Resocialization of Collegiate Sport: 2022 Winter Training and Competition for Tier 1 Individuals

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This document serves as an update to Resocialization of Collegiate Sport: 2021 Fall Training and Competition and addresses broad considerations that differentiate COVID-19 management in Tier 1 individuals based on vaccination and other immunity considerations. As previously defined, Tier 1 individuals are those with the highest exposure (e.g., student-athletes, coaches, athletic trainers, physical therapists, medical staff, equipment staff and officials).

This document is the ninth NCAA publication regarding resocialization of collegiate sport:

1. Core Principles of Resocialization of Collegiate Sport (May 1, 2020).
2. Resocialization of Collegiate Sport: Action Plan Considerations (May 28, 2020).
3. Resocialization of Collegiate Sport: Developing Standards for Practice and Competition (July 16, 2020, updated Aug. 14, 2020).
4. Core Principles of Resocialization of Collegiate Basketball (Sept. 25, 2020).
5. Resocialization of Collegiate Sport: Developing Standards for Practice and Competition, Second Edition (Nov. 13, 2020).
6. Resocialization of Collegiate Sport: Developing Standards for Practice and Competition, Updated Second Edition (May 3, 2021).
7. Resocialization of Collegiate Sport: 2021 Summer Activities (June 8, 2021).
8. Resocialization of Collegiate Sport: 2021 Fall Training and Competition (Aug. 4, 2021).
9. Resocialization of Collegiate Sport: 2022 Winter Training and Competition (Jan. 6, 2022).

These documents were published at important points in time with respect to the availability of COVID-19 data and information and related student-athlete practice and competition timelines.

The information in this 2022 Winter Training and Competition document was developed in consultation with the NCAA COVID-19 Medical Advisory Group, the American Medical Society for Sports Medicine Working Group and the Autonomy 5 Medical Advisory Group and takes into consideration available recommendations from the Centers for Disease Control and Prevention. The federal government has not published uniform guidance related to certain activities that occur within college athletics. However, through continued review and evaluation of available research data, anecdotal evidence and related analysis and discussion, these advisory groups have identified certain practices that should be highlighted for more focused consideration by member schools. While the materials encourage consideration of various factors and actions, they do not speak to every possible scenario, and in no event should members fall below national or public health standards set by their local communities.

As with prior NCAA publications, these materials are meant to be consistent with guidance published by the federal government and its health agencies and reflect the relevant scientific and medical information available at the time of print. These materials

should not be used as a substitute for medical or legal advice. Rather, they are intended as a resource to provide guidance for member schools to use in coordination with applicable government and related institutional policies and guidelines, and they remain subject to revision as available data and information in this space continue to emerge and evolve.

Overview

At the time of this writing, the United States is experiencing a surge of new cases from the highly transmissible omicron variant, although new cases from delta and other variants continue to be documented. Available data indicate that the vaccines authorized in the United States offer high levels of protection against severe illness and death from infection with the delta and omicron variants and other currently circulating variants of the virus. COVID-19 vaccination remains the most effective means to achieve control of both the COVID-19 pandemic and its manifestation in endemic capacities. The CDC's recent endorsement of recommendations made by the Advisory Committee on Immunization Practices for the prevention of COVID-19 expresses a clinical preference for individuals to receive an mRNA vaccine over Johnson & Johnson's vaccine.

Key CDC points regarding COVID-19 vaccinations include:

- COVID-19 vaccines currently approved or authorized by the FDA are effective in preventing serious outcomes of COVID-19, including severe disease, hospitalization and death.
- A COVID-19 primary series vaccination is recommended for everyone 5 years of age and older in the United States.
- In most situations, Pfizer-BioNTech or Moderna vaccines are preferred over the J&J vaccine for primary and booster vaccination.
- An additional primary mRNA vaccine dose is recommended at least 28 days later for moderately or severely immunocompromised people at least 12 years of age who received a two-dose mRNA vaccine primary series.
- A booster dose at least five months after completion of the primary series of Pfizer-BioNTech vaccine is recommended for those 12 and older. Additionally, a booster dose of vaccine is recommended for all persons 18 years of age and older, at least six months after completion of the Moderna primary series or at least two months after completion of a J&J vaccine primary dose.
- Efforts to maximize the proportion of people in the United States who are fully vaccinated against COVID-19 remain critical to ending the COVID-19 pandemic.

- These clinical considerations provide additional information to health care professionals and public health officials on the use of COVID-19 vaccines.

Additional clinical considerations and information, including emerging updates, regarding the use of specific vaccines, dosage and administration, specific populations and situations, and contraindications and precautions, can be found on the CDC website.

For the purpose of this document, the NCAA COVID-19 Medical Advisory Group recommends that *individuals are considered fully vaccinated* at the following times:

- Within two months of having completed the primary series of the J&J vaccine (one dose).
- Within five months of having completed the primary series of the mRNA Pfizer vaccine or within six months of having completed the primary series of the mRNA Moderna vaccine (two doses for both).
- Following a booster vaccine for those who are beyond two months of the J&J vaccine or beyond five or six months of the mRNA Pfizer or Moderna vaccine, respectively.

For the purposes of this document, the equivalent of "fully vaccinated" is a documented COVID-19 infection in the past 90 days. Importantly, while a prior infection offers some protection from future illness, sometimes called "natural immunity," the level of protection acquired from having COVID-19 may vary depending on how mild or severe the illness was, the time since infection and age, and no currently available test can reliably determine whether a prior infection provides adequate protection against reinfection. Accordingly, CDC recommendations provide that individuals who have a prior history of COVID-19 infection should be vaccinated following recovery from the COVID illness and satisfaction of isolation recommendation.

The omicron variant is highly transmissible even in fully vaccinated individuals. Unvaccinated people and individuals with certain medical conditions remain at substantial risk for infection, severe illness and death, especially in areas where the level of community transmission is high.

Despite widespread vaccine availability in the United States, current vaccination rates are inadequate to provide community-level immunity and vary significantly by state and county. However, because of emerging evidence that the delta and omicron variants are highly transmissible relative to prior variants and that fully vaccinated individuals can become infected by either variant and transmit COVID-19 to others even when asymptomatic, the concept of community-level immunity remains only one aspect of

prevention. Standard protection recommendations, including masking, distancing, proper ventilation, hand washing and staying home when ill remain paramount.

Given the rapidly evolving COVID-19 landscape, prevention and management strategies should continue to be developed at the school and community level in conjunction with federal, state and local public health guidance. This document provides broad considerations and does not replace federal, state and local public health guidance. Further, state laws may vary from federal and local public health guidance, so school decision-making should take into consideration any such discrepancies.

Because vaccination against COVID-19 can result in personal health benefits, and because the risks of adverse outcome with COVID-19 infection are higher in unvaccinated individuals, considerations for these two categories of individuals are different. Even though emerging data reveal that omicron is less virulent (less likely to cause severe symptoms) than delta, guidance remains relevant for both variants because both continue to contribute to increases in community and national infections.

Ultimately, unless there is federal guidance to the contrary, all decision-making should be guided by:

- Community-level immunity status.
- Community-level transmission.
- State law.
- Local public health authorities.

The table below provides a non-exhaustive summary of some of the key health and safety considerations for Tier 1 individuals for winter training and competition. The information in this table should serve as a supplement to, and not a substitute for, these broader considerations. In the event of a discrepancy between the considerations below and any law or guidance from any applicable health authority, the latter should be prioritized. Member schools are encouraged to consider actively tracking the level of community transmission, as this may impact decision-making.

Given the rapidly changing scientific landscape, it is anticipated that Table 1 may be updated.

Table 1. Sample Tier 1 COVID-19 Management Considerations and Testing Strategies.

		UNVACCINATED OR NOT FULLY VACCINATED	FULLY VACCINATED OR DOCUMENTED INFECTION IN THE PAST 90 DAYS
TESTING	Upon Arrival to Campus, or Return to Campus from a Winter Break	Single polymerase chain reaction/nucleic acid amplification test within three to five days of arrival, or two antigen tests on non-consecutive days within three to five days of arrival. No team training or competition until single PCR/NAAT or both antigen tests are negative.	No testing unless symptomatic or based on a risk assessment of a documented close contact with COVID-19.
	Surveillance Testing	Based on level of community immunity, community spread, and local public health official recommendations. If community spread is substantial or high, weekly PCR/NAAT testing or three-times-week antigen testing.	No testing unless symptomatic or based on a risk assessment of a documented close contact with COVID-19.
	During Competition Season	During a week with no competition: • Weekly PCR/NAAT testing or three-times-a-week antigen testing. During a week with competition: • PCR/NAAT test within three days of first competition of the week; or • Antigen test within one day of each competition (continue three-times-a-week antigen testing if fewer than three competitions).	No testing unless symptomatic or based on a risk assessment of a documented close contact with COVID-19.
	Sustained Increased Transmission	If sustained increased transmission on a team, test all symptomatic individuals and consider testing individuals with close contacts, or apply a similar risk mitigation strategy.	

		Sustained increased transmission is likely occurring if: • Team of ≤ 50: Concurrent positive cases of three or more. • Team of > 50: Concurrent positive cases of 5 percent or more. When sustained increased transmission is occurring, decisions about continued team activity should be made at the local level and with consideration given to ongoing risk of team transmission or transmission to another team during competition.
		UNVACCINATED OR NOT FULLY VACCINATED / **FULLY VACCINATED OR DOCUMENTED INFECTION IN THE PAST 90 DAYS**
QUARANTINE & ISOLATION	Quarantine Protocol for Close Contacts (defined as within six feet of an infected individual for a cumulative total of 15 minutes or more over a 24-hour period).	Quarantine at home for five days. After that, continue to wear a mask around others for five additional days.* *During days six through 10 of quarantine: Participation in athletic activities without a mask can be considered following a negative PCR/NAAT or antigen test. Previous considerations regarding activity during quarantine (e.g., individual exercise if it does not cause cardiopulmonary symptoms) continue to apply.
		No quarantine. Wear a mask socially when not actively training/competing for 10 days. Test on day five, if possible, and test symptomatic individuals. Athletic activities permitted without a mask. Try to mask socially.
	Positive Test Protocol	Isolate for five days. If no symptoms or symptoms are resolving after five days, isolation may end. Continue to mask around others for five additional days.*** If there is a fever, continue to isolate until fever resolves. ***Participation in athletic activities between days six and 10 without a mask can be considered following a negative PCR/NAAT or antigen test.

		Follow the exercise recommendations of the expert panel with members from the American Medical Society for Sports Medicine and the American College of Cardiology.	
		UNVACCINATED OR NOT FULLY VACCINATED	**FULLY VACCINATED OR DOCUMENTED INFECTION IN THE PAST 90 DAYS**
ATHLETIC ACTIVITIES	Training and Competition	No restrictions for asymptomatic individuals who are not following quarantine or isolation protocols.	
	Team Travel	Masking during travel.	
	Other Athletic Activities (e.g., team meetings)	Consider universal masking.	Consider masking in indoor settings.
NONATHLETIC ACTIVITIES	Nonathletic Activities	Consider universal masking.	Consider masking in public indoor settings. Large crowd avoidance or masking where community immunity is unknown or vaccination status cannot be determined.
	In-Person Interactions	Consider universal masking.	Consider masking in indoor settings.