



AMERICAN
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ACHA COVID-19 Update: November 18, 2020

These updates have been provided by ACHA's COVID-19 Task Force. Please forward this message to others on campus who may benefit. Non-members can subscribe to receive these and other messages [here](#). We will continue to update the [COVID-19 webpage](#) with important alerts and resources.

ACHA COVID-19 Virtual Summit 2: 344 Days and Counting

Summit Program and CE Information Now Available

Date and Time: December 8-9, 2020, 12:00 PM ET to 5:00 PM ET

[Register Here](#)

Since the first reports of a cluster of pneumonia of unknown origin in December 2019, our nation is reminded of the tremendous toll that infectious diseases such as COVID-19 can have on our students and our learning communities. This summit will provide an update on institutions of higher education responses to COVID-19 and will explore strategies for disease mitigation. Continuing education credit and speaker details will be announced soon.

Session and CE details are available [here](#).

Thank you to our generous event sponsors:



ACHA "Ask the Expert" Webinar Series

Recording Available: Creating Support Systems for Students in Isolation and Quarantine

In this webinar recorded on November 6, our experts discussed the significant mental health needs of students in isolation and quarantine and how to put systems in place to best support these students. [View the webinar here](#).

ACHF and Hologic Webinar

Case Studies: Best Practices in Sexual Health Promotion and Clinical Care in the COVID-19 Era

In this webinar, sponsored by the American College Health Foundation with support from Hologic and recorded on November 13, health promotion practitioners and clinical providers discuss how they have implemented aspects of the ACHA Guidelines: [Best Practices in Sexual Health Promotion and Clinical Care](#) and how they have adapted their practices to COVID-19. [View the webinar here](#).

Data, Numbers, and Epidemiology

Tracking COVID-19 in the United States: Progress and Opportunities

Dr. Tom Frieden, former CDC Director and President and CEO of [Resolve to Save Lives](#), an initiative of [Vital Strategies](#), and his team have released their second comprehensive review of [COVID-19 information available to the public at the state level](#), mapping states' progress toward reporting key COVID-19 indicators and providing actionable steps for improvement.

The report shows important gains in the availability of information necessary to track and control COVID-19 in the United States: 54% of essential data points are now being monitored and reported publicly (up from 40% in an [initial review](#) conducted by Resolve to Save Lives in July of this year). But troubling gaps persist, particularly for important indicators on contact tracing, health care worker infections, and the use of masks. The review evaluates state-level dashboards for all 50 states, Washington, D.C., and Puerto Rico on their reporting of essential indicators that would dramatically improve the ability of people in the United States to understand both their own risk and how well each state and county is doing to reduce that risk.

SARS CoV-2 Transmission Among Marine Recruits During Quarantine

This [NEJM prospective study](#) involved 1,848 Marine Corps recruits who were instructed to quarantine at home for two weeks, followed by a strictly supervised quarantine period at the Citadel campus for another two weeks and enrollment in the COVID-19 Health Action Response for Marines (CHARM) study which included a testing regimen with weekly qPCR and IgG antibody testing. Recruits slept in double-occupancy rooms with sinks, ate in shared dining facilities, and used shared bathrooms. All recruits cleaned their rooms daily, sanitized bathrooms after each use with bleach wipes, and ate preplated meals in a dining hall that was cleaned with bleach after each platoon had eaten. Sixteen (1%) tested positive upon arrival (after 14 days of home quarantine) and 35 (an additional 2%) tested positive during the following 2-week military quarantine. Only one had symptoms upon arrival and four had symptoms in the military quarantine group. None of the infections were caught through temperature or symptom screens. A combination of good public health measures is needed to prevent spread.

Being HIV Positive Increases Risk of Death from COVID-19

This Medscape article reports data on an investigation of [whether HIV status affected COVID-19 outcomes](#) in patients hospitalized with COVID-19. Cumulative incidence of mortality at day 28 was 25.2% in HIV-positive patients and 32.1% in HIV-negative patients. However, when stratified by age, 28-day mortality was significantly higher (63%) in those patients with HIV aged <50 and those in the 50–59-year-old category. The author recommends all patients admitted to the hospital with COVID-19 should be queried about HIV status, and if the patient does not know their status, test them for HIV.

Prevention and Treatment

Scientific Brief: Community Use of Cloth Masks to Control the Spread of SARS-CoV-2

CDC updated its mask brief to [emphasize the two-way benefit of wearing a mask](#). Previously, masking was endorsed to reduce emission of virus-laden droplets from the source individual. Masks also benefit the wearer by reducing inhalation of droplets. "The community benefit of masking for SARS-CoV-2 control is due to the combination of these effects; individual prevention benefit increases with increasing numbers of people using masks consistently and correctly."

Is Low Mask Wearing in Rural Communities a Sign of Poor Health Messaging?

This STAT News article looked at the [low adoption of physical distancing and mask wearing in rural counties](#), the areas with the fastest growing case and death rates from COVID-19. Retention of health messaging is lower in rural areas than urban or suburban areas, and the article suggests that health messaging has not

been tailored to rural communities. "It is a challenge to create effective prevention-related messaging when the people it targets believe their risk is relatively low." Individuals living in rural counties with few reported cases of COVID-19 over the summer may perceive a sense of low personal risk. The authors, both professors of health behavior and health education, state, "Public health messaging is not monolithic. It must be tailored to communities, [recognizing cultural norms and engaging local community leaders](#) in its dissemination." This recommendation applies to colleges and universities and the vast array of stakeholders, including HBCUs, vulnerable populations, Greek life, athletes, and others.

Restrictions and Mask Mandates for All 50 States

The New York Times created [maps and text to describe state-by-state restrictions](#), including mask requirements and whether businesses are open and stay-at-home orders are in place.

Testing and Tracking/Tracing

Implementation of a Pooled Surveillance Testing Program for Asymptomatic SARS-CoV-2 Infections on a College Campus-Duke University

This CDC MMWR describes [Duke University's surveillance program](#) utilizing RT-PCR tests for SARS-CoV-2, collected via nasal swabs in a five-to-one pooled testing program that began when the campus reopened for the fall semester. Between August 2 and October 11, all undergrad and grad students residing on campus or in the Durham community (10,265 students) participated in pooled testing. Duke's 781 student athletes and student athletic assistants participated in a separate surveillance program. The 4,452 students attending classes remotely outside of Durham were also excluded. A total of 68,913 tests were performed on students, including 8,873 entry tests, 59,476 pooled tests, 379 contact traced tests, and 185 tests for symptomatic students. During this timeframe, 84 student cases of COVID-19 were identified: 17 cases (20.2%) via entry testing (nine asymptomatic and eight symptomatic), 29 cases (34.5%) by pooled testing (all asymptomatic), 23 cases (27.4%) by contact tracing (five asymptomatic and 18 symptomatic at time of testing), and 15 (17.9%) by symptom monitoring. Overall, among 84 total students who received positive test results, 43 (51%) did not report symptoms at the time of testing.

Since September 20, Duke tested residential undergraduates twice weekly, off-campus undergraduates one to two times per week, and graduate students approximately once weekly. Duke's plan was multipronged, including student self-quarantine at home for 14 days before arrival to campus, entry testing for all incoming students, surveillance of asymptomatic students using pooled testing, and individual testing for symptomatic students. All dorm rooms were converted to single occupancy, classrooms and common areas were modified to accommodate physical distancing, students signed the Duke Compact (student pledge) and installed a symptom checking app (SymMon). Finally, a system of frequent testing, rapid case identification, contact tracing, and quarantine and isolation prevented further transmission of identified clusters.

Rapid Testing May be Less Accurate Than the Government Wants to Admit

This [Medscape article](#) describes the rapid antigen tests by Abbott, Quidel, and BD as less accurate when used off-label for asymptomatic/surveillance screening. Nursing homes received thousands of these tests from the federal government. An October survey found that nearly a third of nursing homes had not used the tests due to time-consuming paperwork for federal reporting requirements and skepticism about their accuracy. The article also describes the scientific community's divide on the use of antigen tests. Some believe frequent use of antigen tests are better at preventing outbreaks than infrequently used highly sensitive PCR tests. All agree that we need a national testing strategy to define "who gets tested, with what tests ... when, how often, and what data should be reported back, and what those data pieces mean."

Using, Interpreting, and Responding to COVID-19 Antigen Tests

The Medscape article listed above includes a link to this easy-to-use [flowchart on the use and interpretation of COVID-19 antigen tests](#), which was developed by the North Carolina Department of Health and Human Services.

FDA Authorizes First COVID-19 Test for Self-Testing at Home

The FDA [has authorized](#) the Lucira COVID-19 All-In-One Test Kit for home use for individuals suspected of COVID-19 by their health care provider (HCP) for those age 14 and older. Samples are via self-collected nasal swabs, placed into a vial, swirled, and then placed into a test unit. Results are given within 30 minutes. It is currently authorized by prescription only. Children under 14 must have a sample collected by an HCP at the point of care. According to a [fact sheet on the Lucira website](#), "In a Community Testing Study, where the Lucira test was compared to a FDA authorized known high sensitivity SARS-CoV-2 test, Lucira achieved a 94% positive percent agreement (PPA) and a 98% negative percent agreement (NPA). Excluding samples with very low levels of virus that possibly no longer reflected active infection, Lucira achieved 100% positive percent agreement." Reportedly, the kit will cost approximately \$50.

Vaccines

Pfizer and Moderna COVID-19 Vaccine: Frequently Asked Questions

Pfizer and Moderna both recently released data showing that their vaccine candidates are highly effective. The Washington Post created this [FAQ guide to the two vaccines](#), including answers to "What will happen next?" and "When will I be able to get vaccinated?"

IAC to Host COVID-19 Vaccination Implementation Webinar

The Immunization Action Coalition (IAC) will host the webinar [COVID-19 Vaccination Implementation and the Vaccinate with Confidence Strategy](#) on December 3 at 1 p.m. ET. Specific topics include an overview of the COVID-19 vaccine distribution strategy, current state planning efforts, and the COVID-19 Vaccinate with Confidence Strategy.

These important and timely topics will be addressed by speakers from the Centers for Disease Control and Prevention's (CDC) COVID-19 Vaccine Task Force. CDC subject matter specialists will be available to answer audience questions at the conclusion of the presentations. You are welcome to submit your questions beforehand to eocevent417@cdc.gov.

Virtual ACIP Meeting: November 23

A live, virtual meeting of the [Advisory Committee on Immunization Practices \(ACIP\)](#) will be held on November 23. The agenda (including times) will be posted soon and is expected to feature COVID-19 vaccination. No registration is required to watch the live November ACIP meeting or listen via telephone.

College Campuses

- [Tracking Coronavirus Cases at U.S. Colleges and Universities](#) (New York Times)
- [Monitoring the Coronavirus Outbreak in Metro Areas Across the U.S.](#) (New York Times)
- Campus Reopening Plans: [List of Colleges' Reopening Models](#) (The Chronicle of Higher Education) and [College Crisis Initiative \(C2i\)](#) (Davidson College)
- [Campuses Mandating Flu Vaccine](#) (Immunization Action Coalition)

How One Campus Has Helped Keep Area Positivity Rates Low

This article examines the [low positivity rate in the area around Charlottesville, Virginia](#), which is home to the University of Virginia. Why is the case rate so low here, compared to the rest of the state? Citizens in the area seem to be much more likely to wear masks than in other parts of the state, and as the article points out, “People in places with higher rates of mask wearing tend to fall naturally into following other safety measures—like restricting large gatherings, frequently cleaning communal spaces and maintaining physical distance between people.” Another factor discussed in the article is “the aggressive approach UVA has taken to controlling COVID-19 cases among its students.” That approach included masking requirements, intensified testing both on and off campus, and containment with isolation and quarantine. However, numbers began climbing again last week, once again emphasizing that campuses cannot remain a bubble from the surrounding community and vice versa.

NCAA Issues Updated Return to Sport Guidelines

NCAA released its guidelines [Resocialization of Collegiate Sport: Developing Standards for Practice and Competition, Second Edition](#). This document updates and extends the guidance provided in the first four resocialization publications considering new and emerging information. Information in this document includes considerations in prevention of community spread in COVID-19 in the athletics setting and examples of recommendations for COVID-19 testing in sports with a high transmission risk, differentiating outdoor from indoor sports.

ASTHO Guide for Responding to the Media

The Association of State and Territorial Health Officials (ASTHO) released the 6th Edition of [COVID-19 Simple Answers to Top Questions](#). This updated edition follows the same format as the previous releases with both short and long answers and is geared towards individuals who respond to the media, providing them with soundbites in the form of key messages, and longer answers for more background. The sections on vaccination, testing, and contact tracing have been updated.

Mental Health

[CDC’s recent science update](#) included a study from the journal Occupational and Environmental Medicine, “[Association between SARS-CoV-2 infection, exposure risk and mental health among a cohort of essential retail workers in the USA](#),” which indicated that among retail workers:

- There was an inverse relationship between practicing social distancing consistently at work and both anxiety (OR 0.3, 95% CI 0.1-0.9) and depression (OR 2, 95% CI 0.03-0.99).
- Workers suffering from depression were more likely to commute by public transportation or share rides compared with those without depression (OR 0.1, 95% CI 0.02-7).

Health Disparities

Mobility Network Models of COVID-19 Explain Inequities and Inform Reopening

[This study](#) took cell phone data and tracked hourly movements of 98 million people from neighborhoods to points of interest (POIs) such as restaurants and religious establishments from March 1 to May 2. The model predicts that a small minority of “superspreader” POIs account for a large majority of infections. (In Chicago, 10% of the POIs visited accounted for 85% of the predicted infections). Full service restaurants, fitness centers, and places of worship had the highest overall risk of disease transmission. Restricting maximum occupancy at each of those POIs to 20% could cut new infections by more than 80% and is more effective than uniformly reducing mobility. The study confirms higher infection rates among “disadvantaged” groups, finding that disadvantaged groups have not been able to reduce mobility as sharply, and that the POIs they visit are more crowded and therefore higher-risk.

See all updates here: https://www.acha.org/ACHA/Resources/Topics/COVID-19_Update.aspx

ACHA COVID-19 Page: <https://www.acha.org/COVID-19>



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