

Health and Well Being Considerations for Pac-12 Institutions

Guidance for Local Planning for Return to Sporting Activity: Updated 9/17/2020

The board of the Pac-12 Student-Athlete Health and Well-being Initiative (SAHWBI) has engaged in daily and weekly calls and discussions throughout the preceding six months reviewing and analyzing our continuously developing understanding of the COVID-19 pandemic. These recommendations have been created through this collaboration and are informed by Pac-12 SAHWBI physicians and athletic trainers as well as national experts in public health, infection disease, epidemiology, and cardiology.

This document is based on the most up-to-date information available to us as of September 16, 2020 and will continue to be updated as new information develops and our understanding evolves. These recommendations should inform the approach for the safest manner to return to various levels of athletic activity when the current status of the pandemic allows for such activity. Only modifications of clarifications to the previous document of 8/10/20 are included. In addition, **each Pac-12 member is subject to the restrictions imposed by its individual institutions, state and local health departments, and state and local laws and regulations.**

DEVELOPMENTS SINCE 8/10/2020

On 8/10/2020 we released recommendations not to proceed to higher risk of transmission contact activity or competition based on the following concerns:

1. High community prevalence and concerns about travel.
2. Concern about health outcomes related to the virus including new information about potential serious cardiac side effects in athletes.
3. Concern that testing needed to be done more frequently and closer to game time, including access to rapid turn-around point of care testing.

At this time, we believe there is a path forward to resuming sports activities that involve higher risk of transmission contact and competition based on the following developments:

1. Community prevalence and percent of test positivity has improved in most places across the Pac-12 footprint and in the United States (with a few exceptions).
2. All Pac-12 members have confirmed the ability to conform to the cardiac monitoring recommendations described in this document and have already begun conducting cardiac work-ups on every athlete with COVID-19. In addition, all Pac-12 members are actively engaged in continuing to collect data in a national COVID-19 cardiac registry. We will continue to monitor cardiac and other outcome information.
3. All Pac-12 members have access to COVID PCR testing (with about half having access to local resources for 24-hour turn-around). The Pac-12 has also contracted with Fulgent Laboratories (max. 36-hour turn-around time) should institutions wish to use this option for PCR or to supplement their own resources. In addition, we recently partnered with Quidel for rapid point-of-care antigen test to begin allowing for testing of higher-contact sports on a near-daily basis.

It should be recognized that the policies and protocols already developed, including regular surveillance testing, disinfection, and contact tracing, have placed substantially increased demands on medical staff, especially the athletic training staff. Increased frequency and volume of testing with point of care tests will place additional demands on staff. As such, the ability of medical staff to follow recommended policies and procedures should be taken into consideration before returning student-athletes to campus and increasing levels of activity. A detailed plan should be created to insure adequate staffing for all health care delivery and implementation of surveillance testing.

COVID-19 TESTING RECOMMENDATIONS

COVID-19 testing is integral to any return to sport strategy. Institutions must submit their plan to the SAHWBI and COVID Advisory Group for approval. The COVID Advisory Group must include independent infectious disease physicians to review the testing methodology and strategy.

This document addresses updated testing recommendations, including the use of point-of-care tests.

Initial Return to Campus

Initial return to campus should include a determination of antibody status to guide cardiac work-up and PCR testing to evaluate for active infection. When athletes return to campus after a period of time away, an individualized decision should be made whether the athlete requires quarantine and repeat antibody testing based on mode of travel and viral conditions both at the institution and at the athlete’s place of origin. Any athlete returning should have repeat PCR testing before being allowed into the athletic footprint.

Testing for Sporting Activity with a Low or Medium Risk of Viral Transmission

Once student-athletes have returned to the campus, a surveillance strategy to screen for active infection should be adopted based on the risk for transmission of the activity, local prevalence, and percent positive tests. This could range from testing the student-athletes and staff who have close contact with the student-athletes only when they become symptomatic, to testing frequently, on a regular schedule.

Testing for Sporting Activity with Higher Risk of Viral Transmission

In the 8/10/20 Considerations document we recommended basing test frequency before return to high risk of transmission activities on standard infectious disease metrics including new daily cases/100,000 people (7 or 14-day average) and percent of tests in a community that are positive.

Table 1: Key Metrics for COVID suppression (Harvard Global Health Institute)

COVID Risk Level	Case Incidence	Features of Infection
Red	>25 daily new cases/100,000 people	Uncontrolled spread
Orange	10<25 daily new cases/100,000 people	Spread has accelerated and is at dangerous levels
Yellow	1<10 daily new cases/100,000 people	Some level of community spread
Green	<1 daily new cases/100,000 people	On track for containment

Table 2: Recommended Testing Frequency for Higher Risk of Viral Transmission Activity*†

Overall COVID Risk Level	COVID daily new cases/100,000 (in community)			% Positive Tests (campus wide or community 7 day rolling average)	Recommended Testing Frequency
	red	orange	yellow		
Red	red	orange	yellow	≥7.5%	Daily
Orange	orange		yellow	≥5 and < 7.5%	Every other day
Yellow	orange		yellow	≥3% and < 5%	Every 3 days
Green	yellow		green	< 3%	Weekly

*updated

†Cases/100,000 figures should be from the Friday preceding the week in the county and taken from COVID ActNow.

% Positive tests should be from COVID ActNow, local public health departments, or, when unavailable best estimate.

We believe that the above recommended frequency is appropriate and will keep spread in the athletic footprint to a minimum. However, this testing frequency does not change the contact tracing required (see “Contact Tracing” below). There is potential, if there is a positive, that large portions of a team or even whole teams may need to be quarantined making progression through a season challenging.

Based on evolving science, we recommend once a week PCR testing supplemented by point-of-care antigen surveillance the day of higher risk of transmission activities, including pre-competition. Any person testing positive for COVID-19 with the antigen test will be isolated and a confirmatory PCR test would be performed. Discordant results would prompt evaluation of the cycle threshold (Ct) values and repeat PCR testing to determine further disposition in consultation with an infectious disease expert.

Antigen testing is not as sensitive as PCR testing, however, there is a trade-off between sensitivity of the test and frequency of testing as well as turn-around time. Daily testing with rapid point of care testing could greatly reduce the chance of infectiousness while on the playing field.²

To be clear, either testing strategy is thought to be reasonable 1) the recommended testing based on COVID-19 disease metrics or 2) daily testing before any higher risk of viral transmission activity including both practice and competition. With either strategy pre-travel and pre-competition (same day) testing is required. The difference between the two strategies is quarantine potentially required should there be a positive test. We expect that when point-of-care antigen testing is available that this will be the preferred strategy.

Contact Tracing with Higher Risk of Transmission Activity

The risk of COVID-19 transmission increases with closer proximity, duration of contact, and if the infected individual is coughing. In sports, shared equipment and heavy breathing, such as occurs with exercise may also contribute to transmission risk. Weightlifting, conditioning, and individual drills can be performed in a manner which maintains physical distancing. Many sports, however, cannot be played without breaching physical distancing recommendations. The current CDC recommendations for quarantine include close contact with a symptomatic or asymptomatic person with COVID-19 and is

defined as a proximity of less than 6 feet for more 15 minutes.³ It is not specified whether or not the time is continuous or cumulative. This is difficult to apply in the setting of sports where there is fluidity of proximity and motion. The CDC acknowledges that data to inform both the definition of close contact and the precise duration of time which constitutes prolonged exposure is limited. Of note, per CDC guidance, mask use by either or both parties does not alter whether someone is considered a close contact.³

Contact tracing involves assessing who has had close contact with an infected individual in the preceding 48 hours. In the community, it is presumed that an individual may be infectious for the 48-hours preceding a positive test. Typically, individuals in the community are only tested for COVID-19 should they be symptomatic or have a known close contact. With a near-daily testing regimen in an asymptomatic population preceding any higher risk of transmission activity, it is proposed that no individual on the field is likely to be infectious and there is not a need for quarantine due to on-field/court activities. Therefore, if an athlete tests positive with antigen testing, they will be isolated per protocol and contact tracing will include activities in the time outside the athletic footprint, to include roommates.

Each institution will need to work closely with local public health officials to agree to this approach. We believe that this approach is reasonable in supporting safety and minimizing spread of COVID-19, above and beyond what is currently employed in any other conference, and similar to what is currently used and approved for some professional teams.

For teams that elect to test at the frequency recommended to prevent spread in the athletic footprint (Table 2) but not daily, a positive test would necessitate contact tracing to include practices or competition included in that 48-hour period.

Monitoring

Infection rates on each team using this approach will be monitored. If there is an outbreak on a team due to athletic-related activity, all team activity will be halted and the team quarantined. Decisions regarding outbreaks and team quarantine will ultimately be up to local public health officials who ideally are working closely and in concert with institutions' medical staff.

Individually de-identified infection rates in the conference will be reviewed weekly by the SAWBI executive team. Any concerns will be reviewed collaboratively with the local institution.

Research

Outcomes will be tracked in a systematic way for both quality improvement and better understanding if the recommended approach is successful and could be applied to community or school settings.

Testing of Staff

Staff should always wear a face covering and maintain physical distancing when possible; however, some "inner bubble" staff such as coaches, strength and conditioning professionals, and athletic trainers may have higher risk encounters than ideal. It is recommended that these "inner bubble" staff who are unable to maintain physical distancing or have instances where they are not properly using face covering, and are therefore at a higher risk of transmission, be tested at a frequency based on their estimated risk.

Travel for Sports with Higher Risk of Viral Transmission Activities

Travel presents particular challenges during the COVID-19 pandemic. Travel on commercial air carriers and through airports presents unknown risk for infection and should be limited when possible. If travel is deemed essential, strict adherence to face coverings, hygiene, and social distancing when possible should be maintained. For team charter flights, the travel party should be limited to essential personnel. Everyone on the flight should be tested with a rapid antigen or PCR test with a maximum turn-around time of 24 hours (with results available prior to travel) prior to the flight. Antigen testing of athletes after travel, on the day of competition should be performed.

For commercial flights, the travel party should undergo testing prior to the flight and antigen testing on the day of competition prior to competing.

WORK-UP AND MONITORING OF CARDIAC CONCERNS

There is evolving information regarding potential cardiac effects of COVID-19 infection. Current guidelines recommend consideration of ECG, troponin, and echocardiogram after isolation period is complete and prior to return to play. We recommend that this battery of tests be done in Pac-12 athletes with new COVID-19 infections prior to return to activity. Restriction from activity and return to exercise should follow [NCAA-American Medical Society for Sports Medicine](#) guidelines. All athletes who have had a COVID-19 infection should be cleared by a physician prior to return to activity. If clinically indicated, in consultation with a cardiologist, a cardiac MRI can be obtained. This is in line with protocols developed by professional leagues and supported by our cardiac experts. If an athlete has had COVID-19 in the past, has returned to exercise successfully and without symptoms, cardiac testing need not be done retrospectively. All Pac-12 institutions are encouraged to report their de-identified cardiac data to the *Outcomes Registry for Cardiac Conditions in Athletes (ORCCA Study) – COVID-19* to inform our ongoing assessment and understanding of COVID-19.

SUSPENSION OR DISCONTINUATION OF COMPETITION

We affirm the principals laid out in the 8/10/20 document for the suspension or discontinuation of competition. Attempting to play sports during the COVID-19 pandemic involves risk. The above strategies and guidelines have been made to try to mitigate that risk to a level that allows for reasonable safety through strict policies and surveillance testing; however, the situation needs to be continually reassessed on individual institutional and local levels, as well as at the conference, and national levels. If a student-athlete deems the potential health risks do not merit play (or continued play), their scholarship will be honored.

From an institutional, conference, local, state, and national level, considerations regarding suspension or discontinuation of activity where physical distancing cannot be maintained include:

- 1) Inability to isolate new positive cases and/or quarantine high-risk contacts
- 2) Lack of availability or inability to perform testing at the recommended frequency, including the ability to test within 24 hours of competition and have results prior to that competition
- 3) Inability to perform adequate contact tracing
- 4) Local public health officials deem that hospital resources are in danger of being overwhelmed

- 5) Lack of access or ability to perform recommended cardiac evaluation
- 6) Inability for medical staff provide adequate care for an institution's student-athletes because of increased workload
- 7) Uncontrolled community/campus spread
- 8) Local public health official's restrictions on group athletics

RESUMPTION OF CONTACT/COMPETITION

Resumption of contact/competition after a pause can be considered when the following criteria are met. There may be other considerations that are important but not listed.

- 1) COVID 19 is not actively spreading uncontrolled among the school community
- 2) Access and ability to complete cardiac evaluation on those who do test positive (troponin, EKG, echo, CMRI)
- 3) Testing access and capacity to satisfy testing recommendations above, including the ability to test within 24 hours of competition and have results prior to that competition
- 4) Capability to isolate new positive cases and quarantine high-risk contacts. Campus or community access to housing and food options to effectively ensure basic conditions for successful quarantine and isolation
- 5) Adequate local health care capacity as determined by local public health officials
- 6) Ability to provide adequate care for the institution's student-athletes

CONCLUSION

The Pac-12 SAHWBI believes that the conditions for resumption of contact/competition can be met by the institutions when antigen testing is available on each campus. We believe access to near-daily rapid point of care testing for contact sports will significantly improve our ability to prevent transmission of COVID during higher risk of transmission activities, change the risk of travel, and provide a path for limiting the potential impact of quarantine. We believe this represents a higher standard than is employed elsewhere, however, we acknowledge the burden that this frequency of testing will increase work for athletic staff and should be carefully considered and addressed when moving forward. We will monitor outcomes with this approach and modify recommendations as required.

1. Rajpal S, Tong MS, Borchers J, et al. Cardiovascular Magnetic Resonance Findings in Competitive Athletes Recovering From COVID-19 Infection. *JAMA Cardiol* 2020 doi: 10.1001/jamacardio.2020.4916 [published Online First: 2020/09/12]
2. Larremore DB, Wilder B, Lester E, et al. Test sensitivity is secondary to frequency and turnaround time for COVID-19 surveillance. *MedRxiv* 2020 doi: <https://doi.org/10.1101/2020.06.22.20136309> [published Online First: June 27, 2020]
3. Public Health Guidance for Community-Related Exposure Centers for Disease Control and Prevention2020 [updated July 31, 2020. Available from: <https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html> accessed August 27 2020.