Summit UU Fellowship Safe Re-Opening Task Force Report, June 2022

(Adopted by the Board of Directors 6-11-22)

Relation to our shared Unitarian Universalist principles

Within our UU community, our response to the COVID-19 pandemic must include consideration of our shared UU principles, including our call to justice, equity, and compassion, and respect for the interdependent web of life. Our Fellowship has also adopted the 8th principle, in which we covenant to "affirm a journey towards spiritual wholeness by working to build a diverse, multicultural Beloved community through actions that accountably dismantle racism and other oppressions in ourselves and our institutions."

When we choose to gather in person, in addition to direct health risks for Fellowship members and staff, we must also face the possibility that infections resulting from our meeting may ripple outward to the wider community. For example, in February 2020 executives at the pharmaceutical company Biogen decided to meet in person despite reports of the emerging pandemic worldwide. The meeting, with 175 attendees, initially resulted in a cluster of ~100 cases in the Boston area. Genetic evidence later showed that within nine months these cases had spread to 333,000 cases in 29 states and at least three other countries, all attributable to one irresponsible meeting[1].

Viral mutations occur randomly as the virus replicates within infected people, so the more cases we allow to occur, the greater probability that new variants will arise with increased vaccine resistance[2]. When we contribute to spread of the virus, our actions also contribute to growing health disparities amongst low wage essential workers, who must contend with job-related exposures combined with lower access to quality medical care. In San Diego County, death rates from COVID-19 have been 3.5 times higher in Hispanics compared to White residents, and Hispanic children accounted for 60% of MIS-C cases[12]. Indigenous people in San Diego are also disproportionately affected, with 2.9-fold higher death rates for indigenous Hawaiians/Pacific Islanders, and 1.6-fold higher death rates in indigenous peoples in the lower 48 states and Alaska compared to Whites[3].

Every Wednesday, when case numbers are released by the County, we will decide our current risk category based on the sources described below.

Metric	Low risk	Medium risk	High risk
Daily case rate (per 100,000)	4	5 to 25	≥ 26
Wastewater viral load (gene copies/liter)	< 1 million	1 to 5 million	≥ 5 million
Test positivity rate	≤ 1%	2% to 5%	≥ 6%

Restrictions for gatherings at each risk level:

Low risk: No restrictions

Medium risk: Masks required indoors for everyone over age 2, limited capacity, food outdoors only

High risk: No indoor services, food and gatherings outdoors only

Decisions when metrics differ in risk category:

Recognizing that no single metric is perfect, we will consider them together to reach a consensus.

(a) If any two metrics are "Low" → we are in "Low" risk

(b) If any two metrics are "Medium" → we are in "Medium" risk

(c) If any two metrics are "High" → we are in "High" risk

(d) If one metric is "Low," one is "Medium," and one is "High" → we are in "Medium" risk

Sources:
Case rates and test positivity percentage graphs: https://covidactnow.org/us/california-ca/county/san_diego_county/?s=34432242
Scroll down to the 'Transmission metric' chart to see the daily **case rate** and **positive test rate**.

Point Loma Wastewater Treatment Plant surveillance (covers our region of San Diego County): https://searchcovid.info/dashboards/wastewater-surveillance/

Comments on the individual metrics

Current official case rates are likely to be undercounting true case rates for several reasons: home tests are not officially reported unless confirmed by PCR tests, federal funding no longer exists for testing uninsured people, and vaccinated people are more likely to be asymptomatic cases and fail to get tested. Moreover, case rates are now reported only once weekly.

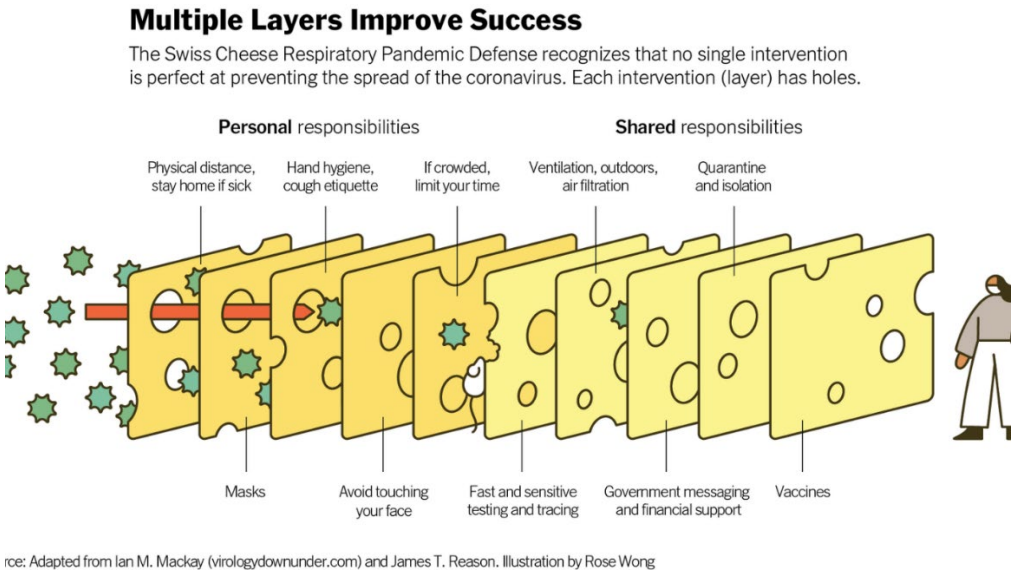
Wastewater surveillance of viral load is unaffected by these issues and is reported more frequently, but an exact correlation with case rates has not been established. Unlike daily case rates, wastewater reflects both new and active cases, but it may include some resolved cases that are no longer infectious.

Finally, we include test positivity rate (percentage of official PCR tests coming back positive) as a measure that reflects both community trends and the amount of testing taking place.

We are not using hospitalization rates or hospital capacity to decide risk level, because hospitalizations lag several weeks behind case surges, and hospital capacity is determined by factors like nursing shortages that are not useful for estimating individual risk of infection.

Mitigation Strategy

Since no single strategy completely eliminates the risk of viral transmission, we have adopted a multi-layered approach illustrated by the "Swiss Cheese Model."



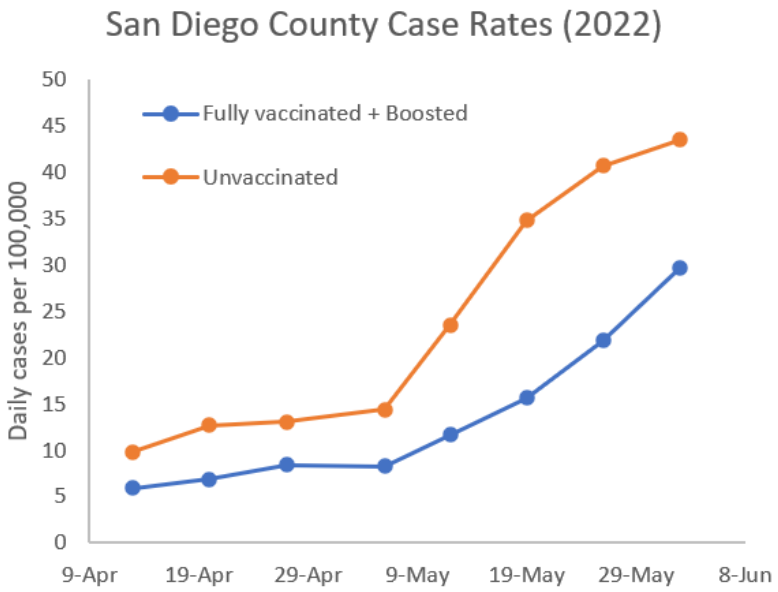
- Within the sanctuary, we have installed air filtration units that together provide 7-8 air exchanges per hour.
- We covenant to stay home if we feel sick, even if it's just a cold.
- We provide high-quality KN95 masks at services for those unable to obtain them.

Recommended masks (source: Johns Hopkins University):

- During periods of indoor masking, any speakers planning to unmask self-test the morning of the service before leaving home.
- We maintain a virtual option and an outdoor option for services, and we encourage outdoor meetings whenever possible.

- Full vaccination is required for all staff, contractors, and RE volunteers.

- Vaccination and up to date boosters are strongly recommended for anyone participating in in-person gatherings at Summit, but we are no longer *requiring* vaccination for indoor attendance. Our previous requirement was based on data with early viral variants showing that unvaccinated people were ~15 times more likely to be infected with COVID-19, so including even a single unvaccinated person significantly increased the probability of a COVID-positive case being present in any gathering. In recent months, this situation has changed: there has been a dramatic increase in cases amongst fully vaccinated and boosted people, as shown in the graph below for San Diego County.



Source: case rates reported in San Diego County COVID-19 Weekly Surveillance Reports, April–June 2022.

There is now consistently less than a 2-fold difference in case rates for unvaccinated vs. fully vaccinated, boosted people, with only 1.5-fold difference in the most recent SD County report. The true difference in case rates may actually be negligible, because vaccinated people are more likely to have mild/asymptomatic cases that are not confirmed by official testing.

We estimate that there is now a similar likelihood of a COVID-positive case being present whether the audience is 100% vaccinated or 80% vaccinated. A 2021 survey of the Summit community indicated that our Fellowship is > 90% vaccinated. While we still strongly recommend vaccination to protect individuals from serious outcomes, there is no longer a compelling scientific rationale for excluding unvaccinated people from indoor meetings as a way to meaningfully reduce transmission of the virus. We also recognize that excluding any portion of our community from full participation in services conflicts with our aspiration to be a welcoming community of caring for all.

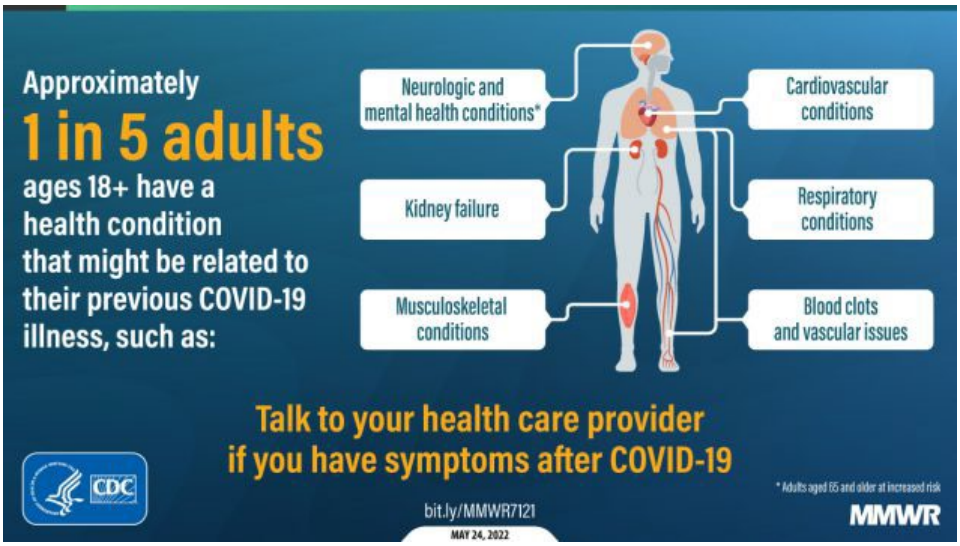
Background

Current landscape of vaccination and new variants

COVID-19 is a highly infectious, airborne virus that continues to evolve, with new variants emerging every few months. Despite tremendous hopes for vaccines, Delta and especially Omicron variants have resulted in high numbers of vaccine "breakthrough" infections. The potential dangers of Omicron first became clear in November 2021, when a company holiday party in Norway resulted in 79 out of 117 attendees becoming infected, despite all being fully vaccinated and required to pass a rapid antigen self-test the day prior to the party[4]. Vaccines have continued to provide protection against hospitalization and death, but this protection wanes over time without additional boosters. For example, with the newer Omicron BA.2 variant, vaccines provided only 56% effectiveness against hospitalization at 15 weeks from last booster[5]. According to the CDC, groups at especially high risk of severe COVID-19 outcomes include anyone age 65 or older, as well as adults of any age with many common chronic health conditions, such as diabetes, cardiovascular disease, and obesity[6]. At the time of this report, there is no FDA-approved vaccine for children under age 5. Although severe disease in children has been rare, 98 children in San Diego County have developed a life-threatening delayed immune response called Multisystem Inflammatory Syndrome in Children (MIS-C) since the start of the pandemic[7].

Long-term effects

The most recent CDC report from May 2022 estimates that approximately 1 in 5 survivors of COVID-19 go on to experience long-term symptoms, commonly known as long COVID[8]. Symptoms involve multiple organ systems and may be extremely debilitating, or even result in death. **Multiple studies have confirmed that even mild COVID-19 cases can result in long-term disability**. Vaccines may provide some protection against long COVID, but estimates vary, with only 15% protection in the largest-scale study to date[9]. A recent *Nature Medicine* study found increased risk for a range of severe cardiovascular outcomes (e.g., stroke, heart attack, heart failure) in the year following a mild COVID-19 infection[10]. A careful comparison of brain imaging before and after mild (non-hospitalized) COVID-19 infection found evidence of cognitive decline and brain atrophy in COVID-19 survivors compared to uninfected controls[11] . Skin biopsies of long COVID patients showed peripheral nerve damage in the majority of patients, most commonly starting within one month after COVID-19 infection[12].



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Acknowledgments

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