



SCHOOL BOARD AGENDA ANALYSIS FORM
September 21, 2021

DISCUSSION ITEM:

COVID-19 Update

Strategic Direction: Strong Communication

BACKGROUND:

MEMO to the ISD#282 School Board

Positive Cases + Quarantine Numbers: Since Sept. 7...

- *No new cases!*

Staff Vaccination Rates:

- An anonymous survey was sent to all staff asking for vaccination status.
- 188 staff members responded (SANB has roughly 250 total staff, with roughly 190 full time staff)
- SANB is showing roughly **98%** of staff are vaccinated.
- This rate of vaccinated staff is similar to last year's vaccination rate for staff.

Student Vaccination Rates:

- For students in grades 7-12:
 - 82.57% have begun the series (at least one shot)
 - 77.9% have completed the series
- By Grade Level: Minnesota Immunization Information Connection (MIIC)

GRADE	# submitted to MIIC	% started the series	% completed series	% not found in MIIC
7th	150	74.66	69.18	2.7
8th	148	85.0	80.0	5.4
9th	180	80.11	75.57	2.2
10th	173	87.5	83.93	2.9
11th	178	84.12	78.8	4.5
12th	167	83.54	79.27	2

COVID Testing At SANB:

Minnesota Department of Health (MDH) and the Centers for Disease Control (CDC) recommends testing for students and staff. Our community has communicated that they want testing, especially at the elementary level. *Please note, we will only test students that have parental consent.* We have a couple different options:

- **Anterior nasal swab pool testing**, ages five and up can do it themselves with adult supervision. These tests would be tested as a batch (“pooled”) at the lab and immediately re-run in the lab (vs. having to re-swab). The district would need parental consent in order to administer the test.
- There is also an option with **Cue for a rapid PCR test** (school health office staff would need to administer to students under 18); would get results within 20 minutes. The district would need parental consent in order to administer the test. This is a better choice for testing staff to improve test result time and decrease staff out waiting for test results.
- Another option is a saliva test. We are still working with **Vault** to provide tests to families that can have their student test via Zoom and get a quick turnaround result (within 24 hours). These tests could be sent home with families if their child is sent home with symptoms.

Local Data Decisions:

What's changed:

- Public health agencies are shifting their pandemic work to focus specifically on supporting in-person learning for schools.
- Varying vaccine rates have created hyper-local disasters within pockets of unvaccinated people and although vaccine-breakthrough-cases are possible, they remain rare and vaccines effective.
- Increasingly, families are using over the counter/home rapid tests which do not show up in reported public health data.

Why did we use case rate:

- Case rates tell us how many cases per 10,000 people we have which gives us a good idea of how many people have COVID in the surrounding community when testing rates are high and there are few mitigating factors to take into account (such as vaccination).
- State policy (now phased out) instructed us to use case rates as the point of reference for mitigation strategy or learning plan adjustments.
- Case rates remain a good gauge of the *shape* of the pandemic, i.e. up, down, going way up, going way down.

What's the issue with case rates:

- As vaccine rates increase, case rates reflect cases among pockets of unvaccinated people *more than* the vaccinated public (especially in a well-vaccinated community like ours).
- As public health focuses on keeping kids in school, public health (the data creators for case-related data) are having less contact with the majority of cases over age 18 who are not employed in schools.
 - Those who are not part of the prioritized school communities are underrepresented in much of the data and many details that were collected during case interviews are missing.

- As over the counter/home rapid tests become more frequently used, officially reported case rates cannot reflect those numbers.

What do we need: We need an indicator (a data point) to tell us which mitigation strategies are recommended for our schools based on relevant disease activity. We use many data points to make recommendations, but we want *one* to help groups like the school board and parents track recommended mitigation measures. It would be ideal if both groups had some stability in what they can expect for the next block of time as well.

What indicator should we use: To reflect the focus on schools, an effective indicator for which mitigation strategies are recommended for us is test positivity among school aged children.

- Test positivity among school age kids tells us how hard we have to look within a given age group to find COVID, so test positivity among school aged children (0 - 19) focuses explicitly on risk for our kids and youth.
- This indicator helps us tell if we still have high spread or not, just like case rates, but it hones in on our population of interest (e.g. school aged children) regardless of testing technique that they are using.
- This indicator is particularly effective when a given population has a strong testing plan, as our district is rapidly bringing online, because we can use district-level data to create an indicator without putting children's privacy at risk or accidentally creating a nonsensical number (i.e. there is no # per 10,000 within a population less than 10,000, which is why we don't create school case rates).
 - Most testing programs use a test positivity calculation to understand if they need to increase testing, so this should not be out of the way.

How do we use this indicator:

- Typical of this stage of the pandemic, there are a variety of local standards, which reflect local risk tolerance and vaccination rates.
 - Regardless of risk tolerance within the community, MDH has consistently said that over 5% is "too high" and tells us that we have too much COVID circulating in that group to lower mitigation strategies yet.
- Test positivity is easy to communicate to parents – two weeks below 5% is the recommendation before lowering mitigation strategies for a population.
- Focusing on school aged people lets us take into account those in the school age group that are not eligible for vaccination vs. a "pocket" that is not vaccinated for a reason other than eligibility.
- This indicator is publicly available and can be reported on locally every two weeks at the most frequent.
 - It reduces the noise for us when trying to understand what our kids are experiencing vs. what groups of adults in the larger community are experiencing as spread becomes less universal and more concentrated among unvaccinated populations.

Test positivity among school age kids lets us have nuance and helps us use data to inform potentially less restrictive measures locally while still keeping an eye on the overall risk to school aged kids.

- Ideally, we would compare a district estimate of test positivity from our school testing program (i.e. of all the tests taken in our school by kids in our regular testing program, how many came back positive?) with test positivity for same age groups across the state, reflecting our intent focus on our local school population.

- If we have low test positivity in the district and the state positivity in school age kids remains high, that tells us that school age kids still have high spread *and* that our district mitigation efforts are working – this is a good place to be until the state’s test positivity falls below 5% among school aged kids.
- Potential examples: Our district test positivity would help us understand if we can recommend dances for our school population even when community case rates remain high based on spread within our school. We might look at the state test positivity among school age kids and know that there is too much spread impacting kids generally to recommend allowing adults to eat inside the gym at basketball games.

Are there disadvantages to this indicator:

- A disadvantage of the test positivity rate indicator is that it is slow because testing is slow (and that’s okay - this indicator smooths out daily/weekly variation to give us a good summary of disease spread).
 - We still have case rates to show us the shape in case of rapid changes – it takes two weeks for test positivity to be meaningful.
 - We are still conducting our usual contact tracing and outbreak response.
- To report the state numbers to the community, we would need to pull it out of MDH’s situation report or folks could go get it themselves.
- To report the district numbers, we would calculate with every test cycle, which is typical of many testing programs anyway and is hopefully not additional work.
- Parents might have a hard time adjusting to a new number (though hopefully ultimately like this one because it is more stable and easy to understand).

PRESENTER(S):

Superintendent Dr. Renee Corneille

PURPOSE: *informational*
