Guidance for Reopening Colleges and Universities

August 2020

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This guidance document outlines recommendations for strategies to reduce the spread of COVID-19 on college and university campuses. Each setting is unique and not all strategies will always be applicable for every setting. In a reality where colleges and universities do not have limitless resources to address the COVID-19 pandemic, there are key priority areas where resources should be focused to have the most impact on controlling the spread of disease in these settings. This guidance is provided to outline options that colleges and universities may implement where feasible.

1. Educating the student, faculty and staff populations on behaviors that reduce, and conversely those behaviors that increase, the risk of becoming infected and infecting others.
2. Restructure classes, common areas, and activities to all allow for physical distancing of at least 6 feet.
3. Require the use of cloth facemasks while on campus.
4. Implement symptom and temperature checkpoints. Be aware of the most current knowledge about the signs and symptoms of COVID-19 disease and screen everyone coming on to the campus for these symptoms.
5. Make sure that your campus health center is ready to test symptomatic students, faculty and staff.
6. Understand the current KDHE mandates for isolation and quarantine.
7. Plan for facilities to house people under isolation and quarantine.
8. Understand your role in helping to identify cases and close contacts.

Priority 1: Promoting Behaviors that Reduce Spread of Disease

Educating the student, faculty and staff populations on behaviors that reduce, and conversely those behaviors that increase, the risk of becoming infected and infecting others. While a college or university might do everything in its power to control behaviors within classrooms, dorms, and other settings, individual risky behavior off campus or away from these controlled environments will inevitably undermine those efforts.

Hand Hygiene and Respiratory Etiquette

- Recommend and reinforce handwashing with soap and water for at least 20 seconds.
    - If soap and water are not readily available, hand sanitizer that contains at least 60% alcohol can be used.
- Encourage students, faculty, staff to cover coughs and sneezes with a tissue or use the inside of their elbow. Used tissues should be thrown in the trash and hands washed immediately with soap and water for at least 20 seconds.
    - If soap and water are not readily available, hand sanitizer that contains at least 60% alcohol can be used.

Adequate Supplies

- Support healthy hygiene behaviors by providing adequate supplies, including:
    - soap, hand sanitizer containing at least 60 percent alcohol, paper towels, tissues, disinfectant wipes, and no-touch/foot pedal trash cans.

- Provide an adequate number of hand sanitizing stations in areas where people eat including any temporary or expanded break areas.

Understanding Risky Behavior

- Completely eliminating the risk of contracting COVID-19 may be near impossible. However, understanding how activities in our daily lives pose different levels of risk and making smart choices about which risks are avoidable can help reduce the overall risk https://covid19.colorado.gov/risks-benefits.

Signs and Messages

- Post signs in highly visible locations (e.g., building entrances, restrooms, dining areas) that promote everyday protective measures and describe how to stop the spread of germs.
- Include messages about behaviors that prevent the spread of COVID-19 when communicating with faculty, staff, and students (such as on websites, in emails, and on institution social media accounts) in accordance with the Clery Act.
    - Find freely available CDC print and digital resources on CDC's communications resources main page.

Priority 2: Physical Distancing

One of the most effective tools we have to contain the spread of COVID-19 is maintaining a physical distance from others. The actual separation of people keeps an infected person from spreading the disease. An added benefit is that, if colleges and universities are able to successfully ensure physical distancing in group settings like classrooms, common areas, etc., then there are fewer close contacts that are mandated to quarantine after being in the same space as a case.

- Restructure classes, common areas, and activities to all allow for physical distancing of at least 6 feet. Reduce populations in classes and on campus housing.
- Lowest risk: Virtual-only learning options, activities, and events for faculty and students
- More risk: Smaller in-person class sizes, activities, and events.
    - Allowing for students and faculty to be at least six foot apart, with no shared objects.
    - Its suggested that hybrid virtual and in-person class structures or staggered/rotated scheduling may be beneficial in achieving this.
- Highest risk: Full-sized in-person classes, activities, and events.
    - No spacing
    - Shared classroom materials or supplies
- Consider practices such as use of visual cues (e.g., floor markings, signs) to promote distancing.
- Stagger break and start times so that common areas are not crowded and to minimize intermingling of students, faculty and staff.

Priority 3: Face Masks

Require the use of cloth facemasks while on campus. The use of cloth facemasks reduces the spread of droplets from an infected person when they cough or sneeze.

- Recommend and reinforce the use of cloth face coverings among students, faculty, and staff in common areas or situations where physical distancing may be difficult to maintain (i.e. riding in elevators, entering/exiting classrooms or student centers, and traveling around the campus).
- Face coverings should be worn as feasible and are most essential in times when physical distancing is difficult.
    - Individuals should be frequently reminded not to touch the face covering and to wash their hands frequently.
- The procurement of medical masks is discouraged as they remain in extremely short supply and should be reserved for healthcare workers.
- All visitors to the campus should also wear a face mask. Plans and procedures should be in place to ensure 100% mask use while on campus. Health education should be provided on the importance of masks.
- Information should be provided to all students, faculty, and staff on proper use, removal, and washing of cloth face coverings.

Priority 4: Symptom and Temperature Checks

Implement symptom and temperature checkpoints. Be aware of the most current knowledge about the signs and symptoms of COVID-19 disease and screen everyone coming on to the campus for these symptoms.

- Ideally, temperature checks should happen before the individual enters the facility. If an infrared device is used to check temperature, accuracy may be an issue so any person measuring 99.0° F or higher should receive a more accurate temperature check and in-depth symptom screening.
- The list of symptoms should be prominently and frequently displayed in the various languages spoken on campus. List of symptoms should be displayed in pre-screen areas.
- As a best practice, have a third party or a person associated with the campus' medical clinic collect symptom information from people rather than having security personnel perform this function.

Priority 5: Be Prepared to Test

Make sure that your campus health center, if there is one, is ready to test symptomatic students, faculty and staff.

- Testing should focus on symptomatic students, faculty and staff. FDA has not authorized any of SARS-CoV-2 tests as applicable to asymptomatic individuals. We know that the tests can pick up the virus in asymptomatic people, which is why KDHE may sometimes do targeted testing to find hidden pockets in vulnerable populations. But the tests have not been validated as a population screening tool. Additionally, they work best in symptomatic people.

- The preferred test for diagnostic purposes is a PCR test. Alternatively, an antigen test may be used. An antibody test should never be used for diagnostic purposes.
- The health center should have an established contract with at least one reference lab that will provide testing supplies and will analyze samples. Currently, the turnaround time from many reference labs is five or more days so consider having more than one contract. Make sure to have testing supplies on hand which include the correct type of swab that the reference lab prefers, the correct viral transport media or saline that the reference lab prefers, tubes, ice packs, and coolers.
- The health center should have adequate PPE for staff that will collect samples. This includes gowns, gloves, and fit-tested N95 respirators with adequate eye protection OR surgical masks used in combination with face shields.
    - KDHE has developed a number of resources about the types of PPE, proper usage, and extending the use of PPE available through this link https://www.coronavirus.kdheks.gov/170/Healthcare-Providers and navigating to the PPE tab.
- Ensure that health center clinic staff are trained and comfortable with collecting nasopharyngeal and nasal swabs. KDHE has developed a series of training videos that may be helpful available through this link https://www.coronavirus.kdheks.gov/170/Healthcare-Providers and navigating to the Videos tab.
- If your health center is thinking of establishing point of care testing, before beginning testing for COVID-19, you must inform the Kansas CLIA Department before patient testing can begin. All test results, positive and negative, are reportable to KDHE and a process for reporting results must be established.

If the campus does not have a health center, for example a community college campus, then plan for testing of students, faculty and staff off campus.

- Anyone with private health insurance should seek testing through a primary care physician.
- The local health department may be able to provide testing for underinsured or uninsured students, faculty and staff. Work with your local health department to determine the capacity for testing.
- Testing should focus on symptomatic students, faculty and staff. FDA has not authorized any of SARS-CoV-2 tests as applicable to asymptomatic individuals.
- The preferred test for diagnostic purposes is a PCR test. Alternatively, an antigen test may be used. An antibody test should never be used for diagnostic purposes.

Priority 6: Understand Isolation and Quarantine Mandates

Isolation of ill people, and quarantine of well people who have been exposed, is an effective and basic tool of Public Health to control the spread of disease. It is important that colleges and universities understand the current KDHE mandates for isolation and quarantine. When colleges and universities are on the same page as Public Health

about the expectations for isolation and quarantine, then all partners can work together to make sure this basic Public Health practice to control the spread of disease is implemented successfully.

Isolation of a Person Under Investigation

- A Person Under Investigation (PUI) is someone who is suspected of having COVID-19 disease. A person who is being tested for COVID-19 is required to be in isolation until test results are received.
- Possible outcomes of the test result include:
    - If the test result is positive, then the person becomes a case or
    - If the test result is negative and the person has a known exposure, then the person must finish their quarantine period, or
    - If the test result is negative and there was no known exposure, then the person is released from isolation.

Isolation of a Case

- KDHE has developed a useful graphic about the release from isolation and quarantine.
- A symptomatic case should stay home for 10 days from the onset of symptoms OR
- 72 hours after fever is gone without the use of fever reducing medication AND there has been a significant improvement in symptoms
- WHICHEVER IS LONGER. Meaning, isolation for confirmed cases is a minimum of 10 days.
- If the case is asymptomatic, then they should stay home for 10 days since the day their sample was taken. If they develop symptoms during this 10-day period, then they would begin a new isolation period as described above for symptomatic cases.

Quarantine of Close Contacts

- A close contact is someone who has been within 6 feet of a case for 10 minutes or more, or had contact with bodily secretions (for example, being coughed or sneezed on) from a case, while the case is infectious.
    - A case is considered infectious starting 48 hours prior to the onset of their first symptom and ending once they meet the 10 day/72-hour criteria described above. Anyone who comes within 6 feet for 10 minutes or more, or comes into direct contact with secretions from the case, during this infectious period is considered a close contact.
    - If the case was asymptomatic, the infectious period starts 48 hours prior to the day the sample was collected and ending 10 days after the day the sample was collected, as long as the case remains asymptomatic. If the case develops symptoms during the isolation period, then their infectious period ends once they meet the 10 day/72-hour criteria described above. Anyone who comes within 6 feet for 10 minutes or more, or comes into direct contact with secretions from the case, during this infectious period is considered a close contact.

- Close contacts of a confirmed case are in quarantine for 14 days after their last contact with a case while the case is infectious. If they do not develop symptoms during the quarantine period, then they are released from quarantine at the end of the 14 days.
- It is important to understand that close household contacts, or close contacts sharing the same living space, cannot begin their 14-day quarantine period until they are away from the case while the case is infectious. Meaning, if the close contact continues to share a living space with the case while the case is infectious, then the 14-day quarantine period for the close contact cannot begin until the case is no longer infectious and released from isolation.
- If the case was wearing a face mask, or if close contacts were wearing face masks, or if both were wearing face masks, what this does is effectively reduce the risk of close contacts getting sick, but it does not eliminate the risk. All close contacts are quarantined for 14 days starting with the last exposure to the case while the case is infectious regardless of the mask usage.
- Those who are under a 14-day home quarantine should not attend school, work or any other setting where they are not able to maintain a 6-foot distance from other people at all times. If they are able to attend settings where they can maintain a 6-foot distance from others, then they can attend as long as they remain asymptomatic. However, this allowance must be made by the county local health officer and is determined on a case by case basis.

Travel-related Quarantine

- KDHE mandates a 14-day home quarantine for people in Kansas that have travelled to certain areas. The list of locations is updated every two weeks.
- Those who are under a 14-day home quarantine should stay home and monitor their symptoms. They should not attend school, work or any other setting where they are not able to maintain a 6-foot distance from other people at all times. If they are able to attend settings where they can maintain a 6-foot distance from others, then they can attend as long as they remain asymptomatic. However, this allowance must be made by the county local health officer and is determined on a case by case basis.
- If a person is tested during their 14-day quarantine period and they test negative, they are not released early from quarantine. Because the incubation period, which is the time period it takes for the body to develop disease, is thought to be up to 14 days, a negative test result during the quarantine period may just indicate that the person was tested too soon.
- If a person is tested during their 14-day quarantine period and they test positive, then they are considered a case and will begin an isolation period for cases.
    - The person should stay home for 10 days from the onset of symptoms OR
    - 72 hours after fever is gone without the use of fever reducing medication AND there has been a significant improvement in symptoms
    - WHICHEVER IS LONGER. Meaning, isolation for confirmed cases is a

minimum of 10 days.

If the person is asymptomatic, then they should stay home for 10 days since the day their sample was taken. If they develop symptoms during this 10-day period, then they would begin a new isolation period as described above for symptomatic cases.

- If symptoms develop during the 14-day quarantine and the person does not seek healthcare:
  - The person should stay home for 10 days from the onset of symptoms OR
  - 72 hours after fever is gone without the use of fever reducing medication AND there has been a significant improvement in symptoms
  - WHICHEVER IS LONGER. Meaning, isolation for suspected cases is a minimum of 10 days.

Priority 7: Plan for Alternate Housing

Work with your local health department and county emergency manager to plan for facilities to house people under isolation and quarantine. Students, faculty and staff that live in congregate housing situations will need alternate housing while placed under isolation and quarantine.

- For space considerations, it is acceptable to house confirmed cases together
- For space considerations, it is acceptable to house close contacts who were exposed to the same person together
- For space considerations, it is acceptable to house people under travel-related quarantine together

There are a number of considerations and best practice guidance that may be considered when establishing alternate housing.

Staffing

- A clinician (Physician, APRN, RN) is tasked with maintaining contact with a cohort of patients in isolation housing. Ideally, the same clinicians, rotating call, would follow the same cohort for continuity, with additional clinicians added as more patients enter housing. A clinician will need sufficient knowledge to understand a wide variety of medical conditions and their management as well as skill in observation and medical assessment to identify worsening symptoms or deteriorating vital signs. There should be a designated on-call clinician available at all hours.
- In the event of a non-English speaker, a telephone interpreter service can be employed.
- It is suggested a mental health professional or social worker be assigned to each person.

Record Keeping

- The clinician will maintain a secure medical record for each patient, this may be paper in form and housed in a locked cabinet in the health care provider or local health department secure storage facility.

- The record will include demographics, medication and pharmacy information, medical history as well as a log of daily contacts, reported symptoms and oxygen saturation measurements.

Medical History

- In addition to the general intake information, the patient should provide a list of current medications and pharmacy information. During initial contact with the clinician, the clinician will perform a medical history and list the status of chronic medical conditions, current therapies aside from medications (i.e. CPAP, glucometers, indwelling catheters, etc.) and primary care physician contact info, as well as any treating specialists.

COVID-19 Specific Record Keeping

- A timeline of symptoms should be kept to allow for assessment for release from isolation. The Kansas Department of Health and Environment (KDHE) defines recovery as 10 days from date of symptoms or 72 hours fever-free without the use of fever-reducing medication and significant improvement in symptoms whichever is longer.

Televisit

- At least one time per day, as scheduled, the clinician should make contact with the patient via phone or video (depending on the technology possessed by patient) and inquire about any new symptoms or concerns.
- Contact information on how to speak with a clinician should be given to each person, and also posted in each alternate hosting facility.
- People should be told to contact a clinician if symptoms worsen or new symptoms appear.

Equipment

- Oxygen monitoring equipment will be deployed to each isolation room with pictorial instructions as to how to use. The patient will be asked to measure their oxygen saturation at the time of their scheduled contact with clinician and report, which the clinician will record. Additionally, the patient may measure their oxygen saturation and will be instructed to contact the on-call clinician if it is low.

Considerations for housing confirmed cases and close contacts together in non-congregate setting

- If it is necessary to house confirmed cases and close contacts together in a non-congregate setting such as a single floor of a dormitory, private rooms for individuals are ideal. If private rooms for individuals are not possible, house confirmed cases together but separate from close contacts. Close contacts who were exposed to the same person may also be housed together, but separate from confirmed cases.
- Minimizing the amount of interaction individuals have with each other is also necessary. If possible, designate a separate bathroom for confirmed cases. Encourage limiting the use of shared spaces as much as possible, such as kitchens and common areas. Encourage use of masks when

entering shared spaces. Any shared spaces should be cleaned regularly using EPA-registered disinfectants, at least twice per day.

- Shared bathrooms should be cleaned regularly using EPA-registered disinfectants, at least twice per day (e.g., in the morning and evening or after times of heavy use). Make sure bathrooms are continuously stocked with soap and paper towels or automated hand dryers. Hand sanitizer could also be made available. Make sure trash cans are emptied regularly. Provide information on how to properly wash hands. Encourage the use of bathroom totes for personal items to avoid direct contact of personal items with surfaces such as sinks or shelves. If bathrooms have exhaust fans, ensure they are functional and operating at full capacity.
- Staff should wear medical face masks plus eye protection (i.e. goggles or face shield), commonly referred to as procedure masks or surgical masks, when interacting with close contacts within 6 feet. If a distance of at least 6 feet will be maintained at all times, a cloth face mask may be substituted for a medical face mask. If there is a shortage of medical face masks, staff may wear the same mask when interacting with close contacts as long as the mask remains unsoiled, or may change their mask between interactions with close contacts, making sure to wash hands before and after donning and doffing.
- Medical face masks should be provided to close contacts. Close contacts should wear the medical face mask when interacting within 6 feet of anyone outside of their quarantine room. Cloth face masks may be used instead of medical face masks if maintaining at least a 6 foot distance.
- Limit staff entering the rooms of confirmed cases unless it is necessary.
- When interacting with confirmed cases, staff should wear medical face masks (i.e. procedure or surgical masks), eye protection (i.e. goggles or face shield), isolation gowns and gloves when interacting with confirmed cases within 6 feet. If a distance of at least 6 feet will be maintained at all times, a cloth face mask may be substituted for a medical face mask. Hand hygiene should be performed before and after donning and doffing PPE, and PPE should be changed between visits with confirmed cases. For more information on how to don and doff PPE, refer to CDC guidance.
- Medical face masks should be provided to confirmed cases. Confirmed cases should wear the medical face mask when interacting with anyone outside of their quarantine room.
- Opening windows and doors to the outside, when weather permits, operating window or attic fans, or running a window air conditioner with the vent control open increases the outdoor ventilation.
- For buildings with HVAC systems with filters, ensure that ventilation systems operate properly. Consider taking steps to improve ventilation in the building in consultation with an HVAC professional. Consider increasing the percentage of outdoor air, (e.g., using economizer modes of HVAC operations) potentially as high as 100% (first verify compatibility with HVAC system capabilities for both temperature and humidity control as well as

compatibility with outdoor/indoor air quality considerations). Other possible actions include increasing total airflow to occupied spaces, disabling demand-control ventilation controls that reduce air supply based on temperature or occupancy, and improving central air filtration. Consider using portable high-efficiency particulate air (HEPA) fan/filtration systems to help enhance air cleaning.

- Ideally, HEPA filtration systems would service the smallest number of rooms possible. For example, a system that services a floor is more ideal than a system that services a whole wing, and a system that services a whole wing is more ideal than a system that services a whole building. A potential non-congregate setting should not be eliminated because of the lack of multiple HEPA filtration systems.
- Increasing ventilation before and after cleaning can also reduce risks from particles resuspended during cleaning, including those potentially carrying SARS-CoV-2.
- If close contacts under quarantine, people under travel-related quarantine, and confirmed cases are to be housed within the same building, the most important measure to prevent transmission from one group to another is to ensure that everyone is maintaining quarantine. Which means no interaction outside of the person(s) with whom someone is under isolation or quarantine, except for visits by staff and medical personnel. Ideally, this would mean separate floors or wings for the different groups with some monitoring of movements. Ideally, staff would dedicated to one group. Ideally, there would also be separate HVAC systems for each of the groups. However, a potential non-congregate setting should not be eliminated because of the lack of multiple HVAC systems.

Cleaning

- When cleaning and disinfecting rooms or surfaces potentially exposed to SARS-CoV-2:
    - Perform adequate hand hygiene immediately before and after removing gloves, and after any contact with potentially infected fluids or contaminated surfaces. Hand sanitizer (at least 60% alcohol) or soap and water both valid options. When hands are visibly soiled always wash with soap and water.
    - Wear disposable gloves and gowns for all tasks in the cleaning process, including handling trash, laundry, wastes.
    - Additional personal protective equipment (PPE) such as respiratory and eye protection might be required based on the cleaning/disinfectant products being used.
    - Disposable PPE should be treated as potentially infectious material (as regulated medical waste, not considered category A waste).
    - PPE should be removed carefully to avoid contamination of the wearer and the surrounding area.
- For more information on the use of disinfectants, types of surfaces, the

frequency of cleaning and disinfection, and waste disposal, see the Healthcare Facility Cleaning and Disinfection Guide.

- When cleaning and disinfecting rooms that have not housed confirmed cases, routine cleaning and disinfecting procedures are adequate.

Priority 8: Understand Your Role in the Public Health Response

Understand your role in helping to identify cases and close contacts. This includes an understanding of a new law regulating the Public Health practice of contact tracing.

- If there is a student, faculty or staff member that tests positive in a college or university setting, Public Health can share information about the case with the school if the information is needed to help manage the health of the case, or if the information is needed to help control the spread of disease on campus.
- The expectation is that the school will work with the local health department to help with identifying close contacts if there are close contacts related to the school. The LHD will interview the case and ask about close contacts during their infectious period. If the case has no close contacts, or can name all of their close contacts and give contact information (phone numbers), then the school may not be involved much with contact tracing.
- A more likely scenario is that students can tell Public Health which classes or activities they went to but cannot identify the names of everyone they came into contact with. In that scenario, the school should come up with the list of close contacts and phone numbers.
- With the new contact tracing law, the list of close contacts and phone numbers that the school has compiled cannot be shared with Public Health without consent from the contact.
- The school can let contacts know that they were potentially exposed and are now quarantined.
- In order for Public Health to know exactly who is in quarantine, so that Public Health can issue official quarantine orders and also follow up with the close contacts during their quarantine period to check for symptoms and help arrange for testing if they become symptomatic, the contact has to consent. The school may decide to obtain individual consent from close contacts prior to sharing their information with Public Health.
- KDHE is recommending that each college and university establish a policy that that states that, for the purposes of disease investigation and controlling the spread of COVID-19, if a student/faculty/staff member is identified as a close contact to a case some limited information including the contact's name and phone number will be shared with Public Health for the purposes of follow-up. Contact tracers will destroy any identifying information including the name and phone number once the close contact is no longer in quarantine. The policy should allow for an option to opt out.

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