

I hope everyone had good weekend as we head into another challenging week.

VII

Today I am devoting the entire Daily Briefing on the just released summary of CDC's public health guidance aimed at controlling the surging COVID-19 pandemic. This may be one of the most significant documents the CDC has issued. You may ask why? Vaccine approval and distribution are less than a week away when manufacturing and distribution will ramp up quickly. However, initially there will not be enough vaccine to immunize everyone and it will not be until the spring when there will be enough vaccine. We need to get to ~70% herd immunity before we can start to relax current mitigation strategies which probably will not occur until ~May 2021. As the virus is surging in many areas of our country, we need to double down on our efforts to reduce the spread of SARS-CoV-2 using the commonsense recommendations in the document below. We cannot let down our resolve especially since there is light at the end of tunnel. Social distancing has decreased dramatically while mask use has increased. Too many Americans are still engaging in ill-advised behavior.

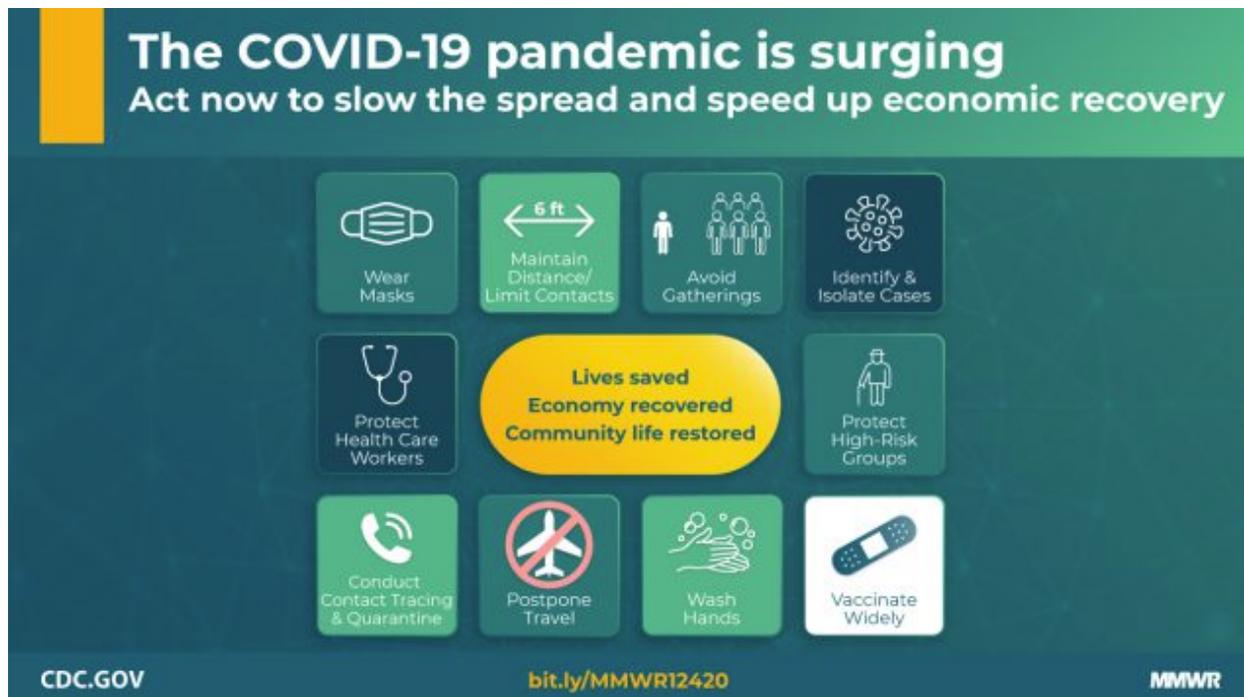
The guidance pulls together 10 prominent recommendations, including universal face mask use, social distancing, avoidance of nonessential indoor spaces (e.g., restaurants) and crowded outdoor spaces, and increased testing, diagnosis, and isolation. The document clearly states kindergarten through grade 12 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. To date we are seeing very little intra-school transmission of SARS-CoV-2 infection. It is my hope and belief that full implementation of public health prevention strategies outlined in this document can help preserve the functioning of essential businesses that supply food to the population, contribute to the health protection of communities and individual persons, and maintain some economic recovery. More importantly full implementation of and adherence to these strategies will save lives! It does not matter how many of us wear masks or social distance if the young who have the least to fear from SARS-CoV-2 ignore these recommendations and unknowingly spread the virus to vulnerable populations. Bottom line, these recommendations mean everyone!

Below is my summary of the publication which I hope you find useful and will share with others. I have integrated the AAP updated guidance on youth sports which recommend for athletes to wear face masks during most sporting events. I have also integrated the CDC's guidance on travel published last week. Due to its length, I have included as an attachment which you can save to your computer and send to others if you choose. I have underlined important or new guidance and I have used brackets to indicate my comments.

Ed

Summary of Guidance for Public Health Strategies to Address High Levels of Community Transmission of SARS-CoV-2 and Related Deaths, December 2020

MMWR early release [December 4, 2020](#)



Universal masking

Compelling evidence now supports the benefits of cloth face masks for both source control (to protect others) and, to a lesser extent, protection of the wearer. CDC recommends non-valved, multilayer cloth masks or nonmedical disposable masks for community use. Face mask use is most important in indoor spaces and outdoors when physical distance of ≥ 6 feet cannot be maintained.

Within households, face masks should be used when a member of the household is infected or has had recent potential COVID-19 exposure. (e.g., known close contact or potential exposure related to occupation, crowded public settings, travel, or non-household members in your house)

Physical distancing and limiting contacts

Maintaining physical distance (≥ 6 feet) can lower the risk for SARS-CoV-2 infection through exposure to infectious respiratory droplets and aerosols and is important, even if no symptoms are apparent, because transmission can occur from asymptomatic infected persons. [~to account for 40-50%] Outside the household setting, close physical contact, shared meals, and being in enclosed spaces have all been associated with an increased risk of infection. One study estimated that physical distancing decreased the average number of daily contacts by as much as 74% and reduced the reproductive number (R_0) to < 1 . (BMC Med 2020;18:124. PMID:32375776) Highest risk for transmission has been documented among household contacts of COVID-19 patients.

Avoiding nonessential indoor spaces and crowded outdoor settings

Indoor venues, where distancing is not maintained and consistent use of face masks is not possible (e.g., restaurant dining), have been identified as particularly high-risk scenarios. (MMWR 2020;69:1258–

64) Crowded events in outdoor settings have also been linked to spread of SARS-CoV-2 especially with inconsistent mask use. Exercise or physical activity (individual or group) can be moved to outdoor settings where physical distance is maintained, and face masks are worn. [Masks are safe for most exercise, physical activity, and sports: The AAP just updated guidance on sports. AAP encourages that athletes always wear them for group training, competition, and on the sidelines. Individual sports performed outside, such as golf and singles tennis, are lower risk for transmission of SARS-CoV-2, and a cloth face covering may not be necessary for these activities. Cloth face coverings should not be worn for competitive cheerleading (tumbling/stunting/flying) and gymnastics (while on the different apparatuses), because the covering may get caught on objects and become a choking hazard or accidentally impair vision. Likewise, during wrestling contact, a cloth face covering could become a choking hazard and is discouraged. Individuals who swim/dive/participate in water sports should not wear a cloth face covering while they are in the water, because a wet cloth face covering may be more difficult to breathe through. Any cloth face covering that becomes saturated with sweat should be changed immediately]

Increased testing, diagnosis, and isolation

Persons who are identified by testing to be infected should be rapidly isolated. ~40-50% of persons infected with SARS-CoV-2 might be asymptomatic, and transmission from presymptomatic persons and asymptomatic persons is estimated to account for >50% of all transmission (Proc Natl Acad Sci U S A 2020;117:17513–5). Therefore, reliance on symptom screening to identify infected persons is inadequate. [this is one of the most challenging facts in controlling the pandemic] Increased testing is an important strategy to interrupt silent transmission of SARS-CoV-2 from asymptomatic and presymptomatic persons. However, because the sensitivity of available tests and the time since exposure varies, a negative test might provide false sense of security; thus, all prevention strategies should continue to be followed including use of face masks and maintaining social distancing. Analysis of data from six large countries recently demonstrated that high levels of testing, combined with robust contact tracing, can substantially reduce the transmission of SARS-CoV-2 (Int J Environ Res Public Health 2020;17:5687). [the challenge with widespread disease and lack of public health resources at the local and national level accomplishing this goal is problematic] Frequent testing and contact tracing, combined with other mitigation measures, effectively limited SARS-CoV-2 transmission on a college campus. (MMWR 2020;69:1743–7) [this is the Duke University experience reviewed in the Daily Briefing in the last few weeks] In addition to testing symptomatic persons and those with known exposure, a strategy of routinely testing certain population groups with high numbers of interactions with other persons, based on their occupational or residential setting, can more rapidly identify asymptomatic and presymptomatic infectious persons and their close contacts for isolation and quarantine. [NH and HCW are potential examples] Expanded screening testing should be implemented in a manner that promotes health equity for persons with limited resources or other barriers to accessing health care.

Prompt case investigation and contact tracing to identify, quarantine, and test close contacts

Case investigation is the process of obtaining comprehensive information about persons with a diagnosis of COVID-19 and is followed by contact tracing. Communicating with persons with close contact to SARS-CoV-2 should be done to inform them of their exposure, educate them about risks for and symptoms of COVID-19, and encourage them to quarantine, seek testing, and monitor themselves for signs or symptoms of illness. Contact tracing is only feasible when the incidence of COVID-19 in the community or workplace is low or declining, when testing and reporting of results can occur quickly, and when most contacts can be reached and quarantined. [see comments above] When local capacity is overwhelmed, health departments should narrow the scope of contact tracing activities and emphasize community mitigation measures. [unfortunately, this is the situation in many areas in the US] Public

health should prioritize persons who most recently were infected with SARS-CoV-2, as well as identify and quarantine household contacts and persons exposed in a congregate living facility, high-density workplace, or other setting (or event) with potential extensive transmission.

Safeguarding persons most at risk for severe illness or death

To protect those who are at highest risk for severe COVID-19–associated outcomes, universal mitigation efforts are critical. Risk for severe illness increases with age and is highest for those aged ≥ 85 years. In the United States, approximately 80% of reported COVID-19 deaths have occurred in patients aged ≥ 65 years. [40% in LTC] Certain underlying medical conditions also increase risk for severe illness or death for persons of any age with COVID-19. [e.g. DM, obesity etc.] Long-term care facilities serve older adults and persons with complex medical conditions; COVID-19 can spread rapidly in these congregate settings, resulting in high rates of morbidity and mortality. To prevent introduction and transmission of SARS-CoV-2, these facilities should implement strict infection prevention and control measures and expanded screening testing of both staff members and residents to rapidly identify and isolate infected persons. COVID-19 has also disproportionately affected racial and ethnic minority groups. Members of racial or ethnic minority groups are more likely to experience lower socioeconomic status, to live in crowded housing, and possibly to be employed in occupations that require in-person work. In addition, access to health care might be limited, including obtaining testing and care for COVID-19. [I believe vaccinations for Phase 1b and Phase 2 should take into account disparities] Persons who are at highest risk for severe COVID-19–associated illness or death or who share a household with someone at high risk should minimize their individual and household risk by avoiding nonessential interactions with persons outside their household whenever possible and implementing all recommended public health prevention strategies. [this includes our young people!]

Protecting essential workers

Essential (critical infrastructure) workers include health care personnel and employees in other essential workplaces. (e.g., first responders, telecommunications, information technology systems, defense, food and agriculture, transportation and logistics, energy, water and wastewater, and law enforcement, and grocery store workers etc.) [some have added teachers] Protecting essential workers requires full implementation of all evidence-based strategies. [When a COVID-19 vaccine is approved for EUA by the FDA, the ACIP has recommended health care personnel and persons in LTC be among the populations being considered for initial phased allocation of limited vaccine doses.] Implementation of infection prevention and control with adequate supplies and extensive use of telehealth options and nurse-directed triage of patients, as well as screening of all persons entering health care facilities for signs and symptoms of COVID-19, can protect health care personnel and reduce risk for SARS-CoV-2 transmission in health care facilities. [many facilities are now testing all admissions] U.S. food manufacturing and agriculture is another sector that has been impacted by COVID-19 infections, especially among workers in meat and poultry processing facilities, with disproportionate effects among persons who belong to racial or ethnic minority groups. CDC and the OSHA has released guidance on administrative and engineering controls that should be part of COVID-19 assessment and control plans for these workplaces.

Postponing travel

Travel increases the likelihood of SARS-CoV-2 exposure and infection and could translocate infection between communities. Postponing travel is the best way to reduce this risk. [easier said than done although fewer people did travel during Thanksgiving] Any traveler who is symptomatic, has had close contact with a person with COVID-19, and has not met criteria for release from quarantine, or has a positive or pending SARS-CoV-2 test result should not travel. For those contemplating international

travel, CDC recommends getting tested with a viral test for SARS-CoV-2 1–3 days before departure and getting retested 3–5 days after arrival. [CDC must have been reading the Daily Briefing for college students returning home for Thanksgiving!] Domestic travelers should also consider testing. Testing does not eliminate all risk and should be combined with other recommended public health strategies. Both domestic and international travelers should stay home or reduce nonessential activities before travel, and for 7 days after travel if tested, even if test results are negative. If not tested, this period should be extended to 10 days. Travelers should be diligent about mask wearing, physical distancing, hand hygiene, and symptom monitoring. For 14 days after arrival, travelers should avoid close contact with persons at higher risk for severe COVID-19–associated outcomes and wear masks in household spaces shared with those who did not travel.

Increased room air ventilation, enhanced hand hygiene, and cleaning and disinfection

Increasing room air ventilation, hand hygiene, and cleaning and disinfecting frequently touched surfaces may reduce transmission of SARS-CoV-2 (23). The current science of SARS-CoV-2 suggests that most transmission is close person-to-person by droplets, however, there have been some documented cases of presumed airborne transmission. [most in crowded poorly ventilated indoor spaces] For indoor settings, increased room air ventilation can decrease the concentration of small droplets and particles carrying infectious virus suspended in the air and thereby, presumably, decrease the risk for transmission. [look at number of air exchanges, how many with outside air, and can your HVAC system be upgraded to the medical grade filter -MERS 13 or 14 or HEPA filter] Opening a window, weather permitting, is another way to improve circulation. Hand hygiene can be performed with soap and water or using alcohol-based hand sanitizer. Handwashing mechanically removes pathogens [use good friction for 15-20 seconds], and laboratory data demonstrate that hand sanitizers that contain at least 60% alcohol inactivate SARS-CoV-2. These strategies, combined with appropriate cleaning and disinfection of surfaces, may prevent indirect transmission through touching surfaces contaminated with virus from an infected person, followed by touching the mouth, nose, or eyes. [this appears to be a minor source for transmission compare to droplet/close contact but still important]

Widespread availability and use of effective vaccines

Widespread availability and high community coverage with safe and effective COVID-19 vaccines represent the most important public health strategy to control the pandemic. [The FDA will hold hearings December 10 and 17 to hopefully give EUA to first Pfizer then Moderna] The federal government has established a centralized system to order, distribute, and track COVID-19 vaccines through states, tribal nations, and territories; these jurisdictions are preparing for vaccination with extensive planning for vaccine distribution and administration. [vaccines will be prepositioned waiting for EUA so vaccinations can begin literally the following day] Ensuring transparency in these efforts, monitoring for adverse events, and working with communities to address concerns will be critical to obtaining the confidence and trust of the public and health care providers. CDC and FDA must monitor the effectiveness and safety of all COVID-19 vaccines and update and communicate this information regularly. Vaccinated persons should continue to adhere to all mitigation measures (e.g., mask use, physical distancing, and hand hygiene) until both doses in the series have been received and the duration of immunity provided by vaccines has been sufficiently established. [I would add until we achieve herd immunity through vaccination and natural infections which will take, I think until April-May timeframe] [We also do not know if the vaccine reduces acquisition of infection since vaccine trial looked at prevention of symptomatic disease only. Do persons still get infected after vaccination and if so, are they still infectious to others?]

Schools

The new recommendations place high priority on keeping schools open, from kindergarten through 12th grade, saying schools should be both “the last settings to close” and “the first to reopen”. Schools provide numerous benefits beyond education, including school meal programs and social, physical, behavioral, and mental health services. Closures take a disproportionate toll on low-income families. [To date we are seeing very little intra-school transmission of SARS-CoV-2 infection]