down and <https://www.oregonlive.com/coronavirus/2020/08/oregon-study-finds-coronavirus-antibodies-in-1-of-people-tested.html>.

Oregon's reported infection rate does not account for persons who were infected but did not seek testing (e.g., those with asymptomatic or mildly symptomatic infections), persons who chose not to be tested, or persons unable to access testing, the rate is believed to be lower than the true cumulative COVID-19 incidence in the state. Oregon's findings underscore what public health officials have long said: Only a fraction of active infections are being identified through diagnostic testing. The data suggest that a substantial number of COVID-19 cases in Oregon have gone undiagnosed and not reported and that a large portion of Oregon's population remains susceptible to COVID-19 infection. This study was consistent with OHA modeling that showed that the infection rate is likely far higher and that only one-fifth of those infected had been identified through diagnostic testing.

The Oregon metrics for schools to reopen generally are:

- **County Metrics - metrics to be met three weeks in a row**
 - *Case rate: ≤10 cases per 100,000 population in the preceding 7 days**
 - *Test positivity: ≤5% in the preceding 7 days*
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- **and - State Metric - metric to be met three weeks in a row**
 - *Test positivity: ≤5% in the preceding 7 days*

It would seem, based on your findings and the actual insight from the research, that given the low testing rate in Oregon and the obvious much more significant rate of infection that is not being shown due to the lack of testing — that testing is only identifying one-fifth of the infections — that the <10 cases per 100,000 should be measured at <2 cases identified through testing per 100,000. Given that <10 cases per 100,000 is really equivalent to <50 cases, doesn't this raise serious concerns?

Then, there is this metric:

1) Provide in-person education for students in kindergarten through third grade (Statewide)

It is expected that schools will offer in-class options for students in grade K-3 to the extent possible. Younger students get the virus at lower rates, get less sick when they get COVID-19 and may spread the virus less than older children or adults. Younger students also need access to in-person instruction to build literacy and numeracy skills critical to their continued learning. An exception to meeting state and county metrics to return to in-person instruction for K-3 grade should be prioritized under the following conditions:

- ● *There have been no confirmed cases of COVID-19 among school staff or students in the past 14 days.*
- ● *The case rate in the county is ≤30 cases per 100,000 population in the preceding 7 days for the past three weeks.*
- ● *The test positivity in the county is ≤5% in the preceding 7 days for the past three weeks.*
- ● *Schools fully comply with sections 1-3 of the Ready Schools, Safe Learners guidance.*

Note first of all the blatant inaccuracy in the premise for this metric given the research as set forth above. “Younger children get the virus at lower rates, get less sick when they get COVID-19 and may spread the virus less than older children or adults.” Younger students do get less sick. Based on clear research data, they do not get the virus at lower rates and appear to spread the virus more than adults. How can this premise for the metric be considered to be “evidence based?” Doesn’t OHA have a strong commitment to be “evidence-based?”

The metric standard of “no confirmed cases among school staff or students in the past 14 days” is a huge concern given current testing circumstances in Oregon. According to your study, only one-fifth of adult cases are confirmed by test. Children often do not have symptoms and therefore are less tested. Pediatricians are not testing most children. And it can take over 14 days in some regions to get the results of the test. This metric is meaningless.

Based on your data, the case identified rate of <30 would translate to 150 cases per 100,000 population. Obviously a huge concern,

The other various metrics use some version of no cases for 14 days or <30 cases per 100,000 population. Based on your study, neither of these bases for the metrics appear to be anywhere close to the level of other countries that have opened schools safely.

An additional concern related to these metrics is that they often reference populations that are known to be more at risk of infection and serious illness, especially students with disabilities and English Language Learners. It does not appear to make any sense for students who are at higher risk, and in the case of ESL children whose families are at significantly higher risk, to be returning to the school building given the lack of adequate testing.

The additional concern is related to the health of staff and family members. Note the following passage in the document:

- **1b. High-Risk Populations**
High-risk populations include people who have one or more of the following characteristics or conditions. *This list was recently revised by CDC, to reflect updated data. People of any age with certain underlying medical conditions are at increased risk for severe illness from COVID-19:*
 - ● Age 65 years or older
 - ● *Cancer*
 - ● COPD (chronic obstructive pulmonary disease)

- - Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- - Immunocompromised state (weakened immune system) from solid organ transplant
- - Obesity (body mass index [BMI] of 30 or higher)
- - Type 2 diabetes mellitus
- - Chronic kidney disease
- - Sickle cell disease
- - Other conditions or risk factors identified by OHA, CDC, or a licensed healthcare provider.

Required

- Serve students in high-risk population(s) whether learning is happening through On-Site, Hybrid (partially On-Site and partially Comprehensive Distance Learning models), or Comprehensive Distance Learning models.

Recommended

- ⇒ To the extent possible, students who are unable to participate in On-Site instructional models due to their high-risk status should be provided the opportunity to attend/interact with their peers. This would allow educators to support all students and synchronously integrate distance learning experiences into their on-site class. When possible, districts may consider adding 360 degree video cameras or video cameras on tripods in classrooms to allow student interaction and collaboration enabling the teacher's primary focus to be instruction. The student who is not able to attend school on-site, will be able to participate in class in a more robust manner listening, engaging in projects with peers, and connecting socially with friends. utilizing outdoor spaces, common areas, and other buildings in planning.
- ⇒ If a school is unable to provide blended classrooms for students, students unable to attend on-site will need to be provided with comprehensive distance learning.

While it is indeed important to be attentive to the concerns of students who are at higher risk, the far larger population that is at higher risk is Oregon's teaching staff and support aides. The Keiser Family foundation conducted an analysis that determined that one in four teachers should be considered at higher risk. <https://www.kff.org/coronavirus-covid-19/issue-brief/how-many-teachers-are-at-risk-of-serious-illness-if-infected-with-coronavirus/>

The most common feeling expressed by Oregon's educators is that state and some district leaders believe them to be expendable—and have placed the priority of academic outcomes (test scores) and providing child care over their health, and indeed, their very lives. I am working on resources for schools on trauma informed practices in the age of COVID-19 and BLM. An important foundation for trauma informed schools is a positive school environment. How are we going to establish a positive school climate when Oregon's teachers and support staff know that no one in leadership roles in this state gives a damn about their well-being?

In addition, the section focusing on addressing those of higher risk does not address the concerns of the family members of students who may be unknowingly exposed to the virus from another child and then unknowingly bring the virus into the home to infect family members.

Can you possibly help me to understand what is happening and how to ensure more evidence based metrics to better protect school staff, family members of students, and students themselves?