

Expert answers commonly asked COVID-19 questions as states begin to reopen

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ummer is coming. Usually, the season comes with thoughts of beach days, ice cream, baseball, and day camp. But for many, the prospect of summer during the [COVID-19 pandemic](#) is met with an overall sense of

[anxiety](#) and confusion—and questions.

Is the beach safe? The ice cream shop is open, but should I really go? And more importantly, how are we any better off, in terms of [infection prevention](#) and treatment, than we were in mid-March, when stay-at-home orders were first put into place?

In other words, why are we reopening now, and how do we make sense of it all?

"I think it is hard for all of us to wrap our heads around reopening," says Jaimie Meyer, MD, MS, a Yale Medicine infectious disease specialist. "There is nothing magically 'safe' about May 20, and very little difference in epidemiologic risk between May 19 and May 21. Only a public health approach that is data-driven will dictate a slow and measured reopening."

Reopening criteria confusion

Part of the confusion may lie in the number and scope of documents detailing the suggested criteria required for reopening the country. The White House has a protocol called "[Opening Up America Again](#)," the Centers for Disease Control and Prevention (CDC) has its own [version](#), in addition to six one-page infographics, and some states, including Connecticut, have their own plans, some of which are more or less stringent than the White House's protocol.

The idea, in theory, is that once the state-specific version of the reopening criteria has been met, it will be safe to begin what's called a "phased reopening"—in other words, a gradual relaxing of some restrictions, as well as the opening of some businesses. With a phased reopening, [state officials](#) (working with county and local officials) are presumably able to monitor the number of COVID-19 cases, and can

move forward with—or stop, if need be—further reopenings, or phases, based on changes in those case numbers.

But many states have opted to [overlook federal criteria](#)—or create their own smaller-scale benchmarks—and move forward with a phased reopening anyway, leaving it up to individuals to make their own decisions about when and how to venture outside safely.

Most Americans are worried about this. According to a recent [Reuters national poll](#), 72% of adults in the United States said people should stay at home "until the doctors and [public health officials](#) say it is safe."

With that in mind, we spoke with Dr. Meyer, who provided answers to frequently asked questions about COVID-19, especially as it relates to the reopening of the country.

The interview has been edited for length and clarity.

Q. Why is it important to have a consensus on the criteria for reopening?

A. The purpose of having standards for a phased reopening is to ensure that the response is data-driven. I strongly believe that if criteria are not met, we risk an uptick in new cases and a setback in terms of progress with this disease.

Q. What does a data-driven public health approach to reopening look like?

A. Five things, really. 1) The presence of protective immunity. There are a number of people (depending on where you live) who have now been infected with SARS-CoV-2, recovered, and have potentially developed

antibodies against the virus. Although it's not clear yet whether these antibodies will completely protect them from reinfection, at what level and for how long, there is likely some protective immunity; 2) The ability for hospitals to care for patients. As hospitals reduce their overload, they will have expanded capacity to care for people who become sick; 3) Adequate testing. Testing is expanding (or should be) in most states, increasing the potential to identify people who are sick and isolate them; 4) Contact tracing. This is also scaling up (or should be) in most states, increasing the potential to identify even more people who are infected and isolate them; and 5) Careful restrictions on social distancing, cleaning and disinfecting, and PPE [personal protective equipment] in [public spaces](#), all of which reduce the spread of disease.

We need all of these components together to keep the curve going down and to prevent a second wave.

Q. Before a safe and effective vaccine is developed, is the goal to make the virus disappear or to let people get infected, but at slower rates that hospitals can keep pace with?

A. The goal of the combined public health measures I just mentioned is to reduce the number of new cases which, in turn, reduces the number of hospitalizations and the number of COVID-related deaths. No one can expect that these measures will "disappear" the virus, or that everyone will eventually become infected. The truth will likely lie somewhere in between, but only the data will tell us exactly where.

Q. How can we be sure that testing is accurate across all states?

A. It's hard to know. There are a wide variety of types of tests being used across [health systems](#), and they have varying degrees of sensitivity—meaning the ability to pick up 'true positives' for people who actually have the disease—and specificity, which is the ability to tease out 'true negatives' for those who do not have the disease.

Tests generally fall into three major categories: tests that look for the genetic material [RNA] of the virus; "antigen" tests that look for a particular part of the virus; and "antibody" tests that look for the human body's response to the virus.

Some of these tests have been fully vetted and validated before they were approved by the FDA [Food and Drug Administration], and others were authorized under an emergency use authorization [EUA] but have not yet been fully vetted and validated. We are really learning on the fly.

Q. Why is there still a delay in the number of tests being made available?

A. This relates to the capacity to collect the samples, availability of materials to run the tests (nasal swabs or liquid reagents to process the samples, for example), and certified labs to analyze the tests.

Q. The FDA issued two EUAs for at-home tests, one for a nasal swab sample and, more recently, one for a saliva sample. Does that mean we will be able to pick these up at a drug store for routine testing?

A. Yes, home collection kits are likely headed our way. This is exciting because it will not only make the tests more widely available, but also reduce risks of exposure to health care workers that can happen during

the collection process. But, I believe home collection kits will still need to be ordered by a health care provider instead of being available over the counter.

Q. What is contact tracing? If I am contacted, does that mean I have the virus?

A. Contact tracing is a way to identify those who have been exposed to people with confirmed cases of COVID so they can get tested—it's a key component of disease containment strategies. Departments of Public Health everywhere, including in Connecticut, are ramping up their ability to conduct contact tracing. They already have systems in place for other highly communicable diseases, such as syphilis, so I imagine it will operate in a similar way.

If you are contacted, it means you had a potentially high-risk exposure to someone who was infected with COVID. This is not a reason to panic, but rather a reason to self-isolate and get tested.

Q. For how long will we have to wear masks?

A. We may have to have some sort of barrier protection for our faces, like cloth face coverings, until we have highly effective vaccines available.

Q. So, it could be for a while—years, even.

A. Yes.

Q. How does wearing a surgical mask or a cloth mask protect others if small particles carrying the virus can

still get through?

A. I like to think of facial coverings as putting your thumb over a hose—some water may escape, but the major flow is blocked. Facial coverings like cloth masks prevent many particles from being disseminated into the environment, but not all. That is why we need social distancing and other prevention strategies, like hand washing and cleaning or disinfection, in addition to cloth masks.

Q. The six-foot physical distance is based on previous coronaviruses, correct? Is it enough? If I am around runners or people who are coughing a lot, should I move farther away?

A. Yes, that's true. If people are coughing, sneezing, or breathing heavily they may aerosolize more droplets, which may be propelled further. That is why we ask people who are sick to stay home, wear facial coverings, and remain socially distant.

Q. If you're running for a long distance behind someone, though, wouldn't that increase your risk? Is it better to move across the street?

A. There is no data on whether it is better to run behind, in front of, or to the side of someone while running. The best bet is to run at least six feet apart, regardless of the direction.

Q. There was a study in [The New England Journal of Medicine \(NEJM\)](#) about SARS-CoV-2 being in aerosols and remaining in the air for three hours. Is that the same as airborne transmission?

A. This means that once virus-coated droplets are sprayed into the air, they can remain there and survive for up to three hours. This facilitates airborne transmission of the virus from person to person, because that live virus can infect someone else if it enters their respiratory tract.

Q. Wouldn't that mean that we are all susceptible to potential infection in any enclosed space, even if we all wear cloth face coverings?

A. We have to be careful when we translate lab experiments into real-life scenarios. The experiment discussed above found that live virus could be recovered from aerosol for up to three hours, but it's not known whether the quantity is enough to actually cause infection in someone else.

As the state/country reopens, however, we know that better-ventilated spaces result in less distribution of the virus-laden droplets. This is the reason for states recommending reopening of outdoor spaces first, where transmission is less likely, especially with social distancing.

Q. That means that two families who are on separate blankets six feet apart at the beach would be relatively safe, even if they stayed on their blankets for 8 hours or so, breathing in the same air.

A. Yes.

Q. Some people think they've already had COVID-19 in December or January. Is there a way for people to know if they had it? And if they did, do they have

some immunity?

A. People who have COVID-19 (whether or not they were ever officially diagnosed) and recover often develop antibodies against the virus. Antibody tests have been developed but are problematic because of high rates of false negatives and false positives. So, right now it's not recommended that they be used to make individual decisions about personal health or safety. We suspect that antibodies will offer some protection from reinfection, but it's not known what level of antibodies is sufficient and how long that protection will last.

So, we don't want people going out to get tested for antibodies and then feeling falsely assured that they are protected.

Q. When returning from the grocery store, is it really a smart strategy to wipe down packaged food with bleach wipes, or is it overkill? If a delivery driver with COVID sneezed on or near my cardboard Amazon package and then dropped it off on my doorstep and I picked it up immediately and opened the box, could I get sick?

A. I think we need to balance anxiety with practicality and safety. I suggest that people practice reasonable precautions. This means unpacking groceries/deliveries from their containers or boxes, washing hands, and wiping down countertops with bleach. Even though the virus can be found on cardboard for up to 72 hours, the NEJM article suggests viable [live] virus is probably on cardboard for closer to 8 hours. Your best bet is to wash your hands after handling potentially contaminated surfaces.

Q. Do we know how long someone is contagious when they're asymptomatic?

A. People can shed virus (and potentially infect others) for three to five days prior to developing symptoms. Those who don't develop symptoms at all can shed virus for approximately 14 days at high enough levels that they may be contagious to others.

People can shed virus for weeks following recovery, but we think that this is either dead virus or virus at low enough levels that they are not contagious to others.

Q. In Connecticut, gatherings of 5 or fewer are OK, and most people have been sheltering-in-place for about two months. So, is it safe for one person to have an indoor visit with someone else if both have sheltered-in-placed for two months and have not had any symptoms for 14 days?

A. Data from over 1,000 people hospitalized in a single week in New York showed that the majority of people infected and newly admitted were people who identified as "mostly staying home." The likely reason for this discrepancy was that there were gaps in home isolation behaviors—social visits with others, being in public spaces without face coverings or appropriate hand hygiene, interacting with others without taking precautions, etc. I know many people who would say they are fully isolated, but are still spending time in public spaces. So, if both people were truly isolated, it would be reasonable to have a visit without any additional risk. Ideally, people could get tested before they gather together.

Q. Some have missed a mammogram or a colonoscopy or a dental procedure, and they're afraid to go to the doctor. Is there a safe way to get these things done?

A. Over the next few months at Yale New Haven Hospital, we are looking towards reopening ambulatory services and elective procedures, as are places elsewhere that are on the downside of their COVID curve. I think telehealth will be with us for the foreseeable future at least to some extent. In the earliest phases of reopening, in-person care will likely be prioritized for urgent health concerns. But please don't miss your routine vaccines and health screenings as we move forward in reopening. General preventive healthcare remains important for long-term and overall health.

Q. What do you think needs to happen before you're confident that we can get this under control?

A. Expanded testing and contact tracing. Safe and effective vaccines. Effective treatment. All are on the horizon and scientists globally are working at a breakneck pace to make these a reality.

Q. Anything you want people to know as we start to reopen around the country?

A. People who have underlying health conditions that place them at higher risk of severe COVID-19 will need to practice precautions for the foreseeable future. I know everyone has COVID fatigue. We have message burnout, are tired of being home, and mourn our "regular" lives. But reopening must be paced and careful and responsive to data so that we don't backtrack.

Provided by Yale University

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