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COVID-19: Going Back to College Safely
Committee on Health, Education, Labor and Pensions
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Chairman Alexander, Ranking Member Murray and members of the committee, thank you for giving me the opportunity to address you today on the important aspects of safely returning our nation's academic institutions to their pre-COVID-19 pandemic status.

I am Georges C. Benjamin, MD, executive director of the American Public Health Association. APHA champions the health of all people and all communities. We strengthen the public health profession, promote best practices and share the latest public health research and information. We are the only organization that combines a nearly 150-year perspective, a broad-based member community and the ability to influence federal policy to improve the public's health.

I am a physician executive, and in addition to having served as a clinician, I have had the opportunity to serve my community in a variety of senior management positions to include: as a military physician serving as the Chief of Emergency Medicine at the Walter Reed Army Medical Center; as chairman of the Department of Community Health and Ambulatory Care at the District of Columbia General Hospital; as interim director of the Emergency Ambulance Bureau of the D.C. Fire and EMS Department; as Acting Commissioner for Public Health for Washington, D.C.; and, finally, as Secretary for Health of the State of Maryland. I have served as the executive director of APHA for the last seventeen and a half years.

I am here today to share my thoughts and professional judgement on the role of community mitigation that should be considered by institutions of higher education as senior academic and administration leaders prepare for the return of students for the fall semester. I recognize that these decisions are not decisions of politicians but rest in the hands of the leadership of the various institutions who must work in close consultation with state and local health officials. I am not a lawyer. I speak as a public health scientist and professional who has spent a fair amount of time advising senior leaders on health policy. These are difficult decisions, and I approach my comments today using the current science to inform what measures and safeguards I would consider if I were leading a university or college at this time.

Reopening the nation's colleges and universities will not come with a one-size-fits-all solution, and any decisions must be science-based, data-driven and done in close consultation with state and local public health authorities. All public health decisions are based on risk reduction. We should make the assumptions that there will be people on campus with COVID-19 infection regardless of what precautions are taken at this state of the pandemic and the level of previously infected individuals in the community. Current estimates of positive antibody prevalence ranges from 3-24% depending on when you are in the country. Considering we need to get to approximately 70% to achieve herd immunity as a

nation, we still have a long way to go to break the chain of infection. A recent report from the U.S. Centers for Disease Control and Prevention also found that presymptomatic and asymptomatic spread does occur from infected individuals.¹ This means we will continue to have undetected broad community spread of COVID-19 as we remingle as a society. It also supports the contention that we need to continue to employ robust community and individual nonpharmacological mitigation until we reach levels of herd immunity. While this is best achieved through a national vaccine effort, a COVID-19 vaccine will not be available for months and certainly not widely before the fall semester.

We have approached this pandemic with a patchwork of authorities from the federal to the local levels, and because of this, it will be important that academic institutions be in alignment, at a minimum, with the local government, industries and businesses in the surrounding community in which it sits, because the academic institution is an integral part of the larger community. Any effort to move forward with reopening institutions of higher education by employing public health protections that are weaker than those in place in the surrounding community would be a critical mistake. While the institutions may seek to enforce stricter requirements for students, faculty and the institution's other employees, any variance between the institution's approach and that of the approach of the community in which it sits must be integrated in a way that does not undermine the health protections. For example, if the surrounding community requires the wearing of masks, then the institution would have a very difficult time establishing a no-mask policy, which might be viewed as a health hazard by the broader community. The converse might not be the case if the institution is able to articulate a greater health risk to students or others on a campus. One example might be the close proximity of students while in certain settings like laboratories or libraries.

The type of student body that the school is structured to accommodate is very important as a component of risk assessment. Institutions that are primarily commuter schools, where the student body comes from a relatively narrow slice of the community, will have a different risk profile than residential schools that attract students nationwide and often from around the world. This is because students will bring with them the infectious disease risk of the communities in which they reside. This disease has not struck all communities equally, and, therefore, the student body will represent the disease outbreak status of their community at the time of presentation to school on any given day.

Existing Guidance and Needed Regulations

Academic institutions should first follow the guidelines published by CDC.² Nothing I say today is meant to be in variance of that guidance. This includes physical distancing, respiratory hygiene to include wearing a mask when appropriate and hand hygiene. Sanitization guidance for the routine cleaning and sanitization of surfaces and facilities should be followed as well.

In addition to students and faculty, all workers at an institution should be protected in the workplace by enforceable workplace regulations. Congress should require the Occupational Safety and Health Administration to propose an emergency temporary standard (ETS) for infectious disease to protect workers from COVID-19.³ California's Aerosol Transmissible Diseases Standard could serve as

¹ Evidence Supporting Transmission of Severe Acute Respiratory Syndrome Coronavirus 2 While Presymptomatic or Asymptomatic. The Centers for Disease Control and Prevention. Emerging Infectious Diseases. July 2020. Available at: https://wwwnc.cdc.gov/eid/article/26/7/20-1595_article

² The Centers for Disease Control and Prevention. [Coronavirus Disease 2019 \(COVID-19\)](https://www.cdc.gov/coronavirus/2019-ncov/community/colleges-universities/index.html). Colleges, Universities, and Higher Learning. Plan, Prepare, and Respond. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/community/colleges-universities/index.html>

³ Organization letter urging Congress to pass the COVID-19 Every Worker Protection Act of 2020. April 29, 2020. Available at: https://apha.org/-/media/files/pdf/advocacy/letters/2020/200429_every_worker_protection_act.ashx

a model.⁴ Without specific safety mandates, academic institutions are left with little enforceable direction, and the result is the increased potential for rapid spread of the disease in the workplace and into our communities.

Disease Prevention and Control

All institutions should ensure they have a robust campus health program. That program must be linked to the local or state health agency to ensure the rapid availability of support and the most current information for disease control activities. **All institutions should be working from the premise that they will have a case of COVID-19 on campus during the academic year.** They should also assume that while students are less likely to have serious disease when infected, the risk for serious disease is not zero. The academic institution must have the organizational capacity to rapidly identify such a case or an outbreak of disease and undertake effective disease containment and control. This includes the ability to ensure adequate rapid PCR testing for COVID-19 and contact tracing. A strong partnership with their local and state health department is essential for testing, contact tracing and ongoing disease surveillance. Together, the academic institution and the public health agency should agree on a testing strategy and plan. Elements should clearly define priorities of testing, the role of symptom-based strategies and how best to test employees who are of high risk either because of underlying disease or their on- or off-campus occupations. Examples of higher risk occupations for consideration might include cafeteria workers, the health clinic nurse or staff living or working in residential dorms.

Campus health systems and clinics must have adequate health center staff, testing and personal protective equipment for providers to ensure they are fully prepared in the event of positive cases among the student population, faculty or employees of the institution. The institution will need to review its overall institutional infection control policies. This is to ensure the policies form a coherent plan to address any potential infectious disease because many disease have similar presenting signs and symptoms.

As academic institutions plan for students' return to school, they should implement basic risk reduction strategies including four key nontherapeutic measures in everything they do: maximizing physical distancing; hand hygiene; controlling respiratory spread (wearing masks); and sanitization of facilities. Administrations should think of these as stacked protections that work together to reduce the risk of infection. Physical distancing can be achieved by maximizing virtual classes where feasible. This is of particular interest for large lecture halls where the content can easily be delivery virtually. Reducing class size through staggered classes and moving to smaller classes should be done when feasible. There are indeed classes where this is not feasible because of the need for in-class participation, or classes that require the use of special equipment — music, physical activity, design, theater and laboratory-driven classes are examples. These types of classes bring unique levels of risk that will need to be managed differently.

Sports activities and other large gatherings pose additional risks not only to those on campus but also to the broader community. The ability to physically distance is a major barrier to safely hosting these activities, as is the number of people who could be exposed due to large crowds. Current guidance from CDC is based on the level of community transmission, the size and density of the gathering and the health risk profile of the attendees. These will be difficult decisions complicated by the participation of large numbers of supporters from all over the country for most college and university events. An infectious exposure could be a flash point for a significant widespread outbreak. One unanswered

⁴ Cal/OSHA Interim General Guidelines on Protecting Workers from COVID-19. Available at: <https://www.dir.ca.gov/dosh/coronavirus/General-Industry.html>

question is how sports programs will deal with screening and the frequency of PCR testing of athletes, the athletic staff and support personnel should these activities be allowed.

Institutions have a variety of controls over shared living and study spaces, from school-owned dormitories, to on- or off-campus fraternity and sorority houses. Plans on managing outbreaks on these facilities will need to be completed. Many students rely on campus-provided housing. Plans must be put in place to address the needs of these students who cannot pick up and go home should the campus lock down for a few days during disease control efforts. Additionally, disease control efforts should plan for alternative housing situations for students who must remain on campus in quarantine or isolation. There will be students who are not sick enough to be hospitalized but are too sick to go home and risk infecting other students or faculty.

Institutions should evaluate how to handle the full range of people who teach, work or attend school on campus. This will be particularly important for individuals with higher underlying health risks. Like the rest of society, the academic institution contains a population of people of all ages with a wide range on preexisting conditions and some of these conditions have been shown to put people at a higher risk of severe disease should they get infected with SARS-2, the virus that causes COVID-19.

There remains a great deal of confusion over coverage for screening exams and tests despite recent laws that were passed to ensure coverage for testing. Some schools have health insurance requirements. These should be reviewed in the context of school policies and procedures to ensure access to COVID-19 testing and broader health screening and treatment to ensure there are no barriers to disease control efforts.

Because the return to school proceeds the start of influenza season, schools should have in place a process to identify and screen influenza-like illnesses to differentiate between COVID-19 and influenza. In addition, universal influenza vaccination should be achieved for all except those who have medical exemptions. Schools must be rigorous about ensuring all students have received all other required vaccinations to help with identifying other infectious diseases of concern that have curative or preventive therapies. I recognize there are states and academic institutions that do not share this view on immunizations and allow for religious or other exemptions. My perspective represents the best science we have today that vaccines are safe and effective and will be essential for the institutional response to infectious disease outbreaks this fall and winter.

Unanswered questions include:

- How do we screen students for disease before they come to campus?
- What is the role of temperatures?
- Is there a role for antibody testing, recognizing CDC currently does not recommend antibody testing as a return-to-work tool?

Resident assistants and other students who provide support in student residential settings are a good early warning asset of the institution. Having these individuals properly trained to identify sick students with COVID-19 symptoms and in the proper procedures for early disease control could help identify ill students and enhance rapid referral for testing and medical care.

Institutions will have to develop robust communications plans to educate students, parents and employees about the institution's COVID-19 plans for preventing the spread of the disease, testing, isolation and quarantine for individuals who test positive. It is critical that all colleges and universities create a centralized resource that students and employees can turn to for all COVID-19-related issues. A robust educational campaign about these resources and the health and safety protections that each institution has put into place is recommended. Institutional spokespersons will need to be well trained, clear and consistent about risk communication.

Equity Consideration: Students and Institutions

COVID-19 has demonstrated a disproportionate impact on some populations, in particular African Americans and Hispanics. This alarming health disparity is due in part to the greater degree of novel coronavirus exposure linked to a higher percentage of African Americans and Hispanics having public-facing jobs, a greater prevalence of underlying chronic diseases among those populations and longstanding inequitable social determinants that impact health. These issues must be factored in as a component of any institution's risk reduction planning.

Additional equity factors to consider include the fact that some students rely on a range of enabling services provided by their colleges and universities, as well as technology support (Wi-Fi and online access to other campus-based technology). Any campus-wide move to virtual learning or even a short shutdown will need to address the ability of these students to thrive and properly participate in virtual learning if they do not have adequate access to the needed technology. Tuition and scholarships are not likely to cover unforeseen costs associated with facility closures or restrictions. Some students also rely on campus-based supports and opportunities such as income earned through campus-based employment and campus-based child care. Schools must have plans in place to ensure low-income students are not disproportionately impacted by a potential COVID-19 outbreak on campus.

There are also significant disparities in available financial resources among the country's colleges and universities to address COVID-19-related activities. There are challenges to basic capacity of many of our institutions of higher learning that have not yet been addressed.

Scenario Planning

I cannot over-emphasize the fact that there will be a case of COVID-19 on campus and institutions should prepare for and practice several predictable scenarios in advance of reopening such as:

- The student with diagnosed COVID-19 who lives in the dormitory.
- The student with diagnosed COVID-19 who lives in a fraternity or sorority house on campus.
- The student with diagnosed COVID-19 who lives in a fraternity or sorority house or other off-campus housing.
- The COVID-19 positive visitor who has left campus.
- The student, faculty or staff member who is identified through contact tracing but is asymptomatic.
- The exposure of students, faculty or employees from a large scale event on campus.
- The exposure of students, faculty or employees from a community event or concert off campus.
- A student death from a non-COVID-19 or unknown infectious disease.
- A nonstudent death from a non-COVID-19 or unknown infectious disease.

I know there are many more considerations academic institutions have to contemplate as they prepare for the fall semester. Let me just reemphasize that this is all about risk reduction. While we still have a lot to learn about SARS-2, the virus that causes COVID-19, we do know enough to reduce the risk of infection substantially if we don't underestimate the risks and plan for its mitigation. The ultimate solution for our return to normal for all of our society is a safe and effective vaccine. I am optimistic that we will have this important prevention tool in the next 12-18 months. But until then, we will continue to rely on community mitigation as our best option.

A Strong, Well-Resourced Public Health System is Essential

None of this is possible without having a robust well-resourced and trained local and state public health system in every community to support the academic institutions in their mitigation preparedness and response. Congress and the administration must continue to support the nation's public health systems as we continue to respond to the COVID-19 pandemic and the coming influenza season later this year. By basing our response to this pandemic using the best science available and in partnership with the community, we can reduce the risk as we receive a quality education.

In addition to ensuring that the federal government is providing adequate support and assistance for testing and contact tracing and to the nation's colleges and universities and students to ensure a safe reopening, APHA strongly urges Congress to support additional measures to strengthen the nation's public health system. Our country's state and local health departments will serve as critical partner to our colleges and universities, businesses, state and local governments and other sectors to help prevent the spread of COVID-19 through testing, conducting disease investigations and contact tracing to help contain further spread of the disease, providing the public with the latest science-based information and data about the disease in their communities, among many other responsibilities. In order to better ensure our state and local health departments are adequately prepared for addressing the current pandemic and future public health emergencies, we must seriously look at fixing our vastly underfunded public health system. APHA is calling on Congress to provide \$4.5 billion in additional long-term annual mandatory funding for CDC and state, local, tribal and territorial public health agencies for core public health infrastructure activities.^{5,6} This funding would support essential activities such as: disease surveillance, epidemiology, laboratory capacity, all-hazards preparedness and response, policy development and support, communications, community partnership development and organizational competencies. This funding is critical to ensuring our state and local health departments have broad core capacity to not only respond to the current pandemic but to better respond to the many other public health challenges they face on a daily basis. For far too long we have neglected our nation's public health infrastructure, and we must end the cycle of temporary infusions of funding during emergencies and provide a sustained and reliable funding mechanism to ensure we are better prepared to protect and improve the public's health from all threats.

Congress should also appropriate funding in fiscal years 2020 and 2021 for the public health workforce loan repayment program authorized in the HEROES Act.⁷ Providing funding for this important program will help incentivize new and recent graduates to join the governmental public health workforce, encourage them to stay in these roles, and strengthen the public health workforce as a whole. The public health workforce is the backbone of our nation's governmental public health system at the county, city, state and tribal levels. These skilled professionals deliver critical public health programs and services. They lead efforts to ensure the tracking and surveillance of infectious disease outbreaks, such as COVID-19, prepare for and respond to natural or man-made disasters, and ensure the safety of the air we breathe, the food we eat, and the water we drink. Health departments employ public health nurses, behavioral health staff, community health workers, environmental health workers,

⁵ Organization letter to House and Senate leaders urging a significant, long-term investment in public health infrastructure in future legislation to speed the response to the COVID-19 pandemic. April 3, 2020. Available at: https://apha.org/-/media/files/pdf/advocacy/letters/2020/200403_ph_infrastructure_covid_stimulus.ashx.

⁶ Public Health Leadership Forum. Developing a financing system to support public health infrastructure. Available at: https://www.resolve.ngo/docs/phlf_developingafinancingsystemtosupportpublichealth636869439688663025.pdf.

⁷ Organization letter to House and Senate leaders supporting the inclusion of the Public Health Workforce Loan Repayment Program in the HEROES Act. May, 14, 2020. Available at: https://apha.org/-/media/files/pdf/advocacy/letters/2020/200514_ph_workforce_loan_repayment.ashx.

epidemiologists, health educators, nutritionists, laboratory workers and other health professionals who use their invaluable skills to keep people in communities across the nation healthy and safe.

Thank you again for the opportunity to speak with you this morning. I look forward to answering any of your questions.