



COVID-19 Initial Lessons Learned: Recommendations to Prepare for a Fall Surge of COVID-19 Cases **Version: June 19, 2020**

A second, larger wave of COVID-19 cases is probable in the fall of 2020 and by coinciding with influenza season, the second wave could strain the U.S. healthcare system even more than the initial wave, resulting in even greater loss of life. The last three pandemics as well as the 1918 influenza pandemic have been characterized by an initial wave of cases in the spring, followed by a larger wave in the fall.¹

The SARS-CoV-2 virus can be expected to continue its spread until a critical mass of the population develops immunity – roughly 70%. As of early May, an estimated 5-6% of people in the U.S. have been infected, and it is unclear how long their immunity will last.² Additional smaller spikes in cases are also expected throughout the summer, as states begin to reopen. For example, multiple states—including Arizona, California, North Carolina, Texas and Washington—are already experiencing increases in cases.³ These spikes are not considered new waves of infections but a continuance of the first wave; more waves can be expected until herd immunity is developed, either through natural infections or a vaccine is developed and made widely available.

The information outlined below provides federal, state and local leaders a critical opportunity to prepare for an upcoming wave of infections to ensure a successful response that minimizes the numbers of new infections, hospitalizations and deaths. Infectious diseases physicians on the frontlines of this pandemic have learned firsthand key lessons to inform our preparedness and offer these to recommendations to mitigate the impact of COVID-19 as we work to identify safe and effective therapeutics and a vaccine.

Personal Protective Equipment and Other Medical Supplies

Multiple studies have confirmed that personal protective equipment (PPE), and specifically N95 respirators for clinicians providing care associated with the highest risks of COVID-19 transmission, is highly successful in preventing transmission.⁴ Unfortunately, despite ongoing efforts, inadequate supplies of PPE persist, and place health care professionals at serious risk of preventable infection, which they can then transmit to other patients, colleagues and family members. The Centers for Disease Control and Prevention (CDC) reports that over 75,000 health care personnel have become infected with COVID-19, with over 400 deaths.⁵ However, the CDC data collection capabilities are

¹ Moore K et al. COVID-19: The CIDRAP Viewpoint. Part 1: The Future of the COVID-19 Pandemic: Lessons Learned from Pandemic Influenza. April 30, 2020.

https://www.cidrap.umn.edu/sites/default/files/public/downloads/cidrap-covid19-viewpoint-part1_0.pdf

²IBID. Moore K et al.

³How We Reopen Safely: Tracking states as they make progress towards a new normal. Online at:

<https://www.covidexitstrategy.org/>.

⁴ Chu D et al. Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis. June 1, 2020.

[https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31142-9/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31142-9/fulltext)

⁵ <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html>

limited, and many believe the actual numbers are significantly higher. A project launched by Kaiser Health News and The Guardian suggests that nearly 600 health care workers – 1.5 times the number reported by the CDC -- in the U.S. have died from COVID-19.⁶

GetUsPPE, a web-based platform through which health care facilities can communicate their PPE needs reported that as of May 2, more than 6,000 health care facilities submitted requests for PPE, including hospitals, outpatient clinics, and skilled nursing facilities. N95 respirators were requested by 74% of facilities, making them the overall most commonly requested type of PPE. This is a conservative estimate of PPE need, as only facilities aware of the platform could report.⁷ Frontline health care providers continue to report that they are extending and reusing PPE, even in areas where cases of COVID-19 are declining because they cannot rely on a dependable supply over the long term. A strong U.S. supply chain for PPE is particularly critical, as some states and facilities—including Washington state—have purchased defective PPE from foreign suppliers. As healthcare facilities resume elective procedures and as other sectors of the U.S. economy require PPE for reopening, PPE demands are increasing significantly, leaving health care providers deeply concerned about continued PPE supply.

Recommendations:

- Develop and implement a long-term, national strategy to rapidly and effectively assess PPE needs [including N95 respirators, powered air purifying respirators (PAPRs), Controlled Air-Purifying Respirators (CAPRs), masks, gowns, gloves and face shields], and scale up the manufacture and data-driven distribution of PPE, including broader and continued utilization of the Defense Production Act, and ensure clear communication between the federal government and state and local officials regarding the availability and delivery schedule of medical supplies. (*Medical Supply Transparency and Delivery Act*, H.R. 6711/S. 3627).
- Federal public health authorities should partner with medical societies with expertise in infection prevention and control to provide clear, evidence-based guidance regarding the type of PPE needed for providers and patients in ambulatory and surgical settings as well as other sectors of the U.S. economy requiring PPE for reopening. Until a robust supply of surgical masks and N95 respirators is available, guidance should be provided to prioritize their use for frontline and essential workers where they are needed most.
- Federal public health authorities should provide clear guidance to health care facilities to fit test health care providers (as supplies allow) on the masks they will ultimately use during a fall surge.

Testing Capacity

The Kaiser Family Foundation compared multiple models for calculating national-level testing capacity and determined that a robust national testing strategy requires conducting 1.25 million tests per day or 8.75 million per week⁸, which is approximately 2.7% of the U.S. population being tested weekly. National testing reports have consistently fallen far below even the lowest estimated targets, and supply limitations continue to daunt frontline providers and patients. Multiple laboratories have reported

⁶ <https://khn.org/news/lost-on-the-frontline-health-care-worker-death-toll-covid19-coronavirus/>

⁷ Gondi S et al. Personal protective equipment needs in the USA during the COVID-19 pandemic. May 14, 2020. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31038-2/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31038-2/fulltext)

⁸ <https://www.kff.org/coronavirus-policy-watch/what-testing-capacity-do-we-need/>

skewed distribution of tests to larger reference centers without corresponding need, and testing supplies including reagents, swabs and skilled personnel remain in short supply. The recent infusion of HHS funding for expanded testing capacity will help alleviate existing shortages but capacity remains insufficient for a long-term, strategic response. Beyond the immediate challenges, a successful national testing strategy must consider medium- and long-term planning for capacity, including for supply stockpiles, public health workforce and infrastructure, health system preparedness, etc.

Recommendations:

- Develop a federal strategy to ensure the development of adequate tests and transparently and equitably distribute testing kits and supplies.
- Expand testing locations to encompass all areas of need, considering population density and heavily impacted communities, and expand deployment of rapid tests to reduce reliance on large commercial reference laboratories.
- Incentivize and streamline the research and development of tests utilizing alternate specimen sources (nares, saliva), alternate media (saline), and alternate collection devices, which will reduce PPE needs for testing and alleviate shortages of testing supplies.
- Utilize technology to communicate negative test results to relieve significant strain on health care personnel.
- Future testing plans should incorporate the need for sentinel monitoring of high-risk populations, including incarcerated, homeless, senior living facilities, skilled nursing facilities, and congregate living settings, individuals with disabilities, individuals with substance use disorders, and populations disproportionately impacted by COVID-19, including African American, Latinx and Native American communities. Plans also should include guidance on how real-time data can be used to improve monitoring where it's needed most (e.g., schools, food processing plants). Sentinel monitoring systems should further aim to identify asymptomatic cases.
- Fund studies necessary to determine the clinical sensitivity and specificity of all available tests and clearly communicate results.

Physical Distancing and Wearing Masks/Face Coverings

Until a vaccine is widely available, face coverings and physical distancing remain among our most effective tools at preventing COVID-19 infections. A review of 172 observational studies across 16 countries and six continents found that transmission was lowered with distancing of one meter or more, and protection increased as distance lengthened.⁹ As states continue reopening at varied paces and with varied guidance or requirements regarding physical distancing and masks, we will likely see differing levels of success in containing the spread of COVID-19.

Recommendations:

⁹ Chu D et al. Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis. June 1, 2020. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31142-9/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31142-9/fulltext)

- Implement an evidence-based public education campaign to emphasize the importance of wearing cloth face coverings, masks or face shields and maintaining physical distancing and to educate the public on the risk levels associated with different activities and ways to reduce risk of transmission.
- Federal public health authorities should work closely with industries (e.g., airlines, restaurants, retail and others) to develop and implement strategies to increase compliance with physical distancing and face covering guidelines.
- Modify policies and guidance if cases increase, including reinstating stay-at home orders if a significant surge of cases occurs.

Contact Tracing

The practice of contact tracing is critical to identify individuals who have been exposed to COVID-19 and contain the spread of the virus and has been found to be an important component of successful efforts to contain COVID-19 in other countries.¹⁰ While several states have begun hiring new contact tracers, additional federal resources are needed to ensure a sufficient and well-coordinated contact tracing workforce and to support public cooperation with contact tracing. Experts estimate that anywhere from 180,000 to 300,000 contact tracers are needed.

Recommendations:

- Provide new funding to hire and train contact tracers. Given the disproportionate impact of COVID-19 on communities of color, a diverse group of contact tracers must be deployed, including individuals who are part of heavily impacted and underserved communities.
- Prioritize contact tracing for populations at greatest risk of transmission and potential super-spreader events.
- Federal public health authorities should provide guidance for utilization of multiple models of contact tracing, including traditional methods and deployment of phone-based and innovative technology-based methods to reduce reliance on limited personnel. Guidance should clearly explain the steps and elements of effective and feasible contact tracing and include recommendations for instances in which optimal tracing of all cases and all contacts is not possible.
- Develop and implement an evidence-based public education plan to encourage individuals to engage with contact tracers and share information about where they have been and with whom they have been in contact. Responses to the 2014-15 West Africa Ebola outbreak demonstrated the importance of community engagement in the success of contact tracing, and partnerships with community-based organizations in communities throughout the U.S. should be leveraged to increase the effectiveness of contact tracing.
- Provide support to help individuals who have been exposed or who have tested positive to isolate and quarantine, including providing safe locations for isolation and quarantine (particularly for individuals experiencing homelessness or living in settings in which isolation and quarantine is not possible), paid sick leave, food and access to medical care.

¹⁰ Sun K, Viboud C. Impact of contact tracing on SARS-COV-2 transmission. April 27, 2020. [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(20\)30357-1/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30357-1/fulltext)

- Develop a national contact tracing plan to ensure coordination of contact tracers across state lines to appropriately follow and contain the spread of COVID-19.

Telehealth

IDSA has long advocated for expanding the use of telehealth services to reach rural and urban underserved communities that do not have access to infectious diseases physicians and their expertise.¹¹ Recognizing that telehealth is an essential tool for providing safe and reliable access to care, the Centers for Medicare and Medicaid Services (CMS) has taken significant measures to increase its use during the COVID-19 pandemic, including expanding the list of services approved for telehealth, establishing payment parity for telephone evaluation and management services delivered in person or through telehealth, allowing telehealth and virtual care visits to be provided to both new and established patients, and allowing physicians to continue to provide telehealth services from their homes without the need to change place of service in the Medicare physician enrollment database.

Recommendations:

- Continue Medicare telehealth flexibilities and policies that were created in response to the Public Health Emergency. Note that the following may be maintained without Congressional action. Specifically, continue to cover the telephone evaluation and management (E/M) codes and maintain payment parity for telephone E/M services (CPT codes 99441-99443) at equal amounts to office visit E/M services for an established patient.
- Congress should remove Medicare originating site requirements and continue to allow practitioners and patients to use non-public facing audio and video technologies including Apple FaceTime, Google Hangouts, Zoom and others.

Workforce Capacity

An expert workforce, including infectious disease (ID) physicians, is a central component to our preparedness. ID physicians manage care for patients with COVID-19 in both inpatient and outpatient settings, lead infection prevention and control programs at health care facilities, and partner with public health administrators and stakeholders to lead preparedness and response efforts in local communities. Ensuring an adequate supply of ID physicians is critical. According to a recent study, approximately 208 million United States citizens live in a county with no or below-average access to an ID physician.¹² Due to high medical student loan debt and lower compensation for infectious diseases specialists, there has been a decline in physician interest in pursuing training in infectious diseases.¹³ While it will be difficult

¹¹ Young et al. Infectious Diseases Society of America Position Statement on Telehealth and Telemedicine as Applied to the Practice of Infectious Diseases *Clinical Infectious Diseases*, Volume 68, Issue 9, 1 May 2019, Pages 1437–1443, <https://doi.org/10.1093/cid/ciy907>

¹² Walensky et al. Where is the ID in COVID-19? *Annals of Internal Medicine*. June 3, 2020. <https://doi.org/10.7326/M20-2684>

¹³ Walensky RP, del Rio C, Armstrong WS. Charting the Future of Infectious Disease: Anticipating and Addressing the Supply and Demand Mismatch. *Clinical Infectious Diseases*, Volume 64, Issue 10, 15 May 2017, Pages 1299–1301, <https://doi.org/10.1093/cid/cix173>.

to significantly expand the number of ID physicians by this fall, policy changes made now can impact specialty choices of current residents, providing a small but important increase in the workforce in the short term and helping to secure a strong and stable workforce to prepare for and respond to future pandemics.

Recommendations:

- Establish an enhanced Medicare payment for outbreak activation activities of health care providers, similar to Medicare's existing trauma activation coding and payment policies, to cover additional costs associated with outbreak preparedness and response, including assembling multidisciplinary teams, managing specialized equipment and supplies, repurposing areas of health care facilities, coordinating with public health authorities, providing updates to the community and collaborating with human resources to ensure the well-being of health care facility staff.
- Ensure that inpatient and outpatient evaluation and management codes, which are used for over 90% of ID physician services, are revalued through a data-driven approach, informed by physician experts, to fully capture the complexity of care provided.
- Offer loan repayment or forgiveness opportunities for infectious diseases physicians. (*Student Loan Forgiveness for Frontline Health Workers Act*, H.R. 6720; [Health Heroes 2020 Act](#), H.R. 6650/S. 3634, and *Strengthening the Public Health Workforce Act*)
- Provide rapid financial relief for infectious diseases physicians and other health care providers on the frontlines of pandemic response, especially those experiencing salary cuts or other financial impacts of the COVID-19 pandemic. (a bill to establish the Pandemic Responder Service Award program, H.R. 6953)
- Better leverage the J-1 Visa program, including by creating additional J-1 visa waiver FLEX slots for each state for specialties deemed essential to pandemic response, and permitting these FLEX slots to be used in all geographic areas. The current extension of J-1 visas should continue. (*Conrad State 30 Physician Access Act*, S.948/H.R.2895 and *Healthcare Workforce Resilience Act*, H.R. 6788/S. 3599)

Access to Care and Treatment

As of June 2020, remdesivir is the only treatment available for COVID-19 authorized by the U.S. Food and Drug Administration (FDA) under emergency use authorization (EUA). The EUA was granted following preliminary trials results finding that hospital stays for patients given remdesivir were shortened from 15 to 11 days.¹⁴ Under the EUA, around 120,500 treatment courses were donated by Gilead Sciences and distributed by the Department of Health and Human Services to state health departments from May to early July.¹⁵ Remdesivir is expected to be commercially available in summer 2020. Pricing and availability of the drug will be critical to mitigate the impact of a fall surge on hospital capacity and to ensure existing COVID-19 disparities are not worsened. According to analysis conducted

¹⁴ John H. Beigel JH, Tomashek KM, Dodd LE, et al. [Remdesivir for the Treatment of Covid-19 — Preliminary Report](#). NEJM. May 22, 2020. DOI: 10.1056/NEJMoa2007764.

¹⁵ Department of Health and Human Services. Remdesivir. Online at: <https://www.phe.gov/emergency/events/COVID19/investigation-MCM/Pages/remdesivir.aspx>. Accessed June 3, 2020.

by the Institute for Clinical and Economic Review (ICER), a pricing strategy based on recovering the cost of producing remdesivir would generate a price of \$10 for a 10-day course or \$5 for a five-day course. Using a model-based cost-effectiveness approach, a fair price for remdesivir would be less than \$4,500 for a 10-day treatment course.¹⁶

Recommendations:

- Ensure reasonable prices for remdesivir and other treatments approved by the FDA and developed with federal support. For example, pricing in the U.S. could align with pricing in other high-income countries in which remdesivir is available through licensed generic manufacturers.
- Ensure equitable access and distribution of remdesivir and other treatments as they become available. Given the disproportionate impact of COVID-19 on vulnerable populations, many of the patients who most need treatment are likely to be those who can least afford high drug costs.
- Ensure sufficient funding for Health Resources and Services Administration (HRSA) program providing reimbursement for COVID-19 testing, care and treatment for individuals who are uninsured.¹⁷
- Require manufacturers to offer continuation of compassionate use for uninsured patients receiving therapies beyond the approval date which typically signals the end of the program. Consider linking compassionate use programs to post-approval requirements set by FDA.

Health Disparities

The current pandemic has revealed the glaring health inequities within the U.S health care system. According to CDC's COVIDView, Non-Hispanic Black and Non-Hispanic American Indian/Alaska Native populations have a hospitalization rate approximately 4.5 times that of non-Hispanic Whites, while Hispanic/Latinos have a rate approximately 3.5 times that of Non-Hispanic Whites.¹⁸ Based on data from 40 states, the mortality rate due to COVID-19 in African Americans is 2.4 times as high as the rate for Whites and 2.2 times as high as the rate for Asians and Latinos.¹⁹ IDSA and HIVMA developed a [policy brief](#) with recommendations for addressing disparities among African American, Latinx and American Indian/Native American communities and other underserved communities as well as within [state and federal correctional facilities](#). A few priority recommendations are highlighted below.

Recommendations:

¹⁶ Institute for Clinical and Economic Review (ICER). ICER Presents Alternative Pricing Models for Remdesivir as a Treatment for COVID-19. Online at: https://icer-review.org/announcements/alternative_pricing_models_for_remdesivir/. Accessed June 3, 2020.

¹⁷ Health Resources and Services Administration. COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing and Treatment of the Uninsured. Online at: <https://coviduninsuredclaim.linkhealth.com/coverage-details.html>. Accessed June 3, 2020.

¹⁸ CDC. COVIDView. Ma 23, 2020. Online at: <https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview-05-29-2020.pdf>. Accessed June 3, 2020.

¹⁹ APM Research Lab. The Color Of Coronavirus: Covid-19 Deaths By Race And Ethnicity In The U.S. May 27, 2020. Online at: <https://www.apmresearchlab.org/covid/deaths-by-race>. Accessed June 3, 2020.

- Increase the federal Medicaid matching rate with strong maintenance of effort protections to prevent cuts to eligibility, benefits or provider payments, and incentivize the 14 states that have not expanded Medicaid to do so.²⁰
- Appropriate new resources specifically to address the disproportionate COVID-19 impact on African Americans, Latinx communities and Native Americans and to strengthen the response with other vulnerable populations, including support for comprehensive strategies to mitigate and control COVID-19 throughout federal, state and local corrections systems and in nursing homes.
- Increase funding for the Federal Communications Commission’s Lifeline program to support unlimited minutes and Internet access for low income individuals and families to stay connected to health care and educational programs.²¹
- Provide a 15% increase in the Supplemental Nutrition Assistance Program maximum benefit level to provide additional resources to low income households to purchase food.
- Continue the federal moratorium on evictions for failure to pay rent.

Antimicrobial Resistance

While the exact impacts of antimicrobial resistance (AMR) on the COVID-19 pandemic are not yet fully understood, we do know that high antibiotic use has been reported among patients with COVID-19. Multiple studies have also indicated that secondary bacterial infections contribute to morbidity and mortality in patients with COVID-19.^{22,23,24} With recent studies showing benefit of steroids in the sickest COVID-19 patients, there is concern that the number of secondary superinfections will increase, including invasive aspergillosis. Many of these secondary bacterial and fungal superinfections have severely limited treatment options. While some of the policies necessary to address AMR will take a longer period of time to yield a significant impact, efforts including strengthening stewardship programs and data collection capabilities and stabilizing the antibiotics market can also provide important benefits in the short term.

Recommendations:

- Provide new funding for hospitals and other health care facilities to establish and improve antimicrobial stewardship programs to guide appropriate use of antimicrobial drugs in patients with confirmed or suspected COVID-19.
- Increase funding for surveillance and data collection specifically to ascertain the impact of secondary bacterial and fungal infections on COVID-19 and to study appropriate antibiotic use in COVID-19 patients.

²⁰ Kaiser Family Foundation. Status of State Medicaid Expansion Decisions: Interactive Map. May 29, 2020, Online at: <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>. Accessed June 3, 2020.

²¹ FCC. Lifeline Program for Low-Income Consumers. Online at: <https://www.fcc.gov/general/lifeline-program-low-income-consumers>. Accessed June 3, 2020.

²² <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2820%2930183-5>

²³ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30211-7/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30211-7/fulltext)

²⁴ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30566-3/fulltext#tbl2](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext#tbl2)

- Support new antimicrobial drug research and development by providing a means for innovators to earn a fair and reasonable return on their investments. (*DISARM Act*, H.R. 4100/S.1712 and antibiotics subscription model legislation)

Increasing Immunization Rates

Since COVID-19 distancing restrictions and business closures were implemented, early childhood immunization rates have dropped considerably. During the week of April 5, the administration of MMR vaccines dropped 50 percent; diphtheria and pertussis vaccines dropped 42 percent; and HPV vaccines dropped 73 percent. The steep decline in vaccination rates may lead to outbreaks of vaccine-preventable diseases, including measles and whooping cough. High rates of immunization for seasonal influenza will be critical to prevent high levels of influenza infections and hospitalizations that, combined with a second wave of COVID-19, could severely overwhelm hospitals. Complete IDSA recommendations to boost vaccination rates may be found [here](#) and are summarized below.

Recommendations:

- Provide funding for novel approaches to safely administer vaccines during the COVID-19 pandemic and to effectively reach underserved populations and individuals living in congregate settings (e.g. drive through clinics, mobile units, personal protective equipment for vaccine providers and physical distancing measures at locations where vaccines are provided).
- Implement a comprehensive campaign to expand seasonal influenza vaccination rates, including providing free or low-cost influenza vaccines in schools and workplaces and requiring influenza vaccinations for all health care workers except those with a medical contraindication.
- Increase funding to support outreach to patients and families who are due or overdue for vaccinations and enhancements to Immunization Information Systems (IIS).
- Increase coverage for vaccines, including ensuring that all vaccines are covered at no cost under Medicaid and eliminating cost-sharing for vaccines under Medicare Part D.

Preparing for a COVID-19 Vaccine

It is critical to plan for the development of a COVID-19 vaccine to ensure sufficient manufacturing capacity, equitable distribution and affordability. A safe, effective vaccine for COVID-19 will be one of our most valuable tools to prevent COVID-19 transmission and allow individuals to safely resume normal activities.

Recommendations:

- Scale up COVID-19 vaccine manufacturing capacity, develop a transparent COVID-19 vaccine distribution strategy that ensures equitable access, including for medically underserved individuals.
- Fund a public education campaign to boost vaccine confidence and prepare communication strategies for a COVID-19 vaccine.

Minimize Viral Spread During Large Gatherings (e.g., Protests)

While large gatherings should still be avoided, especially indoors, the ability to peacefully protest systematic racism and other social justice issues, remains a key tenant of our country's democratic process. We must continue to protect this right and in doing so provide guidance to participants on how to do so while minimizing transmission of COVID-19. The recommendations below are compiled from those released by health departments and other public health officials.^{25,26}

Recommendations:

- Protests should not be limited to a confined space in order to allow participants to maintain a safe physical distance from each other.
- Facial coverings or masks, and hand sanitizer should be made available at protest sites and participants should be strongly encouraged to use them.
- Tear gas and other respiratory irritants should not be used as they may cause coughing, eye watering and runny noses, thereby increasing the potential to spread COVID-19.
- Information on the symptoms of COVID-19 and testing sites should be widely available within the community and made available to participants. Participants should be encouraged to monitor for symptoms for 14 days.

Safe Elections

Voting is a central component of our democracy, and during the COVID-19 pandemic it is our nation's responsibility to ensure that all citizens have an equal opportunity to vote safely. Precautions must be taken to ensure that election day does not cause a spike in COVID-19 cases. A study conducted by economists at the University of Wisconsin and Ball State University found a statistically significant association between in-person voting in Wisconsin's April primary election and a spike in cases. Contact-tracing by the Wisconsin Department of Health tied 52 cases back to people who either voted or had worked at polls on April 7, though the researchers said the state's investigation was not comprehensive and their study showed a much larger potential increase in infections due to the election.²⁷ Multiple experts have provided a host of options to reduce the risk of transmission on election day.^{28,29}

Recommendations:

- Strongly encourage all citizens to vote by mail and automatically mail ballots to all voters. This is the best strategy for reducing the risk of transmission.

²⁵ New York City Department of Health. How to Protest Safely During the COVID-19 Pandemic. Online at: <https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-safe-protest.pdf>. Accessed June 7, 2020.

²⁶ Public Health Insider: Official Insights from Public Health – Seattle & King County Staff. Answering Questions About Protests and Covid-19. Online at: <https://publichealthinsider.com/2020/06/01/answering-questions-about-protests-and-covid-19/> Accessed June 7, 2020.

²⁷ Cotti C et al. The relationship between in-person voting, consolidated polling locations, and absentee voting on evidence from the Wisconsin primary. May 2020. <https://www.nber.org/papers/w27187.pdf>

²⁸ Kamarck E. We can hold safe elections in November—Here's how we get started now. April 13, 2020. <https://www.brookings.edu/blog/fixgov/2020/04/13/we-can-hold-safe-elections-in-november-heres-how-we-get-started-now/>

²⁹ Veuger S. The only victim of voting by mail is the coronavirus. April 16, 2020. <https://www.aei.org/economics/the-only-victim-of-voting-by-mail-is-the-coronavirus/>

- Decrease crowds at polling places by increasing early voting opportunities.
- Consider making election day a federal holiday to allow individuals to vote at assigned times throughout the day, rather than crowding before and after work.
- Provide curbside voting accessible via vehicle or walk-up and/or rapid entry voting for older individuals, individuals with underlying medical conditions and people with disabilities.
- Where possible, establish polling sites in large open locations (e.g., arenas, school gymnasiums, football fields, cafeterias).
- Increase safety at polling places by requiring and providing masks/face coverings for all poll workers and voters, providing hand sanitizer and disinfectant wipes or spray, requiring physical distancing for voters and poll workers (supported by clear physical markings) and placing plexiglass barriers between poll workers and voters. Ensure routine cleaning of bathroom facilities at polling sites.
- Create a separate site within each voting location for individuals over age 65 and individuals who are immunocompromised and allow these individuals to schedule a voting time to eliminate or reduce their need to wait at their polling place.
- Clearly communicate guidance for safe voting in advance of election day and at polling places. Communications should be culturally competent, provided in the native languages of voters, and targeted to communities disproportionately impacted by COVID-19. Encourage voters to not bring additional people or items to their polling place.
- Develop a strategy to help individuals who are displaced due to COVID-19 (e.g. individuals experiencing homelessness, quarantine, isolation) safely vote. This may include providing safe transportation to voting sites, establishing additional targeted voting locations, and targeted education and registration activities.

Comprehensive Data Collection

High quality data on COVID-19 are essential to inform, evaluate and refine our responses. States should collect and publicly report data in a uniform, rigorous manner. Data on total numbers of cases are important to identify spikes in transmission. More granular data are critical to understand and track how specific populations and communities are being impacted by COVID-19 and to target response efforts. We greatly appreciate that CDC has been able to utilize the National Healthcare Safety Network to rapidly improve and expand data collection on COVID-19, but frontline health care providers continue to report a need for improved data to guide their responses.

Recommendations:

- Provide new funding to modernize public health surveillance and data collection.
- Promote uniformity in state data dashboards to allow public health and health care leaders across the country follow trends or establish a national database to allow for automated data migration from electronic health records.
- Require that health departments include race and ethnicity by zip code when reporting every COVID-19 case. This is particularly important given the disproportionate impact of COVID-19 on African American, Latinx and Native American communities in addition to other racial and ethnic minority populations.
- Clearly separate results from serology (or antibody) testing from PCR testing and include the total number of tests performed as well as the percentage of tests that were positive and make uniform the date associated with the report (e.g. the date of test, rather the date of first symptom).

- Report number of hospitalizations and deaths due to COVID-19; total and excess hospitalizations, deaths and pneumonia cases (to account for ongoing under-testing for COVID-19).

Protections for Frontline Workers

Frontline workers include healthcare workers, protective service workers (police and EMTs), cashiers in grocery and general merchandise stores, production and food processing workers, janitors and maintenance workers, agricultural workers, and truck drivers. Because these individuals perform essential jobs and are largely unable to work from home, they face an increased risk of contracting COVID-19. Many of these workers are lower income, and African American, Latinx and other racial and ethnic minority populations are overrepresented in the frontline workforce, contributing to higher rates of COVID-19 among these groups.

Recommendations:

- Provide masks/face coverings/face shields, hand sanitizer, and access to COVID-19 testing and care at no charge to employees.
- Extend and expand paid emergency leave, paid family and medical leave, unemployment insurance, and childcare.
- Provide federal support for small businesses with a focus on supporting minority-owned small businesses and businesses in rural communities.

Global Cooperation

Federal, state and local public health authorities cannot achieve control of COVID-19 without strong U.S. support for and participation in global cooperative efforts to end the pandemic. The U.S. must remain in the World Health Organization and participate fully in global collaborative efforts responding to COVID-19 or risk failing to control the pandemic here at home. The World Health Organization is the only global entity with a mandate and capacity to coordinate a global public health response to the COVID-19 pandemic, including coordinating efforts to develop medical countermeasures like vaccines and treatments, streamline regulatory processes to prioritize and rapidly deploy products, train healthcare workers, provide essential supplies including diagnostic tests and personal protective equipment, and strengthen surveillance and detection capacities in resource-limited countries. Global collaboration with WHO is vital to maintain surveillance and continually assess for early identification of future pandemics as well.

With operations in over 150 countries, the WHO is uniquely positioned to collect new data and information on the pandemic and use it to develop, refine and disseminate technical guidance essential to battling COVID-19. The WHO is also the only global agency with the capacity to coordinate global trials on therapeutics and vaccines, including the Solidarity Trial to find new COVID-19 therapeutics, in which more than 100 countries are participating, and the Access to COVID-19 Tools (ACT) Accelerator, an unprecedented global initiative to fast-track the development and scale-up of COVID-19 vaccines and drugs and make them available to nations who need them the most. U.S. refusal to participate in these efforts may jeopardize or delay U.S. patients' access to life-saving products developed through these global collaborations.

Challenging the WHO's mandate and refusing to engage in cooperative efforts during this crisis, and beyond, will cost American lives, threaten our economic progress, and leave us more vulnerable to deadly infectious diseases.

In addition, current U.S. policy requires foreign aid recipients to submit a request to the U.S. Agency for International Development (USAID) to use aid dollars to purchase PPE. While USAID has received hundreds of requests, none has been approved as of June. This policy prevents resource-limited countries from providing the most basic of COVID-19 services: allowing health workers to treat and care for COVID-19 patients without risk of infection. A failure to equip resource-limited countries with the most basic tools needed to respond to COVID-19 will continue to leave the U.S. more vulnerable to the pandemic.

Recommendations:

- Immediate reinstatement of U.S. membership to the World Health Organization and complete payment of U.S. financial obligations, including voluntary contributions to strengthen efforts against HIV, tuberculosis, malaria, Ebola, polio, measles and other reemerging infectious diseases, along with supporting the WHO's vital efforts to provide immunization services to millions of children.
- U.S. participation in WHO-led global cooperative efforts to rapidly develop and deploy needed tools to fight COVID-19, including the Solidarity Trials to develop therapeutics and the ACT Accelerator to develop a vaccine, drugs and better diagnostics.
- Rescind the Department of State policy barring recipients of COVID-19 foreign aid from using aid money to purchase PPE, including N95 masks, gloves, and other PPE vital for protecting health workers from COVID-19 infection.

Policymakers, public health authorities and the medical community must remain vigilant and work together as we continue the response to COVID-19. The lessons learned in the first wave of this pandemic must inform how we prepare for and respond to future waves of the pandemic. IDSA and HIVMA look forward to continuing to collaborate with federal, state and local leaders in evidence-based actions in the best interests of our patients and public health.