12 August 2020

BRIEF19

A daily review of covid-19 research and policy.

BREAKING POLICY BRIEFING

Two major organizations release an election safety guideline. Yes, it can be done.

The United States presidential election is on November 3rd. Is in-person voting safe during the covid-19 pandemic? A new guideline released August 12th by the Infectious Disease Society of America (IDSA, the nation's governing body on infectious disease medicine) and the Brennan Center for Justice at the New York University School of Law says *yes*. That is, if properly planned and carefully carried out. Their guidance adds to an earlier document released by the U.S. Centers for Disease Control and Prevention and anticipates specific problems and provides workable solutions. The document covers four major topics: General guidance; polling place location considerations; information on keeping polling sites healthy (i.e. decreasing any spread of SARS-CoV-2), and; information on properly selecting and protecting poll workers. Some highlights of the document caught our eye and are worth discussing.

-Many polling places are in buildings that normally serve seniors and other at-risk persons. These polling sites should be relocated. Favored sites include those with ample space and ventilation and filtration systems (e.g. school gymnasiums or large parking lots where possible). Meanwhile, seniors who normally would not have to commute in order to vote must not be forgotten; plans should be made to encourage and allow these citizens to vote.

-Polling places should provide masks for those who do not arrive wearing one.

-Curbside voting should be available to those for whom entering the building may be a risk either to themselves or others.

-Officials should design the flow of voter movement so that crowding is minimized. This includes separate entrance and exits. Other interventions such as placing of plexiglass barriers between voters and poll workers are advised.

-For voting itself, the guidelines emphasize safe distances between booths, frequent cleanings, and other interventions to minimize contamination from one voter to the next such as the use cotton swabs instead of fingers to press buttons (or other appropriate finger covers for buttons or screens). Disposable pens and pencils are also suggested.

-Shared surfaces like door handles, voting booths, and restrooms will need full cleanings on a frequent basis. Full restroom cleanings are suggested every four hours.

-Planners should prioritize adequate PPE for poll workers and recruit a surplus of workers in the event of unplanned illness or concerns regarding contamination. Some poll workers who normally would be fit to work may have to sit this year out (e.g. some retired people). Poll workers will need PPE training as well.

All of these interventions and others strike us necessary, reasonable, and achievable. With adequate planning and care, in-person voting appears to remain a safe and viable option.

—Jeremy Samuel Faust, MD MS

The risk of reimbursement data.

In a recent letter published in the *Journal of the American Medical Association* (JAMA), researchers examined the allocation of funds to healthcare entities under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. In brief, the Medicare Accelerated and Advance Payment Program looked at past Medicare claims data to determine the proportion of

disbursement to affected healthcare entities. The researchers found that disproportionately Black communities had lower reported revenue, and when combined with data showing that minority populations are more heavily affected by coronavirus, resulted in these areas receiving funding not commensurate with the outsized effect of covid-19 in said communities. The authors suggest that to combat this, future packages incorporate an aspect of need in their funding determinations. *JAMA.*

—Joshua Lesko, MD

RESEARCH BRIEFING

The Kiwi Response to covid-19.

New Zealand has been praised for its response to the covid-19 pandemic and a recent correspondence in *New England Journal of Medicine* highlights the keys to its success in what until this week had been an absence of cases for 102 days. Early on, despite its relative geographic isolation, the country recognized its risk due to the large number of tourists and students visiting from Europe and China. Initial modeling suggested possible overwhelming demands to the health care system and a disproportionate disease burden affecting Maori and Pacific people. When most countries were still working on developing plans in February, the New Zealand government began implementing preparedness plans and border control. The first case was identified on February 26 and community transmission was recognized as occurring by mid-March. What happened next as the authors state was "strong, science-based advocacy" and national leadership decisiveness leading to an elimination strategy of essentially a 7-week national stay-at-home order. Five weeks into the lockdown, cases began to decline rapidly and by early May the last case was identified and placed in isolation. All of this took place without a national mask mandate. Since early May, each new case has been an international traveler who was discovered during a government-managed 14-day quarantine upon arrival in New Zealand. The country boasted the lowest covid-19 mortality (4 per 1 million residents) among the 37 nations in the Organization for Economic Co-operation and Development with a total case count of 1,569 and just 22 deaths so far.

Further emphasized in the *NEJM* piece was how New Zealand's leadership displayed empathy and used effective communication strategies in framing the pandemic as the work of a "team of 5 million." The government also provided economic assistance to businesses and employees affected by the seven-week lockdown. As a result, public confidence soared.

With the recent identification of four new cases in New Zealand, the world will be watching its response to this new outbreak. But given their track record to date, one would have to assume they stand the best chance of any nation to control SARS-CoV-2.

—Christopher Sampson, MD, FACEP

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