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# COVID-19 Safety Grades for Businesses—A Possible Mitigation Tool

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Public discourse regarding coronavirus disease 2019 (COVID-19) in the United States has transitioned to intense deliberation about the infeasibility of continuing to implement stay-at-home orders and uncertainty regarding whether socioculturally acceptable alternatives could be developed to manage COVID-19 with less severe economic repercussions. Besides ongoing scientific dialogue about the expansion of testing and tracing efforts,<sup>1,2</sup> comparatively little has been proposed in terms of tangible, but novel, complementary mitigation tactics, despite the national race to reopen. By late May, all states had started reopening, many without meeting recommended benchmarks,<sup>3</sup> while other countries wrestled with disease resurgence.<sup>4</sup> In some states, consumer activity was lower than anticipated after reopening, possibly because the more risk-averse subset of the population continued to voluntarily limit extrahousehold activities. It has been suggested that the reopenings have shifted the onus of disease prevention from public policy to individuals who must now make informed choices about what businesses (if any) to patronize, perhaps based only on their perception of whether businesses are following relevant disease prevention protocols. We propose a tactic that could provide some of the requisite knowledge individuals need to make more informed decisions.

It is unclear to what extent members of the lay public can accurately assess infection risk in various settings. For many, the perception of risk may be primarily based on visible preventive measures (eg, employees wearing face covers), although many precautions—or lack thereof—may not be visible (eg, employee wellness screenings). The average customer has no reliable way of knowing whether those in a restaurant kitchen or in employee-only areas are following good hygiene, wearing facial coverings, and observing social distancing. Many jurisdictions are relying on public health recommendations for businesses, which depend on cooperation and are legally unenforceable. If our current strategy is to reopen society assuming that the lay public will be able to effectively manage their own infection risk, then it is incumbent on public health agencies to provide consumers the information they need to make informed decisions, instead of having the public guess whether a business is taking reasonable measures to keep them safe. Fortunately, many jurisdictions have the existing infrastructure for a means of presenting this information to the public—the food establishment safety grading systems that are already in place in major cities (eg, Los Angeles and New York City) and in some states. These systems could be adapted with relative ease to create a COVID-19 safety rating system for many types of businesses, including nonfood-related industries.

Instead of (or rather, in addition to) using an easy-to-understand letter-grading system to evaluate food safety, a scoring system would be designed to rate adherence to specific COVID-19 prevention practices. Similar to restaurant grading programs, a risk-based schedule for inspections could be developed that customizes the frequency of inspections based on risk assessment categories of each business type (eg, childcare centers, theaters), taking into account potential contact duration, number of contacts, contact intensity, and other factors.

The specific standards used for grading could differ by the needs of each jurisdiction. One idea is to establish a set of core standards that applies to all businesses, building on guidance from the US Centers for Disease Control and Prevention and local health departments. The core set could include consistently using face coverings by on-duty employees (with as-needed exceptions); upholding social distancing practices in both public and employee-only areas; holding documented staff training on COVID-19 safety; posting signage describing hand hygiene; providing touchless payment options

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(where applicable), hand sanitizer for public use in payment or other high-contact areas, and contactless pick-up options (as applicable); using appropriate disinfectants for scheduled sanitization of restrooms and high-contact surfaces, with a displayed cleaning log; requesting that employees self-screen for relevant symptoms; and having a written internal COVID-19 safety plan. Some health departments have already outlined industry-tailored minimum recommendations that could be adapted into business-specific addenda to the core set of standards. Grading criteria can be revised as information on COVID-19 evolves, incentivizing businesses to stay updated on recommendations that will also be communicated by program personnel.

The pilot phase of the program could allow businesses to opt in as a show of good faith to follow preventive measures to promote consumer safety. If the program appears to be useful in preventing outbreaks and increasing consumer confidence, it can then be expanded and adapted by each interested jurisdiction. Enough evidence supports the utility of such programs in aiding with the prevention of foodborne illness that it warrants consideration as a small component in the arsenal of public health tactics that need to be quickly designed and implemented to keep this pandemic at bay in the long term.<sup>5-7</sup>

If resource constraints preclude the use of a grading program, a less resource-intensive alternative (eg, a gold star program) could be considered, in which a business registers a templatebased COVID-19 safety plan with the local health department and receives public recognition for doing so after the health department reviews the plan. Some similar programs have already been implemented or are planned, such as the Good to Go pledge-based program in Nashville, Tennessee, or the mandatory programs in San Diego, California, and Massachusetts, the latter of which involves displayable compliance attestation checklist posters. In contrast to the proposed COVID-19 safety grading system, most such programs involve the business self-reporting adherence to recommendations from health departments or the Centers for Disease Control and Prevention, rather than having the additional assurance of professional inspections to help validate such assertions. Furthermore, the dichotomy of these programs (eg, having a gold star or not) arguably offers less information to consumers than an actual grade, which represents a spectrum of adherence.

The unfortunate reality of the trajectory of COVID-19 in the United States is that no single public health solution, no matter how simple or complex, can eradicate this illness from our nation. Therefore, we are left in a position that compels us to think creatively about developing pragmatic, rapidly deployable tools that will simultaneously allow for increased public autonomy and support disease mitigation during the next 18 to 24 months or until a vaccine becomes available.

#### **ARTICLE INFORMATION**

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