VOICE AND SPEECH TRAINERS ASSOCIATION

2021-2022 COVID-19 VASTA TASKFORCE
UPDATED GUIDELINES

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I. Current Recommendations From VASTA

Safest Possible Recommendation as of January 2022:

It is the recommendation of VASTA that Voice, Speech, Dialect and Text classes be taught online until such time as vaccine(s) or a cure for COVID-19 is developed that refutes the known dangers outlined in current scientific literature for both low-risk and high-risk individuals. Although most nations are in the process of administering vaccines, which offer some protection to those who are fully vaccinated, the vaccines do not offer full protection, especially against activities that are high aerosol producing, including any activity that involves significant vocal projection such as in person teaching of voice, speech, dialect and text classes and on-stage acting, singing, and wind instrumentation.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
At present, teaching online continues to be the best way to avoid risk of exposure to the virus. Voice and speech trainers are advised to avoid face-to-face methods where possible, and to try to limit exposure in instances where it is unavoidable or required by administrators.

Protocols for added protection to consider when exploring the possibility of face-to-face teaching include: the quantity and quality of ventilation, sanitization of frequently touched surfaces between sessions, the use of high particle filtration masks (N95 mask) for students and teacher(s), limiting the number of participants to an appropriate amount to permit physical distancing, regular hand washing, vaccination with booster shots as per recommendations of national infectious disease task forces (such as the Centers for Disease Control in the U.S., the Public Health Agency in Canada, the European Centre for Disease Prevention, Africa Centres for Disease Control and Prevention, Chinese Center for Disease Control and Prevention, the World Health Organization, etc.), and other updates for protection from COVID-19 that become available as more information is learned about the virus that causes COVID-10. Please refer to Part II for a thorough overview of risk factors and considerations.

While continuing online instruction is recommended for teaching voice and speech at this time, we recognize that doing so can deepen issues of access and equity in performance training. We advocate that institutions and organizations take active steps to make online learning accessible and equitable for all students.

This collection of guidelines, data, considerations, and community methodology survey was created as a living document at the onset of the pandemic that is continuing to be updated as new data becomes available and as the disease evolves.

II. The Evolution of COVID-19

In the fall/early winter of 2019, there suddenly appeared a cluster of fatal pneumonias in Wuhan, China. As more and more people began to die of this apparent viral illness that started like a typical URI then suddenly caused irreversible difficulty breathing and then death, it became apparent to physicians in China that people were dying from a new infectious disease. The physician who first reported the appearance of the virus in Wuhan, China, Dr. Li Wenliang in December 2019 subsequently died from COVID-19 a month later. In January 2020, the virus was found to be a novel coronavirus, which was named SARS-CoV2 because it caused an illness similar to the SARS (severe acute respiratory syndrome) illness caused by an earlier coronavirus, SARS-CoV. The disease caused by SARS-CoV-2 was then officially named COVID-19. By late February, it had spread to other parts of China and subsequently to Italy. The first cases of COVID-19 were from people who had been exposed to the virus in other countries and brought it back to the U.S. in February 2020, with Seattle, New York, and Philadelphia being among the early cities in the U.S. to see infections. As COVID-19 infections spread around the world, people on all continents became affected by and were dying from it, thus sparking the advent of a global pandemic. The term pandemic means the prevalence of a disease over the entire world.

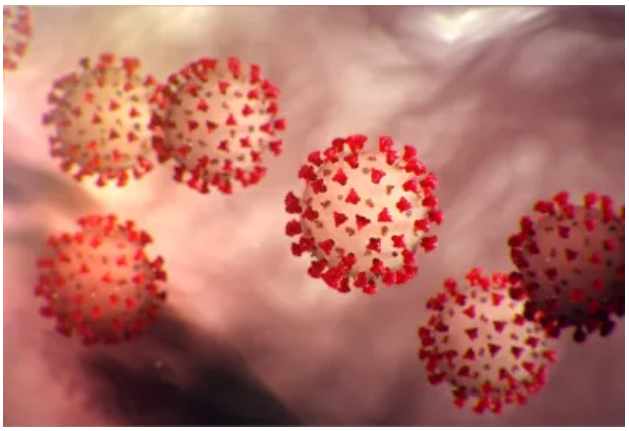


Image from cdc.gov

The coronaviruses are a large group of viruses that can cause illness in humans and animals. The most common natural source of coronaviruses are pigs, camels, bats, and cats, where the viruses typically do not cause disease. When they are present in humans, cows, and chickens, they cause illness. Some strains also cause illness in pigs. They cause respiratory illnesses in humans and chickens and gastrointestinal (GI) illness in humans, pigs, and cows. The most common types of respiratory illness caused by coronaviruses are upper respiratory infections, bronchitis, and pneumonia. GI infections typically cause diarrhea. Under the microscope, coronaviruses have crown-like spikes on their surface, which distinguishes them from other types of viruses. It is because of these crown-like spikes that they are called coronaviruses (corona = crown). There are hundreds of known coronaviruses, most of which circulate among animals. All coronaviruses have the ability to jump from animals to humans and cause disease, which is termed a “spillover event” when it happens naturally. There are seven coronaviruses that are known to cause illness in humans. The coronaviruses that cause mild to moderate upper respiratory illnesses and sometimes GI illness are named

229E, NL63, OC43, and HKU1. The three coronaviruses that cause severe and fatal respiratory illnesses are named MERS-CoV, SARS-CoV, and SARS-CoV-2. MERS-CoV causes the Middle Eastern Respiratory Syndrome, often called MERS for short, which caused respiratory illnesses in the Middle East in 2012, mostly in Saudi Arabia. SARS-CoV causes the severe acute respiratory syndrome, often called SARS, which caused severe respiratory illnesses in Asia that spread to 26 countries from 2002 – 2004. There have been no known cases of SARS since 2004 and only sporadic cases of MERS since 2012. The respiratory illness COVID-19 is caused by the SARS-CoV-2 virus.

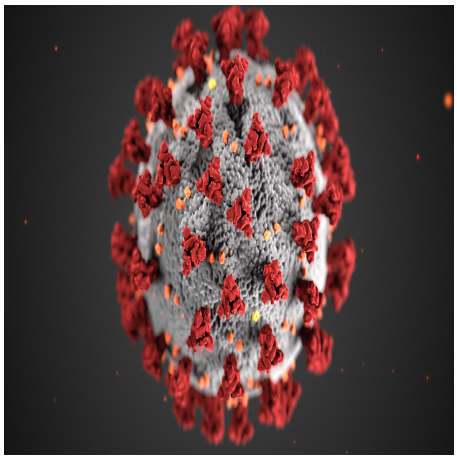


Image from https://www.fda.gov/food/food-safety-during-emergencies/food-safety-and-coronavirus-disease-2019-covid-19

The virus that causes COVID-19 is spread by respiratory secretions in the form of aerosols. Aerosols are very small particles of exhaled moisture suspended in the air exhaled by humans with each breath. Because of the size of the aerosols, they linger in the air for several hours and can then be inhaled by others who breathe in the aerosolized secretions. This is a normal part of the breathing process. However, the virus that causes COVID-19 is small enough to remain inside these aerosolized secretions and when inhaled by another individual, then will infect the person that inhales those particles. The virus is highly contagious and highly virulent. It can cause mild respiratory symptoms including cough, nasal congestion, and runny nose and can progress rapidly to severe shortness of breath and death. Death rates among unvaccinated individuals can be as high as 4-20% among those infected. Those at greatest risk for experiencing severe symptoms include individuals age 65 and older, those with a history of diabetes, asthma, hypertension, and obesity.

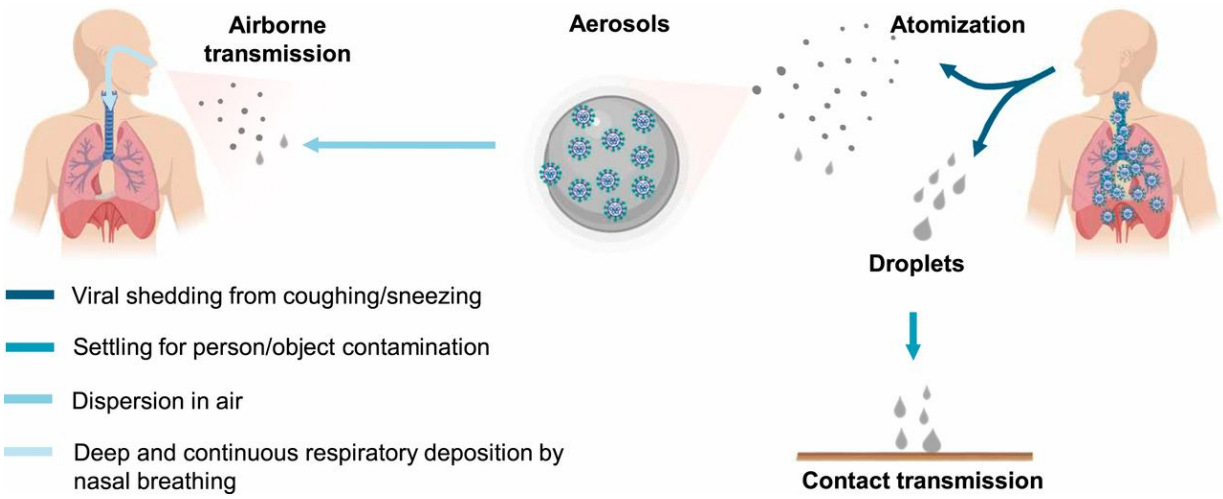


Image from https://doi.org/10.1073/pnas.2009637117

Larger respiratory secretions are exhaled in the form of droplets. These also contain virus particles and tend to fall once exhaled to rest on surfaces. Important means of protecting oneself from COVID-19 infection include social distancing, which means isolating oneself from the presence of others. When it is absolutely necessary to be in the presence of others, maintain a distance of 6 feet or more between individuals, wash hands frequently, sanitize surfaces touched by multiple individuals, and wear a face mask at all times.

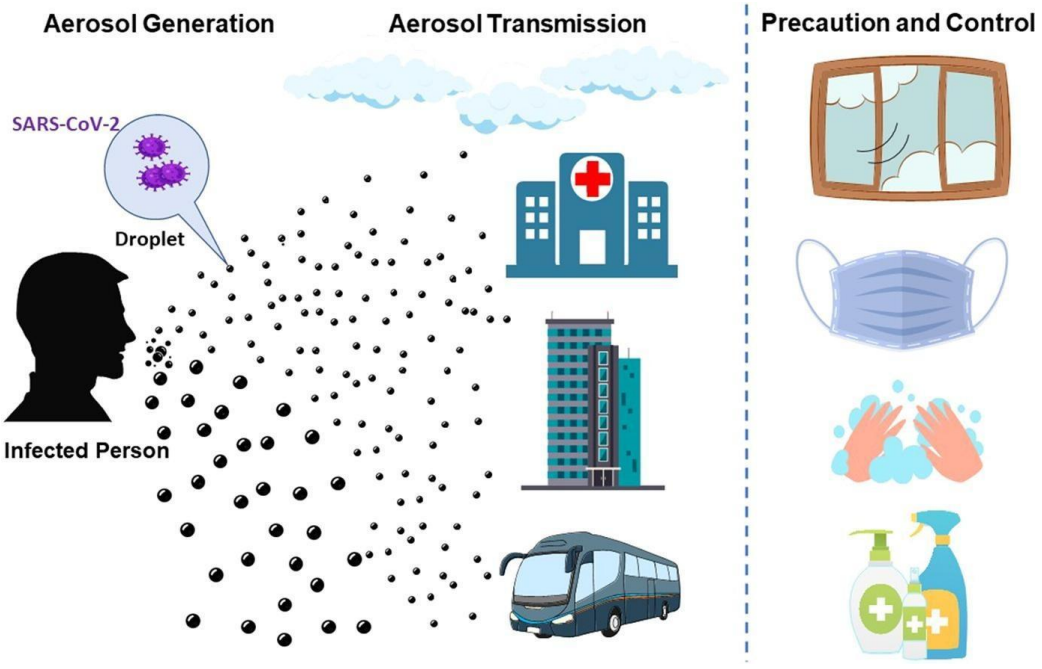


Image from https://www.sciencedirect.com/science/article/pii/S0160412020319942

Cloth face masks should be 2-ply, meaning that there are 2 layers to it. Surgical face masks are water resistant. The concept behind both types of face masks is that they help to keep secretions from being aerosolized. Neither of these types of face masks, though, is protective from becoming infected with the virus from another individual. The best face mask to protect from inhaling the virus from another person is the N95 face mask, which is a high particle filtration mask. Unless the face mask has an N95 filter (i.e. filters 95% or more of particles that are 0.3 microns in size or larger), it is unlikely to be of much benefit in preventing the wearer from inhaling or exhaling the virus. N95 masks are now available to the public for purchase. Purchasing and wearing an N95 mask does offer superior protection from **inhalation** of the virus. When buying an N95 mask, it is crucial to make sure that there is a NIOSH approval label on both the package and the mask itself. The NIOSH approval label should contain both the NIOSH seal as well as the NIOSH approval number, both stamped with NIOSH (US National Institute for Occupational Safety and Health) certification. A mask that reads N95 and does not have a label that reads NIOSH certified with the NIOSH seal, is not an N95 mask and may not offer the same level of protection.

(Approved Respirators, How can they be identified? | NPPTL | NIOSH | CDC https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html)

(Counterfeit Respirators: https://www.cdc.gov/niosh/npptl/usernotices/counterfeitResp.html)

Figure 1 – Example of NIOSH approval label.

Respirator Manufacturing Company

Anytown, Anystate USA

1-800-123-4567

THIS RESPIRATOR IS APPROVED ONLY IN THE FOLLOWING CONFIGURATION:

TC-	Protection [1]	Respirator	Cautions and Limitations [2]
TC-84A-0000	N95	X 1-X2	ABCJMNOP
Additional lines may appear here showing more approval numbers and associated information.			

1. **Protection**

N95 - Particulate Filter (95% filter efficiency level)
Effective against particulate aerosols free of oil;
time use restrictions may apply

2. **Cautions and Limitations**

A - Not for use in atmospheres containing less than 19.5% oxygen.
B - Not for use in atmospheres immediately dangerous to life or health.
C - Do not exceed maximum use concentrations established by regulatory standards.
J - Failure to properly use and maintain this product could result in injury or death.
M - All approved respirators shall be selected, fitted, used, and maintained in accordance with MSHA, OSHA and other applicable regulations.
N - Never substitute, modify, add, or omit parts. Use only exact replacement parts in the configuration as specified by the manufacturer.
O - Refer to users instructions, and/or maintenance manuals for information on use and maintenance of these respirators.
P - NIOSH does not evaluate respirators for use as surgical masks.

All N95 masks should fit flush against the face so that there is a seal and so that no air can be inhaled or exhaled between the face and the mask – all air is inhaled and exhaled directly through the mask itself. The best seal is obtained from masks that have a band that goes over the top of the head. Ear loops tend not to keep the mask sitting flush against the face and risk air escape or entry through the areas not flush with the face (and thus infection through these portal areas as well).

Symptoms of a COVID-19 infection are listed below and tend to occur 2-14 days after exposure to the virus, indicating that there is a period up to about 14 days when an individual may be infected with the virus and not yet symptomatic.

- Symptoms of COVID-19
  - fever
  - cough
  - shortness of breath or difficulty breathing
  - chills
  - fatigue
  - muscle pain or body aches
  - headache
  - sore throat
  - new loss of taste or smell

- congestion or runny nose
- nausea or vomiting
- Diarrhea

Up to 1/3 of those who are COVID-19 positive have no symptoms at all. Among those who develop symptoms, approximately 80% have mild to moderate respiratory symptoms up to mild pneumonia, approximately 15% have severe symptoms of shortness of breath, low oxygen, and 50% lung involvement, and 5% have critical symptoms of respiratory failure, shock, and multi-organ dysfunction.

When the SARS-CoV-2 virus enters the body, it is inhaled and attaches to the surface of respiratory cells in the lungs on the angiotensin converting enzyme receptor site (ACE2), which normally is responsible for the creation of secretions in the lung needed to keep the surface of the lung moist and at the appropriate viscosity. The virus then enters the cell and is multiplied by the natural mechanisms within the cell that usually make cellular proteins. The newly multiplied viral particles then exit the cell and are met by the individual's immune system, which releases a variety of inflammatory mediators. These mediators then cause the accumulation of fluid of abnormal viscosity in the tiny airspaces of the lung and interfere with the normal exchange of oxygen in those airspaces, making the lungs ineffective at transporting inhaled oxygen into the bloodstream.

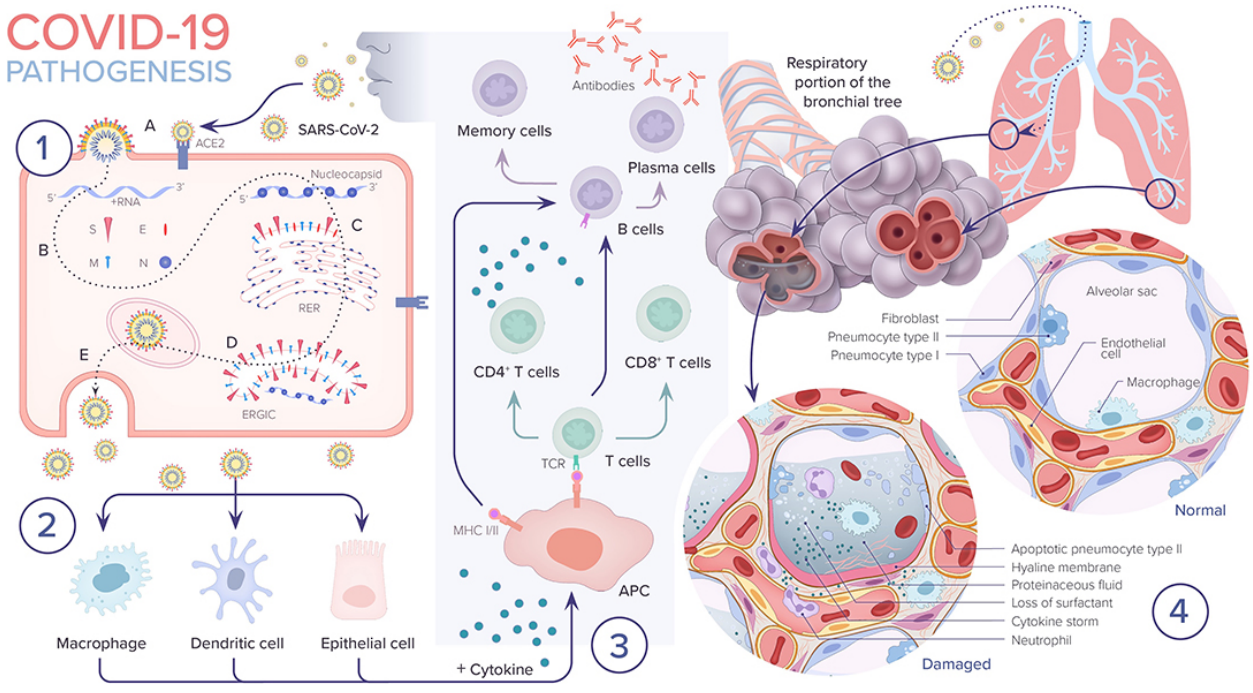
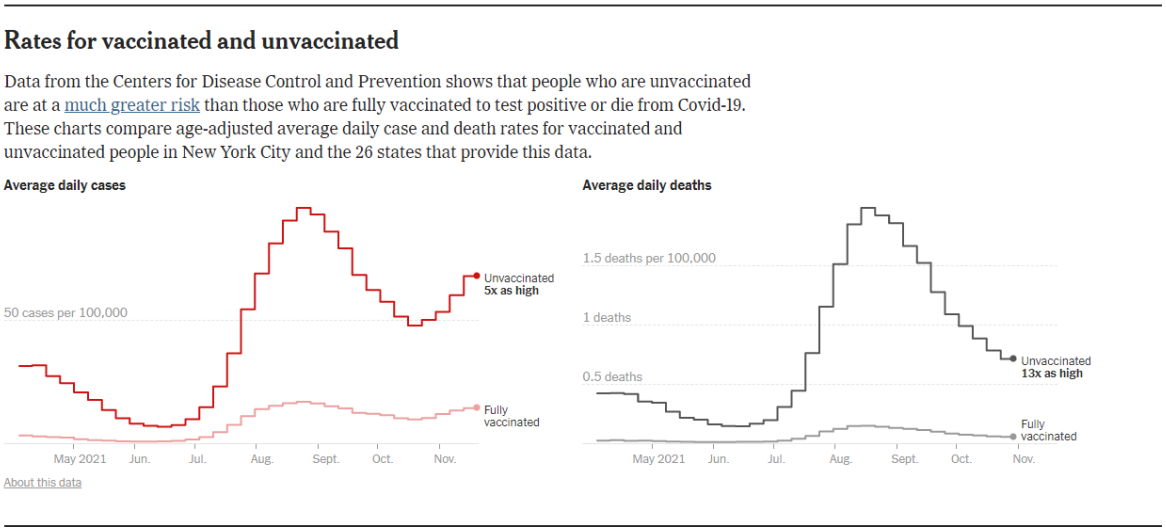


Image from https://doi.org/10.3389/fpubh.2020.00383

Currently (as of November 24, 2021), the Delta variant is the most common variant of the COVID-19 virus in the United States. Often, viruses undergo mutations, which are changes in the genetic information of the virus that dictates how the virus will infect or cause disease in its host (whether it be humans or animals). These mutations can also affect how the host's immune system responds to the virus in its attempt to rid the body of the virus. Mutations, or changes in the genetic code of the virus, occur randomly, similar to the way in which a normal cell in the human body can undergo a mutation of its DNA and then turn into a cancer. There are currently 15 known variants of the SARS-CoV-2 virus that causes COVID-19 worldwide, the newest being Omicron. By matter of convention, and to prevent confusion, the variants are given the name of a letter of the Greek alphabet, in the order in which it was first discovered. So, the first variant to be discovered was called the "Alpha" variant. The second variant to be discovered was called the "Beta" variant, and so forth. As of November 24, 2021, genomic sequencing of the Omicron variant continues to unravel the number of new mutations on the virus (https://www.nature.com/articles/d41586-021-03614-z). The most significant mutations on the Omicron variant have occurred in the spike protein, which increases the ability of the virus to infect human cells by increasing the virus' transmissibility and by helping the virus to evade past immunity. As of December 23, 2021, those who have had COVID-19 in the past and those who have had the COVID-19 vaccine are at increased risk of getting COVID-19 from the Omicron variant compared to the Delta variant, which itself was more transmissible than all previous variants. (https://www.cdc.gov/coronavirus/2019-ncov/science/forecasting/mathematical-modeling-outbreak.html). The Omicron variant was first detected in the southern tip of Africa in early November 2021, and this caused many nations, including the US, to restrict travel again to the 8 nations at the southern tip of Africa on November 25, 2021. Details regarding the relative virulence of Omicron versus the original SARS-CoV-2 virus and the previously most prevalent Delta variant are not yet known.

In June 2021, the Delta variant of the SARS-CoV-2 virus accounted for about 12% of the known infections of COVID-19 in the US. On August 26, 2021, it accounted for 98.9% of all COVID-19 infections in the US. It is twice as contagious as all other previous variants of the virus that causes COVID-19, which means that an unvaccinated individual who comes in contact with someone who is infected with the Delta variant of the virus is twice as likely to get COVID-19 disease as they were one year ago from coming in contact with someone infected with the virus then. Unvaccinated individuals infected with the Delta variant of the virus are also more likely to suffer a severe case of COVID-19 and are also more likely to die from it. Similarly, the COVID-19 vaccine offers good protection from getting the original and earlier variants of the virus but offers less protection against the Delta variant, and there have been several reports of

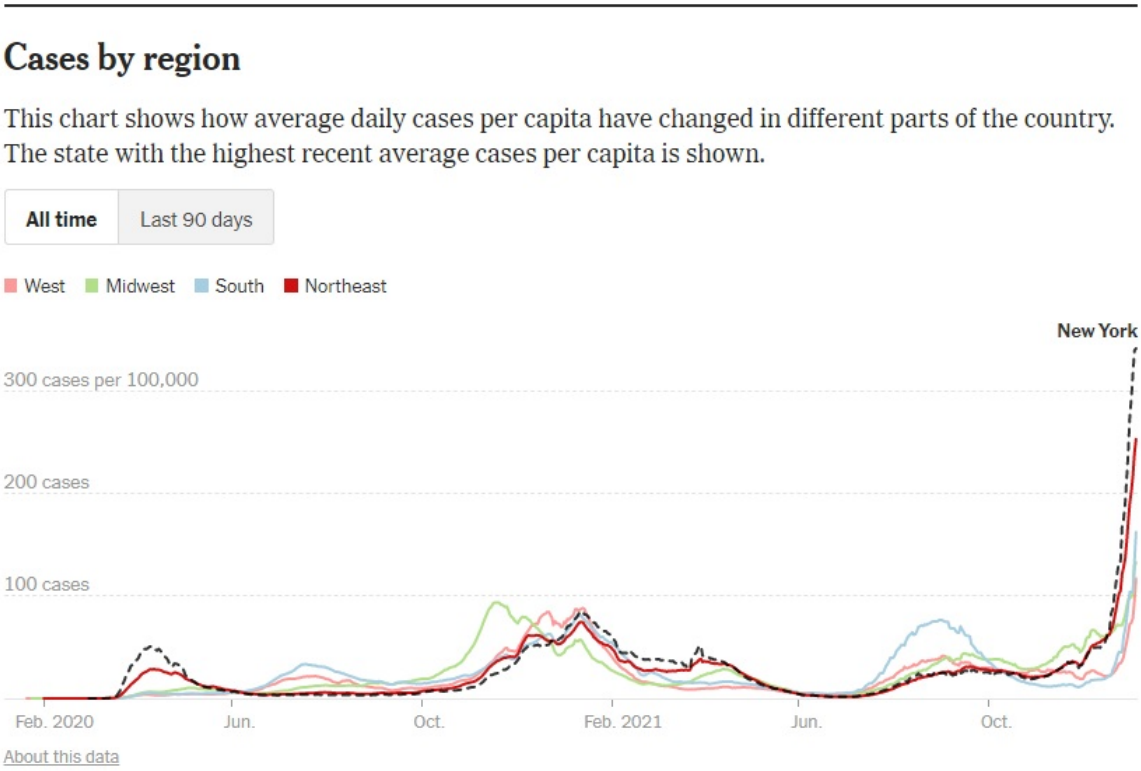
COVID-19 infections from the Delta variant in vaccinated individuals. Most vaccinated individuals who are infected with the Delta variant have either no symptoms or mild symptoms of COVID-19. However, there are increasing numbers of reports of vaccinated individuals having severe COVID-19 infections from the Delta variant that requires them to be hospitalized in an intensive care unit, intubated, and, in some cases, they die. The fact that the COVID-19 vaccine is not as effective in preventing infections and the ability to transmit the Delta variant of SARS-CoV-2 is worrisome to doctors and the CDC. Even more worrisome is the fact that the Omicron virus is even more transmissible than the Delta variant and that it eludes immune protection from the COVID-19 vaccine more so than did the Delta variant. The fear is that a higher number of infections may overload the capacity to treat everyone infected. Most vaccinated individuals have a shorter time frame during which they are contagious, and most do not go on to get severe or fatal infections. Individuals who are not yet vaccinated are most at risk of contracting the Delta variant from both vaccinated and unvaccinated individuals (either of which may have no symptoms at all at the time of transmission of the virus to them) and they are also most at risk of dying from a COVID-19 infection. Current data shows that unvaccinated individuals are five times more likely to get a COVID-19 infection as of November 24, 2021 and 13 times more likely to die from a COVID-19 infection than vaccinated individuals, as shown in the following graph.



Source: New York Times

Click here for current data:
https://www.nytimes.com/interactive/2021/us/covid-cases.html?name=styln-coronavirus&region=TOP_BANNER&block=storyline_menu_recirc&action=click&pgtype=Interactive&variant=0_Control&is_new=false

The issue of the effect of the Delta variant and the potential effects of future variants of the SARS-CoV-2 virus that causes COVID-19 are significant. The following graph depicts the COVID-19 infection rates in various regions of the U.S. from the beginning of the pandemic (which started in the U.S. in February 2020) through January 3, 2022.

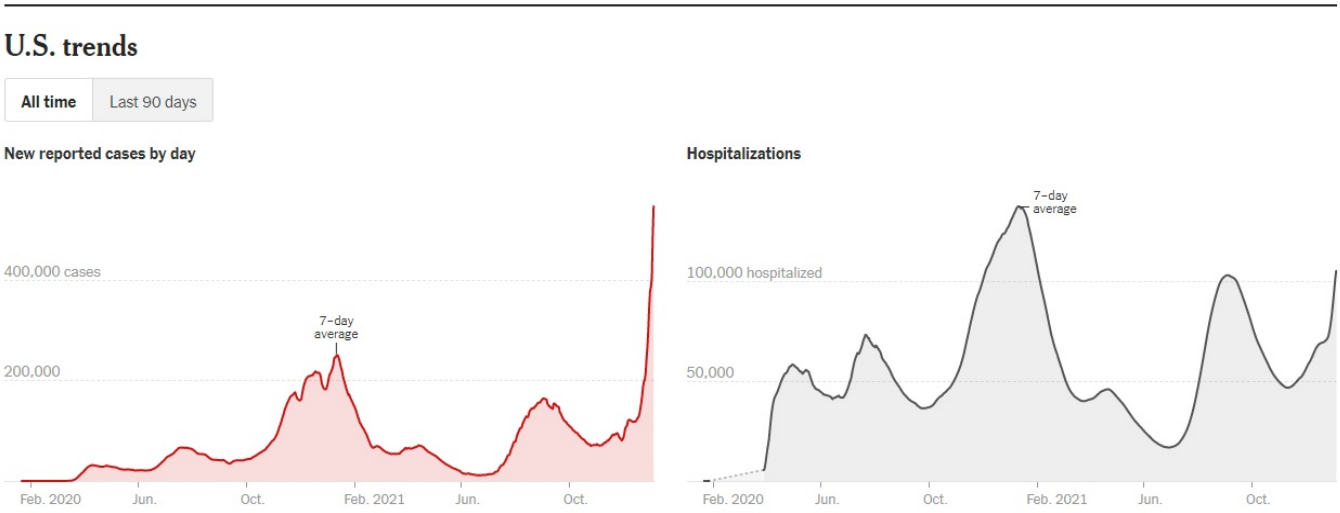


Source: New York Times

Click here for current data:
https://www.nytimes.com/interactive/2021/us/covid-cases.html?name=styln-coronavirus&region=TOP_BANNER&block=storyline_menu_recirc&action=click&pgtype=Interactive&variant=0_Control&is_new=false

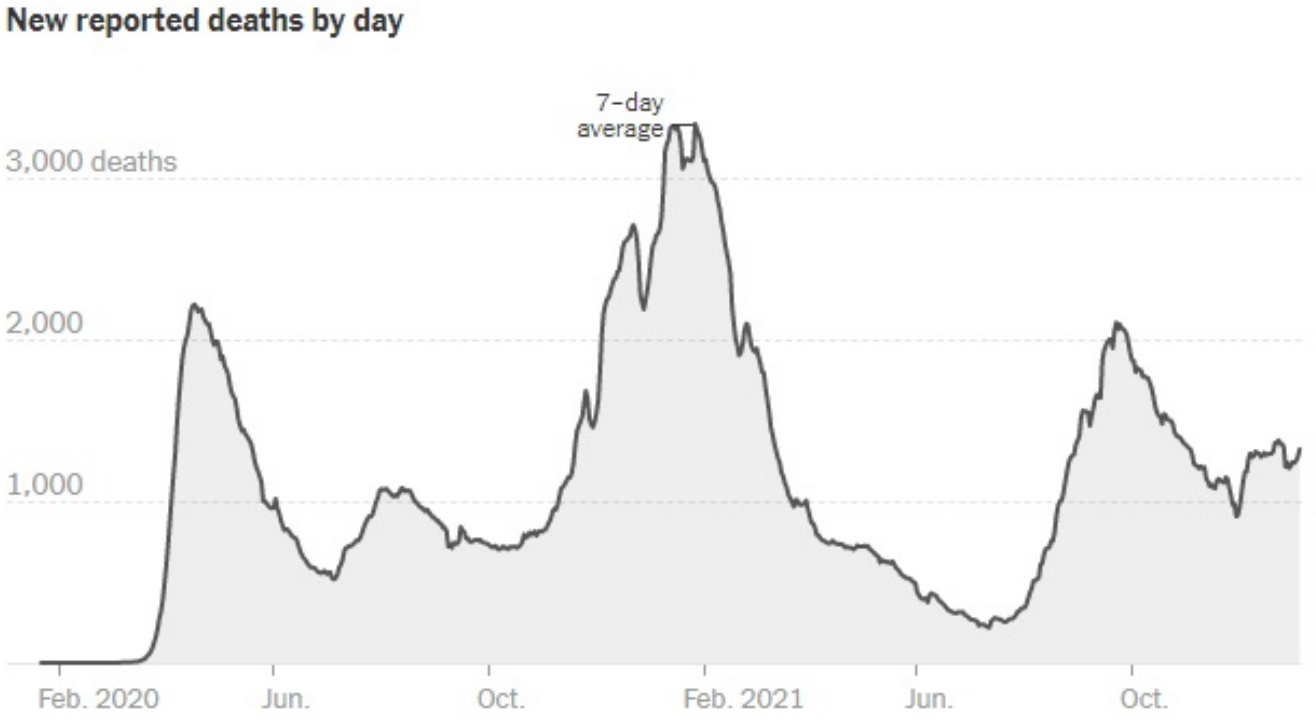
As is shown in the graph, the rates of COVID-19 fell initially after vaccination began from March through June 2021. Since July 2021, infection rates with COVID-19 (the Delta variant in particular) have continued to rise in all areas of the U.S., and in November 2021 infection rates (mostly from the Omicron variant) began to skyrocket and are currently higher in all areas of the country than since the beginning of the pandemic.

A graph of the total U.S. infection rate and hospitalization rate is shown below. In the image below that is the U.S. death rate from COVID-19 over the same time period (Feb. 2020 through January 3, 2022). Again, the U.S. infection rate, hospitalization rate, and death rates are all higher in November 2021 than they were in October 2020, despite the fact that 67% of the U.S. population is fully vaccinated.



Source: New York Times

Click here for current data:
https://www.nytimes.com/interactive/2021/us/covid-cases.html?name=styln-coronavirus&region=TOP_BANNER&block=storyline_menu_recirc&action=click&pgtype=Interactive&variant=0_Control&is_new=false



Source: New York Times

Click here for current data:
https://www.nytimes.com/interactive/2021/us/covid-cases.html?name=styln-coronavirus&region=TOP_BANNER&block=storyline_menu_recirc&action=click&pgtype=Interactive&variant=0_Control&is_new=false

If we look at the data for the state with the highest vaccination rate in the US, we see that of the 48 contiguous states, Vermont has the highest vaccination rate at 72.62% of the population fully vaccinated. However, the two graphs below show the COVID-19 infection rates and death rates, respectively, from February 2020 through January 3, 2022. Despite the fact that more than 70% of the population is fully vaccinated, the number of cases of COVID-19 are significantly higher now than they were when social distancing measures were enforced, suggesting that the decrease infection and death rates seen previously was more due to social distancing and less to a vaccine effect.

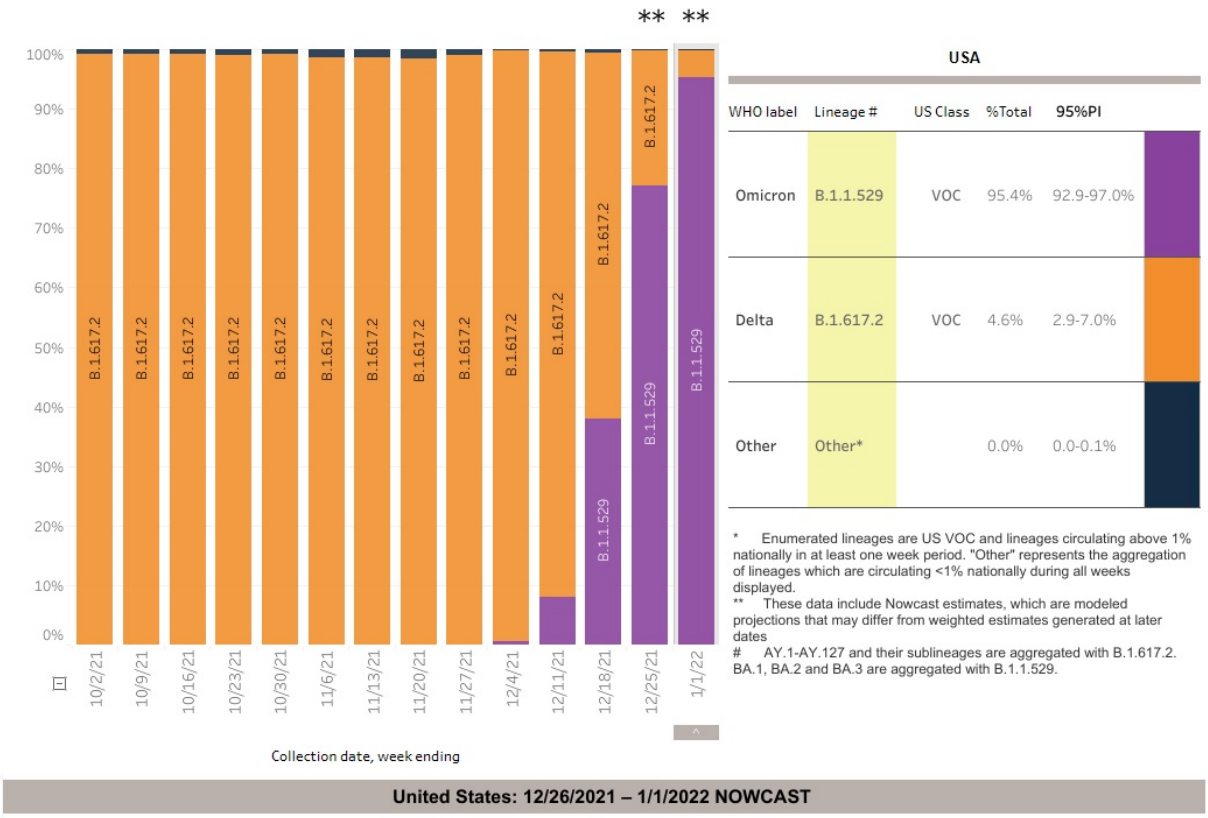
Source: Johns Hopkins Coronavirus Resource Center

Click here for current data:
https://coronavirus.jhu.edu/data/state-timeline/new-confirmed-cases/vermont

Source: Johns Hopkins Coronavirus Resource Center

Click here for current data:
https://coronavirus.jhu.edu/data/state-timeline/new-deaths/vermont/0

The relatively high rate of infection also shows the relative resistance of the Delta variant to the vaccine (vaccinations started January 2021, the Delta variant appeared early July 2021). The Omicron variant first appeared in the U.S. as a single case on December 1, 2021 (see chart below). As of December 20, 2021, it has spread to almost all 50 states. On November 27, 2021, the Delta variant comprised 99.7% of all COVID-19 cases in the U.S. On December 4, 2021, the Delta variant comprised 99.3% of all of the cases of COVID-19 in the U.S. and the Omicron variant just 0.7% of the cases. On December 11, 2021, the Delta variant represented 87% of the cases of COVID-19 in the U.S. and Omicron 12.6%. On December 18, 2021, the Delta variant represents only 26.6% of the cases of COVID-19 in the U.S. and Omicron 73.2% of all of the cases. On January 1, 2022, the Omicron variant represented 95.4% of all COVID-19 cases and the Delta variant 4.6%.



Source: CDC Data Tracker

To see current data click: https://covid.cdc.gov/covid-data-tracker/#variant-proportions

It is possible for an individual to be infected with multiple strains of the Sars-CoV-2 virus, and the numbers that are reported are the “dominant” strain in individuals at the time they are tested.

The bottom line: 1) It is extremely important that everyone worldwide continue to wear face masks, high particle face masks such as the N95 when available, when around others or when in an environment in which it is likely that others will come into the space in which you are sitting. The virus is spread when someone inhales the air that another exhaled that contains the virus. The virus will linger in the air in an enclosed room that has no ventilation for several hours. So, sitting in a room without a mask on, then putting the mask on when someone enters offers the person that entered no protection for virus that the individual in the room may or may not be harboring. **2)** It is extremely important that the COVID-19 vaccine is received to protect against getting a COVID-19 infection. Severe COVID-19 infections are extremely difficult to treat and often result in death. Even when death does not occur, many people who recover from severe

infections suffer multiple organ damage, sometimes strokes, sometimes heart disease, and often long-term debilitating issues. Monoclonal antibodies, which have been effective in treating severe infections of the original and early variants of SARS-CoV-2, are not as effective against the Delta and Omicron variants.

The biggest FEAR: the virus will continue to mutate, a mutation will be born that is completely resistant to the vaccine, and those individuals who are vaccinated will be subject to severe and fatal COVID-19 illnesses again that will be devastating to the human population worldwide and against which we may not be able to conquer.

III. Risk Considerations for In-Person Voice and Speech Training

Based on the available evidence regarding the transmission rates of COVID-19 Delta and Omicron variants, our highest recommendation is that no in-person learning be done at this time (as of December 23, 2021). If the rate of transmission or the transmissibility in vaccinated individuals decreases either through the advent of a new vaccine or through further mutations that eliminate the strains that are highly transmissible and that evade vaccine-given immunity, then in-person teaching and performances can be reconsidered. Everyone, though, should be aware that there is a subset of the population, in general, that even when vaccinated are highly susceptible to getting COVID-19, and the CDC recommends that these individuals be treated as though they are unvaccinated. Because most institutions do not inquire about the medical history of their students, faculty, or staff, it is best that all institutions treat everyone as though they are unvaccinated in order to help protect this class of individuals. Those who are at increased risk of contracting COVID-19 include those on immunosuppressant medications (including people with asthma, rheumatoid arthritis, psoriasis, Crohn's disease, ulcerative colitis, lupus, cancer, HIV, chronic prednisone use, and other diseases that affect the immune system), those who have diabetes, asthma, kidney disease, obesity, liver disease, heart disease (including coronary artery disease), previous history of stroke or heart attack, dementia, lung problems, and those over the age of 65 years. (https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-who-is-at-risk/art-20483301)

When in-person learning and theater production resumes, it is important to have an early indication of when someone is infected with the virus and frequent testing of ALL individuals should be mandatory on an at least weekly basis. Early detection helps to quarantine infected individuals from those around them and helps to limit the spread of the virus. The chart below is an updated version of the chart of recommendations that was published by VASTA in July 2020 and includes recommendations that take into consideration all that we have learned from the virus since then.

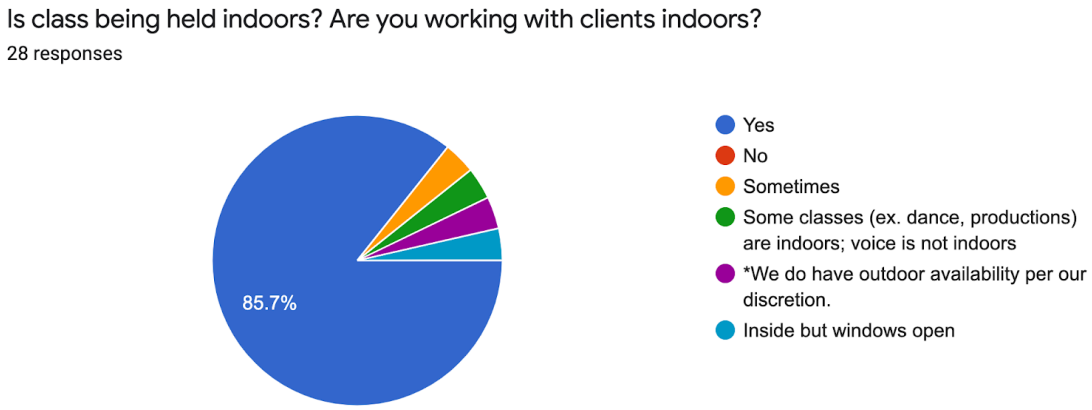
TOPIC	FACTORS THAT INCREASE RISK	FACTORS THAT DECREASE RISK	RECOMMENDATIONS
Entrance Control	• Unvaccinated participants • Commuter student populations: Public Transportation, outside exposures • Residential student populations: outside exposures, social	• Vaccinated participants • Masking • Entrance and exit protocols • Staggered class transitions • One-way trafficking of pedestrians around campus	• Completed vaccination for all participants • Mandatory masking • Enter through one door, exit through another • 10-15 minute break between classes

	gatherings, close quarters, cafeteria • Narrow hallways and stairwells • Elevators	• Temperature checks • Symptom queries • Regular testing and tracing • Protocols for protective practices in shared spaces	• Separate pathways for each direction • Excuse/exclude if Temp > 99.0F • COVID-19 test weekly
Learning Space	• Poor ventilation or lack of ventilation • HVAC Recycled air • Small spaces that don't allow social distancing • Large student groups • Long course periods creating greater exposure to aerosolized virus • Shared instructional materials • Turbulence or convection causing adverse air movement	• Air turnover rate at 10-12 times per hour – supplement HVAC with portable HEPA filter • Vent air to outside, input air from outside • Supplemental UV air filter • Sanitize and disinfect surfaces between students • Access to larger spaces, including outdoor spaces, • Maintain 6 ft social distancing when masked • Assign instructional materials to individuals	• Mandatory masking • Supplemental portable HEPA air filter • 6 ft. social distancing at all times when masked • Disinfect surfaces between classes/students • Outdoor teaching with 9-12 ft social distancing if masking not appropriate, beware of direction of wind
Personal Protection	• Working close to others • Working face-to-face with others • Use of low filtration/used masks • Inadequate access to handwashing and sanitizers • Touching outside of face mask	• Social distancing of 6 ft in all directions • Use N95 masks • Hand sanitizing protocols • Working side by side or back-to-back, not face to face (in addition to social distancing) • Weekly testing • Denying in-person/in-class participation to those who test positive for COVID19 • COVID19 vaccine	• N95 masks • Mandatory quarantine of 14 days if test positive for COVID19 • COVID19 vaccination and booster when appropriate • Weekly testing for vaccinated • Daily testing for unvaccinated https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html
Theater Production	• Working close to others • Working face-to-face with others • Performing/rehearsing without masking • Touching objects touched by others	• Cast quarantine from outside individuals • COVID19 vaccine • Air exchange of 12 exchanges/hour • Sanitizing objects, handwashing before going	• Self-quarantine for 14 days before rehearsal/stage performance without mask • Entire cast/crew quarantine together

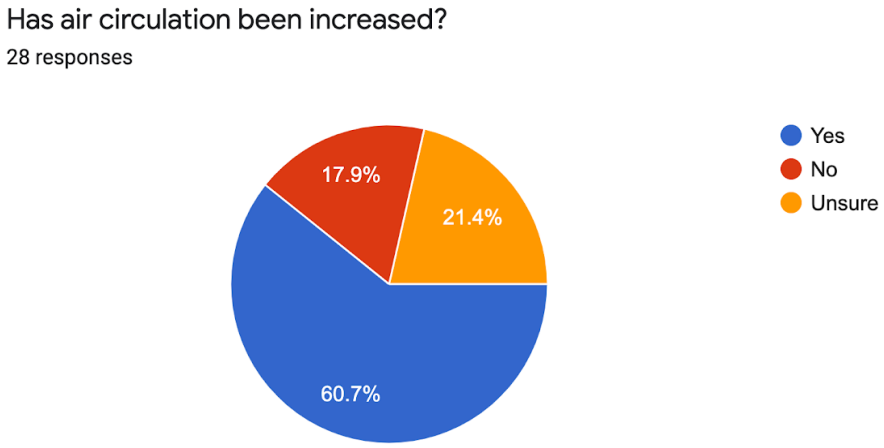
		onstage	for duration of production that is without mask ● Only onstage cast/crew without mask, all others masked ● Daily COVID19 testing starting on 1st day unmasked and every day thereafter ● COVID19 vaccination and boosters as appropriate ● Strict handwashing ● Strict protocols for sanitizing objects on stage

IV. Current Strategies, Considerations, and Models for Voice and Speech Training in the time of COVID-19 (2021 - Present)

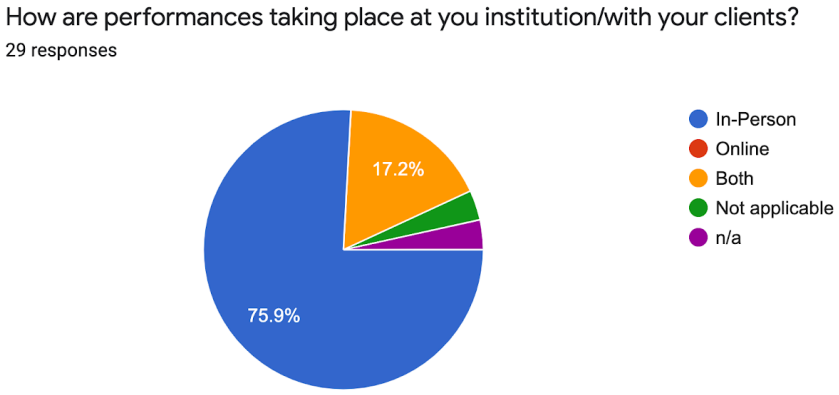
So, how does the voice coach and speech trainer teach students and vocal coach while putting themselves and their students at minimal risk for contracting the coronavirus COVID19? The BEST ADVICE is to **continue with strict social distancing** and deliver classes and voice/speech/theater instruction remotely via virtual media such as Skype[R], Zoom[R], Microsoft Teams[R], etc. However, it is clear that not everyone has this option because of mandates by employers to return to work and in-person teaching/coaching. We polled the membership to get an understanding of how the membership is handling coaching and teaching as of November 2021, and the following information was received.



Eighty-five percent of those that responded reported that they are continuing to have class indoors. Of these, 60.7% have indicated that the air circulation has increased inside. When the risk of aerosolization is high, as it is with acting and singing, the CDC recommends that the air in the room be exchanged no less than 12 times per hour (https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html and https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/interactive-ventilation-tool.html). This can be accomplished by either increasing the capability of the HVAC system in the building or by adding portable HEPA filters to the room to increase the air exchange to 12 per hour. If the HVAC system already does an air exchange of, for instance, 7 times per hour and a portable HEPA filter is purchased that does an air exchange of 5 times per hour, 7+5 = 12 air exchanges/hour, then this is all that is needed. If, however, the HVAC system does, for example, 5 air exchanges per hour and the portable HEPA filter that is purchased does 5 per hour as well, then 2 portable HEPA filters are needed to get to at least 12 air exchanges per hour, i.e. 5+5+5 = 15 air exchanges/hour.

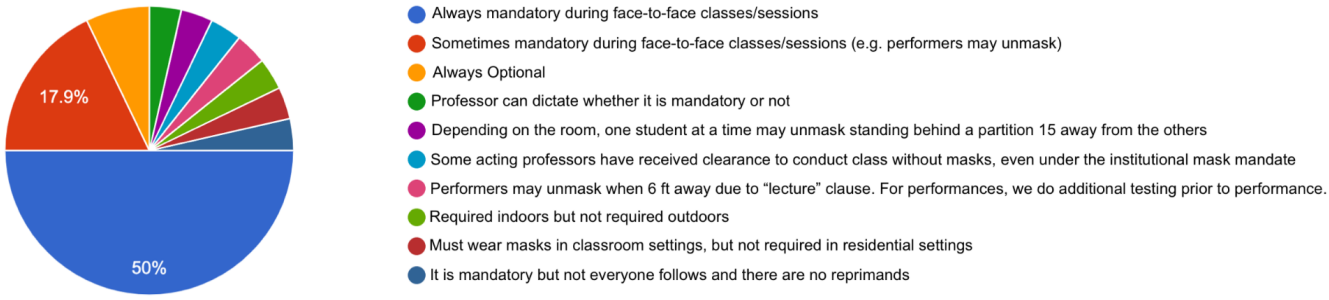


Ninety-three percent of the respondents indicated that performances are taking place either in person (75.9%) or both in person and online (17.2%). Thus, social isolation is not occurring (which is our strongest recommendation). In the absence of social isolation, it is extremely important that all individuals wear face masks, preferably N95 masks, at all times. When the decision is made to perform without a face mask, strict adherence to a protocol that includes a mandatory 14 day quarantine for everyone who will participate in the production, followed by COVID-19 testing before anyone is allowed to assemble for the production, daily testing during the production, and strict quarantine of the cast/crew together (away from others not in the production) for the duration of the production should be followed in order to protect everyone from COVID-19. If this protocol cannot be maintained or performed (i.e. students need to stay at dorms and eat in the cafeteria), then the production should not be unmasked at all.



Mask Use

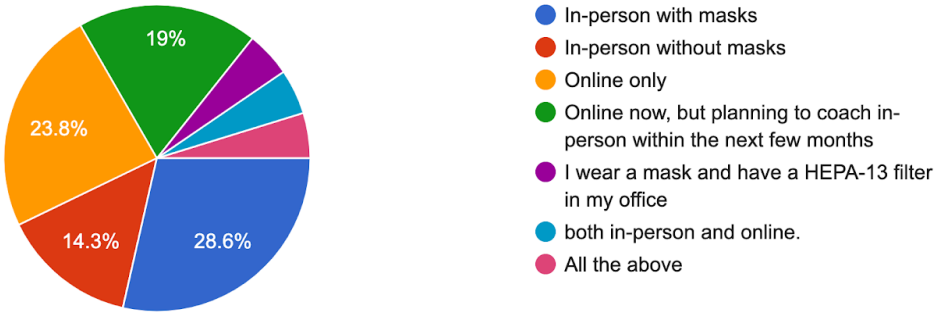
28 responses



Use of N95 masks is strongly recommended for in-person coaching and teaching.

As a coach/practitioner, I am working with my clients

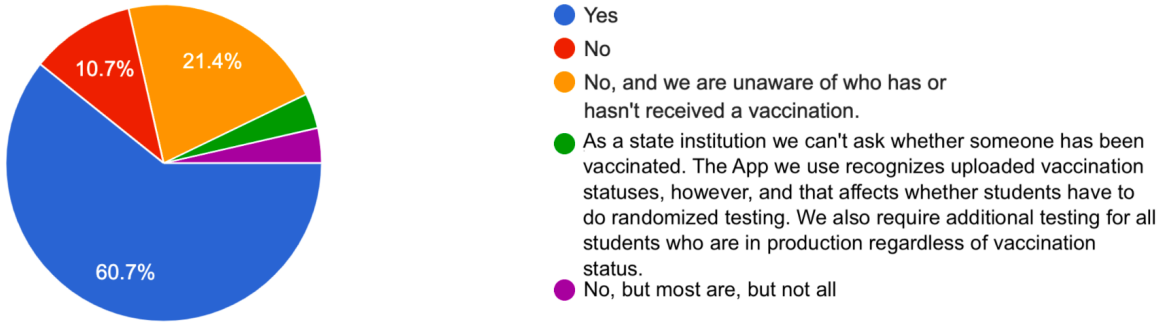
21 responses



Fifty-two percent of the respondents are working with their clients online currently. Of those who responded, 14.3% are working with clients in-person and without masks. The current data from the CDC suggests that not wearing a mask increases the risk of getting COVID-19, even when vaccinated and mask wearing is strongly recommended for in-person contact.

Are vaccinations required for all students/clients, faculty, and staff unless granted special exemption?

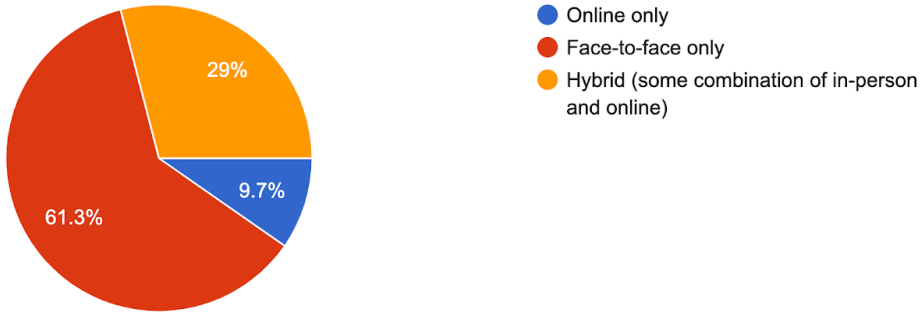
28 responses



Like the national vaccination rate, approximately 60.7% of respondents stated that vaccination is required for all students, clients, faculty and staff.

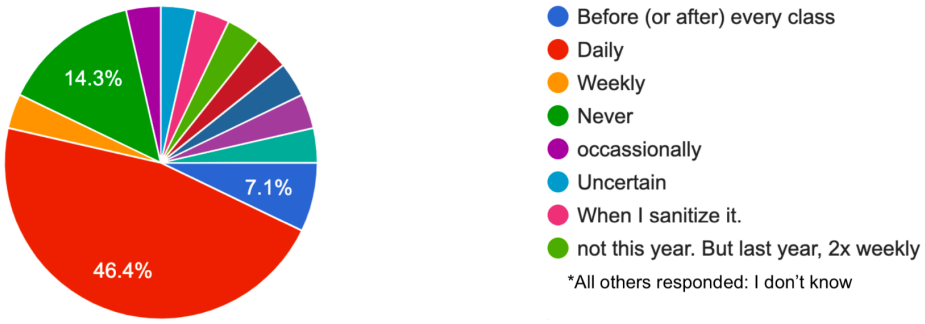
Please indicate the mode of instructional delivery for your courses/coaching:

31 responses



How often are rooms sanitized?

28 responses



Seven percent of respondents reported that the teaching rooms are sanitized before and after each class. 46.4% indicated that the room is sanitized at least daily. Because people often touch the outside of their mask and because respiratory droplets can settle on hard surfaces, it is recommended that rooms and surfaces be sanitized between each user.

In the instance in which one is forced to do in person coaching and vocal instruction, the following represents some suggestions on how to do so (and are not necessarily the recommendations of HealthCore, EduCore, Dr. Heman-Ackah, or VASTA). Each of these suggestions is based on the best current evidence and is meant to be a guide for universities, schools, theaters, and other performance venues that have decided to proceed with in-person activities.

1. The first thing that voice coaches/speech trainers/voice teachers need to consider is whether it's possible to teach outside, even in the winter months. If it is feasible, moving the classroom to the outdoors is likely the best option to help prevent transmission of the virus because there is a greater volume of air for the virus to circulate outdoors, and the rules of diffusion show that the virus will disperse faster away from the individual outside than it will in a confined space inside. If one decides that they cannot teach outside, then the space in which one teaches indoors needs to have good ventilation in which the air is constantly being exchanged on a minute-to-minute basis – such as an active air conditioner (the fan must be running continuously without periods of stopping and starting intermittently). Additionally, having a HEPA filter in the room will help to filter out virus particles. All HEPA filters have a designated maximum room size that they can filter effectively. If a HEPA filter is purchased, it should be capable of filtering the area of the room. All certified HEPA filters by definition are capable of filtering particles the size of the coronavirus.

2. Part of voice/speech coaching involves evaluating how the mouth, tongue, soft palate, neck, jaw, and shoulders are moving during vocal performance as well as evaluating the breath-support mechanism. When the student is wearing a face mask, it is difficult to evaluate these aspects of vocal performance. Outside, standing 9-12 feet away from the student and observing is likely the best way to evaluate and train these aspects of vocal performance. Multiple students should be spaced with a 9 feet – 12 feet bubble around them on all sides outside to prevent transmission from one person to another. When teaching multiple students at a time and doing exercises in which the movement of the mouth is being observed, it is best to do them online or outside. There is no completely safe way to observe multiple students move their mouths, soft palates, jaws, etc. at one time indoors.

3. If teaching requires physically touching the student, an N95 face mask should be worn by both the teacher and student because of the proximity of the two.

4. Everyone should be vaccinated.

5. COVID-19 testing should be performed on everyone weekly.

6. During performances, COVID-19 testing should be performed daily with daily temperature checks if at any time during the production, any cast or crew will be without masks.

7. At least 15 minutes should be given between classes to allow the ventilation system to clear the air before new individuals enter the space.

COVID-19 remains a health threat and a health emergency. Vaccination offers a layer of protection against the most severe illness; however, fully vaccinated people continue to get COVID-19 and they continue to die from it. Social isolation (i.e. quarantine at home) offers the best protection from COVID-19, its Delta and Omicron variants, and any new variants that may arise in the future. Use of N95 face masks when in-person interactions are necessary and limiting cast and crew exposure to outside individuals when the choice has been made to proceed with production without the protection of facemasks.

Some individuals are at higher risk for COVID-19 infection than others, based on the presence of other medical conditions. Every effort must be made by all to protect these individuals as though they are unvaccinated (even when they have received the vaccine), including ensuring that those around them are not engaging in dangerous behavior that would increase the risk of infection.

V. Summary of Survey Responses: Reflecting on Strategies, Considerations, and Models for Voice and Speech Training in the time of COVID-19 (2020 - 2021)

We polled the membership to get an understanding of how they have handled coaching and teaching in remote, hybrid and in-person contexts from 2020-2021. The following represents suggestions and opinions expressed by members in survey responses and are included for information only, not as recommendations. These suggestions and opinions do not necessarily represent the views of HealthCore, EduCore, Dr. Heman-Ackah, or VASTA.

What was your most successful unit/lesson in online teaching or coaching?

- **Summary of Responses**
    - An early lesson where they explored and interacted with their own space
    - One on One Coaching (monologues, Shakespeare, speech and accent work)
    - Personal voice practice work with MFA students
    - Anatomy (images, videos, and up-close look at the vocal tract using the screen as a mirror/to model)
    - Speech and anatomy was much more effective online -- we could see our own and each other's faces and vocal tracts without infringing on social boundaries
    - Verbatim Work
    - Dialect and Accent Work
    - Introducing accents went well because it was easy to share screen/audio for videos and recordings and to annotate something as a group
    - Masterclasses introducing somatic learning concepts
    - When it comes to vocal warm ups, I lead less, and my students lead themselves more. This has been incredibly successful and students feel they have more ownership over their vocal work and warm-up practice.
    - Flipped Classes (students received materials asynchronously to watch/read/listen, then discussed when meeting synchronously online). For example:
        - “For the most part I was doing a lot of flipped classes where students would review videos and work at their own pace and then zoom time was spent getting feedback, hearing each other, and digesting. This worked well for voice-over class - we would introduce topics asynchronously and then listen to each other with videos off during zoom sessions.”

    - Self-Taped Performances
    - Online teaching allows coaches to reach a wider range of clients across the globe than before
    - I think all of them. It was a successful experiment. Much learned.
    - CHALLENGE: What seemed successful in Fall 2020 has revealed gaps in students training now that they are back in-person. For example:
        - "*Interestingly, there were units that I thought were very successful at the time (Fall 2020), but now, a year later, we're seeing a lot of gaps in those students' training. I introduced voice and movement to the sophomores last year and thought their reflections and performances were clear and specific. As juniors now, however, seeing their work in person has proved that the work didn't sink in as well as it usually does. I had a student in my office to whom I was recounting an exercise we did together and she said "it's totally different to hear you describe this in person - I can see your breath coming and going, I see your thoughts travel through your body- that doesn't translate in pixel form."*

If you switched to online teaching or coaching, what was something you discovered in your pedagogical practice that you are carrying with you in future terms?

- **Summary of Responses**
    - Taking the time to connect with students in a meaningful way
        - Lead with patience and kindness
        - PAUSE and wait for the student
        - Give students an opportunity to connect in small groups before engaging as a full group
    - Working in personal spaces offered privacy that made the work more intimate and personal
    - Privacy of doing the physical work (Fitzmaurice particularly) in their own spaces with the power to mute themselves
    - The value of feeling safe to work at home on mute as some become more comfortable this way before being in a large room with strangers
    - My need to teach in a way that elicits an enthusiastic response so that students self-motivate
    - I just notice that I am being more direct and conversational in my teaching, which I quite like. I can't quite explain why this would be.

- The first level of coaching can be done by the actor themselves. I found that using video recording created an iterative process early on in the coaching work. So each student was more advanced when we had our first session. Because they had already gone through a process on video themselves.
- It is absolutely possible for a student to miss a class and to still catch up on the material. The strict policies about dropping students' grades significantly after absences is unnecessary. I feel strongly about giving students more agency in how they learn and how they engage.
- Keeping certain elements (anatomy, speech work, etc) online
- The ability to communicate and share files with clients more effectively
- We don't have a "neutral" in an in-person space
- A super-organized Blackboard course site
- Your pedagogy has to be limited to what you can do virtually, which means more reading and discussion and scene work, and less exploring without existent material
- The use of technology in general. Self-tapes, audio and video resources, sharing screens, etc. were all quite successful. When I teach in-person, I tend to shy away from technology, but this past year and half has shown me what is possible.
- Self-tapes/audio recordings are excellent reference points for students.
- Roll with it
- More flexibility!
- We can still connect through the computer if we have to!

If you are working with students or clients while masked, have you modified your curriculum? If so, how?

- **Summary of Responses**
  - (A number of respondents replied with “no”)
  - I would distance and unmask to show an exercise, and have the students work on it at home and send me videos for me to review (cork/bone prop exercises, for example)
  - Yes. I use pictures or videos when I can't use my face.
  - Everything takes more time. Sometimes we go outdoors or online to demonstrate specific skills, to take off masks.
  - We are working at a slower pace, not covering quite as much material.
  - Had to save articulator work for 1 day per week where all students are online (unmasked)

- Yes, greater emphasis on individual rather than group work so students can unmask during performance in class (while at a distance from others)
- Still figuring it out
- Mostly in the amount of physical contact I have with my students (virtually none)
- Yes - when I introduce concepts or work speech elements depends on when I can coordinate with other studio instructors for students to travel home for mask-less class.
- Changed breathing exercises
- Breathing and some oral cavity warm ups are modified.
- No breath work. Only IPA, basic RP. If we do any vocal warm up it is outside and brief. Cannot fully teach voice.
- I have occasionally arranged for the class to meet outdoors so we can unmask. For speech work, I am much more focused on students' somatic and interoceptive experience of their own vocal tract than on modeling exercises, because they can't see my face or their own.
- More small group and lecture exercises to control larger group interaction.
- Not really. There are little things that I do to adjust and I might go about things differently but the outcomes and the unit goals are still in place. I have generally found that masks are significantly less cumbersome than social distancing requirements. If students can't partner up or work in small groups or have some form of physical contact we miss a lot.
- Only to go outside when we do mask-off work
- Clearer written instruction on class site
- Yes. I am not teaching particular exercises in person, but opting for a flipped classroom where students view a video outside of class, and we discuss it in class.
- Flipped classroom model of sending students videos to work with at home, and then discuss them in class. Particularly with articulation/speech exercises.

If you are working with students or clients while masked, have you felt a need to address concerns and anxieties regarding safety? If so, how did you address these concerns and anxieties?

- **Summary of Responses**
    - I make sure the environment makes the students feel safe, and I respect their need to distance or wear a mask even when they could take it off (like in distanced one-on-one work)
    - Yes, no student will be asked to do anything they might feel uncomfortable with.
    - I have not. I avoid touching the mask when possible.
    - Talk about it
    - Felt the need, but didn't really find a way to address it.
    - No
    - Daily check-ins
    - Absolutely. I have continually reinforced the necessity of mask wearing, of finding masks that stay put on the face through their work, and dipping into conversations regarding how it might feel liberating/hindering to breath in a shared space masked and in unmasked situations. We've discussed boundaries and consent work as often as I can find space for it. I encourage them to practice self regulation and the possibility of changing their mind about their decision to be in a classroom/rehearsal masked or unmasked, but because I operate on the current masked policy in my studio, there isn't the opportunity to practice this with me - only the hope they will grant themselves the permission to do so on their own.
    - Yes. Raised awareness of how we do things safely.
    - Yes, how to do dialect work with mask
    - Students have complete autonomy to decide their level of participation -- they understand each exercise clearly before it begins, how they can modify their level of participation, and are able to "tap out" and observe at will. We also created a simple mechanism for pausing an exercise to express a question or concern, so that consent is continuously sought and reinforced.
    - We have a verbal check-in to begin class. That allows students to express any anxieties. So far, all students in my voice classes are complying with protocols. But they are still anxious....
    - Reminding students that they have a voice to share concerns and are safe to speak up.

- We had two students opt to stay all-virtual in spring 2021 (which was a hybrid semester) so those who would have been nervous had the ability to stay off campus.
- I just continually remind people to take care of themselves by giving themselves the physical distance they need to feel comfortable. I also did a survey about physical touch/contact to gauge how ready they are to return to physical contact with others.
- Straight forward
- Not at this point. By the time we moved back in person, students were comfortable or offered a chance to discuss needs before class began.
- Not sure
- Yes. I noted the extreme circumstances we are all working under in my syllabus and highlighted the mental health resources on campus. My students also know I have an open-door policy when it comes to discussing and addressing safety concerns.
- Yes. We created community agreements and have check-ins when necessary.

VI. REFERENCES

1. The 2021 Committee would like to thank the members of the 2020 Committee: *Barbara Adrian, Eric Armstrong, Michael J Barnes, Amy Chaffee, Colleen Conroy, Kristi Dana, Ginger Eckert, Christine Hamel, Deborah Kinghorn, Ursula Meyer, Daron Oram, Jedd Owen-Ellis Clark, Ann Marie Pollard, Pamela Prather, Matthew Rossoff, Susan Schuld, Lester Thomas Shane, Jeremy Sortore, Amanda Stephens Lee*
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