

COVID Testing Technical Assistance: Frequently Asked Questions

May 5, 2020

Specimen Collection Supplies

General:

1) What types of supplies is the federal government providing states?

The federal government is directly procuring swabs and transport media. For the month of May and June, the federal government will distribute a predetermined allocation of these specimen collection supplies to the United States and localities. These supplies are intended to supplement the specimen collection supplies that states, labs, and healthcare providers are obtaining directly from the private commercial market.

2) What are the exact supplies my state will be getting?

Each state will receive information on the specimen collection supplies it will be receiving. Swabs will include a combination of nasal and nasopharyngeal swabs. Transport media will include a combination of viral transport media, molecular transport media, and sterile saline. Details of the first week's shipment will be provided to states as shipments are released beginning on May 6, 2020. Details of the shipments for the rest of May will be provided as those shipments are released.

3) Can states request a certain breakdown of the supplies that the federal government will provide?

No. Each state will receive approximately the same proportion of each type of supply (e.g., nasal vs. nasopharyngeal swabs, sterile saline vs. viral transport media). The Centers for Disease Control and Prevention (CDC) will share best practices for the use of each type of collection material.

4) When will the supplies arrive?

The delivery for the first week's supplies is underway. States will receive supplies throughout the week through Sunday, May 10, 2020. For the subsequent weeks, the federal government will work to provide a single delivery and tracking number for all supplies. The FEMA Regional Response Coordinate Center (RRCC) will share this tracking number with states. Please see the attached one pager for logistics contact information.

5) Will the supplies arrive at consistent intervals?

Yes. With a few exceptions, states will receive approximately a quarter of their monthly supplies each week.

6) **Who is the logistics point of contact to let us know when supplies will arrive?**

The state's FEMA RRCC will assist with any inquiries related to supply logistics. A list of each state's contacts is attached to this email.

7) **Who is in charge of allocation and distribution throughout the state?**

States are responsible for allocating supplies within their state. The federal government is only responsible for ensuring the supplies reach each state's warehouse.

8) **What do I do if I need more supplies?**

States can reach out to their federal Testing SME contact, who is included on the attached spreadsheet. The federal government will work with states that are on track to exceed their testing goals for the month to meet increased testing demand.

9) **What do I do if I have leftover supplies?**

States are encouraged to reserve excess supplies for future testing needs. States should stay in touch with their Testing SME to report an increase or decrease in testing demand.

10) **Is there an expiration date to the specimen collection supplies?**

In general, unopened swabs do not have an expiration date. Viral transport media does have an expiration date, which is approximately 12 to 18 months after the production date. Check with each manufacturer for the most accurate information on expiration dates for each material.

11) **What do I do if I have a question about supplies?**

Your state has been assigned points of contact who can assist with any questions about supplies. Those points of contact are provided in an attachment to this email.

- For specimen collection logistics questions, please reach out to your FEMA RRCC.
- For questions about best practices for using the supplies, please reach out to your CDC contact.
- For questions about increasing your allotment of supplies, please reach out to your Testing SME.

12) **How do I request tracking numbers?**

FEMA regions will provide tracking numbers to state logistics representatives upon request. Please ensure the appropriate logistics representative from your state has his or her contact information included in your state-specific one pager.

13) **What do I do if my order does not arrive?**

Should your order not arrive, you can contact your FEMA RRCC for assistance.

14) What are the storage requirements for the supplies?

Viral transport media must be kept in a temperature-controlled facility between 2 and 25 degrees Celsius (35 - 77 degrees Fahrenheit). A functioning temperature controlled room should suffice, but please take into account the upcoming summer weather as you evaluate if refrigeration would be more applicable for your state's climate.

15) Can the federal government ship the supplies to multiple addresses in the state?

No. The federal government will be shipping supplies to a single location.

16) What is my state's shipping address and how was it confirmed?

The HHS Regional Emergency Coordinator provided an initial address that has the storage and temperature requirements to receive the upcoming swab and transport media allotments. Each state was asked to verbally confirm that it was the right address, and if not, update the address in an email sent by the CDC. This address should be the correct one through the month of May and June, but should there be an error, the state can reach out to the FEMA RRCC to update its shipping address for future shipments.

17) Will these specimen collection supplies cover the entirety of my state's testing needs?

No. The federal allocations are meant to supplement a state's existing specimen collection supplies.

18) Should the public health lab still request swabs and transport media through the IRR?

No. For the months of May and June, the federal government will be supplying swabs and media directly to states.

19) What does the state order through WebEOC versus the IRR?

States should only request additional PPE through WebEOC. There is no need to order swabs and transport media through WebEOC as specimen collection supplies will be directly provided to states. Public health labs can still request reagents through the IRR.

20) Will the federal government be procuring and allocating specimen collection supplies for the rest of the COVID crisis?

Currently, the federal government plans to procure and allocate specimen collection supplies for May and June only. The federal government believes there will be ample specimen collection supplies in July and thereafter.

21) **Will the federal government be allocating serology specimen collection supplies?**

The federal government does not currently plan to distribute serology specimen collection supplies. If this changes, we will notify states.

Swabs:

1) **What percentage of nasal vs. nasopharyngeal swabs will my state get?**

For week 1, states should expect to receive approximately 15% nasopharyngeal swab kits that include viral transport media, 40% nasopharyngeal swabs, 30% nasal foam swabs, and 15% nasal polyester swabs.

2) **Will we be getting the same percentage of types of swabs each week?**

The percentage of types of swabs will vary by week, and we will provide this information as applicable to each state. On average, over the month of May, states should plan to receive approximately 50% individually wrapped nasal swabs, 25% bulk wrapped nasal swabs, 15% nasopharyngeal swabs, and up to 10% nasopharyngeal swab kits that include transport media.

3) **Can I use any type of swab for any type of test (e.g. nasal swab for asymptomatic testing)?**

Yes. While nasopharyngeal swabs are preferred, the FDA has approved both nasopharyngeal and nasal swabs for both symptomatic and asymptomatic COVID testing.

4) **How do I deal with bulk shipping of swabs?**

Sterile swabs for upper respiratory specimen collection may be packaged in one of two ways: individually wrapped and bulk packaged. Care must be exercised to avoid contamination of any of the swabs in the bulk-packaged container. Please see the full [CDC guidance](#) on bulk-packaged swabs.

5) **What type of PPE is needed for testing with different swab types?**

As of [April 27](#), for the collection of nasopharyngeal or nasal swabs, health care professionals (HCPs) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown. This PPE protocol is required for all swab specimen collection methods except for patient self-collection. When a patient self-collects their sample, HCPs handling the specimen should follow standard precaution procedures, including gloves and a facemask in conjunction with social distancing protocols.

Transport Media:

1) **What percentage of VTM vs. sterile saline vs. other media will I get?**

For week one, states should plan to receive 50% sterile saline, 30% viral transport media (VTM), and 20% molecular transport media (MTM).

2) **Will I get the same percentage of types of media each week?**

The percentage of types of media will vary by week, and we will provide this information as applicable to each state. On average, over the month of May, states should plan to receive approximately 50% sterile saline, 25% molecular transport media, 15% viral transport media, and up to 10% nasopharyngeal kits that include viral transport media.

3) **What types of media are approved for COVID response?**

Viral transport medium (VTM), molecular transport media (MTM), phosphate buffered saline, universal transport media (UTM), and sterile saline are all approved media for the COVID response. Please see the [FDA FAQ](#) for the full list of approved media.

4) **My state prohibits media other than VTM. Can we just receive VTM and no other types of media?**

All states will receive allocations of all media types, as no type of media is officially prohibited in any state.

5) **Are there any media usage restrictions to be aware of?**

Longhorn Vaccines and Diagnostics' Molecular Transport Medium (MTM) is incompatible with the following RT-PCR platforms: Diasorin, Hologic (when post-assay bleach disinfectant is used). In addition, Quest and LabCorp do not accept MTM. Do not send MTM to these labs to perform COVID tests. Please note that MTM is compatible with Roche Cobas, MagnaPure, and Lightcycler; ThermoFisher Applied Biosystems (ABI) 7500, Kingfisher MagMax, and QuantStudio, and Abbott M2000.

Lab Testing Supplies

1) **Who is my lab testing contact?**

Each state has a designated Testing point of contact. Please see the state-specific one pager for their name and email address.

2) **Is the federal government procuring and distributing lab testing supplies?**

With the exception of supplies procured for the International Reagent Resource (IRR) for use by public health labs, the federal government is not directly procuring lab testing supplies. Instead, the federal government is connecting states directly with lab testing supply manufacturers and then working with those manufacturers to ensure each state receives adequate lab testing supplies to meet their testing goals.

3) **How are we supposed to pay for lab testing supplies, like reagents?**

CDC has already provided hundreds of millions of dollars to states, which can be used to purchase lab testing supplies. Congress has also provided \$11 billion to HHS, which will be provided to states and localities before May 23, to assist states with their comprehensive testing needs.

4) **How do I get connected to manufacturers that procure testing supplies?**

The federal government worked with each manufacturer to identify points of contact. Please refer to the below table to reach each manufacturer.

Manufacturer	Name	Contact Info	States
Abbott	Pam Redmond	pamela.redmond@abbott.com, 603-560-9082	All States
Becton, Dickinson and Company	Elizabeth Woody	elizabeth_woody@bd.com	All States
Cepheid	AJ Gopal	805-422-4143	CA, OR, WA, AK, HI, ID, MT, UT, CO, NM, AZ, NV, WY, ND, SD, MN, NE, KS, OK, TX, IA, MO
	Kevin Starr	408-316-8204	WI, IL, IN, MI, OH, PA, NY, CT, RI, NH, MA, ME, DE, VT, NJ
	Dan Jenkins	678-727-6669	MD, WV, VA, NC, SC, KY, TN, AR, MS, LA, GA, FL, AL
Hologic	Jerry Wilson	jerry.wilson2@hologic.com, 858-229-6610	All States
Qiagen	Thierry Bernard	thierry.bernard@qiagen.com	All states
	Gary Nealey	gary.nealey@qiagen.com	All states
Roche	Rajen Bhimaraj	rajendran.bhimaraj@roche.com, 978-430-8577	FL, GA, IL, IN, LA, MI, MO, PR, TN, TX, WI
	Rod Cotton	rodney.cotton@roche.com, 317-502-6622	CA, CO, HI, IA, KS, MN, MO, NE, NM, OR, UT, WA
	Ron DiNizo	ron.dinizo@roche.com, 937-608-4575	AR, AZ, CA, CT, FL, IL, IN, KS, MA, MD, MN, NC, NJ, NY, OH, PA, SC, TN, TX, VA
	Dan Zortman	dan.zortman@roche.com, 317-285-9748	DE, FL, MA, MD, NC, NJ, NY, OH, PA, RI, VA, WV
Thermo Fisher Scientific	Tim Fenton	202-257-4277	All States

5) **What do I do if the manufacturers will not sell to my state because we are a low priority?**

The federal government is working with manufacturers to ensure that each state receives sufficient lab testing supplies to allow each state to meet its testing goal. As your testing strategy evolves, work with your federal Testing point of contact to determine a holistic

approach to testing that diversifies reagent utilization and maximizes the available testing platforms in your state.

- 6) **Can public health labs use lab testing supplies from the International Reagent Resource (IRR) to provide lab testing supplies to all labs in the state?**

No. State and local public health labs must be registered entities with the IRR in order to access its supplies and resources. Entities outside of the state/local public health laboratory system (e.g., private labs, hospitals, clinics, tribal health organizations) are not able to register with IRR. Materials ordered through IRR are intended for use by registered public health labs. The IRR is not intended to serve laboratories beyond the public health system nor is it supplied to fill orders beyond public health lab operations.

- 7) **What do I do if I cannot get the specific types of lab testing supplies that my state needs to run the tests for all of the swab and media allocated by the federal government?**

The federal government is working with manufacturers to ensure that each state receives lab testing supply allocations to allow each state to meet its testing goals. As your testing strategy evolves, work with your federal Testing point of contact to determine a holistic approach to testing that diversifies reagent utilization and maximizes the available testing platforms in your state.

Personnel

- 1) **How do I request CDC personnel?**

CDC's lead for your state will be in touch with your state's health department regarding any personnel needs. In addition, you can read about CDC's available staffing resources [here](#).

- 2) **What types of personnel can CDC provide?**

CDC continues to deploy staff to help states with outbreak response in special settings, including long-term care facilities and meat processing plants. In addition, CDC is able to provide technical assistance for a wide range of activities including surveillance, public health, infection control and contact tracing.

- 3) **Do the states pay for CDC personnel?**

This will depend on how staff are provided to support a state. CDC has provided states with hundreds of millions in COVID supplemental funds, which can be used for a variety of COVID response activities. State funding awards to date can be viewed [here](#). In addition, the Paycheck Protection Program and Health Care Enhancement Act will provide another \$11 billion to states and territories in May 2020.

4) **Can the federal government provide contact tracers?**

No. At this time the CDC is not able to provide contact tracers to each state. CDC is able to provide contact tracing technical assistance, tools, training and resources. The most up-to-date information for contact tracing assistance can be found [here](#).

5) **The limiting factor to increase testing in my state is lab technicians to run the tests. Can the federal government assist?**

CDC does not provide states with lab technicians. We encourage you to reach out to nationwide companies to contract directly with them to fill any personnel needs.

6) **What personnel is available through the CDC Foundation?**

The CDC Foundation is urgently recruiting candidates for critical positions nationwide. Interested parties should go to the CDC Foundation website and [apply directly for positions](#). CDC's lead for your state will be in touch with the health department regarding personnel, including some personnel available through the CDC Foundation.

7) **Can the federal government assist with personnel needs for technology/data?**

CDC recommends states directly contract with technology companies for assistance with technology and data.

Guidance

1) **Is there an appropriate testing volume for each state?**

Each state should develop its own testing strategy but, as guidance, we are recommending that states test a minimum 2% of their population per month.

2) **Who should be tested?**

CDC has released updated guidance for who should be tested for COVID-19. That guidance is summarized below and can be found in detail [here](#).

Testing Priorities for Nucleic Acid or Antigen Testing of Individuals

High Priority Testing

- Hospitalized patients **with** symptoms
- Healthcare facility workers, workers in congregate living settings, and first responders **with** symptoms
- Residents in long-term care facilities or other congregate living settings, including correctional and detention facilities and shelters, **with** symptoms

Priority Testing

- Persons **with** symptoms of potential COVID-19 infection, including fever, cough, shortness of breath, chills, muscle pain, new loss of taste or smell, vomiting or diarrhea and/or sore throat
- Persons **without symptoms** who come from racial and ethnic minority groups disproportionately affected by adverse COVID-19 outcomes-currently African Americans, Hispanics and Latinos, some American Indian tribes (e.g., Navajo Nation).
- Persons **without** symptoms who are prioritized by health departments or clinicians, including but not limited to public health monitoring, sentinel surveillance, presence of underlying medical condition or disability, residency in a congregate housing setting such as a homeless shelter or long term care facility, or screening of other asymptomatic individuals according to state and local plans.

3) **Under what circumstances should testing of asymptomatic persons be considered?**

As noted above, testing should be prioritized for individuals with symptoms. Testing of asymptomatic persons in certain settings (e.g., nursing homes, homeless shelters, prisons) may be warranted for the purposed of surveillance and cohorting of individuals in congregate living settings. Testing of asymptomatic persons may also be considered for public health investigations of outbreak clusters.

4) **Is there guidance on surveillance testing?**

CDC has released guidance on surveillance, including case-based surveillance based on nucleic acid testing.

5) **Is there guidance on sentinel surveillance for vulnerable populations?**

At present, there is no national sentinel surveillance strategy based on nucleic acid or antigen testing. CDC recommends continued use of syndromic surveillance of influenza-like illness and COVID-like illness to identify increases in urgent care and emergency visits related to COVID-19. Sentinel surveillance should be utilized through a strategic approach in critical locations, including senior and other congregate living settings and healthcare clinics (particularly those in underserved urban and tribal settings).

6) **Is there guidance on long-term care facility testing strategy for diagnostic and serological tests?**

CDC has released guidance for long-term care facilities, both general guidance and guidance specific to testing.

7) **Is there guidance on when to use point of care testing?**

Decisions about situations that warrant point-of-care testing should be made by state and local health departments or healthcare providers. Considerations may include overall testing availability and whether there is a need for a rapid test result for public health or clinical decision-making,

8) **Is there guidance on alternative sample types?**

CDC has released guidance on sample types.

9) **Is there guidance on serology testing?**

CDC has released guidance on serologic testing and a serology surveillance strategy.

10) **What are the best resources for finding latest guidance documents?**

CDC maintains an updated list of guidance documents here and a list of “What’s New” for the latest on new guidance here.

Nevada Technical Assistance State Specific Details

Federal Details

State Details

CDC Liaison: Name: Michelle Dittrich Email: yhf8@cdc.gov Functional Email: eoevent375@cdc.gov	Lab Subject Matter Expert: Name: Dr. Mark Pandori Email: mpandori@med.unr.edu
Shipping and Logistics POC: Name: Shawn Matz Email: r9-rssc@fema.dhs.gov Telephone: 510-627-7022	Shipping and Logistics POC: Name: Eric Wilson Email: logisticsndem@gmail.com; erwilson@dps.state.nv.us Telephone: <i>PENDING</i>
Testing Subject Matter Expert: Name: Tommy Acciani Email: Thomas.Acciani@hhs.gov	Swab and Media Shipping Address: Site Name: 

Week of May 4th Allocation Details:

Swabs	Nasopharyngeal	16,000
	Nasal (Individually Wrapped)	3,500
	Nasal (Bulk Wrapped)	4,500
Media	Viral Transport Media	5,800
	Molecular Transport Media	4,500
	Sterile Saline/Phosphate Buffered Saline	10,000

Nevada has already received an initial shipment of 6,000 swabs and should receive the remainder of its weekly allocation by Sunday, May 10, 2020.

Total May Allocation

Swabs	120,000
Media	88,500

Supplies will arrive over the course of May. The percentage of specific types of swabs and media will vary by week.

On average, states should plan to receive approximately 50% individually wrapped nasal swabs, 25% bulk wrapped nasal swabs, 15% nasopharyngeal swabs, and up to 10% nasopharyngeal swab kits that include transport media over the month of May.

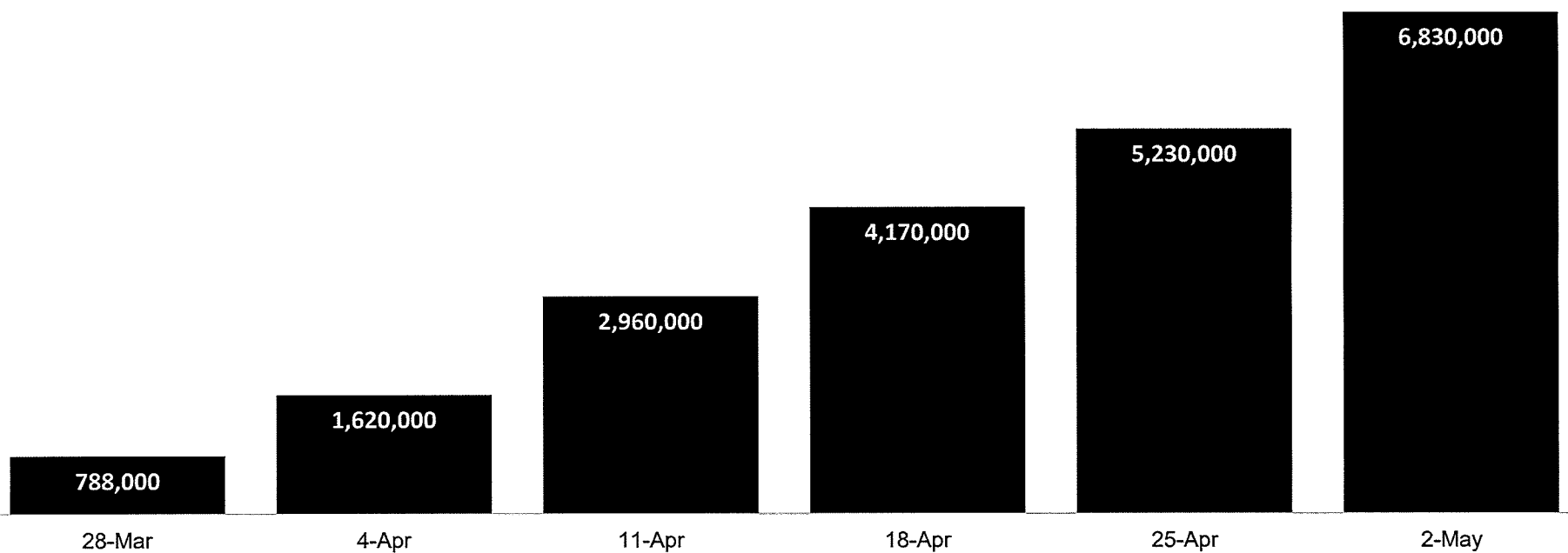
In addition, states should plan to receive approximately 50% sterile saline, 25% molecular transport media, 15% viral transport media, and up to 10% nasopharyngeal kits that include viral transport media over the month of May.

Testing Technical Assistance Update

May 5, 2020



Testing Progress To Date





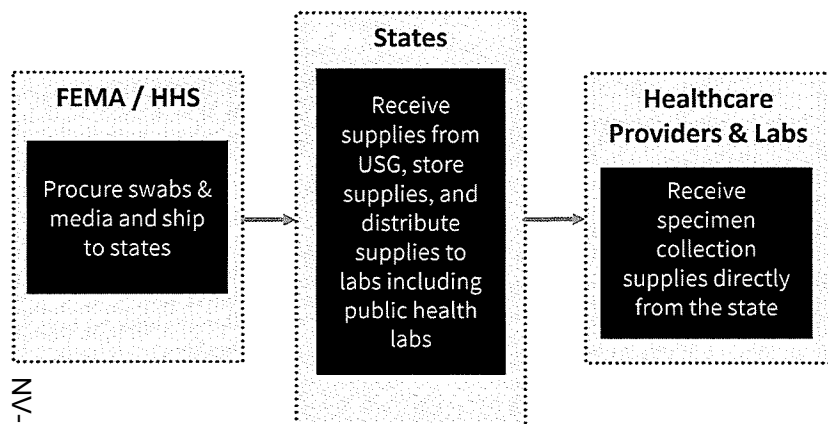
Four Types of Technical Assistance for States

- ✓ Specimen Collection Supplies: The federal government is directly procuring specimen collection supplies to supplement the specimen collection supplies states and healthcare providers are procuring from the private market. For May and June, FEMA will be distributing specimen collection supplies including swabs and transport media directly to states.
- ✓ Lab Testing Capacity Technical Assistance: The federal government is providing each state technical assistance to help states fully utilize their existing lab capacity. This includes providing states a map of their existing lab testing capacity as well as working with commercial manufacturers of lab testing supplies to ensure that states have the necessary lab testing supplies to meet the increased testing demand. States and healthcare providers will purchase lab testing supplies directly from commercial manufacturers, with the exception of public health labs who will still receive reagents through the IRR.
- ✓ Personnel: CDC has already deployed more than 650 personnel to states and is prepared to deploy additional personnel to states as needed, including individuals with expertise in epidemiology, public health, infection control and contact tracing.
- ✓ Guidance: CDC is providing states with guidance and technical assistance on a range of testing-related topics including surveillance, specimen collection, testing in long-term care facilities, point-of care testing, testing in outbreak settings, and serology.



Specimen Collection Supplies

Specimen Collection Supply Workflow

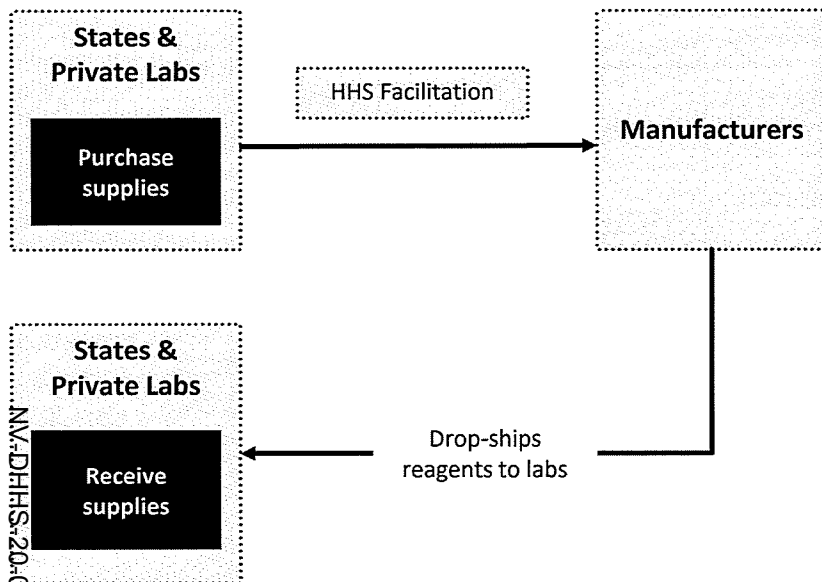


- ✓ Swabs and transport media will be shipped in weekly installments
- ✓ Supplies will be shipped to a single location within each state
- ✓ States will be in charge of distributing supplies within the state
- ✓ States will receive 75% of the transport media and collection tubes they receive in swabs (as many states produce transport media locally)
- ✓ The federal government has additional swabs in reserve to meet the demand of states whose May testing is on pace to exceed their initial allotment of supplies



Lab Testing Capacity

Lab Testing Supply Workflow



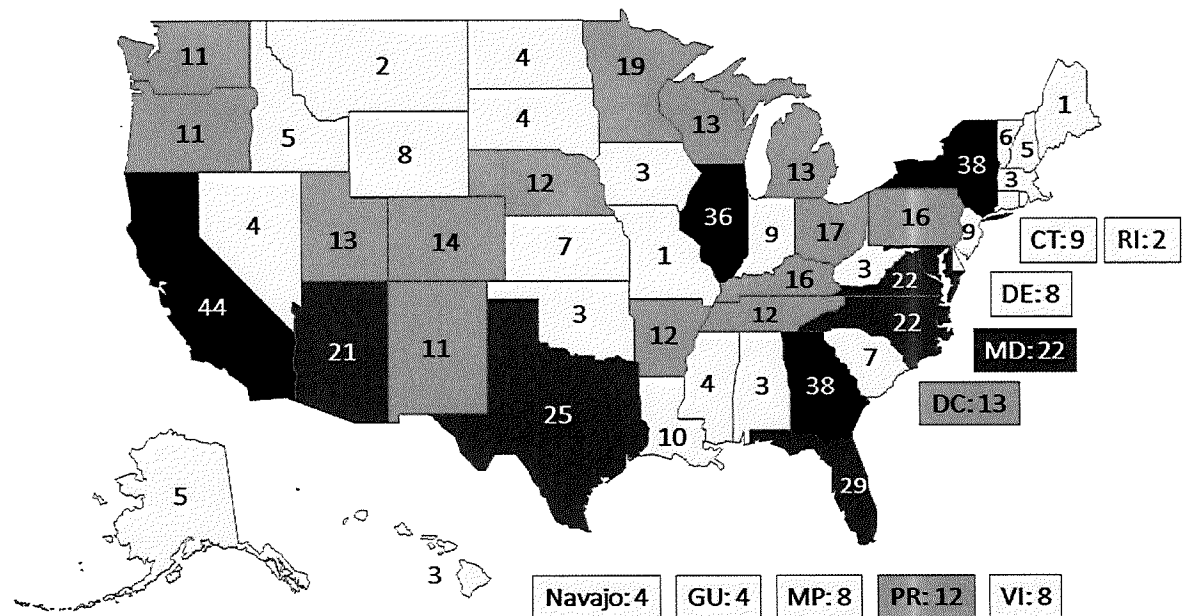
- ✓ Testing Capacity Maps: Each state has been provided a map and a spreadsheet of its testing capacity based on lab testing machines already present in the state.
- ✓ One-on-One Technical Assistance: Each state has been assigned a federal technical expert to advise on strategies to ramp up testing capacity.
- ✓ Manufacturers Introductions: The federal government is providing introductions for state leadership to lab testing supply manufacturers.
- ✓ Lab Testing Supplies: For the most in-demand lab testing supplies, the federal government is partnering with manufacturers to discuss appropriate distribution of supplies across the United States.



Personnel

- ✓ CDC currently has more than 650 staff serving in all 50 states across the country
- ✓ CDC will deploy an additional 5 or more staff to each state, as requested, to provide technical assistance and conduct outbreak investigations
- ✓ Areas of expertise include:
 - ✓ Epidemiology
 - ✓ Public Health
 - ✓ Infection Control & Prevention
 - ✓ Contact Tracing

665 Staff Currently Embedded or Deployed (as of May 2, 2020)





Guidance

- ✓ Share, enhance and increase training around existing guidance including:
 - ✓ Specimen Collection
 - ✓ Surveillance
 - ✓ Contact Tracing
- ✓ Issue new guidelines this week for:
 - ✓ Serology
 - ✓ How To Prioritize Point-of-Care Testing
- ✓ Share state best practices including:
 - ✓ Continuing weekly Monday calls with states
 - ✓ Making regular updates to CDC's STLTS website/repository
- ✓ Continue to offer support from HRSA, IHS and the White House Opportunity and Revitalization Council to support sentinel surveillance and diagnostic testing in vulnerable populations and in underserved and distressed communities

Assessing Case Report, Syndromic, and Laboratory Gating Indicators

The *Opening Up America Again* guideline (<https://www.whitehouse.gov/openingamerica/>) outlines a three-phased approach to reducing community mitigation measures currently in place to limit transmission of the SARS-CoV-2 virus. The stated purpose of the guideline is to outline a path to re-opening the economy while mitigating the risk of resurgence in COVID-19 illnesses and protecting vulnerable populations. The phased approach can be implemented on a statewide basis or community-by-community at governors' discretion. The guideline proposes the use of three categories of “gating” indicators (based on symptoms, based on cases, and for hospitals) to assess when to move through three community mitigation phases (Phase One, Phase Two, and Phase Three). Two gating indicators are in each category, and include:

- *Indicators based on symptoms:*
 1. Downward trajectory of influenza-like illnesses (ILI syndrome) reported within a 14-day period

AND

 2. Downward trajectory of COVID-like syndromic cases (*i.e.*, COVID-like illness or CLI syndrome) reported within a 14-day period
- *Indicators based on cases:*
 3. Downward trajectory of documented cases within a 14-day period

OR

 4. Downward trajectory of positive tests as a percent of total tests within a 14-day period (flat or increasing volume of tests)
- *Indicators for hospitals:*
 5. Treat all patients without crisis care

AND

 6. Robust testing program in place for at-risk healthcare workers, including emerging antibody testing

Of note, indicators 1 through 4 all rely on types of public health surveillance data to determine the trajectory of COVID-19 transmission within a jurisdiction. This document focuses on the measurement and interpretation of these four disease occurrence gating indicators because of their shared objective and use of common public health surveillance methods. This document also highlights other disease occurrence measures that may be important for state or local jurisdictions to consider when adjusting the intensity of community mitigation measures.

Considerations for the measurement and interpretation of the indicators for hospitals (numbered 5 and 6 above) are outside the scope of this current document and may be addressed in an update or in separate documents, including guidance related to the use of emerging antibody tests in healthcare and other settings.

Disease Occurrence Gating Indicators

The following subsections provide further detail for each of the disease occurrence gating indicators outlined in the *Opening Up America Again* guideline, including a description and rationale, potential data sources, considerations for assessing decreases (and moving through the three mitigation phases), considerations for assessing increases (*i.e.*, “rebound”), and interpreting the measure in the context of its strengths and limitations. Numerous data sources and surveillance systems exist at the local, state, and federal levels that can be used to measure and evaluate these indicators. Local and state officials should use the best data available, regardless of source, when assessing the trajectory of COVID-19 illnesses. Variability will exist from jurisdiction to jurisdiction on the quality, completeness, and timeliness of these data sources and sufficient data may not be available for all jurisdictions to evaluate all four of the disease occurrence gating criteria. In situations where all the gating indicators cannot be assessed, additional data sources available locally may assist in determining the trajectory of COVID-19 activity in the jurisdiction.

Downward trajectory of ILI reported within a 14-day period

- **Description/Rationale:** ILI is a syndromic surveillance categorization applied to emergency department (ED) and outpatient visit symptom and diagnostic code data. This measure is intended to identify areas that are experiencing sustained decreases in outpatient clinic or ED visits in people with ILI. ILI is defined as fever with cough and/or a sore throat. COVID-19 may present with symptoms similar to ILI, so the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) and the National Syndromic Surveillance Program (NSSP) can be used to track COVID-19 trends, especially when paired with SARS-CoV-2 and other respiratory pathogen testing data.
- **Data Sources:** Outpatient care facilities and hospital EDs selected by state and/or local health departments for participation in the Outpatient Influenza-Like Illness Network (ILINet) report to CDC either directly or through their health department via a web-based reporting system. In addition, electronic data, including data from CDC’s National Syndromic Surveillance Program (NSSP) can be uploaded to ILINet. These data are stored in a shared database for use by CDC and state/local public health officials. States and jurisdictions may collect syndromic surveillance data on ILI locally that is not submitted to ILINet but could be useful for interpreting the ILI gating indicator. ILINet data is available publicly at the state-level at <https://www.cdc.gov/flu/weekly/fluviewinteractive.htm>.
- **Considerations for Assessing Decreases:**
 - Conceptually, a downward trajectory can be achieved when the number proportion outpatient visits for ILI continues to decrease each day for 14 days (or two consecutive weeks when only weekly data is available).
 - Normal variation in ILI ED and outpatient visits can impact assessment of daily trends, especially in smaller geographies with low daily visits and by variations in

healthcare seeking behavior associated with the day of the week, holidays, and current social distancing measures.

- Interpretation of trends in ILI visits also needs to account for periods of stable or sustained low activity and small increases in ILI on one or a few days in the context of the overall 14-day trend.
- ILI activity levels are traditionally calculated for jurisdictions based on the percent of outpatient visits due to ILI in a jurisdiction compared with the average percent of ILI visits that occur during weeks with little or no influenza virus circulation in that jurisdiction (*i.e.*, non-influenza weeks), adjusted for the sites contributing data for the week. ILI activity values within two standard deviations of the non-influenza week mean are classified as a minimal level of ILI.
- Given potential changes in healthcare seeking behaviors resulting from community mitigation measures that can significantly affect the denominator of ILI proportions, jurisdictions should analyze within-jurisdiction ILI trends using both the number (count) and proportion of visits to account for this potential bias.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the ILI gating indicator is met with respect to these phase transitions.
 - Transition into Phase One: achieve 14 consecutive days (or two weeks) of downward trajectory or maintaining minimal ILI activity level.
 - Transition into Phase Two: achieve an additional 14 consecutive days (or two weeks) of improvement (downward trajectory or minimal ILI activity level) without experiencing a rebound (defined below).
 - Transition into Phase Three: achieve another 14 consecutive days (or two weeks) of improvement (downward trajectory or minimal ILI activity level) without experiencing a rebound (defined below).
- **Identifying Rebound:**
 - An increase in ILI visits or an increase in ILI activity levels over 5 days (or 2 consecutive weeks when analyzing data on a weekly basis) may indicate a potential rebound in COVID-19 activity.
 - Because multiple respiratory pathogens can present with ILI, an increase in ILI should be interpreted as a rebound in COVID-19 activity only if supported by other surveillance data, including data on SARS-CoV-2, influenza, and other respiratory pathogen testing.
- **Interpretation/Limitations:**
 - ILI is a nonspecific syndromic measure and can be influenced by the circulation of numerous respiratory pathogens and should be interpreted in the context of virologic and other surveillance data.

- The purpose of ILI surveillance is to detect changes in outpatient visits for febrile respiratory illness. The percent of patient visits for ILI can be impacted by changes in health care seeking behavior, so jurisdictions should look at numbers (counts) of ILI visits in addition to proportions.
- ILI frequency and activity levels within a jurisdiction are influenced by the mix of primary care practice types submitting data. These changes make direct comparisons of ILI from one jurisdiction to another invalid. Calculation of ILI activity levels allows for more appropriate comparison of ILI between jurisdictions.

Downward trajectory of COVID-like illness (CLI) reported within a 14-day period

- **Description/Rationale:** CLI is a syndromic surveillance categorization applied to ED visit symptom and diagnostic code data. This measure is intended to identify areas that are experiencing sustained decreases in ED visits consistent with the presenting symptoms of COVID-19 illness (fever and either cough, shortness of breath, or difficulty breathing) or with a coronavirus diagnostic code that fits CDC interim coding guidelines, and without a diagnostic code for influenza (<https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Guidance-Interim-Advice-coronavirus-feb-20-2020.pdf>). CLI can be used to track COVID-19 trends, especially when paired with SARS-CoV-2 and other respiratory pathogen testing data.
- **Data Sources:** Hospitals report ED visits in near real-time to state and/or local health departments and to NSSP. These data are stored within the BioSense Platform where they can be analyzed and exchanged by public health officials. States and jurisdictions may collect syndromic surveillance data on CLI locally that is not submitted to NSSP but could be useful for interpreting the CLI gating indicator.
- **Considerations for Assessing Decreases:**
 - Conceptually, a downward trajectory can be achieved when the number or proportion of CLI-related ED visits continues to decrease each day for 14 days.
 - Normal variation in CLI ED visits can impact assessment of daily trends, especially in smaller geographies with low daily visits and by variations in healthcare seeking behavior associated with the day of the week, holidays, and current social distancing measures.
 - Interpretation of trends in CLI-related ED visits also needs to account for plateaus (periods with little or no change in CLI visits), ED visits reaching their pre-pandemic level (in which case no further downward trajectory is expected), and small increases in ED visits on one or a few days in the context of the overall 14-day trend.
 - CDC NSSP analyses of CLI data attempt to address the challenges above by fitting a spline model to the time series data observed for various geographic stratifications and then recording the number of days of continuous decline. Regression models are also used to classify recent trends to understand whether

a historical baseline of visits with these symptoms has been reached. Statistical coding used by CDC (using the R package) can be shared with state and local jurisdictions upon request.

- Given potential changes in healthcare seeking behaviors resulting from community mitigation measures that can significantly affect the denominator of CLI visit rates and onboarding of new NSSP participants, jurisdictions can analyze trends in either the number (count) or rate of CLI visits to account for these potential biases.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the CLI gating indicator is met with respect to these phase transitions.
 - Transition into Phase One: achieve 14 consecutive days of improvement (downward trajectory or near pre-pandemic outbreak CLI ED visits).
 - Transition into Phase Two: achieve an additional 14 consecutive days of improvement (downward trajectory or near pre-pandemic CLI ED visits) without experiencing a rebound (defined below).
 - Transition into Phase Three: achieve another 14 consecutive days of improvement (downward trajectory or near pre-pandemic CLI ED visits) without experiencing a rebound (defined below).
- **Identifying Rebound:** Two primary methods can be used to help assess for a rebound in CLI ED visits.
 - Within the BioSense Platform, daily statistical anomaly detection methods are automatically applied to time series trends and anomalous increases are flagged for further epidemiologic investigation. Multiple consecutive days of anomalies may be an indicator of increases in COVID-19 activity and could be used to focus additional testing of patients.
 - Regression methods (*e.g.*, binomial regression) can be used to classify time series trends in the last 5-7 days to assess whether recent trends show a significant increase in patients being seen with CLI and can also be used to focus additional investigations and/or confirmatory testing.
- **Interpretation/Limitations:**
 - The purpose of syndromic surveillance is to find timely, more automated, indicators of a change in patterns of illness or health seeking behaviors in a community that can initiate further confirmatory investigation. CLI is a non-specific syndromic measure and can likely be influenced by the circulation of other respiratory pathogens and should be interpreted in the context of virologic and other surveillance data.
 - The timeliest element of ED records is the patient chief complaint text describing their symptoms. The CLI syndrome is based in part on the patient's chief

complaint at presentation to the ED, which may or may not actually be COVID-19, but also includes visits that were assigned a COVID-19 diagnosis code.

- The data quality and completeness of chief complaint text and diagnostic codes can vary by reporting hospital and can negatively impact assessment of trends over time. Comparability of findings across geographies may also be impacted should these differences become too large.
- In general, syndromic categorizations emphasize timeliness and sensitivity over specificity. As such, the CLI gating indicator may exhibit changes earlier than other indicators, but may also include visits for other illnesses that have similar symptoms as COVID-19 (e.g., other respiratory viruses). Interpretation of CLI data should always be considered in conjunction with other data sources and local context. This includes data that track the presence of other respiratory illnesses (e.g., respiratory syncytial virus) circulating within the community that may be difficult to distinguish using syndromic data alone.

Downward trajectory of documented (confirmed and probable) cases within a 14-day period

- **Description/Rationale:** On April 5, 2020, the Council of State and Territorial Epidemiologists (CSTE) issued an interim COVID-19 position statement making COVID-19 a nationally notifiable disease and establishing confirmed and probable case definitions (www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf). The case report gating indicator is intended to identify communities experiencing sustained decreases in the number of new cases occurring each day; an indication of decreases in disease transmission.
- **Data Sources:** Case report information for confirmed and probable cases collected by state and local jurisdictions and submitted to CDC; publicly available aggregated case count data (e.g., USAFacts: <https://usafacts.org/visualizations/coronavirus-covid-19-spread-map/>); US Census population estimates (used as denominator for incidence calculations).
- **Considerations for Assessing Decreases:**
 - Conceptually, a downward trajectory can be achieved when the number of new cases reported (or daily incidence rate) continues to decrease each day for 14 days. However, variation in how cases are ascertained and reported can impact this type of daily assessment, especially in smaller geographies with low daily case counts and over weekends or holidays (i.e., reporting artifacts).
 - Interpretation of trends in case report data also needs to account for incidence plateaus (periods with little or no change in daily incidence), incidence reaching zero or near-zero (in which case no further downward trajectory can occur), and small increases in cases on one or a few days in the context of the overall 14-day period.
 - CDC analyses of case report data attempt to address these challenges by using a method that averages the number of new cases observed over a specified period

(e.g., 3-day average) and then fits a model (specifically, a spline model) to those data to assess changes in the slope of each community's "smoothed" epidemic curve. The number of days in a downward trajectory is then calculated as the number of consecutive days the smoothed epidemic curve had a negative slope or was in a low-incidence plateau (e.g., two-week incidence <10 cases per 100,000 and a near-zero slope). Statistical coding used by CDC (using the R package) can be shared with state and local jurisdictions upon request.

- Modeling approaches are not required to assess downward trajectory in case reports, but any method should address how to handle reporting variations, incidence plateaus, and near-zero incidence.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the case report gating indicator is met with respect to these phase transitions. Note that the *Opening Up America Again* guideline specifies that either the case report gating indicator or the percent positive gating indicator should be met.
 - Transition into Phase One: achieve 14 consecutive days of improvement (downward trajectory or near-zero incidence).
 - Transition into Phase Two: achieve an additional 14 consecutive days of improvement (downward trajectory or near-zero incidence) without experiencing a rebound (defined below).
 - Transition into Phase Three: achieve another 14 consecutive days of improvement (downward trajectory or near-zero incidence) without experiencing a rebound (defined below).
- **Identifying Rebound:**
 - Because case reports are a lagging indicator, increases in new cases over a short time period (e.g., 5 or more consecutive days of growth in daily case incidence) should be considered a potential indicator of rebound in COVID-19 activity.
 - CDC analyses of case report data define "rebound" as a community, after entering Phase One, Two, or Three (i.e., achieved at least one period of 14 or more consecutive days of downward trajectory), which experiences an increase in daily cumulative COVID-19 case incidence (slope >0.1 cases per 100,000 per day) for 5 or more consecutive days and has an elevated two-week incidence (>10 cases per 100,000 during the past 2 weeks).
- **Interpretation/Limitations:**
 - Case report data are a lagging indicator for assessing SARS-CoV-2 transmission in the community, as new cases are not identified until after the incubation period occurs, the ill person seeks testing or healthcare for their illness, and the information is reported to health officials.
 - The choice of the dates used (e.g., onset date, report date) are critical in the interpretation of observed trends. In general, it is preferable to use the dates

most proximal to onset date, but even epidemic curves based on onset date should account for the fact that very recent cases have not yet been reported. Excluding recent onset dates (e.g., in the last week) from assessment of trends is recommended to ensure that incomplete reporting of recent cases does not give the false appearance of downward trajectory. Epidemic curves based on date of report do not require a lag window but are limited by the fact that they reflect transmission activity further in the past than in epidemic curves using onset dates.

- CDC analyses are typically based on the date of case report and not diagnosis or onset date because it is the most uniformly available date across jurisdictions. Preliminary analyses of national data show that there is typically an 8- to 10-day lag between the date of symptom onset and the date the case is reported to CDC, but this varies by jurisdiction.
- Data quality, as well as case ascertainment and reporting processes (e.g., beginning to report probable cases), may vary by jurisdiction or over time, which can impact trend assessments and should be accounted for.
- Case report findings should be interpreted in the context of other available data, including COVID-19-related syndromic surveillance, testing intensity, percent positive tests, and hospitalization and death data. For example, changes in the trajectory of case incidence could be the result of changes in testing intensity.
- In circumstances where SARS-CoV-2 testing practices are changing, jurisdictions should consider evaluating trends in case reports meeting either the CSTE confirmed or probable case definition, as the inclusion of probable cases may mitigate some biases resulting from testing practices.
- A sustained downward trajectory demonstrates improvement in daily case incidence but does not necessarily equate to a low disease burden. Communities should consider local resource capacity (e.g., availability of public health staff to conduct contact tracing) when determining appropriate incidence thresholds for making phase transition decisions.

Downward trajectory of positive tests as a percent of total tests within a 14-day period with stable or increasing test volume

- **Description/Rationale:** Laboratory test percent positive can be used in combination with, or as an alternative to, observing a decline in new case reports. In circumstances where testing is adequate and testing practices are largely stable, percent positive can be a reliable indicator of COVID-19 activity.
- **Data Sources:** Positive and negative SARS-CoV-2 test results reported by laboratories to state health departments. If states and counties have more complete data than federal sources, local data should be used. Federal data available at the state and county level include tests from public health and CDC laboratories, six large commercial and reference laboratories, and hospital testing data uploaded by ~500 hospitals to the HHS

Protect system daily. Data from the Census Bureau’s Population Estimates Program can be used to estimate state and county population denominators for per-capita test rates.

- **Considerations for Assessing Decreases:**
 - Percent positive is typically calculated as number of positive tests divided by the total test results, with total test results defined as the sum of positive tests and negative tests, excluding records where the test was not performed because the specimen was not usable or the test was cancelled. The number of tests with indeterminate results has been small, so the decision of whether to include or exclude these in the denominator of total test results should not affect interpretation of the trends observed.
 - Some data sources include a National Provider Index code for the physician who ordered the test, allowing communities to track changes in the relative proportion of tests ordered by clinicians with specialties such as emergency medicine and family medicine over time. Some laboratories include account numbers that can be used to identify community testing programs, such as drive-up testing. And some include a code that indicates whether the test was ordered from a nursing home, prison, or other high-risk setting. Tracking the percent positive in tests from these facility types may allow for improved understanding of the populations tested and for more targeted decision-making.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the percent positive gating indicator is met with respect to these phase transitions. Note that in the *Opening Up America Again*, guideline, the case report gating indicator or the percent positive gating indicator should be met.
 - Transition into Phase One: achieve 14 or more consecutive days of decline in percent positive while total test volume is stable or increasing.
 - Transition into Phase Two: achieve an additional 14 or more consecutive days of decline in percent positive while total test volume is stable or increasing.
 - Transition into Phase Three: achieve an additional 14 or more consecutive days of decline in percent positive while total test volume is stable or increasing.
- **Identifying Rebound:** Communities should consider reviewing multi-day increase in percent positivity with stable or increasing testing volume in the context of other data. Increases in percent positive of laboratory data should be reviewed in context with the case report and CLI data, as fluctuations in testing volume might impact interpretations, especially in smaller communities.
- **Interpretation/Limitations:**
 - The daily percent positive may fluctuate, particularly in areas with smaller populations. Total test volume may also vary by day of the week, based on the number of tests ordered or regular system maintenance at laboratories. It may

thus be helpful in some cases to assess trends using moving averages or other smoothing techniques.

- The percent positive is driven by the number of people who are positive in a community and the number of people who are tested. Declines in percent positive may result from an expansion of testing to more people. Thus, it is important to track percent positive in combination with the number tested, whether measured as the total volume of all test results, or as total test results per capita. Percent positivity should only be used as an indicator of COVID-19 activity when per capita testing levels are stable over the time period being assessed.
- The percent positive may also be affected by a changing proportion of tests in people who are less likely to be infected, such as those who are asymptomatic or who have less severe symptoms. Few laboratories have fields indicating whether the person tested was asymptomatic or whether the patient was in an inpatient or outpatient setting at the time of testing. However, communities can stratify by data source to assess changes in the population tested over time, such as tracking the percent positive in hospital data separately from the percent positive in large commercial laboratories.
- To avoid duplication, hospitals were asked to report only those tests to the HHS Protect system that were not sent out to large commercial laboratories. However, test data reported to HHS Protect do not include patient identifiers, so might still include some duplicates.
- The residence of the person tested may not be validated as thoroughly in laboratory data as in case data. Patient zip code may be based on insurance billing data, and thus less likely to be complete and correct when the person tested is uninsured or on another family member's plan.
- Provider zip code is generally accurate, when available. However, drive-up facilities might use a central zip code that does not reflect where the physical drive-up facility is located.

Joint interpretation of all four disease occurrence gating criteria

The four disease occurrence gating indicators should be interpreted collectively to reach a determination on the trajectory of COVID-19 activity within a jurisdiction, bearing in mind that the measures differ significantly in their lag, specificity, and sensitivity. Lab testing and syndromic data sources generally have less lag than COVID-19 case report data relative to when transmission occurred. SARS-CoV-2 testing and COVID-19 case reports are more specific measures of COVID-19 activity than the CLI syndrome, but all three are likely far more specific than the ILI syndrome. The CLI syndrome likely has superior sensitivity to the other measures, as it is more likely to capture people with COVID-19 that were not tested. While downward trajectory for a period of 14 days is used for each of the disease occurrence gating indicators in the *Opening Up America Again* guideline, state and local jurisdictions should use judgment

based on their knowledge of local disease surveillance practices and infrastructure in determining whether longer time periods (e.g., 21 or 28 days) are needed before moving to different community mitigation phases.

Other Data Sources and Measures

The four disease occurrence gating indicators above can collectively provide insights into both the intensity and trajectory of the COVID-19 pandemic within jurisdictions. However, other epidemiologic data sources potentially available to local, state, and federal health officials can also be useful to verify trends observed in the disease occurrence gating indicators.

- **COVID-19 hospital admissions:** Depending on the overall COVID-19 incidence rate, the size of the jurisdiction, and the regional hospital referral patterns, hospitalizations for laboratory-confirmed COVID-19 can be an important measure to assess trajectory. Testing is likely more complete and less variable in hospitalized populations, providing more assurance that observed trends are not driven by testing practices. In addition to helping verify increases or decreases in the disease occurrence gating indicators, monitoring COVID-19 hospital admissions (and discharges) can help assess the burden on local healthcare capacity.
- **COVID-19 deaths:** Depending on the overall COVID-19 incidence rate and the size of the jurisdiction, deaths due to COVID-19 may occur in high enough numbers to reliably assess the trajectory of the outbreak in the jurisdiction. Although they represent a small proportion of all COVID-19 illnesses and significantly lag the core disease occurrence gating indicators, vital records are a universally collected data source and should be available for review in all jurisdictions. Further, observing declines in newly reported COVID-19 deaths almost certainly indicates that demands on the healthcare system are waning. Care should be taken to understand the extent and variability in SARS-CoV-2 testing for deceased individuals in the jurisdiction when using death as a source of data to understand the overall trajectory of COVID-19 illnesses in the jurisdiction. COVID-19 death data reported to CDC's National Center for Health Statistics are published weekly by state (<https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm>).
- **Measures of trajectory:** The effective reproductive number (the average number of secondary cases from an infectious case in an a particular population at a specific point in time) and doubling time (the time required for the number of cases to double) are epidemiologic measures that can be used to characterize the speed with which illnesses are spreading in an outbreak. Although these measures can be imprecise, especially when calculated within smaller populations, they provide alternative ways to analyze and characterize the trajectory of COVID-19 activity.

Implied in the Core State Preparedness Responsibilities in the *Opening Up America Again* guideline is the need for jurisdictions to have confidence in the epidemiologic data being used to make assessments about the magnitude and trajectory of COVID-19 illnesses. In order for most of the gating indicators to be reliably assessed, 1) rapid testing should be occurring as indicated for all clinical, public health, and infection prevention needs and 2) all new symptomatic COVID-19 cases in the jurisdiction should be able to be rapidly identified through active surveillance of laboratories and healthcare facilities. In the absence of widespread testing and robust active surveillance, jurisdictions should be cautious when adjusting mitigation strategies based on the disease occurrence gating indicators. Several measures, listed below, can be helpful in providing an indirect assessment of the completeness of case ascertainment in a jurisdiction.

- **COVID-19 case-fatality ratio:** Case-fatality is defined as the proportion of COVID-19 cases that die as a result of their infection. Although estimates of the percentage of symptomatic COVID-19 illnesses that result in death has varied widely, the overall percentage is likely lower than 1-2%. Although many factors contribute to disease severity, including the underlying health status of the population, jurisdictions that have very high COVID-19 case-fatality ratios (above 5-10%) may be under-ascertaining COVID-19 illnesses. This could indicate that case reporting is an unreliable measure of true COVID-19 activity. In this situation it may be useful to examine measures for CLI syndrome or COVID-19 hospital admissions as measures of disease activity.
- **High percent positive:** Although changes in percent positive is an indicator in the *Opening Up America Again* guideline, very high proportions of SARS-CoV-2 positivity (e.g., >25%) may be an indicator that testing levels are not adequate and that COVID-19 illnesses are being under-ascertained in the jurisdiction, as it suggests that only a limited number of people with a high likelihood of being infected with SARS-CoV-2 are able to be tested. In this situation it also may be useful to look at the CLI syndrome or at COVID-19 hospital admissions as measures of disease activity, since they are likely less susceptible to the influence of testing availability.
- **Per capita testing:** It is difficult to determine a widely applicable benchmark for a per capita level of SARS-CoV-2 testing that is sufficient to have confidence in the adequacy of COVID-19 case-ascertainment. If data are available, however, jurisdictions can consider evaluating their per capita testing frequency to assist in judging whether testing levels are adequate to perform effective COVID-19 surveillance.
- **Proportion of cases with an unknown source:** Improvements in case ascertainment and contact tracing should lead to a lower proportion of new cases with an unknown exposure to SARS-CoV-2. Jurisdictions can consider tracking the proportion of new COVID-19 cases without a documented exposure source (e.g., travel to a high-incidence region or country, exposure to someone with a confirmed case of COVID-19, attending and event or going to a setting with suspected SARS-CoV-2 transmission). Although difficult to achieve, jurisdictions that have fewer than 50% of new cases with an

unknown exposure source likely have likely achieved high levels of case ascertainment, interviewing, and contact tracing.

Additional Considerations

Overall Incidence Level

The disease occurrence gating indicators all pertain to assessing the trajectory of COVID-19 activity, but do not specify that COVID-19 incidence should reach an absolute level to move through the mitigation phases. Jurisdictions should be cautious in pivoting from a general community mitigation approach back toward an identification and containment approach until incidence is low enough and resources adequate to 1) attempt an initial interview for nearly all new COVID-19 cases within one day of health department notification, 2) to rapidly isolate all newly identified COVID-19 cases, and 3) to initiate appropriate follow up (isolation, self-monitoring, and rapid testing of symptomatic contacts) for nearly all identified contacts of newly identified cases. Incidence should also be low enough that health departments can respond to large outbreaks (*e.g.*, nursing home outbreaks) that require substantial resources to investigate and control. Declines in incidence should also be enough for healthcare capacity to not only meet current demands, but to be able to comfortably surge in the event of an increase in cases (*e.g.*, availability of acute care beds, critical care beds, ventilators, and adequate PPE).

Special Populations and Settings

Infections in high-risk settings and populations can disproportionately impact localized transmission and the ability of public health capacity to keep pace with follow up needs such as contract tracing and screening. Efforts should be taken to monitor infections in some specific populations and settings, including but not limited to healthcare personnel, patients in healthcare facilities (*e.g.*, nursing homes, dialysis centers, long term care facilities), and residents of congregate living settings (*e.g.*, prisons, youth homes, shelters). In addition, identification of illnesses at events with the potential for “explosive spread” (*e.g.*, mass gatherings) may in and of themselves warrant adjustment of community mitigation measures in the absence of community-wide changes in the disease occurrence gating indicators.

Neighboring Jurisdictions

When making decisions about adjusting community mitigation measures, state and local jurisdictions also should coordinate with officials in neighboring areas to assess the burden and trajectory of COVID-19 illnesses in the surrounding region. Neighboring or nearby jurisdictions with significantly higher incidence or with increasing COVID-19 activity could reintroduce SARS-CoV-2 to a jurisdiction, jeopardizing improvements within the jurisdiction.

Measures of Mobility and Social Distancing

If available, it may be important to understand the knowledge, attitudes and behaviors of the community as it relates to the public health guidance provided within the local jurisdiction. Survey data and data on mobility can be useful in understanding if community members are aware of and following established social distancing and isolation guidelines and informing changes in the mitigation strategies used. Several publicly available data sources currently exist that generate measures of social distancing and mobility, frequently based on mobile phone location services or social media data.

Summary

The disease occurrence gating indicators in the *Opening Up America Again* guideline can provide states and communities insight into the trajectory of the COVID-19 pandemic in their jurisdiction. The disease occurrence gating indicators should be evaluated collectively, considering their relative strengths and weaknesses, as well as in the context of other epidemiologic data available for the jurisdiction. This document specifically provides a framework for assessing the four disease occurrence gating indicators in the *Opening Up America Again* guideline. These epidemiologic indicators are just one part of the broad assessment jurisdictions should undertake when deciding when and how to adjust community mitigation strategies for COVID-19. Other factors include, but are not limited to, healthcare capacity, community capacity and characteristics, and economic indicators.

Indicators and Thresholds for Monitoring and Adjusting Mitigation Strategies

WH Gating Criteria	Threshold for entering Phase 1	Threshold for entering Phase 2	Threshold for entering Phase 3
Decreases in newly identified COVID-19 cases	Downward trajectory (or near-zero incidence) of documented cases over a 14-day period	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days <i>after entering Phase 1</i>	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days <i>after entering Phase 2</i>
Decreases in ED and/or outpatient visits for COVID-like illness (CLI)	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported over a 14-day period	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported for at least 14 days <i>after entering Phase 1</i>	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported for at least an additional 14 days <i>after entering Phase 2</i>
Decreases in ED and/or outpatient visits for influenza-like illness (ILI)	Downward trajectory (or near-zero incidence) of ILI reported over a 14-day period	Downward trajectory (or near-zero incidence) of ILI reported for at least 14 days <i>after entering Phase 1</i>	Downward trajectory (or near-zero incidence) of ILI reported for at least an additional 14 days <i>after entering Phase 2</i>
Decreases in percentage of SARS-CoV-2 tests positive	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests over a 14-day period (flat or increasing volume of tests)	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for 14 days <i>after entering Phase 1</i> (flat or increasing volume of tests)	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for at least 14 days <i>after entering Phase 2</i> (flat or increasing volume of tests)
Treat all patients without crisis care	- Jurisdiction inpt & ICU beds <80% full - Staff shortage in last week = no - PPE supplies adequate for >4 days	- Jurisdiction inpt & ICU beds <75% full - Staff shortage in last week = no - PPE supplies adequate for >4 days	- Jurisdiction inpt & ICU beds <70% full - Staff shortage in last week = no - PPE supplies adequate for >15 days
Robust testing program	- Test availability such that % positive tests $\leq$ 20% for 14 days - Median time from test order to result <5 days	- Test availability such that % positive tests $\leq$ 15% for 14 days - Median time from test order to result <4 days	- Test availability such that % positive tests $\leq$ 10% for 14 days - Median time from test order to result <3 days

Community Demographics*

Category	Indicator	Level of Consideration
Population Density	Population density, as a metric for feasibility of physical distancing in select settings	Population density of < 50 people per square mile
High risk population density	Proportion of population over 65 years	Less than 10% of population over 65 years Less than 15% of population over 65 years
	Prevalence of cardiovascular disease and/or COPD	Less than 3.7% of population estimated to have cardiovascular disease and 6% or less with COPD
	Households with limited English literacy	Less than 30% of population Map view (https://bit.ly/2UUtWBn)
	Population below the poverty level	Less than 10-12% of population Map view (https://bit.ly/2woXlOl)
	Percent with no health insurance coverage	Less than 10% of population Map view (https://bit.ly/3e3tubu)
Compliance indicators	Number of violations / complaints related to mandatory or recommended community mitigation	Significant increase in non-compliance

**provided as conditions to consider as having an impact on other indicators*

Mitigation Guidance by Phase

Gating Criteria for all Phases

- **Transmission:** Community transmission is under control (Decrease in the percent of patient visits for influenza-like illness (ILI) **or** a decrease in ILI activity levels over 14 days, **plus** downward trajectory of documented cases within a 14 day period **or** downward trajectory of positive tests as a percent of total tests within a 14-day period- flat or increasing volume of tests).
- **Public Health Capacity:** Public health systems can detect, test, track, isolate, and quarantine cases and quickly contain an outbreak.
- **Health System Capacity:** Health system is able to treat all new cases with capacity to absorb increased transmission.

Pre-Gating/Phase 0: Significant, Uncontrolled Transmission

Jurisdictions in Phase 0 are in need of significant mitigation. Policy makers have often implemented this in the form of stay at home or shelter in place orders. The risk of transmission, or the spread of COVID-19, is still considered significant and uncontrolled in these jurisdictions. The table below describes an overview of strategies to be implemented across different settings in jurisdictions that are in Phase 0.

Leaders of these jurisdictions are tasked with ensuring that significant mitigation strategies are followed to the best extent possible to protect jurisdictions, prevent further COVID-19 spread, and ensure that jurisdictions can safely advance to Phase 1 as the risk of COVID-19 transmission decreases.

It is critically important in this Phase, and in others, that jurisdictions continue to monitor their Gating Criteria data on 1) Transmission, 2) Public Health Capacity, and 3) Health System Capacity to determine any mitigation adjustments that may be needed.

- Jurisdictions remain in Phase 0 until Gating Criteria is met.
- Jurisdictions may consider transitioning to Phase 1 after meeting Gating Criteria.

The following table describes guidelines for individuals, employers, and essential workplaces for jurisdictions that are in Phase 0.

Pre-Gating/Phase 0. Community Mitigation Strategies in Areas with Significant, Uncontrolled Transmission	
Guidelines for All Phases	<u>Individuals</u> Continue to practice good hygiene and implement personal protective measures (e.g., handwashing, cough etiquette, and face coverings) Social distancing (e.g., maintaining physical distance between persons) Environmental surface cleaning at home and in community settings, such as schools or workplaces People who feel sick should stay home
Essential Workplaces	Develop and implement appropriate policies, in accordance with FSLTT regulations and guidance, informed by industry best practices Monitor workforce for indicative symptoms. Do not allow symptomatic people to physically return to work until cleared by a medical provider

	Develop and implement policies and procedures for workforce contact tracing following employee COVID+ test Remain open and ensure social distancing, proper cleaning requirements and protection of workers and customers Institute or continue telework flexibility Staff from low and moderate and transmission settings should be offered telework to eliminate travel to workplaces in high transmission settings Encourage employees and customers to use face coverings when around others Consider identifying childcare, schools and camps serving families of essential workers as essential workplaces
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Phase 1: Significant, Controlled Transmission

Jurisdictions in Phase 1 are in need of **significant** mitigation. That means the risk of transmission, or the spread of COVID-19, is still considered significant and controlled in these jurisdictions.

Leaders of these jurisdictions are tasked with ensuring that significant mitigation strategies are followed to the best extent possible to protect jurisdictions, prevent further COVID-19 spread, and ensure that jurisdictions can safely advance to Phase 2 as the risk of COVID-19 transmission decreases.

It is critically important in this Phase, and in others, that jurisdictions continue to monitor their Gating Criteria data on 1) Transmission, 2) Public Health Capacity, and 3) Health System Capacity to determine any mitigation adjustments that may be needed.

- Jurisdictions may consider transitioning to Phase 2 after meeting Gating Criteria a second time with no rebound.
- Jurisdictions should return to Pre-Gating/Phase 0 if the community experiences rebound in transmission or has insufficient Public Health and Healthcare System capacity to manage an increase in cases.

The following table describes an overview of strategies to be implemented across different settings in jurisdictions that are in **Phase 1**. The next section provides more detailed guidance for each of these settings..

Phase 1. Community Mitigation Strategies in Areas with Significant, Controlled Transmission	
Guidelines for All Phases	<u>Individuals</u> Continue to practice good hygiene and implement personal protective measures (e.g., handwashing, cough etiquette, and face coverings) Social distancing (e.g., maintaining physical distance between persons) Environmental surface cleaning at home and in community settings, such as schools or workplaces People who feel sick should stay home <u>Employers</u> Develop and implement appropriate policies, in accordance with FSLTT regulations and guidance, informed by industry best practices Monitor workforce for indicative symptoms. Do not allow symptomatic people to physically return to work until cleared by a medical provider Develop and implement policies and procedures for workforce contact tracing following employee COVID+ test
Phase 1 Guidelines for Individuals	ALL VULNERABLE INDIVIDUALS* should continue to shelter in place. Members of households with vulnerable residents should be aware that by returning to work or other environments

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	where distancing is not practical, they could carry the virus back home. Precautions should be taken to isolate from vulnerable residents All individuals, WHEN IN PUBLIC (e.g., parks, outdoor recreation areas, shopping areas), should maximize physical distance from others. Social settings of more than 10 people, where appropriate distancing may not be practical, should be avoided unless precautionary measures are observed Avoid SOCIALIZING in groups of more than 10 people in circumstances that do not readily allow for appropriate physical distancing (e.g., receptions, trade shows) MINIMIZE NON-ESSENTIAL TRAVEL and adhere to CDC guidelines regarding isolation following travel
Phase 1 Guidelines for Employers	Continue to ENCOURAGE TELEWORK, whenever possible and feasible with business operations If possible, RETURN TO WORK IN PHASES Close COMMON AREAS where personnel are likely to congregate and interact, or enforce strict social distancing protocols Minimize NON-ESSENTIAL TRAVEL and adhere to CDC guidelines regarding isolation following travel Strongly consider SPECIAL ACCOMMODATIONS for personnel who are members of a VULNERABLE POPULATION
Phase 1 Guidelines for Specific Types of Employers <i>expanded below</i>	SCHOOLS AND ORGANIZED YOUTH ACTIVITIES (e.g., daycare, camp) that are currently closed should remain closed VISITS TO SENIOR LIVING FACILITIES AND HOSPITALS should be prohibited Those who do interact with residents and patients must adhere to strict protocols regarding hygiene LARGE VENUES (e.g., sit down dining, movie theaters, sporting venues, places of worship) can operate under strict physical distancing protocols ELECTIVE SURGERIES can resume, as clinically appropriate, on an outpatient basis at facilities that adhere to CMS guidelines GYMS can open if they adhere to strict physical distancing and sanitation protocols BARS should remain closed
Essential Workplaces	Remain open and ensure social distancing, proper cleaning requirements and protection of workers and customers Institute or continue telework flexibility Staff from low and moderate and transmission settings should be offered telework, where possible, to eliminate travel to workplaces in high transmission settings Encourage employees and customers to use face coverings when around others Close common areas such as breakrooms, cafeterias Install physical barriers, such as sneeze guards and partitions, and change layout of workspaces to ensure all individuals remain at least 6 feet apart Strongly consider special accommodations for personnel who are members of a vulnerable population (e.g., flexible leave policies, telework, reassignment of duties to minimize contact with others) Cancel work-related gatherings (e.g., staff meetings, after-work functions) where 6-foot distancing cannot be maintained Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a cloth face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns Consider identifying childcare, schools and camps serving families of essential workers as essential workplaces

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General Workplaces	Reopen only if business can ensure strict social distancing, proper cleaning and disinfecting, and protection of their workers and customers Limit service to drive-throughs, curbside take out, or delivery Minimize non-essential travel and adhere to CDC guidelines regarding isolation following travel Continue to encourage telework and virtual vs. in-person meetings wherever possible and feasible Encourage employees and customers to use face coverings when around others Close common areas such as breakrooms, cafeterias Install physical barriers, such as sneeze guards and partitions, and change layout of workspaces to ensure all individuals remain at least 6 feet apart Strongly consider special accommodations for personnel who are members of a vulnerable population (e.g. flexible leave and telework policies where possible, reassignment of duties to minimize contact with others) Staff from low and moderate transmission (Phase 2 & 3) areas should be offered telework or other options as feasible to eliminate travel to workplaces in high transmission settings Cancel work-related gatherings (e.g., staff meetings, after-work functions) where 6ft distancing cannot be maintained Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a cloth face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Schools	Schools that are currently closed should remain closed E-learning or distance learning opportunities should be provided for all students Ensure provision of student services such as school meal programs Encourage employees to use face coverings when around others Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering
Childcare Facilities	Childcare facilities should only remain open for children of essential workers Childcare facilities that remain open should maintain enhanced social distancing measures (e.g. spaced seating to at least 6 feet apart when possible, restrict mixing between classes/groups, cancel all field trips, inter-group events, and extracurricular activities). Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Restrict non-essential visitors and volunteers Close communal use spaces such as cafeterias and playgrounds if possible, or stagger use and clean/disinfect in between use. Serve individually plated meals to limit sharing of food or utensils and hold activities in separate classrooms Keep children's belongings separated Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single child) or limit use of supplies and equipment for by one group of children at a time and disinfect between use Routinely clean, sanitize, and disinfect surfaces and objects that are frequently touched (e.g., toys) and avoid use of items that are not easily cleaned Staff from low and moderate transmission (Phase 2 & 3) settings should be offered telework or other options as feasible to eliminate travel to childcare centers in high transmission settings

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	Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Summer Camps	Summer camps should only remain open for children of essential workers and only for children who live in the local geographic area Ensure enhanced distancing measures (e.g., spaced seating to at least 6 feet apart when possible, restrict mixing between classes/groups, cancel all field trips and inter-group events) Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Close communal use spaces such as cafeterias and playgrounds if possible, or stagger use and clean/disinfect in between use. Serve individually plated meals to limit sharing of food or utensils and hold activities in separate areas Keep children's belongings separated Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single camper) Staff from low and moderate transmission (Phase 2 & 3) settings should be offered telework or other options as feasible to eliminate travel to workplaces in high transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Parks and recreational facilities	Remain open, or re-open if closed, with modifications to ensure visitors can maintain social distancing, and practice proper hand hygiene Close facilities and areas where social distancing cannot be maintained (e.g., water parks, courts, playgrounds) Cancel or postpone events and gatherings Use flexible telework policies, especially for staff at higher risk for severe illness Staff from low and moderate transmission (Phase 2 & 3) settings should be offered telework or other options as feasible to eliminate travel to workplaces in high transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Healthcare Settings	Continue telehealth expansion Cancel elective surgeries Only schedule essential outpatient care (routine immunizations, well child care visits, etc.: https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html; https://www.cdc.gov/coronavirus/2019-ncov/hcp/preparedness-checklists.html) Nursing homes and hospitals should restrict all visitors Restrict entry of non-essential staff and contractors Limit group activities, including meals
Colleges and Universities	Guidance will be forthcoming
Communities of Faith	Guidance will be forthcoming

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Restaurants and Bars	Provide physical guides (e.g., tape on floors/sidewalks) to ensure customers remain at least six feet apart in lines or ask customers to wait in cars when picking up food. Post signs to inform customers of food pick-up protocols Consider installing physical barriers, such as sneeze guards and partitions at cash registers or other food pick-up areas where maintaining distancing of at least 6 feet is difficult Restrict the number of employees in shared spaces (e.g., kitchens, break rooms, offices) to maintain at least 6 feet distance between people Rotate/stagger shifts to limit number of employees in the workplace at a time Consider special accommodations for personnel who are members of a vulnerable population (e.g. flexible leave and telework policies where possible, reassignment of duties to minimize contact with others) Staff from low and moderate transmission (Phase 2 & 3) settings should be offered telework or other options as feasible to eliminate travel to workplaces in high transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Social Gatherings	Cancel all gatherings of 10 or more Cancel gatherings of any size where distancing cannot be maintained (this does not include household contacts)
Mass Transit	Restrict ridership to employees of essential businesses and critical infrastructure to the extent possible Restrict routes between areas experiencing different levels of transmission (between areas in different Phases) Ensure strict social distancing, proper cleaning and disinfecting and protection of workers and customers Install no-touch trash cans Clean and disinfect frequently touched surfaces (e.g., kiosks, digital interfaces such as touchscreens and fingerprint scanners, ticket machines, turnstiles, handrails, restroom surfaces, elevator buttons) at least daily Clean and disinfect the operator area between operator shifts Use touchless payment, trash cans, and doors as much as possible, when available. Institute measures to physically separate or create distance of at least 6 feet between all occupants. This may include: Adjust how passengers enter and exit (while allowing exceptions for persons with disabilities) Close every other row of seats Reduce maximum occupancy and increase service on crowded routes Provide physical guides on vehicles and at transit stations and stops. Floor decals, colored tape, or signs to indicate where passengers should not sit or stand can be used to guide passengers Install physical barriers, such as sneeze guards and partitions at staffed kiosks and on transit vehicles to the extent practicable Close communal spaces, such as break rooms or stagger use and clean in between uses Consider assigning vulnerable workers duties that minimize their contact with passengers and other employees. Offer staff from low and moderate transmission (Phase 2 & 3) settings telework or other options as feasible to eliminate travel
Mass Gatherings	Guidance will be forthcoming

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Communities of Faith	Limit gatherings to those that can be held virtually (online video streaming) for vulnerable populations and consider video streaming or drive-in options for services. Limit the size of in person gatherings in accordance with the guidance and directives of state and local authorities, and maintain social distancing Consider modifying clergy visits to over the phone or online Encourage the use of face coverings when around others Encourage proper hand hygiene and avoid direct person-to-person contact and sharing of objects Consider posting signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick leave and related flexible policies and practices for staff (e.g., allow work from home, if feasible)
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Phase 2: Moderate, Controlled Transmission

Jurisdictions in Phase 2 are in need of **moderate** mitigation. That means that risk of transmission, or the spread of COVID-19, is still considered moderate and controlled in these jurisdictions.

Leaders of these jurisdictions are tasked with ensuring that significant mitigation strategies are followed to the best extent possible to protect jurisdictions, prevent further COVID-19 spread, and ensure that jurisdictions can safely advance to the Phase 3 as COVID-19 transmission decreases.

It is critically important in this Phase, and in others, that jurisdictions continue to monitor their **Gating Criteria** data on 1) Transmission, 2) Public Health Capacity, and 3) Health System Capacity to determine any mitigation adjustments that may be needed.

- Jurisdictions may consider transitioning to Phase 3 after meeting **Gating Criteria** a third time with no rebound.
- Jurisdictions should return to Phase 1 if community experiences rebound in transmission or has insufficient public health and healthcare system capacity to manage increase in cases (or return to Pre-Gating/Phase 0, depending on severity of rebound and/or capacity needs).

The following table describes an overview of strategies to be implemented across different settings in jurisdictions that are in Phase 2. Links in the table are also included for more detailed guidance for each of these settings.

Phase 2. Community Mitigation Strategies in Areas with Significant, Controlled Transmission	
Guidelines for All Phases	<u>Individuals</u> Continue to practice good hygiene and implement personal protective measures (e.g., handwashing, cough etiquette, and face coverings) Social distancing (e.g., maintaining physical distance between persons) Environmental surface cleaning at home and in community settings, such as schools or workplaces People who feel sick should stay home <u>Employers</u> Develop and implement appropriate policies, in accordance with FSLTT regulations and guidance, informed by industry best practices Monitor workforce for indicative symptoms. Do not allow symptomatic people to physically return to work until cleared by a medical provider. Develop and implement policies and procedures for workforce contact tracing following employee COVID+ test

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Phase 2 Guidelines for Individuals	ALL VULNERABLE INDIVIDUALS should continue to shelter in place. Members of households with vulnerable residents should be aware that by returning to work or other environments where distancing is not practical, they could carry the virus back home. Precautions should be taken to isolate from vulnerable residents All individuals, WHEN IN PUBLIC (e.g., parks, outdoor recreation areas, shopping areas), should maximize physical distance from others. Social settings of more than 50 people, where appropriate distancing may not be practical, should be avoided unless precautionary measures are observed
Phase 2 Guidelines for Employers	NON-ESSENTIAL BUSINESS AND PERSONAL TRAVEL can resume. Businesses continue to ENCOURAGE TELEWORK, whenever possible and feasible with business operations Businesses close COMMON AREAS where personnel are likely to congregate and interact, or enforce moderate social distancing protocols Businesses strongly consider SPECIAL ACCOMMODATIONS for personnel who are members of a VULNERABLE POPULATION
Phase 2 Guidelines for Specific Types of Employers <i>expanded below</i>	SCHOOLS AND ORGANIZED YOUTH ACTIVITIES (e.g., daycare, camp) can VISITS TO SENIOR CARE FACILITIES AND HOSPITALS should be prohibited. Those who do interact with residents and patients must adhere to strict protocols regarding hygiene LARGE VENUES (e.g., sit down dining, movie theaters, sporting venues, places of worship) can operate under moderate physical distancing protocols ELECTIVE SURGERIES can resume, as clinically appropriate, on an outpatient and inpatient basis at facilities that adhere to CMS guidelines GYMS can remain open if they adhere to strict physical distancing and sanitation protocols BARS may operate with diminished standing room occupancy, where applicable and appropriate
Essential Workplaces	Remain open and ensure social distancing, proper cleaning and disinfecting requirements and protection of workers and customers Institute or continue telework to the extent feasible Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to workplaces in moderate transmission settings Encourage employees and customers to use cloth face coverings when around others Close common areas such as breakrooms, cafeterias or stagger use and clean/disinfect between use Install physical barriers, such as sneeze guards and partitions, and change layout of workspaces to ensure all individuals remain at least 6 feet apart Strongly consider special accommodations for personnel who are members of a vulnerable population (e.g., flexible leave and telework policies where possible reassignment of duties to minimize contact with others) Consider resuming non-essential travel in accordance with state and local regulations and guidance Cancel work-related gatherings (e.g., staff meetings, after-work functions) where 6-foot distancing cannot be maintained Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a cloth face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
General Workplaces	Reopen only if business can ensure moderate social distancing (e.g. staggered work shifts to limit number of employees in workplace at a time), proper cleaning and disinfecting

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	requirements (Infection Prevention Certification), and protection of their workers and customers Continue to encourage telework and virtual vs. in-person meetings wherever possible and feasible Encourage employees and customers to use face coverings when around others Close common areas such as breakrooms, cafeterias or stagger use and clean/disinfect between use Install physical barriers, such as sneeze guards and partitions, and change layout of workspaces to ensure all individuals remain at least 6 feet apart Strongly consider special accommodations for personnel who are members of a vulnerable population (e.g. flexible leave and telework policies where possible, reassignment of duties to minimize contact with others) Consider resuming non-essential travel in accordance with state and local regulations and guidance Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to workplaces in moderate transmission settings Cancel work-related gatherings (e.g., staff meetings, after-work functions) where 6 feet distancing cannot be maintained Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a cloth face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Schools	Remain open with enhanced distancing measures (e.g., spaced seating to at least 6 feet apart when possible, restrict mixing between classes/groups, cancel field trips, limit gatherings & extracurricular events to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from significant mitigation (Phase 1) areas) Restrict non-essential visitors and volunteers Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Close communal use spaces such as cafeterias and playgrounds if possible, or stagger use and clean/disinfect in between use. Serve individually plated meals to limit sharing of food or utensils and hold activities in separate classrooms. Keep children's belongings separated Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single camper) student) or limit use of supplies and equipment for by one group of children at a time and clean and disinfect between use E-learning or distance learning opportunities should be provided for higher-risk students, and those with vulnerable family members Teachers, staff, and students from significant transmission (Phase 1) areas should be offered telework, e-learning, or other options as feasible to eliminate travel to schools in moderate controlled transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Childcare Facilities	Childcare facilities should remain open with enhanced social distancing measures (e.g., spaced seating to at least 6 feet apart when possible, restrict mixing between classes/groups, cancel field trips, limit gatherings & extracurricular events to those that where can maintain social

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	distancing can be maintained, support proper hand hygiene, and restrict attendance of those from significant mitigation (Phase 1) areas). Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Restrict non-essential visitors and volunteers Close communal use spaces such as cafeterias and playgrounds if possible, or stagger use and clean/disinfect in between use. Serve individually plated meals to limit sharing of food or utensils and hold activities in separate classrooms Keep children’s belongings separated Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single child) or limit use of supplies and equipment for by one group of children at a time and disinfect between use Routinely clean, sanitize, and disinfect surfaces and objects that are frequently touched (e.g., toys) and avoid use of items that are not easily cleaned Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to childcare centers in moderate controlled transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Summer Camps	Remain open with enhanced distancing measures (e.g., spaced seating to at least 6 feet apart when possible, restrict mixing between classes/groups, cancel field trips, limit gatherings & extracurricular events to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from significant mitigation (Phase 1) areas) Restrict attendance to those from the local geographic area Restrict non-essential visitors and volunteers Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Close communal use spaces such as cafeterias and playgrounds if possible, or stagger use and clean/disinfect in between use. Serve individually plated meals to limit sharing of food or utensils and hold activities in separate areas. Keep children’s belongings separated Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single camper) or limit use of supplies and equipment for by one group of children at a time and disinfect between use Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to camps in moderate controlled transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Parks and recreational facilities	Open with modifications to ensure visitors can maintain social distancing, and practice proper hand hygiene Close facilities and areas where social distancing cannot be maintained (e.g., water parks, courts, playgrounds)

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	Cancel or postpone events and gatherings that do not ensure social distancing Use flexible telework policies where possible, especially for staff at higher risk for severe illness Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to workplaces in moderate transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Healthcare Settings	Continue Tele-health expansion Schedule elective surgeries on a case-by-case basis based on the clinical urgency (e.g., procedures that cannot be postponed for greater than 1 week) Schedule routine outpatient care on a case-by-case basis considering factors such as clinical urgency, need for follow-up for pre-existing conditions, as well as potential vulnerability of patients based on underlying comorbidities Nursing homes and hospitals should restrict all visitors, including consider restriction of entry of non-essential staff and contractors Continue tele-health expansion Nursing homes and hospitals should restrict all visitors, including consider restriction of entry of non-essential staff and contractors Consider limiting group activities, including meals
Colleges and Universities	Guidance will be forthcoming
Communities of Faith	Guidance will be forthcoming
Restaurants and Bars	Restaurants open dining areas with limited seating that allows for social distancing (minimum of 6 feet between groups of people) to protect employees and guests Bars open with limited standing room only capacity that can allow for 6- foot social distancing among patrons Provide drive-through, delivery, or curb-side pick-up options and prioritize outdoor seating as much as possible Ensure proper cleaning, sanitizing, and disinfecting requirements, and protection of workers and customers Reduce occupancy and limit the size of parties dining together to ensure all customer parties Install physical barriers, such as sneeze guards and partitions, at cash registers, bars, host stands, and other areas where maintaining physical distance of six feet is difficult Provide physical guides (e.g., tape on floors/sidewalks) to ensure customers remain at least 6 feet apart in lines/waiting for seating Use phone apps to alert patrons when their table is ready to avoid use of communal “buzzers” and ask patrons to wait for their table in cars or away from establishment Avoid offering any self-serve food or drink options (e.g., buffets, salad bars, drink stations) Offer disposable or digital menus, single serving condiments, and no-touch payment, trash cans, doors Consider special accommodations for personnel who are members of a vulnerable population (e.g. flexible leave and telework policies where possible, reassignment of duties to minimize contact with others) Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to workplaces in moderate transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering.

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	Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Social Gatherings	Cancel all gatherings of 50 or more Cancel gatherings of any size where distancing cannot be maintained. Do not allow attendance of individuals from significant transmission jurisdictions
Mass Transit	Restrict routes between areas experiencing different levels of transmission (between areas in different Phases) to the extent possible Ensure strict social distancing, proper cleaning and disinfecting requirements and protection of workers and customers Install no-touch trash cans Clean and disinfect frequently touched surfaces (for example e.g., kiosks, digital interfaces such as touchscreens and fingerprint scanners, ticket machines, turnstiles, handrails, restroom surfaces, elevator buttons) at least daily. Clean and disinfect the operator area between operator shifts Use touchless payment options as much as possible, when available. Institute measures to physically separate or create distance of at least 6 feet between all occupants. This may include: Adjust how passengers enter and exit (while allowing exceptions for persons with disabilities) Close every other row of seats Reduce maximum occupancy and increase service on crowded routes Provide physical guides on vehicles and at transit stations and stops. Floor decals, colored tape, or signs to indicate where passengers should not sit or stand can be used to guide passengers Install physical barriers, such as sneeze guards and partitions at staffed kiosks and on transit vehicles to the extent practicable Close communal spaces, such as break rooms or stagger use and clean in between uses Consider assigning vulnerable workers duties that minimize their contact with passengers and other employees. Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to workplaces in moderate transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Mass Gatherings	Guidance will be forthcoming
Communities of Faith	Consider holding gatherings virtually (online video streaming) for vulnerable populations and consider video streaming or drive-in options for services. Limit the size of in person gatherings in accordance with the guidance and directives of state and local authorities, and maintain social distancing. Consider limiting in home or in hospital clergy visits and offering visits over the phone or online Encourage the use of face coverings when around others Encourage proper hand hygiene and avoid direct person-to-person contact and sharing of objects Consider posting signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick leave and related flexible policies and practices for staff (e.g., allow work from home, if feasible).

Phase 3: Low, Controlled Transmission

States and Jurisdictions in Phase 3 are in need of **low** mitigation. That means that risk of transmission, or the spread of COVID-19, is still considered low and controlled in these jurisdictions.

Leaders of these jurisdictions are tasked with ensuring that significant mitigation strategies are followed to the best extent possible to protect jurisdictions, prevent further COVID-19 spread, and ensure that jurisdictions can safely remain in Phase 3 as risk for COVID-19 transmission remains low.

It is critically important in this Phase, and in others, that jurisdictions continue to monitor their **Gating Criteria** data on 1) Transmission, 2) Public Health Capacity, and 3) Health System Capacity to determine any mitigation adjustments that may be needed.

- Jurisdictions may remain in Phase 3 if **Gating Criteria** remain stable.
- Jurisdictions should return to Phase 2 if community experiences rebound in transmission or has insufficient Public Health and Healthcare System capacity to manage increase in cases (or return to an earlier stage/Pre-Gating, depending on severity of rebound and/or capacity needs).

The following table describes an overview of strategies to be implemented across different settings in jurisdictions that are in Phase 3. Links in the table are also included for more detailed guidance for each of these settings.

Phase 3. Community Mitigation Strategies in Areas with Low, Controlled Transmission	
Guidelines for All Phases	Individuals Continue to practice good hygiene and implement personal protective measures (e.g., handwashing, cough etiquette, and face coverings) Social distancing (e.g., maintaining physical distance between persons) Environmental surface cleaning at home and in community settings, such as schools or workplaces People who feel sick should stay home Employers Develop and implement appropriate policies, in accordance with FSLTT regulations and guidance, informed by industry best practices Monitor workforce for indicative symptoms. Do not allow symptomatic people to physically return to work until cleared by a medical provider. Develop and implement policies and procedures for workforce contact tracing following employee COVID+ test.
Phase 3 Guidelines for Individuals	VULNERABLE INDIVIDUALS can resume public interactions, but should practice physical distancing, minimizing exposure to social settings where distancing may not be practical, unless precautionary measures are observed. LOW RISK POPULATIONS should consider minimizing time spent in crowded environments.
Phase 3 Guidelines for Employers	Resume UNRESTRICTED STAFFING of worksites.
Phase 3 Guidelines for Specific Types of Employers <i>expanded below</i>	VISITS TO SENIOR CARE FACILITIES AND HOSPITALS can resume. Those who interact with residents and patients must be diligent regarding hygiene LARGE VENUES (e.g., sit down dining, movie theaters, sporting venues, places of worship) can operate under limited physical distancing protocols. GYMS can remain open if they adhere to standard sanitation protocols BARS may operate with increased standing room occupancy

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Essential Workplaces	Remain open and ensure social distancing, proper cleaning and disinfecting, and protection of workers and customers Institute or continue telework flexibility Staff from moderate and significant transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to workplaces in low transmission settings Encourage employees and customers to use cloth face coverings when around others Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering
General Workplaces	Remain open if business can ensure limited social distancing, proper cleaning and disinfecting, and protection of their workers and customers Continue to encourage telework and virtual vs. in-person meetings wherever possible and feasible Encourage employees and customers to use face coverings when around others Stagger use of common areas such as breakrooms, cafeterias and clean/disinfect between use Install physical barriers, such as sneeze guards and partitions, and change layout of workspaces to ensure all individuals remain at least 6 feet apart Staff from significant and moderate transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to workplaces in low controlled transmission settings Consider canceling work-related gatherings (e.g., staff meetings, after-work functions) where 6-foot distancing cannot be maintained Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a cloth face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Schools	Remain open with distancing measures (e.g., spaced seating to at least 6 feet apart when possible, limit mixing between classes/groups, and limit gatherings & extracurricular events to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission (Phase 1 & 2) areas. Consider limiting non-essential visitors and volunteers. Restrict attendance of those from higher transmission (Phase 1 & 2) areas. Encourage employees to use cloth face coverings when around others, particularly when physical distancing is not possible. Consider keeping communal use spaces such as cafeterias and playgrounds closed if possible, or stagger use and clean/disinfect in between use. Consider serving individually plated meals to limit sharing of food or utensils and holding activities in separate classrooms. Keep children's belongings separated Consider staggering arrival and drop-off times or locations, or putting in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single student or limit use of supplies and equipment for one group of children at a time and clean and disinfect between use E-learning or distance learning and telework opportunities should be provided, where feasible, for higher-risk students and staff Teachers, staff, and students from higher transmission (Phase 1 & 2) areas should be offered telework, e-learning, and other options as feasible to eliminate travel to schools in low controlled transmission settings

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	Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Childcare Facilities	Childcare facilities should remain open with limited social distancing measures (e.g., spaced seating to at least 6 feet apart when possible, limit mixing between classes/groups, and limit gatherings & extracurricular events to those where social distancing can be maintained, support proper hand hygiene, and restrict attendance of those from higher mitigation (Phase 1 & 2) areas. Consider limiting non-essential visitors and volunteers. Restrict attendance of those from higher transmission (Phase 1 & 2) areas. Encourage employees to use face coverings when around others, particularly when physical distancing is not possible. Consider keeping communal use spaces such as cafeterias and playgrounds closed if possible, or stagger use and clean/disinfect in between use. Consider serving individually plated meals to limit sharing of food or utensils and holding activities in separate classrooms. Keep children's belongings separated Consider staggering arrival and drop-off times or locations, or putting in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single child) or limit use of supplies and equipment for by one group of children at a time and disinfect between use Routinely clean, sanitize, and disinfect surfaces and objects that are frequently touched (e.g., toys) and avoid use of items that are not easily cleaned Staff from significant and moderate transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to childcare centers in low controlled transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Summer Camps	Remain open with distancing measures (e.g., spaced seating to at least 6 feet apart when possible, limit mixing between classes/groups, and limit gatherings & extracurricular events to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from significant and moderate mitigation (Phase 1 & 2) areas). Restrict attendance to those from limited transmission areas Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Consider keeping communal use spaces such as cafeterias and playgrounds closed if possible, or stagger use and clean/disinfect in between use. Consider serving individually plated meals to limit sharing of food or utensils and holding activities in separate areas. Keep children's belongings separated Consider staggering arrival and drop-off times or locations, or putting in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single camper) or limit use of supplies and equipment for by one group of children at a time and disinfect between use Staff from significant and moderate transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to camps in low controlled transmission settings

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	Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Parks and recreational facilities	Open with modifications to ensure visitors can maintain social distancing, and practice proper hand hygiene. Cancel or postpone large events and gatherings Use flexible telework policies, especially for staff at higher risk for severe illness. Staff from moderate and significant transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to workplaces in low transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Healthcare Settings	Continue telehealth expansion Schedule elective surgeries Consider gradually returning to normal scheduling of all routine outpatient medical and dental care Nursing homes and hospitals can consider relaxing visitor restrictions on a case-by-case basis (variables to consider include the widespread availability of testing to ensure rapid identification of potential nursing home clusters; adequacy of personal protective equipment and training of staff on appropriate IPC practices to help mitigate risk of nosocomial transmission) Resume non-COVID care {insert link to new CMS guidance}
Colleges and Universities	Guidance will be forthcoming
Communities of Faith	Guidance will be forthcoming
Restaurants and Bars	Restaurants operate with increased seating capacity while maintaining social distancing to protect employees and guests Bars operate with increased standing room occupancy that allows for social distancing. Provide drive-through, delivery, or curbside pick-up options and prioritize outdoor seating as much as possible Consider options for dine-in customers to order ahead of time to limit the amount of time spent in the establishment Ensure proper cleaning, sanitizing, and disinfecting, and protection of workers and customers. Install physical barriers, such as sneeze guards and partitions, at cash registers, bars, host stands, and other areas where maintaining physical distance of six feet is difficult. Provide physical guides (e.g., tape on floors/sidewalks) to ensure customers remain at least 6 feet apart in lines/waiting for seating. Consider using phone apps to alert patrons when their table is ready to avoid use of communal “buzzers” and ask patrons to wait for their table in cars or away from establishment Avoid offering any self-serve food or drink options (e.g., buffets, salad bars, drink stations) Consider special accommodations for personnel who are members of a vulnerable population (e.g. flexible leave and telework policies where possible, reassignment of duties to minimize contact with others)

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	Staff from moderate and significant transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to workplaces in low transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Social Gatherings	Cancel gatherings where social distancing cannot be maintained. Discourage attendance of individuals from significant transmission jurisdictions
Mass Transit	Restrict routes between areas experiencing different levels of transmission (between areas in different Phases) to the extent possible Continue to encourage social distancing Ensure proper cleaning and disinfecting and protection of workers and customers Clean and disinfect frequently touched surfaces (e.g., kiosks, digital interfaces such as touchscreens and fingerprint scanners, ticket machines, turnstiles, handrails, restroom surfaces, elevator buttons) at least daily. Clean and disinfect the operator area between operator shifts Use touchless payment, trash cans, and doors as much as possible, when available. Consider or continue instituting measures to physically separate or create distance between occupants Provide physical guides on vehicles and at transit stations and stops. Floor decals, colored tape, or signs to indicate where passengers should not sit or stand can be used to guide passengers Maintain physical barriers, such as sneeze guards and partitions at staffed kiosks and on transit vehicles to the extent practicable Consider assigning vulnerable workers duties that minimize their contact with passengers and other employees. Staff from moderate and significant transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to workplaces in low transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Mass Gatherings	Guidance will be forthcoming
Communities of Faith	Consider video streaming or drive-in options for vulnerable populations Limit gatherings to those that can maintain social distancing, and practice proper hand hygiene. Consider limiting in home or in hospital clergy visits and offer visits over the phone or online for those who are at vulnerable Encourage the use of face coverings when around others Encourage proper hand hygiene and avoid direct person-to-person contact and sharing of objects Consider posting signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick leave and related flexible policies and practices for staff (e.g., allow work from home, if feasible)

Indicators: Data, Data Sources, Tools

Dashboards and Platforms for Assessing Case Report, Syndromic, and Laboratory Gating Indicators

Dashboard / Platform	Possible audience	Key attributes	Product	Purpose	Data elements	Who has access	How to access
NHSN/Case surveillance Reports	State Epidemiologist, SHO, State Officials, HAI Coordinators	Granular Easier to Interpret Static	Reports: State Indicator report, NHSN report	<i>State indicator reports:</i> Purpose – to provide state and local public health partners with data on cases, syndromic surveillance and health care capacity indicators at a higher level of granularity than other sources like HHS Protect/GeoHealth for COVID-19 indicators for gating criteria	<i>NHSN reports:</i> Number of hospitalized COVID-19 patients, overall beds, ICU beds and ventilator use, staffing shortages and supply shortages. Data available, by state, county and facility. <i>State Indicator reports:</i> COVID-19 case counts, epi curves, case report indicator metrics including downward trajectory and rebound, CLI ED visits and indicator metrics including increasing and decreasing trends, % positive tests and testing rates along with indicators such as increasing and decreasing trends	HAI coordinator, Epidemiologists, PHEP Directors	Biweekly email on Tuesdays and Fridays with a link to a secure folder with a login to access the reports. Other methods to access NHSN data: https://www.cdc.gov/nhsn/covid19/report-overview.html and through the NHSN application (https://www.cdc.gov/nhsn/pdfs/covid19/grp-dashboard-508.pdf)
Geohealth Dashboard	State Epidemiologist, SHO, State Officials	Simple Easy to use Interactive	Dashboard	High level overview of COVID-19 indicators for WH gating criteria nationally, and by state. Few data elements available by county	ILI, CLI, COVID-19 Cases, Deaths, Testing, Hospital bed availability, ICU bed availability, Ventilator availability	U.S. Government	Request access at: https://geohealth.hhs.gov/arcgis/home/
HHS Protect	State and local health officials	Powerful Flexible Interactive	Dashboard, Application	Custom analyses with wide variety of data sources, dashboards under development	Multiple sources of data, including COVID and non-COVID data	State and local health officials	Information coming soon!

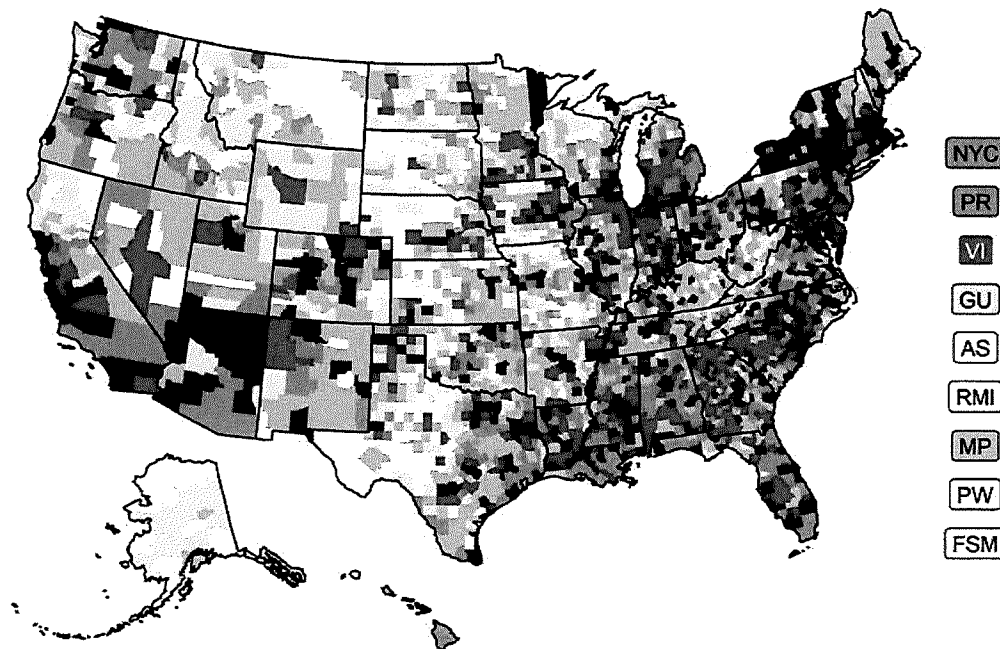
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CDC.GOV Data Tracker Dashboards	Public	Simple Easy to use Interactive	Website, Dashboard	High level overview of COVID-19 cases nationally, and by state	COVID-19 cases and deaths, social impact, school closures	Public	Cases: https://www.cdc.gov/covid-data-tracker/index.html Additional data: https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/index.html
CDC.GOV Healthcare Capacity Dashboards	Public	Simple Easy to use Interactive	Website, Dashboard	High level overview of healthcare capacity nationally, and by state, using NHSN data	Percent Inpatient beds occupied by state, percent ICU beds occupied by state, number of facilities reporting	Public	https://www.cdc.gov/nhsn/covid19/report-patient-impact.html
CDC.GOV Forecasting Dashboard	Public	Simple Easy to use Static	Website, Dashboard	Emsemble modeling that forecasts COVID-19 deaths nationally, and by state	Forecasted cumulative COVID-19 deaths	Public	https://www.cdc.gov/coronavirus/2019-ncov/covid-data/forecasting-us.html

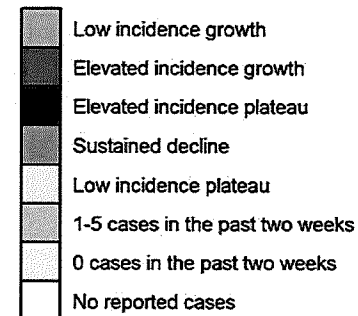
Example Maps:

Downward trajectory of documented (confirmed and probable) cases within a 14-day period
Interested in SAS or R code for this method to use for your own data? Contact us!

Coronavirus Disease 2019 (COVID-19)
Current epidemic curve status*,
by U.S. County, 29 April 2020



Epi curve status



Purpose of this map

Provides the most detailed view into both the burden of illness and the trajectory of new illnesses

Main Findings

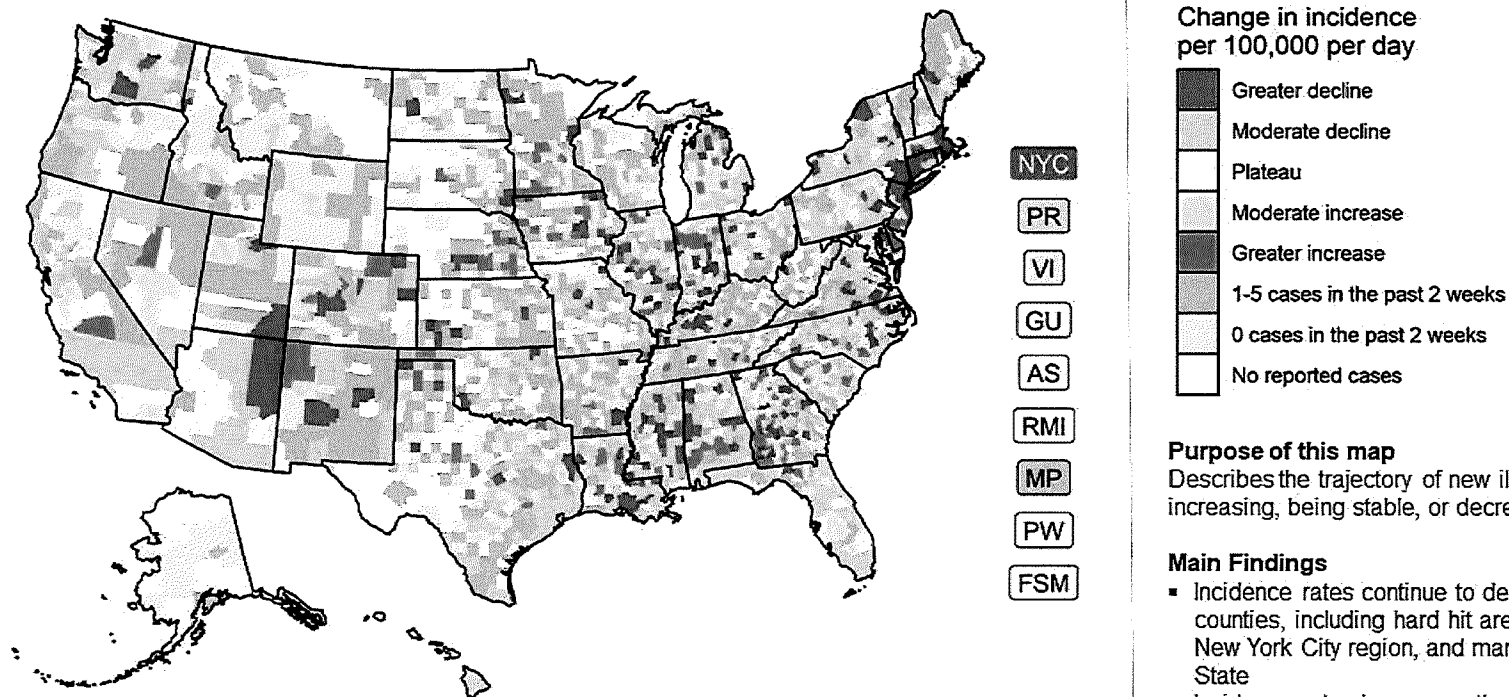
- There remains a large number of counties whose burden continues to grow or are in an elevated incidence plateau, including in the Great Lakes region and parts of the Southeast
- The goal is to have all communities be represented in the lighter colors, demonstrating little to no disease burden and no increase in trajectory

*Categorized according to the slope of a spline fit to the 3 day moving average of daily incidence and the number of new cases (per 100,000) in the past 2 weeks. Elevated incidence is defined as >10 new cases per 100,000 in the past two weeks.

Sources: USAFacts, US Census



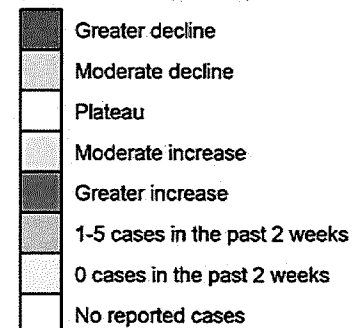
**Coronavirus Disease 2019 (COVID-19)
Change in Daily Incidence*,
by U.S. County, 29 April 2020**



*Measured as the change in slope of a spline fit to smoothed daily incidence. Incidence was smoothed using a 3-day moving average. These values therefore represent the change in 3-day average number of new cases per 100,000 per day. Greater declines are ≤ -1 , moderate declines are > -1 to -0.1 , plateaus are > -0.1 to ≤ 0.1 , moderate increases are > 0.1 to 1 , greater increases are > 1 . Counties denoted as 0 cases in the past 2 weeks have had at least 1 case previously.

Sources: USAFacts, US Census

Change in incidence
per 100,000 per day



Purpose of this map

Describes the trajectory of new illnesses as recently increasing, being stable, or decreasing in number

Main Findings

- Incidence rates continue to decrease in multiple counties, including hard hit areas in Louisiana, the New York City region, and many counties in New York State
- Incidence rates have recently shown a moderate increase in areas around Chicago

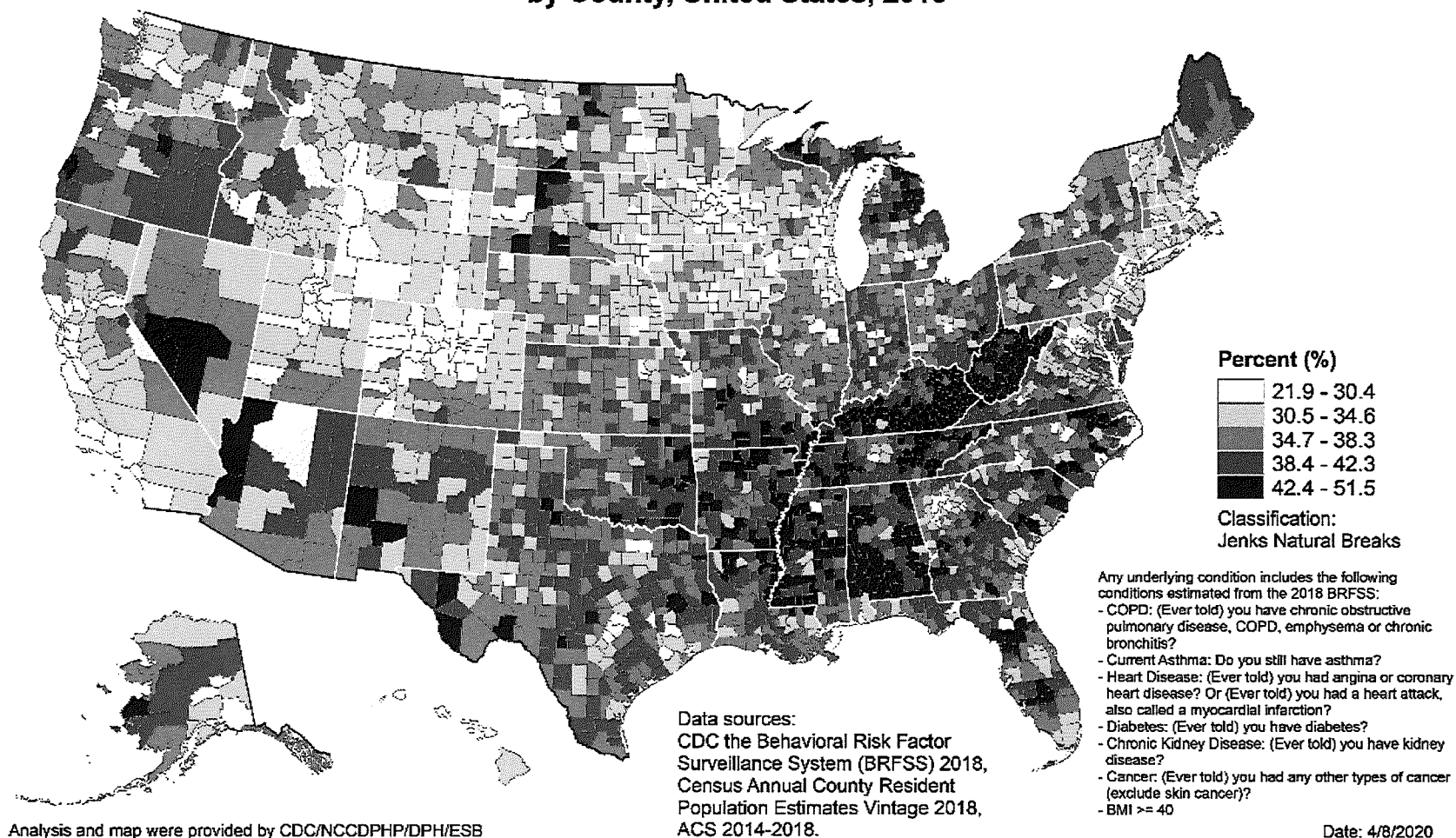


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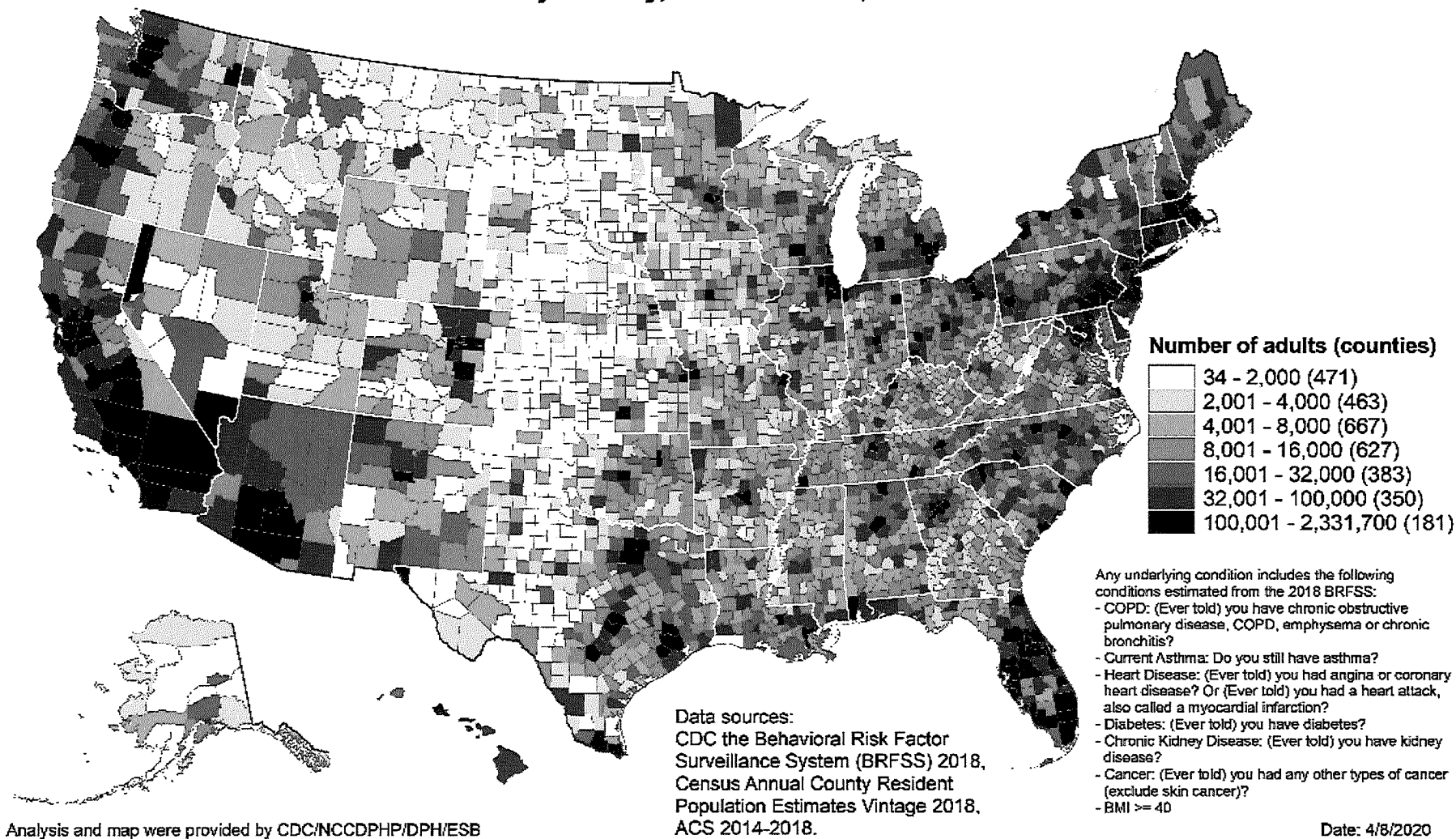
Medical vulnerability: Determining prevalence and number of people with serious underlying medical conditions who might be at higher risk for severe illness from COVID-19 listed on CDC website, using BRFSS data.

- <https://www.cdc.gov/coronavirus/2019-ncov/hcp/underlying-conditions.html>
- <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html>

Model-Based Prevalence Estimates for Adults Aged ≥ 18 Years with Select Underlying Conditions by County, United States, 2018



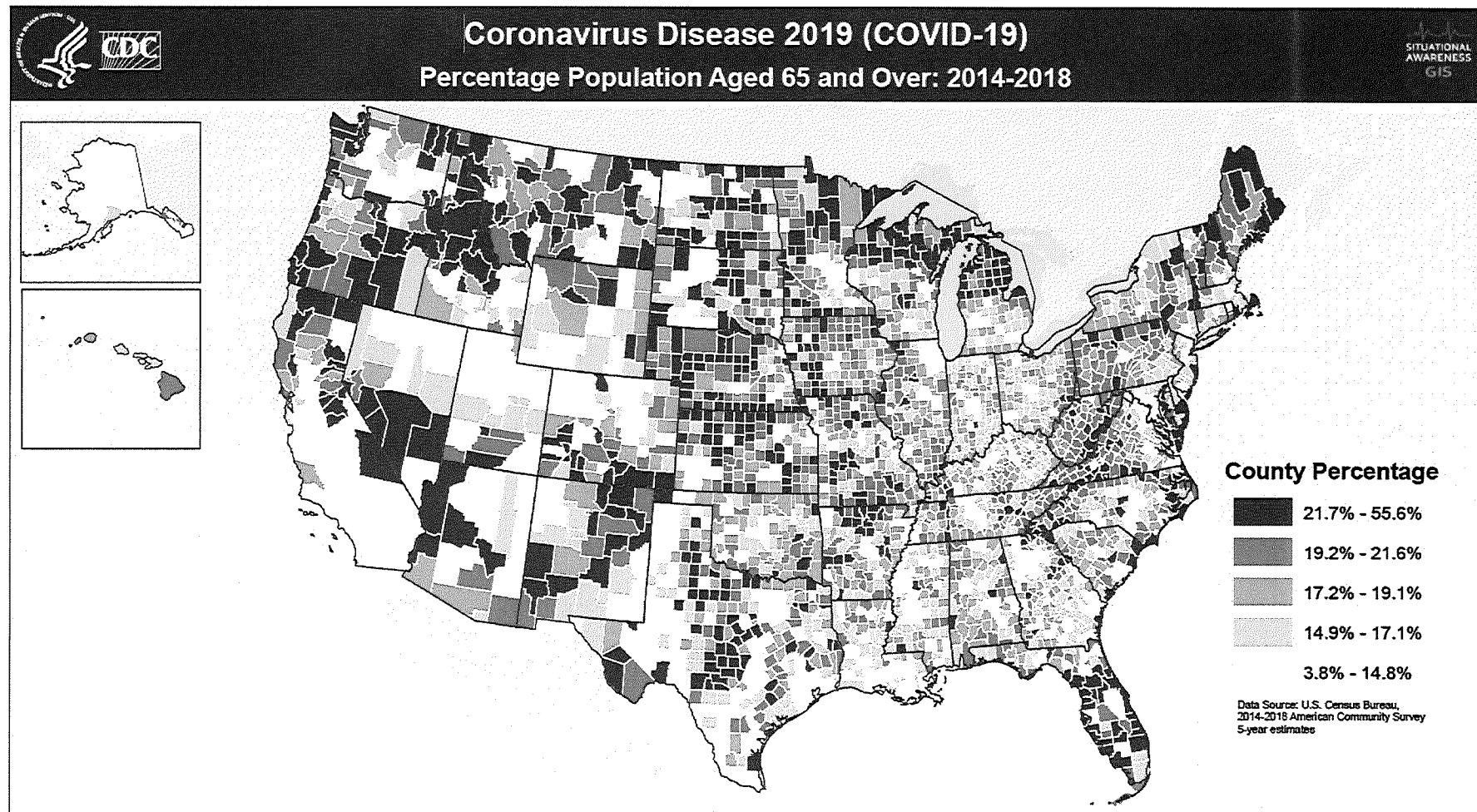
Model-Based Estimates of Number of Adults Aged ≥ 18 Years with Select Underlying Conditions by County, United States, 2018



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Medical vulnerability: Determining prevalence and number of people age 65 and up who might be at higher risk for severe illness from COVID-19 listed on CDC website.

- <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html>



Guidance for Implementing the Opening Up America Again Framework

This implementation guidance provides tools and resources to assist decision makers to implement the Guidelines for Opening Up America Again framework. Guidance is provided to monitor local conditions (transmission, public health, and healthcare system capacity) and adjust mitigation strategies over time to effectively contain outbreaks and minimize negative side effects of more significant restrictions on commerce and education.

It begins with steps that all Americans need to take in every community. From there, it outlines core capacities needed in communities to respond to and manage COVID-19 cases as well as delineates key metrics to monitor community mitigation efforts. All of the guidance is anchored to the phases of the *Opening Up America Again* framework.

It also contains more detailed tools for communities such as indicators to better track and adjust mitigation efforts as well as comprehensive mitigation guidance organized by phase and by setting. Finally, there are user-friendly decision trees to help leaders make informed decisions about reopening.

Steps for All Americans in Every Community

ALL JURISDICTIONS SHOULD CONTINUE TO PROMOTE INDIVIDUAL AND WORKPLACE practices that reduce the risk of transmission AS PEOPLE MOVE THROUGH THE COMMUNITY.

INDIVIDUALS SHOULD:

- ✓ CONTINUE TO wash their hands OFTEN
- ✓ COVER THEIR COUGHS AND SNEEZES
- ✓ AVOID CLOSE CONTACT WITH OTHERS
- ✓ DISINFECT FREQUENTLY-USED ITEMS AND SURFACES
- ✓ STAY HOME WHEN THEY FEEL SICK
- ✓ USE cloth face coverings WHEN OUT IN PUBLIC

EMPLOYERS SHOULD:

- ✓ NOTIFY AND WORK WITH STATE & LOCAL PUBLIC HEALTH OFFICIALS IF AN EMPLOYEE TESTS POSITIVE FOR COVID-19
- ✓ DEVELOP AND IMPLEMENT APPROPRIATE POLICIES, IN ACCORDANCE WITH FEDERAL, STATE, AND LOCAL REGULATIONS AND GUIDANCE AND INFORMED BY INDUSTRY BEST PRACTICES, REGARDING:
 - SOCIAL DISTANCING
 - PERSONAL PROTECTIVE EQUIPMENT
 - HEALTH CHECKS LIKE TEMPERATURE SCREENING
 - ISOLATING AND SENDING HOME THOSE WHO ARE SICK
 - NOT ALLOWING EMPLOYEES POSITIVE FOR COVID-19 TO PHYSICALLY RETURN TO WORK UNTIL CLEARED BY A MEDICAL PROVIDER, OR ACCORDING TO the guidance for discontinuing home isolation for COVID+ cases managed at home
 - NOTIFYING LOCAL HEALTH OFFICIALS AND INDIVIDUALS WHO MAY HAVE BEEN EXPOSED WHEN SOMEONE IS CONFIRMED, OR PRESUMED TO BE POSITIVE FOR COVID-19
 - SANITIZATION, CLEANING AND DISINFECTION
 - BUSINESS TRAVEL

Preparing— Establishing Core Capacity

All jurisdictions need to build and maintain a core capacity to respond to and manage COVID-19 cases. Leaders should convene a broad set of stakeholders across sectors to:

- ✓ Communicate data about local transmission, public health and healthcare system capacity, risk to vulnerable populations, and economic considerations;
- ✓ Share local status of gating criteria (as described by Opening America Up Again framework, and below); and
- ✓ Develop coordinated re-opening plans and guidance

The framework for *Opening America up Again* outlines core preparedness plans every jurisdiction needs before beginning the process of “gating” or reducing mitigation strategies. This is especially important in a jurisdiction that has experienced significant transmission and healthcare system strain. Assistance is available, including staffing, to support states, tribes, localities, and territories to establish and maintain this capacity.

Plans should be updated throughout the response to ensure lessons learned are rapidly assimilated into practice and at a minimum address the following components:

Testing and Contact Tracing

- Ability to quickly set up safe and efficient screening and testing sites for symptomatic individuals, and to trace contacts of COVID-19+ cases
- Ability to test syndromic/Influenza-Like Illness (ILI)-indicated persons for COVID-19 and trace contacts of COVID-19+ cases
- Ability to test at sentinel surveillance sites for asymptomatic cases, and trace contacts of COVID-19+ cases

Healthcare System Capacity

- Ability to quickly and independently ensure adequate staff and provide critical medical equipment and supplies (e.g. personal protective equipment (PPE)) to meet unexpected surge demands
- Ability to surge ICU capacity

Develop Plans Specific to Community Needs

- Protect the health and safety of workers in all settings
- Protect the health and safety of vulnerable populations and those living and working in high-risk settings (e.g., senior care facilities, correctional facilities)
- Protect employees and users of mass transit
- Implement strategies to promote social distancing and use of cloth face coverings
- Monitor local transmission and public health and healthcare system capacity
- Immediately take steps to limit any rebounds in transmission, or outbreaks, by increasing mitigation strategies to address a specific outbreak (e.g., returning to an earlier phase as outlined in the Opening America Up Again framework, depending on severity).

Monitoring Community Conditions and Gating Criteria

Once the core capacity is in place, monitoring community transmission, public health, and healthcare system capacity will help jurisdictions assess readiness for moving between phases for lifting mitigation strategies. The *Opening Up America Again* framework outlines gating criteria for states and localities to use in determining when and how to decrease or increase community mitigation strategies over time as the risk of transmission for COVID-19 changes.

These gating criteria are anchored to time-bound, population-level metrics of COVID-19 burden (newly identified cases, emergency department or outpatient visits associated with the disease, and percentage of COVID-19 positive tests) as well as measures of the public health and health-system capacity to address current circumstances (robust testing and contact tracing capabilities, hospital inpatient and ICU beds, and access to PPE).

Communities with significant or uncontrolled community transmission are considered in pre-gating or Phase 0. Jurisdictions need to meet all the gating criteria prior to removing any shelter in place order or entering Phase 1. These metrics and how to utilize them to inform decision-making are described in the Indicators and Thresholds for Monitoring and Adjusting Mitigation Strategies table.

Once the gating criteria are met, jurisdictions enter Phase 1 and proceed to move between three phases, altering the level of community mitigation recommended as they pass through each gate. Phase 1 corresponds to areas with the highest disease burden and ongoing community transmission, with the most significant mitigation strategies in place. At the other end, Phase 3 corresponds to areas with lower disease burden and less frequent community transmission with the least significant community mitigation strategies deployed.

Each phase outlines necessary mitigation strategies to protect public health. Until a vaccine is widely available and/or medications are broadly accessible to manage COVID-19 symptoms, individuals need to follow good personal hygiene practices, stay at home when sick, and practice some amount of physical distancing to lower the risk of disease spread. These precautions are needed regardless of the phase a community is in.

It is also critical to identify when transmission begins to place the public health and healthcare system at risk, so appropriate actions can be taken. A [gating indicators dashboard](#) has been created as a tool to help pull relevant data streams into one platform to support decision making and regional planning and coordination. It can be accessed by jurisdiction officials through GeoHealth.

Community Mitigation Across the Phases

Protecting public health is at the center of the *Opening Up America Again* framework. However, jurisdictions are also addressing the economic and social consequences of COVID-19. Mitigation strategies should be implemented in a manner that is sufficient to contain transmission and allow sectors to plan for and minimize the negative impacts of the mitigation. The earliest signs of a cluster of new cases or a reemergence of broader community transmission should result in a re-evaluation of community mitigation strategies and a decision on whether they should be strengthened. Increasing mitigation should be tailored and measured, specific to any increase observed.

For example, an outbreak in a high risk setting such as a nursing home or correctional facility would result in strict mitigation, contact tracing and isolation of cases for all individuals entering that setting, but may not necessitate implementing strict community-wide measures such as a shelter-in-place order if the outbreak can

be effectively contained. Assessing the appropriate mitigation approach and only implementing the strategies appropriate to the observed transmission will help minimize the societal and economic impacts of mitigation.

The following framework categorizes jurisdictions based on the level of transmission and community capacity to contain the transmission. The categories align with the phases in the *Opening Up America Again* plan to assist with transitions between the gates and phases.

Community Mitigation by Re-Opening Phases				
Opening Up America Again Phase	Pre-Gating or Phase Zero	Phase One	Phase Two	Phase Three
Transmission Characteristics	Significant or Uncontrolled Transmission	Significant Controlled Transmission	Moderate, Controlled Transmission	Low, Controlled Transmission
Community Description	Emerging and Current Hot Spots Public health and health system capacity exceeded	Previous hotspots where transmission has met thresholds and public health and health care systems can manage level of transmission	Moderate transmission that is within capacity of the public health and health systems	Limited Transmission (rural, low density areas)
Mitigation Needs	Shelter In Place	Significant Mitigation	Moderate Mitigation	Low Mitigation
Thresholds for Gating & Mitigation Adjustments	Thresholds for gating not met; maintain or initiate significant mitigation, or implement additional mitigation if not currently in place	Thresholds for gating met/maintained: reduce mitigation to Phase 1 then maintain until next gating thresholds are met OR Moderate Transmission community where public health or healthcare system capacity thresholds are no longer met; increase mitigation across all settings to Phase 1 level	Thresholds for gating met/maintained: reduce mitigation to Phase 2 then maintain until next gating thresholds are met OR Low Transmission community where public health or healthcare system capacity thresholds are no longer met; increase mitigation across all settings to Phase 2 level	Thresholds for gating not necessary if community never experienced transmission that exceeded public health or healthcare system capacity: apply Guidelines for all Phases OR Moderate Transmission community where thresholds for gating met/maintained: reduce mitigation across all settings to Phase 3 level

Travel patterns within and between jurisdictions will impact efforts to reduce community transmission too. Coordination across state and local jurisdictions is critical – especially between jurisdictions with different mitigation needs. Refer to the latest [CDC travel guidance](#) for additional information (and specific travel related information for consideration in the table below).

Decision-Making for Community Mitigation

State, local, tribal, and territorial officials are best positioned to determine which phase their jurisdiction falls within. Decisions about moving to a different phase will be made at the state, local, tribal and territorial level.

Travel Recommendations

Travel Recommendations by Phase				
Opening Up America Again Phase	Pre-Gating or Phase Zero	Phase One	Phase Two	Phase Three
Transmission Characteristics	Significant or Uncontrolled Transmission	Significant Controlled Transmission	Moderate, Controlled Transmission	Low, Controlled Transmission
Impact of virus introduction into this setting by a domestic traveler	Low	Low	Low	High
Likelihood of virus exportation from this setting to a new community by a domestic traveler	High	High	Medium	Low
Domestic Travel Guidance	- Avoid non-essential travel to, from, and within to prevent infection during travel and spread to other jurisdictions - Work-related travel needed for critical infrastructure is exempt from restrictions	- Avoid non-essential travel to, from, and within to prevent infection during travel and spread to other jurisdictions - Work-related travel needed for critical infrastructure is exempt from restrictions	- Avoid non-essential travel to Phase 0 and Phase 1 jurisdictions to prevent infection during travel - Avoid non-essential travel to Phase 3 jurisdictions to prevent spreading - Work-related travel needed for critical infrastructure is exempt from restrictions	- Non-essential travel may be considered within and between low, controlled transmission jurisdictions - Avoid non-essential travel to moderate, controlled or significant, uncontrolled transmission jurisdictions to protect those in low, controlled transmission jurisdictions

International Travel	• Avoid non-essential international travel • Returning international travelers should be managed according to Travel Health Notice	• Avoid non-essential international travel	• Avoid non-essential international travel	• International travel may be considered following CDC international travel guidance • Avoid international travel to Travel Health Notice Level 3 countries • Returning international travelers should be managed according to Travel Health Notice guidance
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Setting Specific Guidance

INTERIM GUIDANCE FOR CHILD CARE PROGRAMS

The reopening of child care programs is crucial to helping parents and guardians return to work. Many States have closed schools for the academic year and, with summer quickly approaching, an increasing number of working parents may need to rely on these programs. CDC's [Interim Guidance for Administrators of US K-12 Schools and Child Care Programs](#) and supplemental [Guidance for Child Care Programs that Remain Open](#) provide recommendations for operating child care programs in low, moderate, and significant mitigation communities. In communities that are deemed significant mitigation areas by State and local authorities, child care programs should be closed. However, child care programs can choose to remain open to serve children of [essential workers](#), such as healthcare workers. All decisions about following these recommendations should be made locally, in collaboration with local health officials who can help determine levels of COVID-19 community transmission and the capacities of the local public health system and healthcare systems.

(Re) Opening

o In all Phases:

- o Establish and continue communication with local and State authorities to determine current mitigation levels in your community.
- o [Protect](#) and support staff, children, and their family members who are at [higher risk](#) for severe illness.
- o Provide staff from higher transmission areas (earlier Phase areas) telework and other options as feasible to eliminate travel to childcare programs in lower transmission (later Phase) areas and vice versa.
- o Follow CDC's supplemental [Guidance for Child Care Programs that Remain Open](#).
- o Ensure that any other community groups or organizations that use the child care facilities also follow this guidance: [Guidance for Child Care Programs that Remain Open](#).

o **Phase 1:** Restrict to children of [essential workers](#).

o **Phase 2:** Expand to all children with **enhanced** social distancing measures.

o **Phase 3:** Remain open for all children with social distancing measures.

Safety Actions

Promote healthy hygiene practices (Phases 1-3)

- o Teach and reinforce washing hands and covering coughs and sneezes among children and staff.
- o Teach and reinforce use of cloth face coverings among all staff. Face coverings are most essential at times when social distancing is not possible. Staff should be frequently reminded not to touch the face covering and to wash their hands frequently. Information should be provided to all staff on proper use, removal, and washing of cloth face coverings.
- o Have adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol (for staff and older children who can safely use hand sanitizer), and tissues.
- o Post signs on how to stop the spread of COVID-19, properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Phases 1-3)

- o Clean, sanitize, and disinfect frequently touched surfaces (for example, playground equipment, door handles, sink handles, drinking fountains) multiple times per day. and shared objects between use.
- o Avoid use of items (for example, soft or plush toys) that are not easily cleaned, sanitized, or disinfected. o
Ensure safe and correct application of disinfectants and keep products away from children.
- o Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible by opening windows and doors, using fans, and other methods. Do not open windows and doors if doing so poses a safety or health risk (for example, allowing pollens in or exacerbating asthma symptoms) to children using the facility.
- o Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Ensure social distancing

o Phase 1 and 2

- o Ensure that classes include the same group of children each day, and that the same child care providers remain with the same group each day.
- o Restrict mixing between groups
- o Cancel all field trips, inter-group events, and extracurricular activities (Phase 1)
- o Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Phase 2; Note: restricting attendance from those in Phase 1 areas).
- o Restrict nonessential visitors, volunteers, and activities involving other groups at the same time.
- o Space out seating and bedding (head-to-toe positioning) to six feet apart if possible.
- o Close communal use spaces, such as game rooms or dining halls, if possible; if this is not possible, stagger use and disinfect in between uses.

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INTERIM GUIDANCE FOR CHILD CARE PROGRAMS

- o If a cafeteria or group dining room is typically used, serve meals in classrooms instead. Put each child's meal on a plate, to limit the use of shared serving utensils.
- o Stagger arrival and drop-off times or put in place other protocols to limit direct contact with parents as much as possible.

o Phase 3

- o Consider keeping classes together to include the same group of children each day, and consider keeping the same child care providers with the same group each day.
- o Allow minimal mixing between groups. Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Phase 1 or 2 areas).
- o Continue to space out seating and bedding (head-to-toe positioning) to six feet apart, if possible.
- o Consider keeping communal use spaces closed, such as game rooms, playgrounds, or dining halls, if possible; if this is not possible, stagger use and disinfect in between uses.
- o Consider continuing to plate each child's meal, to limit the use of shared serving utensils.
- o Consider limiting nonessential visitors, volunteers, and activities involving other groups. Restrict attendance of those from higher transmission areas (Phase 1 or 2 areas).
- o Consider staggering arrival and drop-off times or put in place other protocols to limit direct contact with parents as much as possible.

Limit sharing (Phases 1-3)

- o Keep each child's belongings separated and in individually labeled storage containers, cubbies, or areas and taken home each day and cleaned.
- o Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single camper) or limit use of supplies and equipment by one group of children at a time and clean and disinfect between use.
- o If food is offered at any event, have pre-packaged boxes or bags for each attendee instead of a buffet or family-style meal. Avoid sharing of foods and utensils.
- o Avoid sharing electronic devices, toys, books, other games, and learning aids.
- o Prevent risk of transmitting COVID-19 by avoiding immediate contact (such as shaking or holding hands, hugging, or kissing), as well as by mediated contact.

Train all staff (Phases 1-3)

- o Train all staff in the above safety actions. Consider conducting the training virtually, or, if in-person, ensure social distancing is maintained.

Monitoring and Preparing

Check for signs and symptoms (Phases 1-3)

- o Screen children upon arrival, if possible. Establish routine, daily health checks on arrival, such as temperature screening of both staff and children. Options for daily health check screenings for children are provided in CDC's supplemental Guidance for Child Care Programs that Remain Open and in CDC's General Business FAQs for screening staff.
- o Implement health checks (e.g. temperature checks and symptom screening) screenings safely, and respectfully, and with measures in place to ensure confidentiality as well as in accordance with any applicable privacy laws or regulations. Confidentiality should be maintained.
- o Employers and child care directors may use examples of screening methods in CDC's supplemental Guidance for Child Care Programs that Remain Open as a guide.
- o Encourage staff to stay home if they are sick and encourage parents to keep sick children home.

Plan for when a staff member, child, or visitor becomes sick (Phases 1-3)

- o Identify an area to separate anyone who exhibits COVID-like symptoms during hours of operation, and ensure that children are not left without adult supervision.
- o Establish procedures for safely transporting anyone sick to their home or to a healthcare facility, as appropriate.
- o Notify local health officials, staff, and families immediately of any possible case of COVID-19 while maintaining confidentiality as required by the Americans with Disabilities Act (ADA).
- o Close off areas used by any sick person and do not use them until they have been cleaned. Wait 24 hours before you clean or disinfect to reduce risk to individuals cleaning. If it is not possible to wait 24 hours, wait as long as possible. Ensure safe and correct application of disinfectants and keep disinfectant products away from children
- o Advise sick staff members not to return until they have met CDC criteria to discontinue home isolation.
- o Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.

Maintain healthy operations (Phases 1-3)

- o Implement flexible sick leave policies and practices, if feasible.
- o Monitor absenteeism to identify any trends in employee or child absences due to illness. This might indicate spread of COVID-19 or other illness. Have a roster of trained back-up staff in order to maintain sufficient staffing levels.
- o Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- o Create a communication system for staff and families for self-reporting of symptoms and notification of exposures and closures

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Phases 1-3

- o It is very important to check State and local health department notices daily about spread of COVID-19 in the area and adjust operations accordingly.
- o Where a community is deemed a significant mitigation community, child care programs should close, except for those caring for the children of essential workers, such as the children of health care workers.
- o In the event a person diagnosed with COVID-19 is determined to have been in the building and poses a risk to the community, programs may consider closing for a few days for cleaning and disinfection.

INTERIM GUIDANCE FOR SCHOOLS AND DAY CAMPS

As communities consider reopening centers for learning, such as K-12 schools and summer day camps, CDC offers the following recommendations to keep communities safe while resuming peer-to-peer learning and providing crucial support for parents and guardians returning to work. These recommendations depend on community monitoring to prevent COVID-19 from spreading. Communities with low levels of COVID-19 spread and those with confidence that the incidence of infection is genuinely low (e.g. communities that remain in low transmission or that have entered Phase two or three) may put in place the practices described below as part of a phased reopening. All decisions about following these recommendations should be made in collaboration with local health officials and other State and local authorities who can help assess the current level of mitigation needed based on levels of COVID-19 community transmission and the capacities of the local public health and healthcare systems, among other relevant factors.

(Re)Opening

o In all Phases:

- o Establish and continue communication with local and State authorities to determine current mitigation levels in your community.
- o Protect and support staff and students who are at higher risk for severe illness, such as providing options for telework and virtual learning.
- o Follow CDC's Guidance for Schools and Childcare Programs.
- o Provide teachers and staff from higher transmission areas (earlier Phase areas) telework and other options as feasible to eliminate travel to schools and camps in lower transmission (later Phase) areas and vice versa.
- o Ensure external community organizations that use the facilities also follow this guidance.
- o **Phase 1:** Schools that are currently closed, remain closed. E-learning or distance learning opportunities should be provided for all students. Ensure provision of student services such as school meal programs. Camps restrict to children of essential workers and for children who live in the local geographic area only.
- o **Phase 2:** Remain open with **enhanced** social distancing measures and for children who live in the local geographic area only.
- o **Phase 3:** Remain open with distancing measures. Restrict attendance to those from limited transmission areas (other Phase 3 areas) only.

Safety Actions

Promote healthy hygiene practices (Phases 1-3)

- o Teach and reinforce washing hands and covering coughs and sneezes among children and staff.
- o Teach and reinforce use of cloth face coverings among all staff. Face coverings are most essential in times when physical distancing is not possible. Staff should be frequently reminded not to touch the face covering and to wash their hands frequently. Information should be provided to all staff on proper use, removal, and washing of cloth face coverings.
- o Have adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol (for staff and older children who can safely use hand sanitizer), tissues, and no-touch trash cans.
- o Post signs on how to stop the spread of COVID-19, properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Phases 1-3)

- o Clean and disinfect frequently touched surfaces within the school and on school buses at least daily (for example, playground equipment, door handles, sink handles, drinking fountains) and shared objects (for example, toys, games, art supplies) between uses.
- o To clean and disinfect school buses see guidance for bus transit operators.
- o Ensure safe and correct application of disinfectants and keep products away from children.
- o Ensure ventilation systems operate properly and increase circulation of outdoor air as much as possible by opening windows and doors, using fans, or other methods. Do not open windows and doors if they pose a safety or health risk (e.g., allowing pollens in or exacerbating asthma symptoms) risk to children using the facility.
- o Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Ensure social distancing

- o **Phase 1 and 2**
 - o Ensure that student and staff groupings are as static as possible by having the same group of children stay with the same staff (all day for young children, and as much as possible for older children).
 - o Restrict mixing between groups
 - o Cancel all field trips, inter-group events, and extracurricular activities (Phase 1)
 - o Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Phase 2; Note: restricting attendance from those in Phase 1 areas).
- o Restrict nonessential visitors, volunteers, and activities involving other groups at the same time o
Space seating/desks to at least six feet apart.

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- o Close communal use spaces such as dining halls and playgrounds if possible; otherwise stagger use and disinfect in between use.
- o If a cafeteria or group dining room is typically used, serve meals in classrooms instead. Serve individually plated meals and hold activities in separate classrooms. Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible.
- o Create social distance between children on school buses where possible.

o Phase 3

- o Consider keeping classes together to include the same group of children each day, and consider keeping the same child care providers with the same group each day.
- o Allow minimal mixing between groups. Limit gatherings, events, and extracurricular activities to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission areas (Phase 1 or 2 areas).
- o Continue to space out seating and bedding (head-to-toe positioning) to six feet apart, if possible.
- o Consider keeping communal use spaces closed, such as game rooms or dining halls, if possible; if this is not possible, stagger use and disinfect in between uses.
- o Consider continuing to plate each child's meal, to limit the use of shared serving utensils.
- o Consider limiting nonessential visitors, volunteers, and activities involving other groups. Restrict attendance of those from higher transmission areas (Phase 1 or 2 areas).
- o Consider staggering arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible. Continue to stagger arrival and drop-off times and plan to continue limiting direct contact with parents as much as possible.

Limit sharing (Phases 1-3)

- o Keep each child's belongings separated from others' and in individually labeled containers, cubbies, or areas.
- o Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single camper) or limit use of supplies and equipment by one group of children at a time and clean and disinfect between use.
- o If food is offered at any event, have pre-packaged boxes or bags for each attendee instead of a buffet or family-style meal. Avoid sharing of foods and utensils.
- o Avoid sharing electronic devices, toys, books, and other games or learning aids.

Train all staff (Phases 1-3)

- o Train all teachers and staff in the above safety actions. Consider conducting the training virtually, or, if in-person, ensure that social distancing is maintained.

Monitoring and Preparing

Check for signs and symptoms (Phases 1-3)

- o Implement screenings safely, respectfully, as well as in accordance with any applicable privacy laws or regulations. Confidentiality should be maintained.
- o School and camp administrators may use examples of screening methods in CDC’s supplemental Guidance for Child Care Programs that Remain Open as a guide for screening children and CDC’s General Business FAQs for screening staff.
- o Encourage staff to stay home if they are sick and encourage parents to keep sick children home. o
Encourage staff or children who are sick to stay at home.

Plan for when a staff member, child, or visitor becomes sick (Phases 1-3)

- o Work with school administrators, nurses, and other healthcare providers to identify an isolation room or area to separate anyone who exhibits COVID-like symptoms. School nurses and other healthcare providers should use Standard and Transmission-Based Precautions when caring for sick people. See: What Healthcare Personnel Should Know About Caring for Patients with Confirmed or Possible COVID-19 Infection.
- o Establish procedures for safely transporting anyone sick home or to a healthcare facility.
- o Notify local health officials, staff, and families immediately of a possible case while maintaining confidentiality as required by the Americans with Disabilities Act (ADA).
- o Close off areas used by a sick person and do not use before cleaning and disinfection. Wait 24 hours before you clean and disinfect. If it is not possible to wait 24 hours is, wait as long as possible. Ensure safe and correct application of disinfectants and keep disinfectant products away from children.
- o Advise sick staff members not to return until they have met CDC criteria to discontinue home isolation.
- o Inform those who have had close contact to a person diagnosed with COVID-19 to stay home and self-monitor for symptoms, and to follow CDC guidance if symptoms develop. If a person does not have symptoms follow appropriate CDC guidance for home isolation.

Maintain healthy operations (Phases 1-3)

- o Implement flexible sick leave policies and practices, if feasible. o
Monitor staff absenteeism and have a roster of trained back-up staff.
- o Monitor health clinic traffic. School nurses and other healthcare providers play an important role in monitoring health clinic traffic and the types of illnesses and symptoms among students.
- o Designate a staff person to be responsible for responding to COVID-19 concerns. Employees should know who this person is and how to contact them.
- o Create a communication systems for staff and families for self-reporting of symptoms and notification of exposures and closures.

Closing

Phases 1-3

- o Check State and local health department notices daily about transmission in the area and adjust operations accordingly
- o In the event a person diagnosed with COVID-19 is determined to have been in the building and poses a risk to the community, programs may consider closing for a short time (1-2 days) for cleaning and disinfection.

INTERIM GUIDANCE FOR EMPLOYERS WITH VULNERABLE WORKERS

As workplaces consider re-opening it is particularly important to keep in mind that some workers are at higher risk for severe illness from COVID-19. These vulnerable workers include individuals over age 65 and those with underlying medical conditions. Such underlying conditions include, but are not limited to, chronic lung disease, moderate to severe asthma, hypertension, severe heart conditions, weakened immunity, severe obesity, diabetes, liver disease, and chronic kidney disease that requires dialysis. Vulnerable workers should be encouraged to self-identify, and employers should avoid making unnecessary medical inquiries. Employers should take particular care to reduce vulnerable workers' risk of exposure to COVID-19, while making sure to be compliant with relevant Americans with Disabilities Act (ADA) and Age Discrimination in Employment Act (ADEA) regulations. First and foremost, this means following CDC's and the Occupational Safety and Health Administration (OSHA) guidance for reducing workplace exposure for all employees. All decisions about following these recommendations should be made in collaboration with local health officials and other State and local authorities who can help assess the current level of mitigation needed based on levels of COVID-19 community transmission and the capacities of the local public health and healthcare systems. In addition, the guidance offered below applies to workplaces generally; specific industries may require more stringent safety precautions. Finally, there may be essential workplaces in which the recommended mitigation strategies are not feasible.

(Re)Opening

o In all Phases:

- o Establish and continue communication with local and State authorities to determine current mitigation levels in your community.
- o Protect employees at higher risk for severe illness by supporting and encouraging options to telework.
- o Consider offering vulnerable workers duties that minimize their contact with customers and other employees (e.g., restocking shelves rather than working as a cashier), if agreed to by the worker.
- o Ensure that any other entities sharing the same work space also follow this guidance.
- o Provide employees from higher transmission areas (earlier Phase areas) telework and other options as feasible to eliminate travel to workplaces in lower transmission (later Phase) areas and vice versa.
- o **Phase 1:** Reopen only if business can ensure **strict** social distancing, proper cleaning and disinfecting requirements, and protection of their workers and customers; vulnerable workers are recommended to shelter in place.

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- o **Phase 2:** Reopen only if business can ensure moderate social distancing, proper cleaning and disinfecting requirements, and protection of their workers and customers; vulnerable workers are recommended to shelter in place.
- o **Phase 3:** Reopen only if business can ensure limited social distancing, proper cleaning and disinfecting requirements, and protection of their workers and customers.

Safety Actions

Promote healthy hygiene practices (Phases 1-3)

- o Enforce hand washing, covering coughs and sneezes, and using cloth face coverings when around others where feasible; however, certain industries may require face shields.
- o Ensure that adequate supplies to support healthy hygiene behaviors, including soap, hand sanitizer with at least 60 percent alcohol, tissues, and no-touch trash cans
- o Post signs on how to stop the spread of COVID-19 properly wash hands, promote everyday protective measures, and properly wear a face covering.

Intensify cleaning, disinfection, and ventilation (Phases 1-3)

- o Clean, sanitize, and disinfect frequently touched surfaces at least daily and shared objects between use.
- o Avoid use or sharing of items that are not easily cleaned, sanitized, or disinfected.
- o Ensure safe and correct application of disinfectants.
- o Ensure that ventilation systems operate properly and increase circulation of outdoor air as much as possible by opening windows and doors, using fans, or other methods. Do not open windows and doors if doing so poses a safety risk to individuals and employees using the workspace.
- o Take steps to ensure that all water systems and features (for example, drinking fountains, decorative fountains) are safe to use after a prolonged facility shutdown to minimize the risk of Legionnaires' disease and other diseases associated with water.

Ensure social distancing (Phases 1-3)

- o Limit service to drive-throughs, curbside take out, or delivery options, if possible (Phase 1).
- o Consider installing physical barriers, such as sneeze guards and partitions, and changing workspace layouts to ensure all individuals remain at least six feet apart.
- o Close communal spaces, such as break rooms, if possible (Phase 1) or stagger use and clean and disinfect in between uses (Phases 2 & 3).
- o Encourage telework for as many employees as possible.
- o Consider rotating or staggering shifts to limit the number of employees in the workplace at the same time
- o Replace in-person meetings with video- or tele-conference calls whenever possible.

Cancel all group events, gatherings, or meetings of more than 10 people (Phase 1), of more than 50 people (Phase 2), and any events where social distancing of at least 6 feet cannot be maintained between participants (all Phases)

Assessing Case Report, Syndromic, and Laboratory Gating Indicators

Background

On April 16, 2020, the White House released the *Opening Up America Again* guideline (<https://www.whitehouse.gov/openingamerica/>), which outlines a three-phased approach to reducing community mitigation measures currently in place to limit transmission of the SARS-CoV-2 virus. The stated purpose of the guideline is to outline a path to re-opening the economy while mitigating the risk of resurgence in COVID-19 illnesses and protecting vulnerable populations. The phased approach can be implemented on a statewide basis or community-by-community at governors' discretion. The guideline proposes the use of three categories of "gating" indicators (based on symptoms, based on cases, and for hospitals) to assess when to move through three community mitigation phases (Phase One, Phase Two, and Phase Three). Two gating indicators are in each category, and include:

- *Indicators based on symptoms:*
 1. Downward trajectory of influenza-like illnesses (ILI syndrome) reported within a 14-day period
 - AND**
 2. Downward trajectory of COVID-like syndromic cases (*i.e.*, COVID-like illness or CLI syndrome) reported within a 14-day period
- *Indicators based on cases:*
 3. Downward trajectory of documented cases within a 14-day period
 - OR**
 4. Downward trajectory of positive tests as a percent of total tests within a 14-day period (flat or increasing volume of tests)
- *Indicators for hospitals:*
 5. Treat all patients without crisis care
 - AND**
 6. Robust testing program in place for at-risk healthcare workers, including emerging antibody testing

Of note, indicators 1 through 4 all rely on types of public health surveillance data to determine the trajectory of COVID-19 transmission within a jurisdiction. This document focuses on the measurement and interpretation of these four disease occurrence gating indicators because of their shared objective and use of common public health surveillance methods. This document also highlights other disease occurrence measures that may be important for state or local jurisdictions to consider when adjusting the intensity of community mitigation measures.

Considerations for the measurement and interpretation of the indicators for hospitals (numbered 5 and 6 above) are outside the scope of this current document and may be

addressed in an update or in separate documents, including guidance related to the use of emerging antibody tests in healthcare and other settings.

Disease Occurrence Gating Indicators

The following subsections provide further detail for each of the disease occurrence gating indicators outlined in the *Opening Up America Again* guideline, including a description and rationale, potential data sources, considerations for assessing decreases (and moving through the three mitigation phases), considerations for assessing increases (*i.e.*, “rebound”), and interpreting the measure in the context of its strengths and limitations. Numerous data sources and surveillance systems exist at the local, state, and federal levels that can be used to measure and evaluate these indicators. Local and state officials should use the best data available, regardless of source, when assessing the trajectory of COVID-19 illnesses. Variability will exist from jurisdiction to jurisdiction on the quality, completeness, and timeliness of these data sources and sufficient data may not be available for all jurisdictions to evaluate all four of the disease occurrence gating criteria. In situations where all the gating indicators cannot be assessed, additional data sources available locally may assist in determining the trajectory of COVID-19 activity in the jurisdiction.

Downward trajectory of ILI reported within a 14-day period

- **Description/Rationale:** ILI is a syndromic surveillance categorization applied to emergency department (ED) and outpatient visit symptom and diagnostic code data. This measure is intended to identify areas that are experiencing sustained decreases in outpatient clinic or ED visits in people with ILI. ILI is defined as fever with cough and/or a sore throat. COVID-19 may present with symptoms similar to ILI, so the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) and the National Syndromic Surveillance Program (NSSP) can be used to track COVID-19 trends, especially when paired with SARS-CoV-2 and other respiratory pathogen testing data.
- **Data Sources:** Outpatient care facilities and hospital EDs selected by state and/or local health departments for participation in the Outpatient Influenza-Like Illness Network (ILINet) report to CDC either directly or through their health department via a web-based reporting system. In addition, electronic data, including data from CDC’s National Syndromic Surveillance Program (NSSP) can be uploaded to ILINet. These data are stored in a shared database for use by CDC and state/local public health officials. States and jurisdictions may collect syndromic surveillance data on ILI locally that is not submitted to ILINet but could be useful for interpreting the ILI gating indicator. ILINet data is available publicly at the state-level at <https://www.cdc.gov/flu/weekly/fluviewinteractive.htm>.

- **Considerations for Assessing Decreases:**
 - Conceptually, a downward trajectory can be achieved when the number proportion outpatient visits for ILI continues to decrease each day for 14 days (or two consecutive weeks when only weekly data is available).
 - Normal variation in ILI ED and outpatient visits can impact assessment of daily trends, especially in smaller geographies with low daily visits and by variations in healthcare seeking behavior associated with the day of the week, holidays, and current social distancing measures.
 - Interpretation of trends in ILI visits also needs to account for periods of stable or sustained low activity and small increases in ILI on one or a few days in the context of the overall 14-day trend.
 - ILI activity levels are traditionally calculated for jurisdictions based on the percent of outpatient visits due to ILI in a jurisdiction compared with the average percent of ILI visits that occur during weeks with little or no influenza virus circulation in that jurisdiction (*i.e.*, non-influenza weeks), adjusted for the sites contributing data for the week. ILI activity values within two standard deviations of the non-influenza week mean are classified as a minimal level of ILI.
 - Given potential changes in healthcare seeking behaviors resulting from community mitigation measures that can significantly affect the denominator of ILI proportions, jurisdictions should analyze within-jurisdiction ILI trends using both the number (count) and proportion of visits to account for this potential bias.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the ILI gating indicator is met with respect to these phase transitions.
 - Transition into Phase One: achieve 14 consecutive days (or two weeks) of downward trajectory or maintaining minimal ILI activity level.
 - Transition into Phase Two: achieve an additional 14 consecutive days (or two weeks) of improvement (downward trajectory or minimal ILI activity level) without experiencing a rebound (defined below).
 - Transition into Phase Three: achieve another 14 consecutive days (or two weeks) of improvement (downward trajectory or minimal ILI activity level) without experiencing a rebound (defined below).
- **Identifying Rebound:**
 - An increase in ILI visits or an increase in ILI activity levels over 14 days (or 2 weeks) may indicate a potential rebound in COVID-19 activity.
 - Because multiple respiratory pathogens can present with ILI, an increase in ILI should be interpreted as a rebound in COVID-19 activity only if supported by

other surveillance data, including data on SARS-CoV-2, influenza, and other respiratory pathogen testing.

- **Interpretation/Limitations:**

- ILI is a nonspecific syndromic measure and can be influenced by the circulation of numerous respiratory pathogens and should be interpreted in the context of virologic and other surveillance data.
- The purpose of ILI surveillance is to detect changes in outpatient visits for febrile respiratory illness. The percent of patient visits for ILI can be impacted by changes in health care seeking behavior, so jurisdictions should look at numbers (counts) of ILI visits in addition to proportions.
- ILI frequency and activity levels within a jurisdiction are influenced by the mix of primary care practice types submitting data. These changes make direct comparisons of ILI from one jurisdiction to another invalid. Calculation of ILI activity levels allows for more appropriate comparison of ILI between jurisdictions.

Downward trajectory of COVID-like illness (CLI) reported within a 14-day period

- **Description/Rationale:** CLI is a syndromic surveillance categorization applied to ED visit symptom and diagnostic code data. This measure is intended to identify areas that are experiencing sustained decreases in ED visits consistent with the presenting symptoms of COVID-19 illness (fever and either cough, shortness of breath, or difficulty breathing) or with a coronavirus diagnostic code that fits CDC interim coding guidelines, and without a diagnostic code for influenza (<https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Guidance-Interim-Advice-coronavirus-feb-20-2020.pdf>). CLI can be used to track COVID-19 trends, especially when paired with SARS-CoV-2 and other respiratory pathogen testing data.
- **Data Sources:** Hospitals report ED visits in near real-time to state and/or local health departments and to NSSP. These data are stored within the BioSense Platform where they can be analyzed and exchanged by public health officials. States and jurisdictions may collect syndromic surveillance data on CLI locally that is not submitted to NSSP but could be useful for interpreting the CLI gating indicator.
- **Considerations for Assessing Decreases:**
 - Conceptually, a downward trajectory can be achieved when the number or proportion of CLI-related ED visits continues to decrease each day for 14 days.
 - Normal variation in CLI ED visits can impact assessment of daily trends, especially in smaller geographies with low daily visits and by variations in healthcare seeking behavior associated with the day of the week, holidays, and current social distancing measures.

- Interpretation of trends in CLI-related ED visits also needs to account for plateaus (periods with little or no change in CLI visits), ED visits reaching their pre-pandemic level (in which case no further downward trajectory is expected), and small increases in ED visits on one or a few days in the context of the overall 14-day trend.
- CDC NSSP analyses of CLI data attempt to address the challenges above by fitting a spline model to the time series data observed for various geographic stratifications and then recording the number of days of continuous decline. Regression models are also used to classify recent trends to understand whether a historical baseline of visits with these symptoms has been reached. Statistical coding used by CDC (using the R package) can be shared with state and local jurisdictions upon request.
- Given potential changes in healthcare seeking behaviors resulting from community mitigation measures that can significantly affect the denominator of CLI visit rates and onboarding of new NSSP participants, jurisdictions can analyze trends in either the number (count) or rate of CLI visits to account for these potential biases.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the CLI gating indicator is met with respect to these phase transitions.
 - Transition into Phase One: achieve 14 consecutive days of improvement (downward trajectory or near pre-pandemic outbreak CLI ED visits).
 - Transition into Phase Two: achieve an additional 14 consecutive days of improvement (downward trajectory or near pre-pandemic CLI ED visits) without experiencing a rebound (defined below).
 - Transition into Phase Three: achieve another 14 consecutive days of improvement (downward trajectory or near pre-pandemic CLI ED visits) without experiencing a rebound (defined below).
- **Identifying Rebound:** Two primary methods can be used to help assess for a rebound in CLI ED visits.
 - Within the BioSense Platform, daily statistical anomaly detection methods are automatically applied to time series trends and anomalous increases are flagged for further epidemiologic investigation. Multiple consecutive days of anomalies may be an indicator of increases in COVID-19 activity and could be used to focus additional testing of patients.
 - Regression methods (*e.g.*, binomial regression) can be used to classify time series trends in the last 14 days to assess whether recent trends show a

significant increase in patients being seen with CLI and can also be used to focus additional investigations and/or confirmatory testing.

- **Interpretation/Limitations:**

- The purpose of syndromic surveillance is to find timely, more automated, indicators of a change in patterns of illness or health seeking behaviors in a community that can initiate further confirmatory investigation. CLI is a non-specific syndromic measure and can likely be influenced by the circulation of other respiratory pathogens and should be interpreted in the context of virologic and other surveillance data.
- The timeliest element of ED records is the patient chief complaint text describing their symptoms. The CLI syndrome is based in part on the patient's chief complaint at presentation to the ED, which may or may not actually be COVID-19, but also includes visits that were assigned a COVID-19 diagnosis code.
- The data quality and completeness of chief complaint text and diagnostic codes can vary by reporting hospital and can negatively impact assessment of trends over time. Comparability of findings across geographies may also be impacted should these differences become too large.
- In general, syndromic categorizations emphasize timeliness and sensitivity over specificity. As such, the CLI gating indicator may exhibit changes earlier than other indicators, but may also include visits for other illnesses that have similar symptoms as COVID-19 (*e.g.*, other respiratory viruses). Interpretation of CLI data should always be considered in conjunction with other data sources and local context. This includes data that track the presence of other respiratory illnesses (*e.g.*, respiratory syncytial virus) circulating within the community that may be difficult to distinguish using syndromic data alone.

Downward trajectory of documented (confirmed and probable) cases within a 14-day period

- **Description/Rationale:** On April 5, 2020, the Council of State and Territorial Epidemiologists (CSTE) issued an interim COVID-19 position statement making COVID-19 a nationally notifiable disease and establishing confirmed and probable case definitions (www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf). The case report gating indicator is intended to identify communities experiencing sustained decreases in the number of new cases occurring each day; an indication of decreases in disease transmission.
- **Data Sources:** Case report information for confirmed and probable cases collected by state and local jurisdictions and submitted to CDC; publicly available aggregated case count data (*e.g.*, USAFacts: <https://usafacts.org/visualizations/coronavirus-covid-19-spread-map/>); US Census population estimates (used as denominator for incidence calculations).

- **Considerations for Assessing Decreases:**
 - Conceptually, a downward trajectory can be achieved when the number of new cases reported (or daily incidence rate) continues to decrease each day for 14 days. However, variation in how cases are ascertained and reported can impact this type of daily assessment, especially in smaller geographies with low daily case counts and over weekends or holidays (*i.e.*, reporting artifacts).
 - Interpretation of trends in case report data also needs to account for incidence plateaus (periods with little or no change in daily incidence), incidence reaching zero or near-zero (in which case no further downward trajectory can occur), and small increases in cases on one or a few days in the context of the overall 14-day period.
 - CDC analyses of case report data attempt to address these challenges by using a method that averages the number of new cases observed over a specified period (*e.g.*, 3-day average) and then fits a model (specifically, a spline model) to those data to assess changes in the slope of each community’s “smoothed” epidemic curve. The number of days in a downward trajectory is then calculated as the number of consecutive days the smoothed epidemic curve had a negative slope or was in a low-incidence plateau (*e.g.*, two-week incidence <10 cases per 100,000 and a near-zero slope). Statistical coding used by CDC (using the R package) can be shared with state and local jurisdictions upon request.
 - Modeling approaches are not required to assess downward trajectory in case reports, but any method should address how to handle reporting variations, incidence plateaus, and near-zero incidence.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the case report gating indicator is met with respect to these phase transitions. Note that the *Opening Up America Again* guideline specifies that either the case report gating indicator or the percent positive gating indicator should be met.
 - Transition into Phase One: achieve 14 consecutive days of improvement (downward trajectory or near-zero incidence).
 - Transition into Phase Two: achieve an additional 14 consecutive days of improvement (downward trajectory or near-zero incidence) without experiencing a rebound (defined below).
 - Transition into Phase Three: achieve another 14 consecutive days of improvement (downward trajectory or near-zero incidence) without experiencing a rebound (defined below).
- **Identifying Rebound:**

- Because case reports are a lagging indicator, increases in new cases over a short time period (*e.g.*, 5 or more consecutive days of growth in daily case incidence) should be considered a potential indicator of rebound in COVID-19 activity.
- CDC analyses of case report data define “rebound” as a community, after entering Phase One, Two, or Three (*i.e.*, achieved at least one period of 14 or more consecutive days of downward trajectory), which experiences an increase in daily cumulative COVID-19 case incidence (slope >0.1 cases per 100,000 per day) for 5 or more consecutive days and has an elevated two-week incidence (>10 cases per 100,000 during the past 2 weeks).
- **Interpretation/Limitations:**
 - Case report data are a lagging indicator for assessing SARS-CoV-2 transmission in the community, as new cases are not identified until after the incubation period occurs, the ill person seeks testing or healthcare for their illness, and the information is reported to health officials.
 - The choice of the dates used (*e.g.*, onset date, report date) are critical in the interpretation of observed trends. In general, it is preferable to use the dates most proximal to onset date, but even epidemic curves based on onset date should account for the fact that very recent cases have not yet been reported. Excluding recent onset dates (*e.g.*, in the last week) from assessment of trends is recommended to ensure that incomplete reporting of recent cases does not give the false appearance of downward trajectory. Epidemic curves based on date of report do not require a lag window but are limited by the fact that they reflect transmission activity further in the past than in epidemic curves using onset dates.
 - CDC analyses are typically based on the date of case report and not diagnosis or onset date because it is the most uniformly available date across jurisdictions. Preliminary analyses of national data show that there is typically an 8- to 10-day lag between the date of symptom onset and the date the case is reported to CDC, but this varies by jurisdiction.
 - Data quality, as well as case ascertainment and reporting processes (*e.g.*, beginning to report probable cases), may vary by jurisdiction or over time, which can impact trend assessments and should be accounted for.
 - Case report findings should be interpreted in the context of other available data, including COVID-19-related syndromic surveillance, testing intensity, percent positive tests, and hospitalization and death data. For example, changes in the trajectory of case incidence could be the result of changes in testing intensity.
 - A sustained downward trajectory demonstrates improvement in daily case incidence but does not necessarily equate to a low disease burden. Communities should consider local resource capacity (*e.g.*, availability of public health staff to

conduct contact tracing) when determining appropriate incidence thresholds for making phase transition decisions.

Downward trajectory of positive tests as a percent of total tests within a 14-day period with stable or increasing test volume

- **Description/Rationale:** Laboratory test percent positive can be used in combination with, or as an alternative to, observing a decline in new case reports. In circumstances where testing is adequate and testing practices are largely stable, percent positive can be a reliable indicator of COVID-19 activity.
- **Data Sources:** Positive and negative SARS-CoV-2 test results reported by laboratories to state health departments. If states and counties have more complete data than federal sources, local data should be used. Federal data available at the state and county level include tests from public health and CDC laboratories, six large commercial and reference laboratories, and hospital testing data uploaded by ~500 hospitals to the HHS Protect system daily. Data from the Census Bureau's Population Estimates Program can be used to estimate state and county population denominators for per-capita test rates.
- **Considerations for Assessing Decreases:**
 - Percent positive is typically calculated as number of positive tests divided by the total test results, with total test results defined as the sum of positive tests and negative tests, excluding records where the test was not performed because the specimen was not usable or the test was cancelled. The number of tests with indeterminate results has been small, so the decision of whether to include or exclude these in the denominator of total test results should not affect interpretation of the trends observed.
 - Some data sources include a National Provider Index code for the physician who ordered the test, allowing communities to track changes in the relative proportion of tests ordered by clinicians with specialties such as emergency medicine and family medicine over time. Some laboratories include account numbers that can be used to identify community testing programs, such as drive-up testing. And some include a code that indicates whether the test was ordered from a nursing home, prison, or other high-risk setting. Tracking the percent positive in tests from these facility types may allow for improved understanding of the populations tested and for more targeted decision-making.
- **Mitigation Phase Transitions:** All the gating indicators as well as other information available locally should be used by jurisdictions when choosing to move through the community mitigation phases. Below is a framework for specifically evaluating whether the percent positive gating indicator is met with respect to these phase transitions. Note that in the *Opening Up America Again*, guideline, the case report gating indicator or the percent positive gating indicator should be met.

- Transition into Phase One: achieve 14 or more consecutive days of decline in percent positive while total test volume is stable or increasing.
- Transition into Phase Two: achieve an additional 14 or more consecutive days of decline in percent positive while total test volume is stable or increasing.
- Transition into Phase Three: achieve an additional 14 or more consecutive days of decline in percent positive while total test volume is stable or increasing.
- **Identifying Rebound:** Communities should consider reviewing multi-day increase in percent positivity with stable or increasing testing volume in the context of other data. Increases in percent positive of laboratory data should be reviewed in context with the case report and CLI data, as fluctuations in testing volume might impact interpretations, especially in smaller communities.
- **Interpretation/Limitations:**
 - The daily percent positive may fluctuate, particularly in areas with smaller populations. Total test volume may also vary by day of the week, based on the number of tests ordered or regular system maintenance at laboratories. It may thus be helpful in some cases to assess trends using moving averages or other smoothing techniques.
 - The percent positive is driven by the number of people who are positive in a community and the number of people who are tested. Declines in percent positive may result from an expansion of testing to more people. Thus, it is important to track percent positive in combination with the number tested, whether measured as the total volume of all test results, or as total test results per capita. Percent positivity should only be used as an indicator of COVID-19 activity when per capita testing levels are stable over the time period being assessed.
 - The percent positive may also be affected by a changing proportion of tests in people who are less likely to be infected, such as those who are asymptomatic or who have less severe symptoms. Few laboratories have fields indicating whether the person tested was asymptomatic or whether the patient was in an inpatient or outpatient setting at the time of testing. However, communities can stratify by data source to assess changes in the population tested over time, such as tracking the percent positive in hospital data separately from the percent positive in large commercial laboratories.
 - To avoid duplication, hospitals were asked to report only those tests to the HHS Protect system that were not sent out to large commercial laboratories. However, test data reported to HHS Protect do not include patient identifiers, so might still include some duplicates.
 - The residence of the person tested may not be validated as thoroughly in laboratory data as in case data. Patient zip code may be based on insurance

billing data, and thus less likely to be complete and correct when the person tested is uninsured or on another family member's plan.

- Provider zip code is generally accurate, when available. However, drive-up facilities might use a central zip code that does not reflect where the physical drive-up facility is located.

Joint interpretation of all four disease occurrence gating criteria

The four disease occurrence gating indicators should be interpreted collectively to reach a determination on the trajectory of COVID-19 activity within a jurisdiction, bearing in mind that the measures differ significantly in their lag, specificity, and sensitivity. Lab testing and syndromic data sources generally have less lag than COVID-19 case report data relative to when transmission occurred. SARS-CoV-2 testing and COVID-19 case reports are more specific measures of COVID-19 activity than the CLI syndrome, but all three are likely far more specific than the ILI syndrome. The CLI syndrome likely has superior sensitivity to the other measures, as it is more likely to capture people with COVID-19 that were not tested. While downward trajectory for a period of 14 days is used for each of the disease occurrence gating indicators in the *Opening Up America Again* guideline, state and local jurisdictions should use judgment based on their knowledge of local disease surveillance practices and infrastructure in determining whether longer time periods (e.g., 21 or 28 days) are needed before moving to different community mitigation phases.

Other Data Sources and Measures

The four disease occurrence gating indicators above can collectively provide insights into both the intensity and trajectory of the COVID-19 pandemic within jurisdictions. However, other epidemiologic data sources potentially available to local, state, and federal health officials can also be useful to verify trends observed in the disease occurrence gating indicators.

- **COVID-19 hospital admissions:** Depending on the overall COVID-19 incidence rate, the size of the jurisdiction, and the regional hospital referral patterns, hospitalizations for laboratory-confirmed COVID-19 can be an important measure to assess trajectory. Testing is likely more complete and less variable in hospitalized populations, providing more assurance that observed trends are not driven by testing practices. In addition to helping verify increases or decreases in the disease occurrence gating indicators, monitoring COVID-19 hospital admissions (and discharges) can help assess the burden on local healthcare capacity.
- **COVID-19 deaths:** Depending on the overall COVID-19 incidence rate and the size of the jurisdiction, deaths due to COVID-19 may occur in high enough numbers to reliably assess the trajectory of the outbreak in the jurisdiction. Although they represent a small

proportion of all COVID-19 illnesses and significantly lag the core disease occurrence gating indicators, vital records are a universally collected data source and should be available for review in all jurisdictions. Further, observing declines in newly reported COVID-19 deaths almost certainly indicates that demands on the healthcare system are waning. Care should be taken to understand the extent and variability in SARS-CoV-2 testing for deceased individuals in the jurisdiction when using death as a source of data to understand the overall trajectory of COVID-19 illnesses in the jurisdiction. COVID-19 death data reported to CDC's National Center for Health Statistics are published weekly by state (<https://www.cdc.gov/nchs/nvss/vsrr/covid19/index.htm>).

- **Measures of trajectory:** The effective reproductive number (the average number of secondary cases from an infectious case in an a particular population at a specific point in time) and doubling time (the time required for the number of cases to double) are epidemiologic measures that can be used to characterize the speed with which illnesses are spreading in an outbreak. Although these measures can be imprecise, especially when calculated within smaller populations, they provide alternative ways to analyze and characterize the trajectory of COVID-19 activity.

Implied in the Core State Preparedness Responsibilities in the *Opening Up America Again* guideline is the need for jurisdictions to have confidence in the epidemiologic data being used to make assessments about the magnitude and trajectory of COVID-19 illnesses. In order for most of the gating indicators to be reliably assessed, 1) rapid testing should be occurring as indicated for all clinical, public health, and infection prevention needs and 2) all new symptomatic COVID-19 cases in the jurisdiction should be able to be rapidly identified through active surveillance of laboratories and healthcare facilities. In the absence of widespread testing and robust active surveillance, jurisdictions should be cautious when adjusting mitigation strategies based on the disease occurrence gating indicators. Several measures, listed below, can be helpful in providing an indirect assessment of the completeness of case ascertainment in a jurisdiction.

- **COVID-19 case-fatality ratio:** Case-fatality is defined as the proportion of COVID-19 cases that die as a result of their infection. Although estimates of the percentage of symptomatic COVID-19 illnesses that result in death has varied widely, the overall percentage is likely lower than 1-2%. Although many factors contribute to disease severity, including the underlying health status of the population, jurisdictions that have very high COVID-19 case-fatality ratios (above 5-10%) may be under-ascertaining COVID-19 illnesses. This could indicate that case reporting is an unreliable measure of true COVID-19 activity. In this situation it may be useful to examine measures for CLI syndrome or COVID-19 hospital admissions as measures of disease activity.
- **High percent positive:** Although changes in percent positive is an indicator in the *Opening Up America Again* guideline, very high proportions of SARS-CoV-2 positivity

(e.g., >25%) may be an indicator that testing levels are not adequate and that COVID-19 illnesses are being under-ascertained in the jurisdiction, as it suggests that only a limited number of people with a high likelihood of being infected with SARS-CoV-2 are able to be tested. In this situation it also may be useful to look at the CLI syndrome or at COVID-19 hospital admissions as measures of disease activity, since they are likely less susceptible to the influence of testing availability.

- **Per capita testing:** It is difficult to determine a widely applicable benchmark for a per capita level of SARS-CoV-2 testing that is sufficient to have confidence in the adequacy of COVID-19 case-ascertainment. If data are available, however, jurisdictions can consider evaluating their per capita testing frequency to assist in judging whether testing levels are adequate to perform effective COVID-19 surveillance.
- **Proportion of cases with an unknown source:** Improvements in case ascertainment and contact tracing should lead to a lower proportion of new cases with an unknown exposure to SARS-CoV-2. Jurisdictions can consider tracking the proportion of new COVID-19 cases without a documented exposure source (e.g., travel to a high-incidence region or country, exposure to someone with a confirmed case of COVID-19, attending an event or going to a setting with suspected SARS-CoV-2 transmission). Although difficult to achieve, jurisdictions that have fewer than 50% of new cases with an unknown exposure source likely have achieved high levels of case ascertainment, interviewing, and contact tracing.

Additional Considerations

Overall Incidence Level

The disease occurrence gating indicators all pertain to assessing the trajectory of COVID-19 activity, but do not specify that COVID-19 incidence should reach an absolute level to move through the mitigation phases. Jurisdictions should be cautious in pivoting from a general community mitigation approach back toward an identification and containment approach until incidence is low enough and resources adequate to 1) attempt an initial interview for nearly all new COVID-19 cases within one day of health department notification, 2) to rapidly isolate all newly identified COVID-19 cases, and 3) to initiate appropriate follow up (isolation, self-monitoring, and rapid testing of symptomatic contacts) for nearly all identified contacts of newly identified cases. Incidence should also be low enough that health departments can respond to large outbreaks (e.g., nursing home outbreaks) that require substantial resources to investigate and control. Declines in incidence should also be enough for healthcare capacity to not only meet current demands, but to be able to comfortably surge in the event of an increase in cases (e.g., availability of acute care beds, critical care beds, ventilators, and adequate PPE).

Special Populations and Settings

Infections in high-risk settings and populations can disproportionately impact localized transmission and the ability of public health capacity to keep pace with follow up needs such as contact tracing and screening. Efforts should be taken to monitor infections in some specific populations and settings, including but not limited to healthcare personnel, patients in healthcare facilities (e.g., nursing homes, dialysis centers, long term care facilities), and residents of congregate living settings (e.g., prisons, youth homes, shelters). In addition, identification of illnesses at events with the potential for “explosive spread” (e.g., mass gatherings) may in and of themselves warrant adjustment of community mitigation measures in the absence of community-wide changes in the disease occurrence gating indicators.

Neighboring Jurisdictions

When making decisions about adjusting community mitigation measures, state and local jurisdictions also should coordinate with officials in neighboring areas to assess the burden and trajectory of COVID-19 illnesses in the surrounding region. Neighboring or nearby jurisdictions with significantly higher incidence or with increasing COVID-19 activity could reintroduce SARS-CoV-2 to a jurisdiction, jeopardizing improvements within the jurisdiction.

Measures of Mobility and Social Distancing

If available, it may be important to understand the knowledge, attitudes and behaviors of the community as it relates to the public health guidance provided within the local jurisdiction. Survey data and data on mobility can be useful in understanding if community members are aware of and following established social distancing and isolation guidelines and informing changes in the mitigation strategies used. Several publicly available data sources currently exist that generate measures of social distancing and mobility, frequently based on mobile phone location services or social media data.

Summary

The disease occurrence gating indicators in the *Opening Up America Again* guideline can provide states and communities insight into the trajectory of the COVID-19 pandemic in their jurisdiction. The disease occurrence gating indicators should be evaluated collectively, considering their relative strengths and weaknesses, as well as in the context of other epidemiologic data available for the jurisdiction. This document specifically provides a framework for assessing the four disease occurrence gating indicators in the *Opening Up America Again* guideline. These epidemiologic indicators are just one part of the broad assessment jurisdictions should undertake when deciding when and how to adjust community

mitigation strategies for COVID-19. Other factors include, but are not limited to, healthcare capacity, community capacity and characteristics, and economic indicators.

Guidance for Implementing the Opening Up America Again Framework

This implementation guidance provides tools and resources to assist decision makers to implement the Guidelines for Opening Up America Again framework. Guidance is provided to monitor local conditions (transmission, public health, and healthcare system capacity) and adjust mitigation strategies over time to effectively contain outbreaks and minimize negative side effects of more significant restrictions on commerce and education.

It begins with steps that all Americans need to take in every community. From there, it outlines core capacities needed in communities to respond to and manage COVID-19 cases as well as delineates key metrics to monitor community mitigation efforts. All of the guidance is anchored to the phases of the *Opening Up America Again* framework.

The appendices contain more detailed tools for communities such as indicators to better track and adjust mitigation efforts as well as comprehensive mitigation guidance organized by phase and by setting. Finally, there are user-friendly decision trees to help leaders make informed decisions about reopening. A companion community leader's guide to further enable implementation activities accompanies this resource.

Steps for All Americans in Every Community

ALL JURISDICTIONS SHOULD CONTINUE TO PROMOTE INDIVIDUAL AND WORKPLACE practices that reduce the risk of transmission AS PEOPLE MOVE THROUGH THE COMMUNITY.

INDIVIDUALS SHOULD:

- ✓ CONTINUE TO wash their hands OFTEN
- ✓ COVER THEIR COUGHS AND SNEEZES
- ✓ AVOID CLOSE CONTACT WITH OTHERS
- ✓ DISINFECT FREQUENTLY-USED ITEMS AND SURFACES
- ✓ STAY HOME WHEN THEY FEEL SICK
- ✓ USE cloth face coverings WHEN OUT IN PUBLIC

EMPLOYERS SHOULD:

- ✓ NOTIFY AND WORK WITH STATE & LOCAL PUBLIC HEALTH OFFICIALS IF AN EMPLOYEE TESTS POSITIVE FOR COVID-19
- ✓ DEVELOP AND IMPLEMENT APPROPRIATE POLICIES, IN ACCORDANCE WITH FEDERAL, STATE, AND LOCAL REGULATIONS AND GUIDANCE AND INFORMED BY INDUSTRY BEST PRACTICES, REGARDING:
 - SOCIAL DISTANCING
 - PERSONAL PROTECTIVE EQUIPMENT
 - HEALTH CHECKS LIKE TEMPERATURE SCREENING
 - ISOLATING AND SENDING HOME THOSE WHO ARE SICK
 - NOT ALLOWING EMPLOYEES POSITIVE FOR COVID-19 TO PHYSICALLY RETURN TO WORK UNTIL CLEARED BY A MEDICAL PROVIDER, OR ACCORDING TO the guidance for discontinuing home isolation for COVID+ cases managed at home
 - NOTIFYING LOCAL HEALTH OFFICIALS AND INDIVIDUALS WHO MAY HAVE BEEN EXPOSED WHEN SOMEONE IS CONFIRMED, OR PRESUMED TO BE POSITIVE FOR COVID-19
 - SANITIZATION, CLEANING AND DISINFECTION
 - BUSINESS TRAVEL

Preparing— Establishing Core Capacity

All jurisdictions need to build and maintain a core capacity to respond to and manage COVID-19 cases. Leaders should convene a broad set of stakeholders across sectors to:

- ✓ Communicate data about local transmission, public health and healthcare system capacity, risk to vulnerable populations, and economic considerations;
- ✓ Share local status of gating criteria (as described by Opening America Up Again framework, and below); and
- ✓ Develop coordinated re-opening plans and guidance

The framework for *Opening America up Again* outlines core preparedness plans every jurisdiction needs before beginning the process of “gating” or reducing mitigation strategies. This is especially important in a jurisdiction that has experienced significant transmission and healthcare system strain. Assistance is available, including staffing, to support states, tribes, localities, and territories to establish and maintain this capacity.

Plans should be updated throughout the response to ensure lessons learned are rapidly assimilated into practice and at a minimum address the following components:

Testing and Contact Tracing

- Ability to quickly set up safe and efficient screening and testing sites for symptomatic individuals, and to trace contacts of COVID-19+ cases
- Ability to test syndromic/Influenza-Like Illness (ILI)-indicated persons for COVID-19 and trace contacts of COVID-19+ cases
- Ability to test at sentinel surveillance sites for asymptomatic cases, and trace contacts of COVID-19+ cases

Healthcare System Capacity

- Ability to quickly and independently ensure adequate staff and provide critical medical equipment and supplies (e.g. personal protective equipment (PPE)) to meet unexpected surge demands
- Ability to surge ICU capacity

Develop Plans Specific to Community Needs

- Protect the health and safety of workers in all settings
- Protect the health and safety of vulnerable populations and those living and working in high-risk settings (e.g., senior care facilities, correctional facilities)
- Protect employees and users of mass transit
- Implement strategies to promote social distancing and use of cloth face coverings
- Monitor local transmission and public health and healthcare system capacity
- Immediately take steps to limit any rebounds in transmission, or outbreaks, by increasing mitigation strategies to address a specific outbreak (e.g., returning to an earlier phase as outlined in the Opening America Up Again framework, depending on severity).

Monitoring Community Conditions and Gating Criteria

Once the core capacity is in place, monitoring community transmission, public health, and healthcare system capacity will help jurisdictions assess readiness for moving between phases for lifting mitigation strategies. The *Opening Up America Again* framework outlines gating criteria for states and localities to use in determining when and how to decrease or increase community mitigation strategies over time as the risk of transmission for COVID-19 changes.

These gating criteria are anchored to time-bound, population-level metrics of COVID-19 burden (newly identified cases, emergency department or outpatient visits associated with the disease, and percentage of COVID-19 positive tests) as well as measures of the public health and health-system capacity to address current circumstances (robust testing and contact tracing capabilities, hospital inpatient and ICU beds, and access to PPE).

Communities with significant or uncontrolled community transmission are considered in pre-gating or Phase 0. Jurisdictions need to meet all the gating criteria prior to removing any shelter in place order or entering Phase 1. These metrics and how to utilize them to inform decision-making are described in Appendix 1.

Once the gating criteria are met, jurisdictions enter Phase 1 and proceed to move between three phases, altering the level of community mitigation recommended as they pass through each gate. Phase 1 corresponds to areas with the highest disease burden and ongoing community transmission, with the most significant mitigation strategies in place. At the other end, Phase 3 corresponds to areas with lower disease burden and less frequent community transmission with the least significant community mitigation strategies deployed.

Each phase outlines necessary mitigation strategies to protect public health. Until a vaccine is widely available and/or medications are broadly accessible to manage COVID-19 symptoms, individuals need to follow good personal hygiene practices, stay at home when sick, and practice some amount of physical distancing to lower the risk of disease spread. These precautions are needed regardless of the phase a community is in.

It is also critical to identify when transmission begins to place the public health and healthcare system at risk, so appropriate actions can be taken. A [gating indicators dashboard](#) has been created as a tool to help pull relevant data streams into one platform to support decision making and regional planning and coordination. It can be accessed by jurisdiction officials through GeoHealth. Again, indicators and thresholds can be found in Appendix 1.

Community Mitigation Across the Phases

Protecting public health is at the center of the *Opening Up America Again* framework. However, jurisdictions are also addressing the economic and social consequences of COVID-19. Mitigation strategies should be implemented in a manner that is sufficient to contain transmission and allow sectors to plan for and minimize the negative impacts of the mitigation. The earliest signs of a cluster of new cases or a reemergence of broader community transmission should result in a re-evaluation of community mitigation strategies and a decision on whether they should be strengthened. Increasing mitigation should be tailored and measured, specific to any increase observed.

For example, an outbreak in a high risk setting such as a nursing home or correctional facility would result in strict mitigation, contact tracing and isolation of cases for all individuals entering that setting, but may not necessitate implementing strict community-wide measures such as a shelter-in-place order if the outbreak can be effectively contained. Assessing the appropriate mitigation approach and only implementing the strategies appropriate to the observed transmission will help minimize the societal and economic impacts of mitigation.

The following framework categorizes jurisdictions based on the level of transmission and community capacity to contain the transmission. The categories align with the phases in the *Opening Up America Again* plan to assist with transitions between the gates and phases.

Community Mitigation by Re-Opening Phases				
Opening Up America Again Phase	Pre-Gating or Phase Zero	Phase One	Phase Two	Phase Three
Transmission Characteristics	Significant or Uncontrolled Transmission	Significant Controlled Transmission	Moderate, Controlled Transmission	Low, Controlled Transmission
Community Description	Emerging and Current Hot Spots Public health and health system capacity exceeded	Previous hotspots where transmission has met thresholds and public health and health care systems can manage level of transmission	Moderate transmission that is within capacity of the public health and health systems	Limited Transmission (rural, low density areas)
Mitigation Needs	Shelter In Place	Significant Mitigation	Moderate Mitigation	Low Mitigation
Thresholds for Gating & Mitigation Adjustments	Thresholds for gating not met; maintain or initiate significant mitigation, or implement additional mitigation if not currently in place	Thresholds for gating met/maintained: reduce mitigation to Phase 1 then maintain until next gating thresholds are met OR Moderate Transmission community where public health or healthcare system capacity thresholds are no longer met; increase mitigation across all settings to Phase 1 level	Thresholds for gating met/maintained: reduce mitigation to Phase 2 then maintain until next gating thresholds are met OR Low Transmission community where public health or healthcare system capacity thresholds are no longer met: increase mitigation across all settings to Phase 2 level	Thresholds for gating not necessary if community never experienced transmission that exceeded public health or healthcare system capacity; apply Guidelines for all Phases OR Moderate Transmission community where thresholds for gating met/maintained: reduce mitigation across all settings to Phase 3 level

Travel patterns within and between jurisdictions will impact efforts to reduce community transmission too. Coordination across state and local jurisdictions is critical – especially between jurisdictions with different mitigation needs. Considerations for employers and employees are outlined in Appendix 2. Refer to the latest [CDC travel guidance](#) for additional information.

Decision-Making for Community Mitigation

State, local, tribal, and territorial officials are best positioned to determine which phase their jurisdiction falls within. Decisions about moving to a different phase will be made at the state, local, tribal and territorial level.

APPENDICES 3-5 CONTAIN MORE DETAILED TOOLS AND RESOURCES TO HELP OFFICIALS MAKE DECISIONS ABOUT THE APPROPRIATE LEVEL OF COMMUNITY MITIGATION BY PHASE AND SETTING. APPENDIX 6 CONTAINS THE DEVELOPMENT AND PRE-PRODUCTION CONCEPTS FOR A COMMUNITY LEADER'S GUIDE TOOLKIT.

Appendix 1: Indicators and Thresholds for Monitoring and Adjusting Mitigation Strategies

WH Gating Criteria	Threshold for entering Phase 1	Threshold for entering Phase 2	Threshold for entering Phase 3
Decreases in newly identified COVID-19 cases	Downward trajectory (or near-zero incidence) of documented cases over a 14-day period	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days <i>after entering Phase 1</i>	Downward trajectory (or near-zero incidence) of documented cases for at least 14 days <i>after entering Phase 2</i>
Decreases in ED and/or outpatient visits for COVID-like illness (CLI)	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported over a 14-day period	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported for at least 14 days <i>after entering Phase 1</i>	Downward trajectory (or near-zero incidence) of CLI syndromic cases reported for at least an additional 14 days <i>after entering Phase 2</i>
Decreases in ED and/or outpatient visits for influenza-like illness (ILI)	Downward trajectory (or near-zero incidence) of ILI reported over a 14-day period	Downward trajectory (or near-zero incidence) of ILI reported for at least 14 days <i>after entering Phase 1</i>	Downward trajectory (or near-zero incidence) of ILI reported for at least an additional 14 days <i>after entering Phase 2</i>
Decreases in percentage of SARS-CoV-2 tests positive	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests over a 14-day period (flat or increasing volume of tests)	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for 14 days <i>after entering Phase 1</i> (flat or increasing volume of tests)	Downward trajectory (or near-zero percent positive) of positive tests as a percent of total tests for at least 14 days <i>after entering Phase 2</i> (flat or increasing volume of tests)
Treat all patients without crisis care	- Jurisdiction inpt & ICU beds <80% full - Staff shortage in last week = no - PPE supplies adequate for >4 days	- Jurisdiction inpt & ICU beds <75% full - Staff shortage in last week = no - PPE supplies adequate for >4 days	- Jurisdiction inpt & ICU beds <70% full - Staff shortage in last week = no - PPE supplies adequate for >15 days
Robust testing program	- Test availability such that % positive tests $\leq$ 20% for 14 days - Median time from test order to result <5 days	- Test availability such that % positive tests $\leq$ 15% for 14 days - Median time from test order to result <4 days	- Test availability such that % positive tests $\leq$ 10% for 14 days - Median time from test order to result <3 days

Community Demographics***provided as conditions to consider as having an impact on other indicators*

Category	Indicator	Level of Consideration
Population Density	Population density, as a metric for feasibility of physical distancing in select settings	Population density of < 50 people per square mile
High risk population density	Proportion of population over 65 years	Less than 10% of population over 65 years Less than 15% of population over 65 years
	Prevalence of cardiovascular disease and/or COPD	Less than 3.7% of population estimated to have cardiovascular disease and 6% or less with COPD
	Households with limited English literacy	Less than 30% of population Map view (https://bit.ly/2UUtWBn)
	Population below the poverty level	Less than 10-12% of population Map view (https://bit.ly/2woXlOl)
	Percent with no health insurance coverage	Less than 10% of population Map view (https://bit.ly/3e3tubu)
Compliance indicators	Number of violations / complaints related to mandatory or recommended community mitigation	Significant increase in non-compliance

Economic Health Indicators******Provided as conditions to observe as indications of civic strain under strict mitigation measures**

Category	Indicator	Thresholds
Economic Activity	Overall & Small Business Health Indices	+/- monthly / quarterly change per industry, lifeline, CIKR
	Foot traffic (leading), COVID-19 Business Impact Index (lagging)	Federal, state and local orders are lifted with ability for 65-80% of in-person business activity to safely resume with guidance.
	Daily Economic Loss	- Onsite worker wages lost - Permanent business closures
	Loss of jobs, businesses, real estate (lagging)	Number of evictions foreclosures and in community (commercial and residential)
	High output economic producers	List, ranking by state, community
	Loss of sales and business revenue	- Quarterly and Annual sales and earnings reports - Earnings before interest/tax/depreciation by industry and geography (state, community)
	Permanent Business Closure	# or % in a community or state # or % of a sector
	GDP Loss	- Less than 30% loss from pre-COVID-19 baseline - Monthly business activity index at 80% pre-COVID19 levels
Testing Required to Safely Operate Business	# Employees, customers and household members exposed with planned business and industry re-openings	Testing availability for 100% symptomatic individuals exposed contacts

	Screening	Company screening processes / guidelines exist
	# Testing Units	10 business day standby inventory of 1 test per 10 employees; - Production targets established and supply chains coordinated to ensure targets are met for 30 days for employees and households including critical infrastructure, small businesses and retail business market segments.
	Number or percentage of businesses with high contact rates	Percentage or number of businesses that cannot socially distance (e.g., meat packing)
PPE Required to Safely Operate Business	# PPE/day/ employee for normal workplace requirements	Sufficient routine PPE / day / employee for a minimum of 5 business days in the health & medical lifeline, safety & security lifeline, retail marketplace, manufacturing and constructions sites
	# PPE/day/employee for COVID-19 workplace requirements	PPE production targets established and supply chains coordinated to ensure production and delivery targets are met for a period of 15 business days for employees of critical infrastructure, small business and retail market segments.
	Ability of businesses to obtain PPE and disinfectants to support operations	PPE and cleaning requirements for essential and reopened businesses (contact rate (high, medium, low))

Business & Industry Capacity Indicators******Provided as conditions to observe as indications of civic strain under strict mitigation measures**

Category	Indicator	Thresholds
Business Continuity	COVID-19 continuity plan	Workplace has standard risk management guidance, safe work plans, and a monitoring and surveillance system; ability to enforce strict mitigation.
	# workforce lost and \$ wages lost per day	Employee and sales losses exceed stimulus provisions and will result in intractable service disruptions and business deaths
	Financial benefits of industry reopening	# Businesses per state, county, industry, lifeline, critical infrastructure # Employees per state, county, industry, lifeline, critical infrastructure
	Public health cost/risk of industry reopening	# Projected new cases (growth rate) # Impacted employees and households # Impacted patrons per establishment, and patron households
	COVID-19 Compliance Score	DUNS-level certification that business is ready to reopen. Scored by industry (e.g. Score above 70 = ready to reopen)
Supply Chain	# Essential supplies	Businesses have essential health and safety supplies in place to ensure safe and responsible operations for workers and customers.
	Supply chain and critical infrastructure disruptions increase and viability and risk rates trend negative month over month.	Critical infrastructure and supply chain performance targets established to enable market segments of the economy to reopen.
	Stability in supply chains and consumer confidence indicators	Stability in supply chains and consumer confidence indicators
	Import / Export Supplier Relationships	# of OCONUS suppliers, supplies that require overseas production

	Food acquisition capability	Is food available? Is food accessible through government assistance?
Workforce	Business/industry reopens	Ability to provide onsite social distancing, alternative staffing, cohorts, or splitting shift workers for high, medium and low exposure workers.
	Telework rate	- Percentage of workforce teleworking - Percentage of business/positions that cannot pivot to TW options
	# COVID+ staff and household members	Decline in number of COVID+ staff and household members for a minimum of 5 consecutive days.
	Workforce Loss Per Industry	% loss in productivity
	New Medicaid enrollments	Less than 5% increase in new applications for Medicaid
	Unemployment Claims	# Repetitive (% of total) # First time (% of total)
	Return to work or job loss	#/% Returning to pre-COVID job #/% Returning to work in different job - Number of layoffs above a threshold

Appendix 2: Travel Recommendations

Travel Recommendations by Phase				
Opening Up America Again Phase	Pre-Gating or Phase Zero	Phase One	Phase Two	Phase Three
Transmission Characteristics	Significant or Uncontrolled Transmission	Significant Controlled Transmission	Moderate, Controlled Transmission	Low, Controlled Transmission
Impact of virus introduction into this setting by a domestic traveler	Low	Low	Low	High
Likelihood of virus exportation from this setting to a new community by a domestic traveler	High	High	Medium	Low
Domestic Travel Guidance	- Avoid non-essential travel to, from, and within to prevent infection during travel and spread to other jurisdictions - Work-related travel needed for critical infrastructure is exempt from restrictions	- Avoid non-essential travel to, from, and within to prevent infection during travel and spread to other jurisdictions - Work-related travel needed for critical infrastructure is exempt from restrictions	- Avoid non-essential travel to Phase 0 and Phase 1 jurisdictions to prevent infection during travel - Avoid non-essential travel to Phase 3 jurisdictions to prevent spreading - Work-related travel needed for critical infrastructure is exempt from restrictions	- Non-essential travel may be considered within and between low, controlled transmission jurisdictions - Avoid non-essential travel to moderate, controlled or significant, uncontrolled transmission jurisdictions to protect those in low, controlled transmission jurisdictions
International Travel	- Avoid non-essential international travel - Returning international travelers should be	Avoid non-essential international travel	Avoid non-essential international travel	International travel may be considered following CDC international travel guidance

NV-DHHS-20-0838-C-000103



managed according
to Travel Health
Notice

- Avoid international travel to Travel Health Notice Level 3 countries
- Returning international travelers should be managed according to Travel Health Notice guidance

Mitigation Guidance by Phase

Gating Criteria for all Phases

- **Transmission:** Community transmission is under control (Decrease in the percent of patient visits for influenza-like illness (ILI) **or** a decrease in ILI activity levels over 14 days, plus downward trajectory of documented cases within a 14 day period **or** downward trajectory of positive tests as a percent of total tests within a 14-day period- flat or increasing volume of tests).
- **Public Health Capacity:** Public health systems can detect, test, track, isolate, and quarantine cases and quickly contain an outbreak.
- **Health System Capacity:** Health system is able to treat all new cases with capacity to absorb increased transmission.

Pre-Gating/Phase 0: Significant, Uncontrolled Transmission

Jurisdictions in Phase 0 are in need of significant mitigation. Policy makers have often implemented this in the form of stay at home or shelter in place orders. The risk of transmission, or the spread of COVID-19, is still considered significant and uncontrolled in these jurisdictions. The table below describes an overview of strategies to be implemented across different settings in jurisdictions that are in Phase 0.

Leaders of these jurisdictions are tasked with ensuring that significant mitigation strategies are followed to the best extent possible to protect jurisdictions, prevent further COVID-19 spread, and ensure that jurisdictions can safely advance to Phase 1 as the risk of COVID-19 transmission decreases.

It is critically important in this Phase, and in others, that jurisdictions continue to monitor their Gating Criteria data on 1) Transmission, 2) Public Health Capacity, and 3) Health System Capacity to determine any mitigation adjustments that may be needed.

- Jurisdictions remain in Phase 0 until Gating Criteria is met.
- Jurisdictions may consider transitioning to Phase 1 after meeting Gating Criteria.

The following table describes guidelines for individuals, employers, and essential workplaces for jurisdictions that are in Phase 0.

Pre-Gating/Phase 0. Community Mitigation Strategies in Areas with Significant, Uncontrolled Transmission	
Guidelines for All Phases	<u>Individuals</u> Continue to practice good hygiene and implement personal protective measures (e.g., handwashing, cough etiquette, and face coverings) Social distancing (e.g., maintaining physical distance between persons) Environmental surface cleaning at home and in community settings, such as schools or workplaces People who feel sick should stay home
Essential Workplaces	Develop and implement appropriate policies, in accordance with FSLTT regulations and guidance, informed by industry best practices Monitor workforce for indicative symptoms. Do not allow symptomatic people to physically return to work until cleared by a medical provider Develop and implement policies and procedures for workforce contact tracing following employee COVID+ test Remain open and ensure social distancing, proper cleaning requirements and protection of workers and customers

	Institute or continue telework flexibility Staff from low and moderate and transmission settings should be offered telework to eliminate travel to workplaces in high transmission settings Encourage employees and customers to use face coverings when around others Consider identifying childcare, schools and camps serving families of essential workers as essential workplaces
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Phase 1: Significant, Controlled Transmission

Jurisdictions in Phase 1 are in need of **significant** mitigation. That means the risk of transmission, or the spread of COVID-19, is still considered significant and controlled in these jurisdictions.

Leaders of these jurisdictions are tasked with ensuring that significant mitigation strategies are followed to the best extent possible to protect jurisdictions, prevent further COVID-19 spread, and ensure that jurisdictions can safely advance to Phase 2 as the risk of COVID-19 transmission decreases.

It is critically important in this Phase, and in others, that jurisdictions continue to monitor their **Gating Criteria** data on 1) Transmission, 2) Public Health Capacity, and 3) Health System Capacity to determine any mitigation adjustments that may be needed.

- Jurisdictions may consider transitioning to Phase 2 after meeting **Gating Criteria** a second time with no rebound.
- Jurisdictions should return to Pre-Gating/Phase 0 if the community experiences rebound in transmission or has insufficient Public Health and Healthcare System capacity to manage an increase in cases.

The following table describes an overview of strategies to be implemented across different settings in jurisdictions that are in **Phase 1**. The next section provides more detailed guidance for each of these settings..

Phase 1. Community Mitigation Strategies in Areas with Significant, Controlled Transmission	
Guidelines for All Phases	<u>Individuals</u> Continue to practice good hygiene and implement personal protective measures (e.g., handwashing, cough etiquette, and face coverings) Social distancing (e.g., maintaining physical distance between persons) Environmental surface cleaning at home and in community settings, such as schools or workplaces People who feel sick should stay home <u>Employers</u> Develop and implement appropriate policies, in accordance with FSLTT regulations and guidance, informed by industry best practices Monitor workforce for indicative symptoms. Do not allow symptomatic people to physically return to work until cleared by a medical provider Develop and implement policies and procedures for workforce contact tracing following employee COVID+ test
Phase 1 Guidelines for Individuals	ALL VULNERABLE INDIVIDUALS* should continue to shelter in place. Members of households with vulnerable residents should be aware that by returning to work or other environments where distancing is not practical, they could carry the virus back home. Precautions should be taken to isolate from vulnerable residents All individuals, WHEN IN PUBLIC (e.g., parks, outdoor recreation areas, shopping areas), should maximize physical distance from others. Social settings of more than 10 people, where appropriate distancing may not be practical, should be avoided unless precautionary measures are observed Avoid SOCIALIZING in groups of more than 10 people in circumstances that do not readily allow for appropriate physical distancing (e.g., receptions, trade shows) MINIMIZE NON-ESSENTIAL TRAVEL and adhere to CDC guidelines regarding isolation following travel
Phase 1 Guidelines for Employers	Continue to ENCOURAGE TELEWORK, whenever possible and feasible with business operations If possible, RETURN TO WORK IN PHASES Close COMMON AREAS where personnel are likely to congregate and interact, or enforce strict social distancing protocols

	Minimize NON-ESSENTIAL TRAVEL and adhere to CDC guidelines regarding isolation following travel Strongly consider SPECIAL ACCOMMODATIONS for personnel who are members of a VULNERABLE POPULATION
Phase 1 Guidelines for Specific Types of Employers <i>expanded below</i>	SCHOOLS AND ORGANIZED YOUTH ACTIVITIES (e.g., daycare, camp) that are currently closed should remain closed VISITS TO SENIOR LIVING FACILITIES AND HOSPITALS should be prohibited Those who do interact with residents and patients must adhere to strict protocols regarding hygiene LARGE VENUES (e.g., sit down dining, movie theaters, sporting venues, places of worship) can operate under strict physical distancing protocols ELECTIVE SURGERIES can resume, as clinically appropriate, on an outpatient basis at facilities that adhere to CMS guidelines GYMS can open if they adhere to strict physical distancing and sanitation protocols BARS should remain closed
Essential Workplaces	Remain open and ensure social distancing, proper cleaning requirements and protection of workers and customers Institute or continue telework flexibility Staff from low and moderate and transmission settings should be offered telework, where possible, to eliminate travel to workplaces in high transmission settings Encourage employees and customers to use face coverings when around others Close common areas such as breakrooms, cafeterias Install physical barriers, such as sneeze guards and partitions, and change layout of workspaces to ensure all individuals remain at least 6 feet apart Strongly consider special accommodations for personnel who are members of a vulnerable population (e.g., flexible leave policies, telework, reassignment of duties to minimize contact with others) Cancel work-related gatherings (e.g., staff meetings, after-work functions) where 6-foot distancing cannot be maintained Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a cloth face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns Consider identifying childcare, schools and camps serving families of essential workers as essential workplaces
General Workplaces	Reopen only if business can ensure strict social distancing, proper cleaning and disinfecting, and protection of their workers and customers Limit service to drive-throughs, curbside take out, or delivery Minimize non-essential travel and adhere to CDC guidelines regarding isolation following travel Continue to encourage telework and virtual vs. in-person meetings wherever possible and feasible Encourage employees and customers to use face coverings when around others Close common areas such as breakrooms, cafeterias Install physical barriers, such as sneeze guards and partitions, and change layout of workspaces to ensure all individuals remain at least 6 feet apart Strongly consider special accommodations for personnel who are members of a vulnerable population (e.g. flexible leave and telework policies where possible, reassignment of duties to minimize contact with others)

	Staff from low and moderate transmission (Phase 2 & 3) areas should be offered telework or other options as feasible to eliminate travel to workplaces in high transmission settings Cancel work-related gatherings (e.g., staff meetings, after-work functions) where 6ft distancing cannot be maintained Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a cloth face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Schools	Schools that are currently closed should remain closed E-learning or distance learning opportunities should be provided for all students Ensure provision of student services such as school meal programs Encourage employees to use face coverings when around others Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering
Childcare Facilities	Childcare facilities should only remain open for children of essential workers Childcare facilities that remain open should maintain enhanced social distancing measures (e.g. spaced seating to at least 6 feet apart when possible, restrict mixing between classes/groups, cancel all field trips, inter-group events, and extracurricular activities). Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Restrict non-essential visitors and volunteers Close communal use spaces such as cafeterias and playgrounds if possible, or stagger use and clean/disinfect in between use. Serve individually plated meals to limit sharing of food or utensils and hold activities in separate classrooms Keep children's belongings separated Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single child) or limit use of supplies and equipment for by one group of children at a time and disinfect between use Routinely clean, sanitize, and disinfect surfaces and objects that are frequently touched (e.g., toys) and avoid use of items that are not easily cleaned Staff from low and moderate transmission (Phase 2 & 3) settings should be offered telework or other options as feasible to eliminate travel to childcare centers in high transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Summer Camps	Summer camps should only remain open for children of essential workers and only for children who live in the local geographic area Ensure enhanced distancing measures (e.g., spaced seating to at least 6 feet apart when possible, restrict mixing between classes/groups, cancel all field trips and inter-group events) Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Close communal use spaces such as cafeterias and playgrounds if possible, or stagger use and clean/disinfect in between use. Serve individually plated meals to limit sharing of food or utensils and hold activities in separate areas Keep children's belongings separated Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible

	Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single camper) Staff from low and moderate transmission (Phase 2 & 3) settings should be offered telework or other options as feasible to eliminate travel to workplaces in high transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Parks and recreational facilities	Remain open, or re-open if closed, with modifications to ensure visitors can maintain social distancing, and practice proper hand hygiene Close facilities and areas where social distancing cannot be maintained (e.g., water parks, courts, playgrounds) Cancel or postpone events and gatherings Use flexible telework policies, especially for staff at higher risk for severe illness Staff from low and moderate transmission (Phase 2 & 3) settings should be offered telework or other options as feasible to eliminate travel to workplaces in high transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Healthcare Settings	Continue telehealth expansion Cancel elective surgeries Only schedule essential outpatient care (routine immunizations, well child care visits, etc.: https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html; https://www.cdc.gov/coronavirus/2019-ncov/hcp/preparedness-checklists.html) Nursing homes and hospitals should restrict all visitors Restrict entry of non-essential staff and contractors Limit group activities, including meals
Colleges and Universities	Guidance will be forthcoming
Communities of Faith	Guidance will be forthcoming
Restaurants and Bars	Provide physical guides (e.g., tape on floors/sidewalks) to ensure customers remain at least six feet apart in lines or ask customers to wait in cars when picking up food. Post signs to inform customers of food pick-up protocols Consider installing physical barriers, such as sneeze guards and partitions at cash registers or other food pick-up areas where maintaining distancing of at least 6 feet is difficult Restrict the number of employees in shared spaces (e.g., kitchens, break rooms, offices) to maintain at least 6 feet distance between people Rotate/stagger shifts to limit number of employees in the workplace at a time Consider special accommodations for personnel who are members of a vulnerable population (e.g. flexible leave and telework policies where possible, reassignment of duties to minimize contact with others) Staff from low and moderate transmission (Phase 2 & 3) settings should be offered telework or other options as feasible to eliminate travel to workplaces in high transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns

Social Gatherings	Cancel all gatherings of 10 or more Cancel gatherings of any size where distancing cannot be maintained (this does not include household contacts)
Mass Transit	Restrict ridership to employees of essential businesses and critical infrastructure to the extent possible Restrict routes between areas experiencing different levels of transmission (between areas in different Phases) Ensure strict social distancing, proper cleaning and disinfecting and protection of workers and customers Install no-touch trash cans Clean and disinfect frequently touched surfaces (e.g., kiosks, digital interfaces such as touchscreens and fingerprint scanners, ticket machines, turnstiles, handrails, restroom surfaces, elevator buttons) at least daily Clean and disinfect the operator area between operator shifts Use touchless payment, trash cans, and doors as much as possible, when available. Institute measures to physically separate or create distance of at least 6 feet between all occupants. This may include: Adjust how passengers enter and exit (while allowing exceptions for persons with disabilities) Close every other row of seats Reduce maximum occupancy and increase service on crowded routes Provide physical guides on vehicles and at transit stations and stops. Floor decals, colored tape, or signs to indicate where passengers should not sit or stand can be used to guide passengers Install physical barriers, such as sneeze guards and partitions at staffed kiosks and on transit vehicles to the extent practicable Close communal spaces, such as break rooms or stagger use and clean in between uses Consider assigning vulnerable workers duties that minimize their contact with passengers and other employees. Offer staff from low and moderate transmission (Phase 2 & 3) settings telework or other options as feasible to eliminate travel
Mass Gatherings	Guidance will be forthcoming
Communities of Faith	Limit gatherings to those that can be held virtually (online video streaming) for vulnerable populations and consider video streaming or drive-in options for services. Limit the size of in person gatherings in accordance with the guidance and directives of state and local authorities, and maintain social distancing Consider modifying clergy visits to over the phone or online Encourage the use of face coverings when around others Encourage proper hand hygiene and avoid direct person-to-person contact and sharing of objects Consider posting signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick leave and related flexible policies and practices for staff (e.g., allow work from home, if feasible).

Phase 2: Moderate, Controlled Transmission

Jurisdictions in Phase 2 are in need of **moderate** mitigation. That means that risk of transmission, or the spread of COVID-19, is still considered moderate and controlled in these jurisdictions.

Leaders of these jurisdictions are tasked with ensuring that significant mitigation strategies are followed to the best extent possible to protect jurisdictions, prevent further COVID-19 spread, and ensure that jurisdictions can safely advance to the Phase 3 as COVID-19 transmission decreases.

It is critically important in this Phase, and in others, that jurisdictions continue to monitor their **Gating Criteria** data on 1) Transmission, 2) Public Health Capacity, and 3) Health System Capacity to determine any mitigation adjustments that may be needed.

- Jurisdictions may consider transitioning to Phase 3 after meeting **Gating Criteria** a third time with no rebound.
- Jurisdictions should return to Phase 1 if community experiences rebound in transmission or has insufficient public health and healthcare system capacity to manage increase in cases (or return to Pre-Gating/Phase 0, depending on severity of rebound and/or capacity needs).

The following table describes an overview of strategies to be implemented across different settings in jurisdictions that are in Phase 2. Links in the table are also included for more detailed guidance for each of these settings.

Phase 2. Community Mitigation Strategies in Areas with Significant, Controlled Transmission	
Guidelines for All Phases	<u>Individuals</u> Continue to practice good hygiene and implement personal protective measures (e.g., handwashing, cough etiquette, and face coverings) Social distancing (e.g., maintaining physical distance between persons) Environmental surface cleaning at home and in community settings, such as schools or workplaces People who feel sick should stay home <u>Employers</u> Develop and implement appropriate policies, in accordance with FSLTT regulations and guidance, informed by industry best practices Monitor workforce for indicative symptoms. Do not allow symptomatic people to physically return to work until cleared by a medical provider. Develop and implement policies and procedures for workforce contact tracing following employee COVID+ test.
Phase 2 Guidelines for Individuals	ALL VULNERABLE INDIVIDUALS should continue to shelter in place. Members of households with vulnerable residents should be aware that by returning to work or other environments where distancing is not practical, they could carry the virus back home. Precautions should be taken to isolate from vulnerable residents All individuals, WHEN IN PUBLIC (e.g., parks, outdoor recreation areas, shopping areas), should maximize physical distance from others. Social settings of more than 50 people, where appropriate distancing may not be practical, should be avoided unless precautionary measures are observed
Phase 2 Guidelines for Employers	NON-ESSENTIAL BUSINESS AND PERSONAL TRAVEL can resume. Businesses continue to ENCOURAGE TELEWORK, whenever possible and feasible with business operations Businesses close COMMON AREAS where personnel are likely to congregate and interact, or enforce moderate social distancing protocols Businesses strongly consider SPECIAL ACCOMMODATIONS for personnel who are members of a VULNERABLE POPULATION

Phase 2 Guidelines for Specific Types of Employers <i>expanded below</i>	SCHOOLS AND ORGANIZED YOUTH ACTIVITIES (e.g., daycare, camp) can VISITS TO SENIOR CARE FACILITIES AND HOSPITALS should be prohibited. Those who do interact with residents and patients must adhere to strict protocols regarding hygiene LARGE VENUES (e.g., sit down dining, movie theaters, sporting venues, places of worship) can operate under moderate physical distancing protocols ELECTIVE SURGERIES can resume, as clinically appropriate, on an outpatient and inpatient basis at facilities that adhere to CMS guidelines GYMS can remain open if they adhere to strict physical distancing and sanitation protocols BARS may operate with diminished standing room occupancy, where applicable and appropriate
Essential Workplaces	Remain open and ensure social distancing, proper cleaning and disinfecting requirements and protection of workers and customers Institute or continue telework to the extent feasible Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to workplaces in moderate transmission settings Encourage employees and customers to use cloth face coverings when around others Close common areas such as breakrooms, cafeterias or stagger use and clean/disinfect between use Install physical barriers, such as sneeze guards and partitions, and change layout of workspaces to ensure all individuals remain at least 6 feet apart Strongly consider special accommodations for personnel who are members of a vulnerable population (e.g., flexible leave and telework policies where possible reassignment of duties to minimize contact with others) Consider resuming non-essential travel in accordance with state and local regulations and guidance Cancel work-related gatherings (e.g., staff meetings, after-work functions) where 6-foot distancing cannot be maintained Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a cloth face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
General Workplaces	Reopen only if business can ensure moderate social distancing (e.g. staggered work shifts to limit number of employees in workplace at a time), proper cleaning and disinfecting requirements (Infection Prevention Certification), and protection of their workers and customers Continue to encourage telework and virtual vs. in-person meetings wherever possible and feasible Encourage employees and customers to use face coverings when around others Close common areas such as breakrooms, cafeterias or stagger use and clean/disinfect between use Install physical barriers, such as sneeze guards and partitions, and change layout of workspaces to ensure all individuals remain at least 6 feet apart Strongly consider special accommodations for personnel who are members of a vulnerable population (e.g. flexible leave and telework policies where possible, reassignment of duties to minimize contact with others) Consider resuming non-essential travel in accordance with state and local regulations and guidance Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to workplaces in moderate transmission settings Cancel work-related gatherings (e.g., staff meetings, after-work functions) where 6 feet distancing cannot be maintained

	Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a cloth face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Schools	Remain open with enhanced distancing measures (e.g., spaced seating to at least 6 feet apart when possible, restrict mixing between classes/groups, cancel field trips, limit gatherings & extracurricular events to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from significant mitigation (Phase 1) areas) Restrict non-essential visitors and volunteers Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Close communal use spaces such as cafeterias and playgrounds if possible, or stagger use and clean/disinfect in between use. Serve individually plated meals to limit sharing of food or utensils and hold activities in separate classrooms. Keep children's belongings separated Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single camper) student) or limit use of supplies and equipment for by one group of children at a time and clean and disinfect between use E-learning or distance learning opportunities should be provided for higher-risk students, and those with vulnerable family members Teachers, staff, and students from significant transmission (Phase 1) areas should be offered telework, e-learning, or other options as feasible to eliminate travel to schools in moderate controlled transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Childcare Facilities	Childcare facilities should remain open with enhanced social distancing measures (e.g., spaced seating to at least 6 feet apart when possible, restrict mixing between classes/groups, cancel field trips, limit gatherings & extracurricular events to those that where can maintain social distancing can be maintained, support proper hand hygiene, and restrict attendance of those from significant mitigation (Phase 1) areas). Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Restrict non-essential visitors and volunteers Close communal use spaces such as cafeterias and playgrounds if possible, or stagger use and clean/disinfect in between use. Serve individually plated meals to limit sharing of food or utensils and hold activities in separate classrooms Keep children's belongings separated Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single child) or limit use of supplies and equipment for by one group of children at a time and disinfect between use Routinely clean, sanitize, and disinfect surfaces and objects that are frequently touched (e.g., toys) and avoid use of items that are not easily cleaned Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to childcare centers in moderate controlled transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering

	Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Summer Camps	Remain open with enhanced distancing measures (e.g., spaced seating to at least 6 feet apart when possible, restrict mixing between classes/groups, cancel field trips, limit gatherings & extracurricular events to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from significant mitigation (Phase 1) areas) Restrict attendance to those from the local geographic area Restrict non-essential visitors and volunteers Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Close communal use spaces such as cafeterias and playgrounds if possible, or stagger use and clean/disinfect in between use. Serve individually plated meals to limit sharing of food or utensils and hold activities in separate areas. Keep children's belongings separated Stagger arrival and drop-off times or locations, or put in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single camper) or limit use of supplies and equipment for by one group of children at a time and disinfect between use Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to camps in moderate controlled transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Parks and recreational facilities	Open with modifications to ensure visitors can maintain social distancing, and practice proper hand hygiene Close facilities and areas where social distancing cannot be maintained (e.g., water parks, courts, playgrounds) Cancel or postpone events and gatherings that do not ensure social distancing Use flexible telework policies where possible, especially for staff at higher risk for severe illness Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to workplaces in moderate transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Healthcare Settings	Continue Tele-health expansion Schedule elective surgeries on a case-by-case basis based on the clinical urgency (e.g., procedures that cannot be postponed for greater than 1 week) Schedule routine outpatient care on a case-by-case basis considering factors such as clinical urgency, need for follow-up for pre-existing conditions, as well as potential vulnerability of patients based on underlying comorbidities Nursing homes and hospitals should restrict all visitors, including consider restriction of entry of non-essential staff and contractors Continue tele-health expansion Nursing homes and hospitals should restrict all visitors, including consider restriction of entry of non-essential staff and contractors Consider limiting group activities, including meals

Colleges and Universities	Guidance will be forthcoming
Communities of Faith	Guidance will be forthcoming
Restaurants and Bars	Restaurants open dining areas with limited seating that allows for social distancing (minimum of 6 feet between groups of people) to protect employees and guests Bars open with limited standing room only capacity that can allow for 6-foot social distancing among patrons Provide drive-through, delivery, or curbside pick-up options and prioritize outdoor seating as much as possible Ensure proper cleaning, sanitizing, and disinfecting requirements, and protection of workers and customers Reduce occupancy and limit the size of parties dining together to ensure all customer parties Install physical barriers, such as sneeze guards and partitions, at cash registers, bars, host stands, and other areas where maintaining physical distance of six feet is difficult Provide physical guides (e.g., tape on floors/sidewalks) to ensure customers remain at least 6 feet apart in lines/waiting for seating Use phone apps to alert patrons when their table is ready to avoid use of communal “buzzers” and ask patrons to wait for their table in cars or away from establishment Avoid offering any self-serve food or drink options (e.g., buffets, salad bars, drink stations) Offer disposable or digital menus, single serving condiments, and no-touch payment, trash cans, doors Consider special accommodations for personnel who are members of a vulnerable population (e.g. flexible leave and telework policies where possible, reassignment of duties to minimize contact with others) Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to workplaces in moderate transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Social Gatherings	Cancel all gatherings of 50 or more Cancel gatherings of any size where distancing cannot be maintained. Do not allow attendance of individuals from significant transmission jurisdictions
Mass Transit	Restrict routes between areas experiencing different levels of transmission (between areas in different Phases) to the extent possible Ensure strict social distancing, proper cleaning and disinfecting requirements and protection of workers and customers Install no-touch trash cans Clean and disinfect frequently touched surfaces (for example e.g., kiosks, digital interfaces such as touchscreens and fingerprint scanners, ticket machines, turnstiles, handrails, restroom surfaces, elevator buttons) at least daily. Clean and disinfect the operator area between operator shifts Use touchless payment options as much as possible, when available. Institute measures to physically separate or create distance of at least 6 feet between all occupants. This may include: Adjust how passengers enter and exit (while allowing exceptions for persons with disabilities) Close every other row of seats Reduce maximum occupancy and increase service on crowded routes

	Provide physical guides on vehicles and at transit stations and stops. Floor decals, colored tape, or signs to indicate where passengers should not sit or stand can be used to guide passengers Install physical barriers, such as sneeze guards and partitions at staffed kiosks and on transit vehicles to the extent practicable Close communal spaces, such as break rooms or stagger use and clean in between uses Consider assigning vulnerable workers duties that minimize their contact with passengers and other employees. Staff from significant transmission (Phase 1) areas should be offered telework or other options as feasible to eliminate travel to workplaces in moderate transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Mass Gatherings	Guidance will be forthcoming
Communities of Faith	Consider holding gatherings virtually (online video streaming) for vulnerable populations and consider video streaming or drive-in options for services. Limit the size of in person gatherings in accordance with the guidance and directives of state and local authorities, and maintain social distancing. Consider limiting in home or in hospital clergy visits and offering visits over the phone or online Encourage the use of face coverings when around others Encourage proper hand hygiene and avoid direct person-to-person contact and sharing of objects Consider posting signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick leave and related flexible policies and practices for staff (e.g., allow work from home, if feasible).

Phase 3: Low, Controlled Transmission

States and Jurisdictions in Phase 3 are in need of **low** mitigation. That means that risk of transmission, or the spread of COVID-19, is still considered low and controlled in these jurisdictions.

Leaders of these jurisdictions are tasked with ensuring that significant mitigation strategies are followed to the best extent possible to protect jurisdictions, prevent further COVID-19 spread, and ensure that jurisdictions can safely remain in Phase 3 as risk for COVID-19 transmission remains low.

It is critically important in this Phase, and in others, that jurisdictions continue to monitor their **Gating Criteria** data on 1) Transmission, 2) Public Health Capacity, and 3) Health System Capacity to determine any mitigation adjustments that may be needed.

- Jurisdictions may remain in Phase 3 if **Gating Criteria** remain stable.
- Jurisdictions should return to Phase 2 if community experiences rebound in transmission or has insufficient Public Health and Healthcare System capacity to manage increase in cases (or return to an earlier stage/Pre-Gating, depending on severity of rebound and/or capacity needs).

The following table describes an overview of strategies to be implemented across different settings in jurisdictions that are in Phase 3. Links in the table are also included for more detailed guidance for each of these settings.

Phase 3. Community Mitigation Strategies in Areas with Low, Controlled Transmission	
Guidelines for All Phases	<u>Individuals</u> Continue to practice good hygiene and implement personal protective measures (e.g., handwashing, cough etiquette, and face coverings) Social distancing (e.g., maintaining physical distance between persons) Environmental surface cleaning at home and in community settings, such as schools or workplaces People who feel sick should stay home <u>Employers</u> Develop and implement appropriate policies, in accordance with FSLTT regulations and guidance, informed by industry best practices Monitor workforce for indicative symptoms. Do not allow symptomatic people to physically return to work until cleared by a medical provider. Develop and implement policies and procedures for workforce contact tracing following employee COVID+ test.
Phase 3 Guidelines for Individuals	VULNERABLE INDIVIDUALS can resume public interactions, but should practice physical distancing, minimizing exposure to social settings where distancing may not be practical, unless precautionary measures are observed. LOW RISK POPULATIONS should consider minimizing time spent in crowded environments.
Phase 3 Guidelines for Employers	Resume UNRESTRICTED STAFFING of worksites.
Phase 3 Guidelines for Specific Types of Employers <i>expanded below</i>	VISITS TO SENIOR CARE FACILITIES AND HOSPITALS can resume. Those who interact with residents and patients must be diligent regarding hygiene LARGE VENUES (e.g., sit down dining, movie theaters, sporting venues, places of worship) can operate under limited physical distancing protocols. NV-DHHS-20-0838-C-000118 GYMS can remain open if they adhere to standard sanitation protocols

	BARS may operate with increased standing room occupancy, where applicable.
Essential Workplaces	Remain open and ensure social distancing, proper cleaning and disinfecting, and protection of workers and customers Institute or continue telework flexibility Staff from moderate and significant transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to workplaces in low transmission settings Encourage employees and customers to use cloth face coverings when around others Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering
General Workplaces	Remain open if business can ensure limited social distancing, proper cleaning and disinfecting, and protection of their workers and customers Continue to encourage telework and virtual vs. in-person meetings wherever possible and feasible Encourage employees and customers to use face coverings when around others Stagger use of common areas such as breakrooms, cafeterias and clean/disinfect between use Install physical barriers, such as sneeze guards and partitions, and change layout of workspaces to ensure all individuals remain at least 6 feet apart Staff from significant and moderate transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to workplaces in low controlled transmission settings Consider canceling work-related gatherings (e.g., staff meetings, after-work functions) where 6-foot distancing cannot be maintained Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a cloth face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Schools	Remain open with distancing measures (e.g., spaced seating to at least 6 feet apart when possible, limit mixing between classes/groups, and limit gatherings & extracurricular events to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from higher transmission (Phase 1 & 2) areas. Consider limiting non-essential visitors and volunteers. Restrict attendance of those from higher transmission (Phase 1 & 2) areas. Encourage employees to use cloth face coverings when around others, particularly when physical distancing is not possible. Consider keeping communal use spaces such as cafeterias and playgrounds closed if possible, or stagger use and clean/disinfect in between use. Consider serving individually plated meals to limit sharing of food or utensils and holding activities in separate classrooms. Keep children's belongings separated Consider staggering arrival and drop-off times or locations, or putting in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single student or limit use of supplies and equipment for one group of children at a time and clean and disinfect between use E-learning or distance learning and telework opportunities should be provided, where feasible, for higher-risk students and staff Teachers, staff, and students from higher transmission (Phase 1 & 2) areas should be offered telework, e-learning, and other options as feasible to eliminate travel to schools in low controlled transmission settings

	Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Childcare Facilities	Childcare facilities should remain open with limited social distancing measures (e.g., spaced seating to at least 6 feet apart when possible, limit mixing between classes/groups, and limit gatherings & extracurricular events to those where social distancing can be maintained, support proper hand hygiene, and restrict attendance of those from higher mitigation (Phase 1 & 2) areas. Consider limiting non-essential visitors and volunteers. Restrict attendance of those from higher transmission (Phase 1 & 2) areas. Encourage employees to use face coverings when around others, particularly when physical distancing is not possible. Consider keeping communal use spaces such as cafeterias and playgrounds closed if possible, or stagger use and clean/disinfect in between use. Consider serving individually plated meals to limit sharing of food or utensils and holding activities in separate classrooms. Keep children's belongings separated Consider staggering arrival and drop-off times or locations, or putting in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single child) or limit use of supplies and equipment for by one group of children at a time and disinfect between use Routinely clean, sanitize, and disinfect surfaces and objects that are frequently touched (e.g., toys) and avoid use of items that are not easily cleaned Staff from significant and moderate transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to childcare centers in low controlled transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering. Implement flexible sick-leave policies where possible, create a roster of trained back-up staff, and designate someone to be responsible for responding to COVID-19 concerns
Summer Camps	Remain open with distancing measures (e.g., spaced seating to at least 6 feet apart when possible, limit mixing between classes/groups, and limit gatherings & extracurricular events to those that can maintain social distancing, support proper hand hygiene, and restrict attendance of those from significant and moderate mitigation (Phase 1 & 2) areas). Restrict attendance to those from limited transmission areas Encourage employees to use face coverings when around others, particularly when physical distancing is not possible Consider keeping communal use spaces such as cafeterias and playgrounds closed if possible, or stagger use and clean/disinfect in between use. Consider serving individually plated meals to limit sharing of food or utensils and holding activities in separate areas. Keep children's belongings separated Consider staggering arrival and drop-off times or locations, or putting in place other protocols to limit direct contact with parents as much as possible Ensure adequate supplies to minimize sharing of high touch materials to the extent possible (art supplies, equipment etc. assigned to a single camper) or limit use of supplies and equipment for by one group of children at a time and disinfect between use Staff from significant and moderate transmission (Phase 1 & 2) areas should be offered telework or other options as feasible to eliminate travel to camps in low controlled transmission settings Post signs on how to stop the spread of COVID-19, wash hands, and properly wear a face covering.



April 22, 2020

COVID-19 Pandemic Vaccination Planning: High-Level Overview for State and Local Public Health Programs

Background

The SARS-CoV-2 virus, which causes COVID-19 disease, continues to seriously threaten the health of Americans and society. The U.S. Department of Health and Human Services (HHS) is working with partners, including vaccine manufacturers, to develop vaccine candidates against SARS-CoV-2 infection. Thoughtful allocation of COVID-19 vaccines will be critical to prevent morbidity and mortality and reduce the impact of COVID-19 on society. COVID-19 vaccination response operational guidance is forthcoming, providing instructions to public health programs for implementation of state and local COVID-19 vaccination response. In the interim, public health programs can begin initial COVID-19 vaccination response planning, using the preliminary assumptions and recommended initial action steps below.

Planning Assumptions

Many vaccine candidates are in development, and it is not known what vaccine(s) will be used. However, certain vaccination campaign planning assumptions can be made:

- Limited COVID-19 vaccine doses may be available as early as fall, 2020.
- Initial COVID-19 vaccination efforts should target those in the critical workforce who provide health care and maintain essential functions of society, and then those at highest risk developing complications from COVID-19, depending on supply.
- Initial doses of COVID-19 vaccine may be authorized for use under an [Emergency Use Authorization \(EUA\) issued by the Food and Drug Administration \(FDA\)](#), based upon available safety and efficacy data.
- Two doses of pandemic COVID-19 vaccine, separated by ≥ 28 days, may be needed for immunity, requiring the ability to track vaccination administration and provide patient reminders.
- Routine immunization programs will continue.
- Recommendations on groups to target will likely change throughout the response, depending on vaccine supply and disease epidemiology.
- Public demand for COVID-19 vaccination will likely be high, especially when there is limited supply and if there is severe disease in the community.

- Seasonal influenza vaccination will be particularly important for all persons ≥ 6 months of age, especially front-line HCPs, to limit influenza as another respiratory illness.
- Assuming COVID-19 will continue to spread in the community in the fall and next year, vaccination plans must ensure vaccine clinics will not put patients at risk for COVID-19, which in the setting of mass vaccination may need to include considerations for personal protective equipment (PPE), social distancing or spacing of persons vaccinated and staff, and scheduling individual vaccination appointment times, among other approaches
- IIS will be used to document vaccination and mass-vaccination modules in IIS may be needed, in addition, CDC is exploring additional systems and tools for targeting and tracking vaccination of critical workforce.

Although plans may change as the pandemic progresses, CDC currently assumes COVID-19 vaccine distribution and tracking will be conducted using principles exercised in influenza pandemic planning:

- When COVID-19 vaccine becomes available, distribution will be through existing infrastructure used for publicly funded routine vaccines. Distribution may be expanded to include additional health care organizations and vaccination providers who can provide pandemic vaccinations to targeted groups (<https://www.cdc.gov/flu/pdf/pandemic-resources/pandemic-influenza-vaccine-distribution-9p-508.pdf>).
- COVID-19 vaccine providers must enroll with their jurisdiction's immunization program to receive the vaccine.
- COVID-19 vaccine will be allocated proportional to each state's population size, will be centrally maintained, and directly distributed by CDC's distributor to COVID-19 vaccination providers.
- Enrolled vaccination providers will order COVID-19 vaccine from their immunization program's allocation.
- COVID-19 vaccine and ancillary supplies will be procured and distributed by the federal government at no cost to enrolled pandemic vaccination providers and their patients.
- Immunization programs will be required to report timely vaccination data to CDC to provide tracking of vaccination administration and inform safety monitoring and assessment of vaccine effectiveness.

At this time, state and local public health programs should begin COVID-19 vaccination planning efforts by:

- Reviewing pandemic influenza vaccination plans, identifying strengths and gaps
- Formalizing plans with partners for targeting vaccination efforts for front-line health care personnel (HCP) who will be evaluating and caring for persons with COVID-19 in the late fall of 2020, when the first COVID-19 vaccine dose may be available
- Identifying other critical occupational groups in each jurisdiction (safety, emergency and other essential services which may include supermarket workers, delivery drivers, and others), and ensuring relationships and plans are in place for targeted vaccination efforts

- Conducting additional outreach to healthcare providers treating persons at highest risk for severe outcomes of COVID-19 (e.g. those with advanced age, hypertension, diabetes, cardiovascular disease, chronic obstructive pulmonary disease, immunosuppression, liver disease) to ensure efficient education and vaccination of these groups when COVID-19 vaccine supply increases
- Reviewing and enhancing IIS capacity for documenting and reporting vaccination efforts, including the ability for reminder and recall

Because influenza season will also be occurring when the risk of COVID-19 will likely remain high, public health programs should undertake activities to enhance seasonal influenza vaccination efforts to reduce demand on hospitals, protect healthcare workers, and reduce respiratory diseases among individuals. Encourage vaccination providers to order additional doses of influenza vaccine; work with these providers to consider how to safely administer influenza vaccine during COVID-19.

Critical Workforce Personnel Vaccination Resources

Although epidemiology of COVID-19 differs from that of pandemic influenza, when planning vaccination of critical workforce personnel, including front-line HCP, public health programs should review resources developed for pandemic influenza vaccination, including:

- [*Interim Updated Planning Guidance on Allocating and Targeting Pandemic Influenza Vaccine during an Influenza Pandemic*](#)
- [*Pandemic Influenza Vaccine Targeting Checklist*](#)
- [*Roadmap to Implementing Pandemic Influenza Vaccination of Critical Workforce*](#)
- [*Checklist of Best Practices for Vaccination Clinics Held at Temporary, or Off-site, Satellite Clinics*](#)
- [*Guideline for Large-Scale Influenza Vaccination Clinic Planning*](#)

COVID-19 Crisis Cooperative Agreement Vaccination Activities

Public health program can use funds from the CDC's Division of State and Local Response's COVID-19 crisis cooperative agreement to begin the process of operationalizing COVID-19 vaccination plans. COVID-19 specific vaccination planning objectives in the current crisis cooperative agreement are:

- o *Ensure jurisdictional capacity for a mass vaccination campaign once vaccine becomes available, including:*
 - *Enhancement of immunization information systems*
 - *Maintain ability for vaccine-specific cold chain management*
 - *(Ability to implement) mass vaccination clinics for emergency response*
 - *Assess and track vaccination coverage*
 - *Rapidly identify high-risk persons requiring vaccine*

- *Plan to prioritize limited medical countermeasure material (MCM) based on guidance from CDC and the Department of Health and Human Services (HHS) (NOTE: this includes potential COVID-19 vaccine)*
- o *Ensure jurisdictional capacity for distribution of MCM and supplies.*
(NOTE: CDC has capacity for centralized distribution directly to most vaccination provider sites, so jurisdictions should not need to plan for significant COVID-19 vaccine storage, repacking, and redistribution at receive, stage, and store (RSS) sites)