



Guiding Metrics for a Phased Attendance Model

Introduction

The COVID-19 pandemic is a public health crisis not seen for many generations. School districts across the United States are working through ways to safely reopen schools, despite continued community transmission of SARS-CoV-2, the virus that causes COVID-19. No solution is without risk, but this risk can be kept relatively low as long as our school community fosters a culture of healthy compliance among students; employs an array of safety strategies for students, teachers, and staff; and we work collaboratively to isolate outbreaks quickly.

The level of COVID-19 transmission in the community is essential in determining when it is safe to resume in-person instruction. Other countries' experiences have indicated that reopening schools may be low risk in communities with low transmission rates. Despite children having similar viral loads in their upper airways as adults, there appears to be a lower risk that children under 10 with COVID-19 will transmit to household members, compared to children 10 or older and adults. Large-scale epidemiological surveys and smaller analyses of household clusters suggest that younger children are less likely to infect the adults in their household with COVID. However, at a regional level, there have been documented cases of COVID-positive cases at several parochial schools (full-onsite attendance model) in students under 10. This reinforces that the importance of children in transmitting the virus remains uncertain. Those charged with monitoring the pandemic and creating guidance must remain attentive and connected to the fluctuating environment surrounding COVID-19 for all age groups.

Our goal is to return students and staff to onsite learning safely. We can achieve our goal by instituting a phased attendance approach based on a set of guiding metrics. The metrics we use are based on guidance from the Illinois Department of Public Health, Village of Oak Park Public Health, Northern Illinois Public Health Consortium Return to School Metrics Workgroup, research from the Harvard Global Health Institute, and a dashboard provided by the Northwestern University Feinberg School of Medicine.

All of our decisions will continue to be guided by our three priorities: the health and safety of our students and staff; providing consistent, high-quality learning experiences; and our commitment to equity.

Benchmarks

There are two critical components to reopening our school buildings for in-person instruction. First is the District mitigation plan, or the "how." This plan outlines our strategies to reduce the spread of COVID-19 among students and staff upon reopening school buildings. The second is the level of spread occurring within the community, or the "when." The district/school mitigation plans and the degree of community spread are equally important in determining when it is safe to reopen a school building.

The CDC defines community spread as follows:

- **Minimal community spread:** Evidence of isolated cases or limited community transmission, case investigations underway, no evidence of exposure in large communal settings.
- **Moderate Community Spread:** Sustained transmission with a high likelihood or confirmed exposure within communal settings and potential for a rapid increase in cases.
- **Substantial Community Spread:** Large scale, controlled community transmission, including communal settings (e.g., schools, workplaces).

Community spread is further defined by using threshold levels. Thresholds are defined as values that determine if a statistic is above, below, or within a normal range. District 97 has established four attendance stages and assigned threshold values. These threshold values are a combination of recommendations from the Harvard Global Institute for Health, the Northern Illinois Public Health Consortium Return to School Metrics Workgroup, and the Illinois Department of Public Health.

The value for the positivity rate will be obtained from the Illinois Department of Public Health dashboard. The weekly cases per 100,000 people will be obtained from the Northwestern University Feinberg School of Medicine COVID dashboard. The Northwestern dashboard was selected because the data is updated daily, as opposed to the IPDH dashboard that is updated weekly, thus providing a better snapshot of the current situation.

District 97 Metrics for Decision-Making

Stage Number	Learning Plan Details	Weekly Cases per 100,000 People	Positivity Rate
Stage 1	Fully remote learning for all students	150 or greater	Greater than 8%
Stage 2	Partially Remote with hybrid on-site programming for specialized populations and programs	Less than 150	Less than 8%
Stage 3	Partially remote with hybrid on-site programming for all students (PK-8)	Less than 70	Less than 5%
Stage 4	Full in-person learning	Must be in Phase 5 - Illinois Restored	

[Click here to check the current weekly cases per 100,000 people.](#)

[Click here to check the current positivity rate.](#)

Remember to refresh the screen to update the results.

Disclaimers

There are two disclaimers for the information provided:

1. The dashboards depend on models that are only as good as the data provided—data that we have no control over. Data represent the total number of tests performed and reported electronically at IDPH, commercial, or hospital laboratories. The data are continually being entered and may change as cases are investigated.
2. There is no historical precedent for what is happening. This is a novel virus, and everyone's knowledge of COVID continues to evolve. New public health guidance may necessitate revisions of this document.

Case Incidence

Incidence is a measure of new confirmed COVID cases per day. It is calculated as a proportion of the population, specifically new daily cases for every 100,000 people. Adding the case incidence metric depicts risk more accurately since it takes the overall number of cases into account. Incidence does not account for new infections that are not caught by testing. It also does not include the duration of each infection (how long each infected person is exhibiting symptoms or is contagious). The dashboard measurement we will focus on is the 14-day rolling average obtained from data provided by the Surgical Outcomes and Quality Improvement Center (SOQIC) at the Northwestern University Feinberg School of Medicine ([click here to view the dashboard](#)). Data on this website are dependent on the information entered into Illinois' National Electronic Disease Surveillance System (I-NEDSS). This dashboard allows for the data to be filtered by zip code. We will use data from the following zip codes: 60301, 60302, and 60304 (60303 is classified as a PO Box zip code and is not included in public health population data).

Positivity Rate

One of the most important metrics for tracking the spread of COVID-19 in Illinois is the positivity rate—or how prevalent positive cases of the disease are compared to the number of tests completed. In general, a low positivity rate is a good sign. Because not everyone who has COVID-19 gets tested, rising case numbers could mean that the disease is spreading, or that testing efforts are identifying a larger share of the sick people in society. Positivity rate controls for the amount of testing being done. Calculating the positivity rate is more complicated than it might seem because some people get tested multiple times for COVID-19.

For Illinois, the testing data represents data reported to IDPH through Electronic Laboratory Reporting (ELR) only. It is based on the date results are entered into the ELR. It excludes testing data received from sites that have not implemented ELR, which excludes 3-5% of test data. The number is obtained using the following equation that IDPH feels produces accurate results:

Weekly test positivity = [County positive tests for 7 days] / [County total tests for same 7 days] x 100

District 97 will use the Restore Illinois 8% positivity rate metric during Stages 1-3. The limited number of people in the building during these two phases allows for social distancing and other preventative measures. A transition to Stage 5 will require Region 10 (suburban Cook County) entering Phase 5 of the Restore Illinois Plan. The dashboard measurement we will focus on is the Region 10 seven-day rolling average as presented on the IDPH website: (<https://www.dph.illinois.gov/countyschool?county=Cook>)

Operational Variables

The statistical metrics listed above do not consider operational barriers that may arise as we negotiate a transition to onsite learning. These barriers could be a myriad of issues, including those associated with transportation and staffing, changes to the guidance provided by ISBE and IDPH, delays in PPE procurement, or school-specific matters related to physical distancing. We will continue to monitor these variables and work to mitigate their impact on the school environment.

Adaptive Pause

An Adaptive Pause is a strategy that allows for movement into any level of remote learning to prevent disease transmission during a pandemic. An Adaptive Pause may result in delayed reopening at the start of a specific school term or a pivot to remote learning once the school year is underway for school officials to have time to plan for next steps with parents, teachers, and staff. An Adaptive Pause may also include a pivot to remote learning for a classroom, a grade level, a wing, a school, or the entire district. At all community transmission levels, we may need an Adaptive Pause to consult with the Oak Park Department of Public Health to understand community transmission metrics and plan how to respond to a given scenario. Adaptive Pauses may be for a set timeframe or indefinite, depending on the specific metrics related to transmission and infection rates within Cook County or Oak Park and our student population. District administration will determine how long an Adaptive Pause will last (days, weeks, months, rest of school year) to respond effectively.

Several Adaptive Pauses may be needed until COVID-19 transmission is controlled, and an effective vaccine is available. However, the goal of implementing the suggested interventions is to reduce the frequency of these interruptions and allowing for in-person learning when feasible.

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