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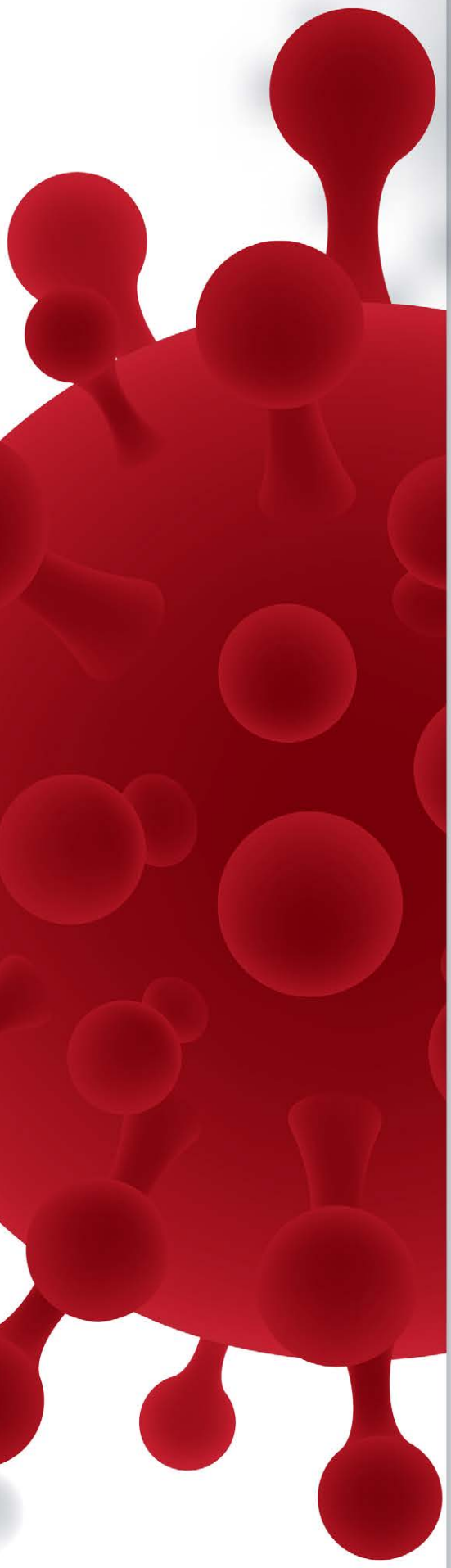

Child Development Center

PANDEMIC

MITIGATION & RESPONSE GUIDE

Prepared by

University of Nebraska Medical Center
Global Center for Health Security
& College of Public Health

rev. 08/12/2020

GLOBAL CENTER FOR HEALTH SECURITY

The Global Center for Health Security encompasses all biopreparedness, infectious disease, and special pathogens research, education, and clinical care at the University of Nebraska Medical Center (UNMC) and its clinical partner, Nebraska Medicine. This includes the Nebraska Biocontainment Unit and the Training, Simulation, and Quarantine Center, which features the nation's only federal quarantine unit and simulated biocontainment patient care units for advanced experiential training.

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This guide is intended to provide best practices and recommendations for each early childhood facility and gathering place to minimize the risk that COVID-19 presents to employees, children and the community and to reduce disruptions to child care operations. This is a guide only and should be adapted to the context of each organization and its students and employees.

Users of this guide should work in coordination with local public health departments to tailor their use of the guide to their specific situations and needs. The information provided in this guide does not, and is not intended to, constitute medical or legal advice and is provided for informational and educational purposes only. The recommendations in this guide reflect the best available information at the time this guide was prepared. All recommendations are consistent with CDC environmental services recommendations. For more information, please visit: https://www.cdc.gov/coronavirus/2019-ncov/community/reopen-guidance.html?deliveryName=USCDC_2067-DM26911 [cdc.gov].

Adherence to the recommendations in this guide does not guarantee that there will be no outbreak or further spread of COVID-19, and we do not assume responsibility for any injury or damage to persons.

CHILD DEVELOPMENT CENTER MITIGATION & RESPONSE GUIDE

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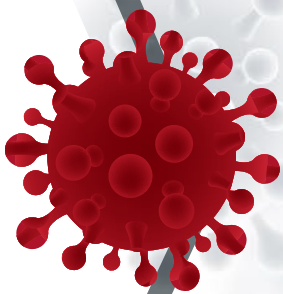


GENERAL CONSIDERATIONS OF PANDEMIC MITIGATION & RESPONSE

This document outlines a proposed checklist as a tool to guide child development centers for COVID-19 recovery management strategies and facilitate readiness during three different steps that are based on disease prevalence and stability of available center and community resources. The check list is intended to be used during each of the three steps, which will be a minimum of 14 days apart and possibly longer as the center-specific and community-specific impacts of each step need to be fully understood before proceeding forward. The three steps which are suggested below, are based upon the ability to maintain full center pandemic control with the levels of community pandemic control averaged for a minimum of 14 consecutive days for implementation of each step:

School & Regional Disease Prevalence & Resource Availability

☑ STEP 1:
Stable for >14 Days

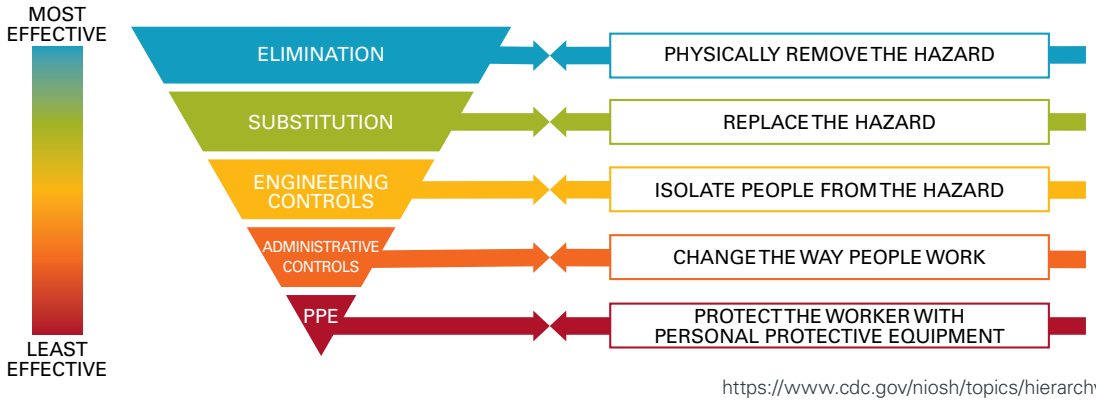
☑ STEP 2:
Stable for >28 Days

☑ STEP 3:
Stable for >42 Days

The implementation of guidance provided through the checklist ***may be guided if*** and when there is routine availability of COVID-19 clinical screening, access to health status evaluation for individuals, and availability and use of virus detection (PCR from nasopharyngeal or possibly oral specimens) and antibody (serologic) testing, and should include availability of public health measures, including timely case contact tracing. Recommended measures to be implemented are based on the hierarchy of different controls, policies and considerations. This checklist provides preliminary guidance for the following sets of controls, policies and procedures, which in combination will enable institutions to assess their readiness to move between Steps 1-3 and sustain a safe and effective learning environment. It is anticipated that numerous aspects of these three steps will endure far longer than the initial set of 14-day intervals.

The measures recommended in the checklist must be placed into the context of the prevalence of active and recovered COVID-19 in the broader regional community and the ready availability of comprehensive community-specific outpatient and inpatient clinical diagnostic and treatment services, as well as timely and accurate data monitoring and pandemic impacts on the center and in the surrounding community. It is understood that the broader community prevalence and the availability of comprehensive health care resources will fluctuate over time and hopefully continue to improve. As such, the progression forward and/or backward from one recovery step to another will occur in this broader context.

Figure 1: Hierarchy of controls



https://www.cdc.gov/niosh/topics/hierarchy/

Clearly, there is no known or well established "play-book" for COVID-19 recovery planning, let alone for organizations as complex as child care centers. The guide and checklists are built upon the premise of a hierarchy of controls (see Figure 1), an accepted framework for hazard mitigation from the field of industrial hygiene that infection prevention and control experts use in managing highly hazardous communicable pathogens.

Child Development Center COVID-19 Pandemic Mitigation Guide Contents

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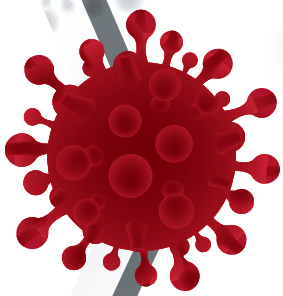
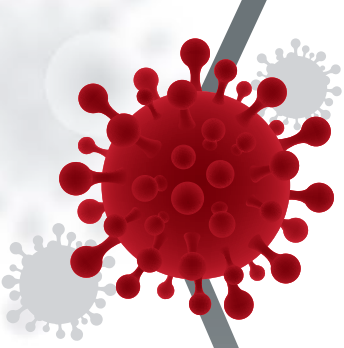
3. PCR, Antigen and Serologic Antibody Testing
4. Personal Protective Equipment Policy & Practice
5. Medical and Behavioral Health Policy & Practice

This guide is intended to provide best practices and recommendations for each child development center and gathering place to minimize the risk that COVID-19 presents to the children who attend and the community and to reduce disruptions to care within the centers. This is a guide only and should be adapted to the context of each child development center. All recommendations are consistent with CDC guidance for childcare programs that remain open which are found on the CDC web site at *https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/guidance-for-childcare.html#General*.





PRIME DIRECTIVES

This document provides a comprehensive list of COVID-19 risk mitigation strategies to implement in child development centers. These Prime Directives identify the *foundational principles* centers should consider and adopt.

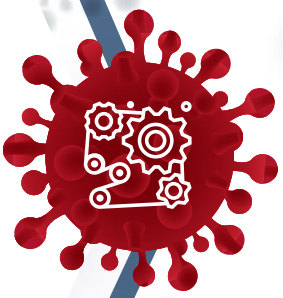
1. Nothing protects children and staff more, including from getting infected within the child development center setting, than decreasing community transmission.
2. Designate a staff person to be responsible for responding to COVID-19 concerns. Staff, parents, and volunteers should know who this person is and how to contact the designated staff member if they become sick or are around others diagnosed with COVID-19. The designated staff person should also be aware of state or local regulatory agency policies related to center guidelines and will serve as the contact with local health authorities and monitor illness among center staff and children. A back-up person should be identified who can fill this role if the designated person becomes unavailable due to illness or other reason.
3. Understand current levels of community transmission. Is it controlled or uncontrolled? If controlled, is there substantial, moderate or low transmission in your community? Most local public health jurisdictions have a data dashboard to help monitor the situation.
4. Establish and maintain communication with local and State authorities to determine current levels of community mitigation. These authorities may frame this as phases of reopening. Please note that these reopening guidelines are often determined by multiple competing interests and community conditions that may be independent of actual disease transmission risk in the community.
5. Review local, state, and organization guidelines for child development centers. Review your facility plans including the size of the building, all points of entry, and air handling systems to understand how to implement recommended state and local guidelines and the considerations detailed in this document.
6. Develop strategies to reduce the potential for mass exposure of cases occurring in centers that include social distancing of all persons, defined and consistent groups of children and staff who remain together with limited interaction to others, considerations to reduce the maximum number of people allowed in a building based on social distancing, and implementation of mask wearing requirements for indoor activities.
7. All staff and volunteers must wear face coverings – with medical caveats. Babies and children younger than 2 years should not wear masks. If tolerated, masks should be used for children between 3 years of age and older.
8. Assess the health status of your staff and children as voluntarily shared or based on basic demographics such as age distribution. Staff and children at higher risk (or who reside in households with persons at particularly high risk) for severe illness from COVID-19 may not be able to attend. Offer options for staff at highest risk for severe illness (including older adults and people of all ages with certain underlying medical conditions) that limit their exposure risk.
9. Attempt to implement and maintain consistent small cohorts of children and staff so that a single infection does not lead to closure of the whole center.
10. ALL sick children and adults will stay home; and quarantine will be observed by those with COVID-19 infected persons at home (ALL with direct exposure to COVID-19 cases will stay home in accordance with local quarantine rules).
11. All children and adults with confirmed infection will not be allowed to return to the center until completing a CDC-defined period of isolation.
12. Child development centers and public health authorities will work together to rapidly report, assess, and act on frequent absenteeism, influenza-like illness and other disease reporting health measures.
13. Plan to address the increased behavioral health and emotional needs of the children and the mental health of staff and volunteers.

1. ENGINEERING FACILITY CONTROLS, POLICY & PROCEDURES

Engineering Controls are controls that either change the environmental conditions or place a barrier between the individual and the virus. These engineering controls are also directed to remove and/or reduce the droplet/aerosol spread of viral particles. They are not dependent on a person's knowledge, practice, or compliance; therefore, they reduce the opportunity for error. These recommended controls represent best practices; the more of them that can be implemented based on available resources, the lower the risk. However, it is recognized that every institution may not be able to institute each control for every building or situation.

☑ STEPS 1	2	3	1. ENGINEERING FACILITY CONTROLS POLICY & PROCEDURES RECOMMENDATIONS:
☐	☐	☐	Adjust HVAC systems to create negative pressure, or inward directed airflow, in areas of higher risk for contamination and aerosol generation (e.g., bathrooms, classrooms, etc.).
☐	☐	☐	Create dedicated facility entry and exit points. There may be several depending upon the building traffic patterns and the number of individuals entering and exiting.
☐	☐	☐	Establish locations and routines that take into account adult social distancing when children are dropped off and picked up.
☐	☐	☐	Secure all facility entry and exit points, preferably with proximity ID cards, etc.
☐	☐	☐	Identify "isolation room" or area where sick child could be kept under supervision pending transport home or to a health care facility.
☐	☐	☐	Maximize fresh air in all facilities by minimizing recirculation; where recirculation is required, explore options for HEPA-equivalent filtering or sterilization measures (e.g., UV light irradiation).
☐	☐	☐	Increase air flow exchange rates in buildings. This is particularly important for higher used building areas and less important for relatively lesser used building areas, such as storage, closets, etc.
☐	☐	☐	In buildings without forced air cooling systems, open windows and doors can be used to maximize airflow. Ensure fans are positioned to maintain inward air flow toward higher-risk rooms and areas of the building.
☐	☐	☐	Place physical barrier between individuals on production or service line such as in food preparation and cafeteria services (e.g., plexiglass).
☐	☐	☐	Identify opportunities to implement non-touch controls starting with door handles, faucets, elevators, carts, vehicles, etc.
☐	☐	☐	Place tape, arrows and/or physical barriers (e.g., plastic barriers/sheeting, tape) in hallways to guide learner, faculty and staff traffic create one-way flow and limit crossover whenever possible.
☐	☐	☐	Place physical barrier at cafeteria lunch tables for tables with built-in seating (e.g., cardboard, plexiglass) where possible.
☐	☐	☐	At nap time, ensure that all naptime mats, cots or cribs are spaced out as much as possible, ideally six feet apart. Consider placing the mats, cots and cribs head to toe in order to further reduce the potential for viral spread.

Step 1: Stable for >14 days | Step 2: Stable for >28 days | Step 3: Stable for >42 days



2. ADMINISTRATIVE CENTER CONTROLS POLICY & PROCEDURES

Administrative controls are considered less effective than engineering controls but are the primary control measures available for COVID-19. These include policies, procedures, training, and center practices. Ineffective policies or practices or inconsistent compliance may heighten exposure risks.

☑ STEPS 1	2	3	2.i. ADMINISTRATION STRUCTURES, COORDINATION & LOGISTICS RECOMMENDATIONS:
☐	☐	☐	Identify center and experts in the community who can advise in critical areas, such as engineering, environmental services, public safety and health care. This group should convene regularly in a standing schedule and be available to deal with challenges and opportunities.
☐	☐	☐	Work closely with the center's clinical health center/clinic and community referral centers with expertise in the diagnosis and treatment of COVID-19 patients. Ensure confidential and ready access for all children and staff for clinical matters related to pandemic spread and recovery.
☐	☐	☐	Develop and widely distribute standard operating procedures (SOPs) that detail actions to be taken if a child, staff, parent or visitor is symptomatic for COVID-19 and/or tests positive for COVID-19 or is exposed to an individual positive for COVID-19. This should include:
☐	☐	☐	• Processes to trace and contact relevant third parties who may have been exposed.
☐	☐	☐	• Communication with environmental services to facilitate rapid cleaning and disinfecting surfaces to immediately limit child and staff exposure.
☐	☐	☐	• Working with families and local authorities to take appropriate steps to prevent, diagnose and if necessary, quarantine/isolate or refer for treatment.
☐	☐	☐	• Working with local public health authorities to make emerging antiviral therapy and/or vaccines available in a timely way as they become available.
☐	☐	☐	Develop and implement a return-to-center policy in coordination with local public health department for all recovering children and staff, those returning after exposure to an infected individual and those returning to the community from international and high-risk national locations.
☐	☐	☐	Limit off-center visitors and guests as much as possible. Allow only one parent/guardian to enter site for visit/pick up child at a time. All parents/guardians visitors and guests are to be self screened (preferably using a mobile device application) and have an accessible profile either on the mobile device or a hard copy that is updated by the individual within the past 24 hours.
☐	☐	☐	Establish greetings and routines that take into account adult social distancing when children are dropped off and picked up.
☐	☐	☐	At nap time, ensure that children at naptime are spaced out as much as possible, ideally 6 feet apart. Consider placing children head to toe in order to further reduce the potential for viral spread.
☐	☐	☐	Maintain an updated incident command structure with current contact information of center leadership and outside resources for center safety, health care, public health organizations and others.
☐	☐	☐	Parents and staff who are unable or unwilling to comply with the implemented guidelines will be advised to refrain and remove their child from the center until such time the requirements change.

Step 1: Stable for >14 days | Step 2: Stable for >28 days | Step 3: Stable for >42 days

☑ STEPS 1 2 3	2.i. ADMINISTRATION STRUCTURES, COORDINATION & LOGISTICS RECOMMENDATIONS:
☐ ☐ ☐	All child, parent/guardian staff "Code of Conduct" policies and procedures as well as community/state level requirements will apply and should provide guidance in event of intentional noncompliance.

☑ STEPS 1 2 3	2.ii. UNIVERSAL MASK USE POLICY & PRACTICE RECOMMENDATIONS:
☐ ☐ ☐	Policy in place for all staff, parents/guardians and visitors, and when feasible all children (e.g., those over 5 years of age) to wear face masks at all times while on the center unless while eating, etc. This policy will be specific to the type of mask, frequency of mask replacement, use of mask recycling as well as specific recommendations for activity , location, day and times of mask use.
☐ ☐ ☐	Cloth face coverings should NOT be put on babies and children under age two because of the danger of suffocation.
☐ ☐ ☐	Provide staff, parents/guardians and visitors with information on proper face mask selection, use and disposal.
☐ ☐ ☐	Provide children, staff, parents/guardians and visitors with information on proper face mask instructions on proper donning and doffing.
☐ ☐ ☐	Provide children, staff, parents/guardians and visitors an assessment of their face mask donning and doffing technique. Restrict access to center facilities and programs until assessment is completed.

☑ STEPS 1 2 3	2.iii. COMMUNICATIONS AND EDUCATIONAL PROGRAMS RECOMMENDATIONS:
☐ ☐ ☐	Provide frequent updates from leadership to staff, parents/guardians and community partners using multiple communication modalities (social media, e-mail, video, virtual town halls, open letters, FAQs, etc.).
☐ ☐ ☐	Communicate with parents on a daily basis about the child's behavior and social-emotional needs.
☐ ☐ ☐	Provide easily translated and understandable posters/infographics, web materials and social media in multiple languages.
☐ ☐ ☐	Post signage throughout facility directing risk-minimizing behavior for children, staff, parents/guardians and visitors. Examples include:
☐ ☐ ☐	• Hand-washing and surface sanitizing procedures.
☐ ☐ ☐	• COVID-19 symptoms and how to stop the spread.
☐ ☐ ☐	• Screening and testing access, process and requirements.
☐ ☐ ☐	Implement a self-screening and reporting policy for staff, parents/guardians and visitors, preferably using mobile or web-based technology.
☐ ☐ ☐	Provide information and resources to staff, parents/guardians and visitors on social distancing outside of workplace (e.g., in homes, places of worship, transportation).

Step 1: Stable for >14 days | Step 2: Stable for >28 days | Step 3: Stable for >42 days

☑ STEPS 1	2	3	2.iii. COMMUNICATIONS AND EDUCATIONAL PROGRAMS RECOMMENDATIONS:
☐	☐	☐	Refresh staff, parents/guardians and visitors on proper hand hygiene and refraining from touching their face.
☐	☐	☐	Share information and training via onsite televisions, mobile devices, web pages, etc. Demonstrations with center children, staff, parents/guardians and visitors of best practices are useful.

☑ STEPS 1	2	3	2.iv. GUIDANCE FOR PROTECTION AT HOME AND IN COMMUNITY RECOMMENDATIONS:
☐	☐	☐	Provide information to staff and parents/guardians on self-monitoring of COVID-19 symptoms, preferably with mobile or web-based technology on a fixed schedule.
☐	☐	☐	Discourage all off center gatherings, including any social, business, religious or other gatherings of more than ten individuals.
☐	☐	☐	Provide information to staff and parents/guardians on safe physical distancing practices when off center, particularly at any social, business, religious or other gatherings.
☐	☐	☐	Provide information to staff and parents/guardians on necessary protective measures against COVID-19. Examples include:
☐	☐	☐	• Hand-washing and surface sanitizing procedures procedures.
☐	☐	☐	• Staying home when sick or caring for family members if they are sick.
☐	☐	☐	• Avoiding contact with people who are sick.
☐	☐	☐	• Following guidance of local and state public health officials on staying home and avoiding unnecessary trips outside of the home such as shopping or travel.
☐	☐	☐	Encourage staff and parents/guardians and their children over 5 years (when feasible) to wear their masks home after leaving the center to protect themselves and with who they reside.
☐	☐	☐	Encourage staff and parents/guardians to wear a face covering during transportation to and from the center to protect themselves and others.
☐	☐	☐	Encourage staff and parents/guardians to exchange used masks for new masks at frequent intervals and at fixed locations.
☐	☐	☐	Provide educational materials for home cleaning. Recommendations for approved equipment and materials by environmental safety professionals.
☐	☐	☐	Provide carpooling, center bus service and group travel.
☐	☐	☐	• Encourage staff, parents/guardians and their children to minimize carpooling when possible.
☐	☐	☐	• As able, limit the number of people per vehicle and space out.
☐	☐	☐	• Remind carpoolers of basic protective measures, cleanse contact surfaces frequently, masking, etc.

Step 1: Stable for >14 days | Step 2: Stable for >28 days | Step 3: Stable for >42 days

☑ STEPS 1	2	3	2.v. ENVIRONMENTAL SAFETY AND CLEANING POLICY & PROCEDURES RECOMMENDATIONS:
☐	☐	☐	Develop and implement standard operating procedures (SOPs) for enhanced cleaning and disinfection of common contact areas, including classrooms and restrooms.
☐	☐	☐	Maintain a well-trained and cross trained environmental services workforce with expertise in best practices, equipment use and approved materials.
☐	☐	☐	Frequently assess the stock of personal protective equipment (PPE), cleaning supplies, sanitizers and disinfectants.
☐	☐	☐	Maintain a sufficient reserve stock of approved personal protective equipment (PPE), cleaning supplies and equipment.
☐	☐	☐	Provide updated training for those providing environmental services, public safety and other "first responders" servicing the center.
☐	☐	☐	Identify common high-touch surfaces and develop a checklist to ensure frequent sanitization throughout each day. Common high-touch surfaces include: • Door knobs and handles • Push plates and crash bars on doors • Automatic door openers • Overhead light and lamp switches • Stair doors and hand rails • Elevator call and interior buttons • Touch key pads • Drinking fountains • Vending machines and ATM's • Tables and chairs in break rooms • Fridge/microwave handles in lunch rooms • Faucet handles in kitchens and bathrooms • Restroom surfaces and fixtures
☐	☐	☐	Playgrounds and gyms will only be used by one group at a time and will be cleaned after each use.
☐	☐	☐	In the event a staff or child tests positive for COVID-19, develop an SOP for immediate cleaning and disinfecting impacted areas (e.g., classrooms, cafeteria, washrooms, play areas, pathways, etc.).
☐	☐	☐	Have a sink with soap and water or hand sanitizer dispensers available and functional throughout each facility, particularly at entrance, exits, cafeterias, and high traffic transition areas.
☐	☐	☐	Keep hand sanitizer out of children's reach and supervise use.
☐	☐	☐	Place sign-in stations outside the building, and provide sanitary wipes for cleaning pens between each use.
☐	☐	☐	Hand hygiene stations should be set up at the entrance of the facility, so that children can clean their hands before they enter. If a sink with soap and water is not available, provide hand sanitizer with at least 60% alcohol next to parent sign-in sheets.
☐	☐	☐	Meals and snacks will be served in classrooms by an adult (not family-style with children serving themselves) and then passing the dish to others.
☐	☐	☐	Make sanitizing wipes and hand soap dispensers readily available in food service, nap and bathroom areas and common areas.
☐	☐	☐	Identify common shared technology and equipment. Develop and implement procedures to sanitize between users.
☐	☐	☐	Develop a process and route for routine deep cleaning of common areas, either daily/nightly or, at minimum, weekly in a systematic fashion.
☐	☐	☐	Use no-touch handles, knobs, faucets, receptacles, etc., when possible.

Step 1: Stable for >14 days | Step 2: Stable for >28 days | Step 3: Stable for >42 days

☑ STEPS 1	2	3	2.vi. ACTIVE SCREENING OF CHILDREN, TEACHERS, PARENTS/GUARDIANS, STAFF & VISITORS RECOMMENDATIONS:
☐	☐	☐	Designate limited points of entry for each facility. If possible, identify a different point(s) of exit.
☐	☐	☐	Establish greetings and routines that take into account adult social distancing when children are dropped off and picked up.
☐	☐	☐	Develop and implement COVID-19 specific screening questions conducted daily for all individuals entering facility.
☐	☐	☐	Use a web-based or mobile device screening application to prepopulate a single secured database for staff, children and visitors .
☐	☐	☐	Staff, parents/guardians and visitors are subject to daily temperature screening prior to entering the center and/or facility.
☐	☐	☐	• The screener(s) is /are trained to administer, record and transmit the temperature checks.
☐	☐	☐	• The screener(s) are well versed in a center wide policy and procedure in event an individual is found to be febrile on screening.
☐	☐	☐	• The screener(s) have adequate PPE and, as applicable, maintain social distancing as testing is performed.
☐	☐	☐	• If using an infrared thermometer, ensure proper validation prior to use and periodically thereafter.
☐	☐	☐	If self screening for COVID-19 symptoms is positive, children and staff will be not be able to attend the center and will be referred for secondary screening/testing conducted by staff with medical training.
☐	☐	☐	All who screen positive or have an immediate family member or ones residing in the same dwelling who has screened positive must be asymptomatic for 14 days and test PCR negative before returning to center common areas (class, library, cafeteria, etc.).

☑ STEPS 1	2	3	2.vii. CENTER PHYSICAL DISTANCING POLICY & PRACTICES RECOMMENDATIONS:
☐	☐	☐	Develop and implement policy to limit center admission to no more than one parent/guardian at a time and no visitors except for required essential services.
☐	☐	☐	Stagger arrival and drop off times and plan to limit direct contact with parents as much as possible.
☐	☐	☐	Maintain at least a 6 feet of physical distance whenever possible when there is no physical barrier between individuals. Group size shall be limited to 10 children or fewer in a single classroom; smaller staff-child ratios than those allowed by the state, especially for infants and toddlers, are preferred.
☐	☐	☐	Put strategies in place to ensure physical distancing during breaks. Examples Include:
☐	☐	☐	• Staggered break times between center group actvities to avoid large groups of children and staff.
☐	☐	☐	• Classroom and conference/meeting room seating is reset to promote physical distancing.
☐	☐	☐	• Stagger playground times and keep groups separate for special activities such as art, music, and exercising.
☐	☐	☐	Limit chairs per table for dining, desk and/or gathering areas.

Step 1: Stable for >14 days | Step 2: Stable for >28 days | Step 3: Stable for >42 days

☑ STEPS 1	2	3	2.vii. CENTER PHYSICAL DISTANCING POLICY & PRACTICES RECOMMENDATIONS:
☐	☐	☐	Use tape on floors, if necessary, to designate locations that are six feet apart.
☐	☐	☐	Ensure cleaning of tables between use (e.g., use of laminated card flipped to red when one finishes eating lunch to inform EVS worker table is in need of cleaning; once the user or EVS cleans, flips to green side indicating table ready for use).
☐	☐	☐	If office staff required onsite, maintain 6 feet distancing practice when there is no physical barrier between individuals.
☐	☐	☐	Create online options for traditionally walk-up window services for parents and visitors.
☐	☐	☐	If possible, arrange for administrative staff to telework from their homes.

☑ STEPS 1	2	3	2.viii. COHORTING, PERSONNEL WORKFLOW AND MOVEMENT POLICY RECOMMENDATIONS:
☐	☐	☐	Implement cohorting of small groups of children (no more than 10).
☐	☐	☐	The number of children in a class should be small and consistent, so that staff in close proximity to each other always work together, with classroom seating, cafeterias, lockers, breaks and meals taken together.
☐	☐	☐	Limit crossover in entrances, hallways, and common spaces by adjusting personnel workflow and physical structure as needed. Encourage staff and children to walk to the right in common hallways, corridors and paths.
☐	☐	☐	Attempt to use dedicated separate entries and separate exits for each facility.
☐	☐	☐	Limit the number of children or staff in a hallway or entryway at one time.
☐	☐	☐	Limit contact with high-touch surfaces (e.g., keep doors open to allow movement without touching knobs when possible and when it doesn't impact fire and other safety zoning).
☐	☐	☐	Promote unidirectional flow through hallways and meeting areas and when entering/exiting buildings, floor and gathering spaces.
☐	☐	☐	Staff and children should enter each area with clean hands with easy access to hand sanitizers.
☐	☐	☐	Roving monitors guide best handwashing practices and cite staff who fail to do so.

☑ STEPS 1	2	3	2.ix. LEARNING AND CARE ENVIRONMENT POLICY & PRACTICE RECOMMENDATIONS:
☐	☐	☐	Identify coordinators for each center facility or area, implementing COVID-19 guidelines, addressing issues and evaluating facility impact.
☐	☐	☐	Focus on establishing consistent, reliable relationships between adults and children. Try to reduce staff-child ratios and hours of care and ensure that a consistent adult is with the children all day.
☐	☐	☐	Provide easily-cleaned toy thermometers, disposable masks, and other PPE equipment for dramatic play in order to reduce anxiety and enhance children's sense of mastery.
☐	☐	☐	Avoid use of items (for example, soft or plush toys) that are not easily cleaned, sanitized, or disinfected.
☐	☐	☐	Cross-train employees to perform essential functions to maintain center safety and a full set of instructional operations.

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☑ STEPS 1	2	3	2.ix. LEARNING AND CARE ENVIRONMENT POLICY & PRACTICE RECOMMENDATIONS:
☐	☐	☐	Center and/or community support for staff with loss of resiliency, stress, depression and suicidial ideation needs to be accessible and confidential using web-based, mobile and other more traditional modalities.
☐	☐	☐	Facilitate staff participation in professional development courses and experiences that focus on trauma-informed practices and resources for parents/guardians.
☐	☐	☐	Institute flexible employee sick leave policies.

☑ STEPS 1	2	3	2.x. BUSINESS AND PERSONAL TRAVEL POLICY & PRACTICE RECOMMENDATIONS:
☐	☐	☐	Staff should eliminate all nonessential business statewide, national and international travel.
☐	☐	☐	Staff should limit all nonessential business statewide, national and international travel.
☐	☐	☐	Staff should eliminate all nonessential personal statewide, national and international travel.
☐	☐	☐	Staff should limit all nonessential personal statewide, national and international travel.
☐	☐	☐	Staff and children returning to center from higher risk in state, higher risk national travel and all international travel should be screened with a mobile or web-based protocol, and if determined to be at elevated risk, are asked to be PCR tested prior to return to center. Those individuals screened low-risk, testing PCR negative with/without immunity will be able to return to center academic facilities.
☐	☐	☐	Staff and children returning to center from higher risk in state, higher risk national travel and higher risk international travel should be screened with a mobile or web-based protocol and if determined to be at high risk, are asked to be PCR tested prior to return to center. Those individuals screened low risk, testing PCR negative with/without immunity will be able to return to center academic facilities.
☐	☐	☐	Staff and children returning from higher risk in-state, all higher risk national travel and all international travel who screen at elevated risk, are positive on PCR testing or refuse to be PCR tested, will self-quarantine in their homes or residence halls for 14 days prior to returning to center facilities.
☐	☐	☐	Staff and children returning from higher risk in-state, all higher risk national travel and all international travel will abide by all federal and local public health policy prior to returning to center facilities.

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3. PCR, ANTIGEN AND SEROLOGIC ANTIBODY TESTING

PCR and antibody testing (from nasopharyngeal swab or other appropriate sample), as well as, antibody testing are critical to provide both pandemic surveillance and contact tracing. These testing protocols must be FDA EUA (Emergency Use Authorization) certified and validated. These recommendations apply to those with influenza like illness (ILI) and/or COVID-19 associated symptoms and other asymptomatic cohorts or individuals. Specimen collection and handling are also critical to protect those managing the specimens and optimizing the accuracy of the testing.

☑ STEPS 1	2	3	3. PCR, ANTIGEN AND SEROLOGIC ANTIBODY TESTING RECOMMENDATIONS:
☐	☐	☐	A routine testing strategy should be developed for staff in coordination with local public health officials based upon center and home syndromic surveillance.
☐	☐	☐	Use mobile device technology as much as possible for syndromic surveillance and pretesting and post-testing determinations.
☐	☐	☐	If a staff member is suspected or confirmed to have COVID-19, quarantine, isolation and testing should be prioritized among close contacts of the confirmed case including all family members and domestic partners.
☐	☐	☐	If a child is suspected or confirmed to have COVID-19, the family should provide evidence of quarantine, isolation and testing prior to return to the center.
☐	☐	☐	Work with local and state public health officials to conduct testing of all staff cases. Provide on-site professional screening and testing whenever possible in locations convenient for staff.
☐	☐	☐	Initiate required testing for all suspected and/or confirmed staff cases with testing confirmation provided by local health system or public health official. Require follow-up prior to access to center facilities.
☐	☐	☐	Utilize only testing protocols and technology that have been FDA EUA (Emergency Use Authorization) and validated.
☐	☐	☐	Have protocols in place for referral to telehealth and traditional medical care in event that a child or staff member needs a referral. Ensure appropriate contact information is available in case of need to transfer child to a health and wellness center or community health care organizations.

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4. PERSONAL PROTECTIVE EQUIPMENT POLICY & PROCEDURES

Personal Protective Equipment (PPE), other than masking, is considered among the least effective method to protect due to its reliance on the user; if the user wears improperly, or the PPE fails, the worker is exposed. However, in certain high-risk areas, particularly when performing screening/testing, high-risk communicable disease research, and deep cleaning after exposure to a suspected or confirmed case, the proper use of PPE is essential.

☑ STEPS 1	2	3	4. PERSONAL PROTECTIVE EQUIPMENT POLICY & PRACTICE RECOMMENDATIONS:
☐	☐	☐	Cloth face coverings should NOT be put on babies and children under age two because of the danger of suffocation.
☐	☐	☐	Emphasize that all PPE must be worn properly and correctly by all age appropriate child and staff when and where such use is deemed necessary.
☐	☐	☐	Following appropriate CDC and local health authority guidance, provide adequate PPE to all staff on request, particularly those cleaning high-use areas and all center-based isolation/quarantine residential facilities.
☐	☐	☐	Institute measures to distribute and redistribute daily recycled PPE with ability to avoid unnecessary contamination due to handling.
☐	☐	☐	Provide PPE donning and doffing instruction and assessment for each age appropriate child and staff depending on type of PPE.
☐	☐	☐	Emphasize proper hand hygiene after gloves or facial coverings are removed. Provide necessary hand hygiene instruction and materials.
☐	☐	☐	Post checklist/instructions for donning/doffing PPE in multiple languages. Provide credentialing at frequent intervals for staff.
☐	☐	☐	Offer ongoing incentives for continuous donning and doffing best practices. Recognize the PPE champion staff routinely.

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5. MEDICAL AND BEHAVIORAL HEALTH POLICY & PROCEDURES

☑ STEPS 1	2	3	5. MEDICAL AND BEHAVIORAL HEALTH POLICY & PRACTICE RECOMMENDATIONS:
☐	☐	☐	Children, families and staff should be kept aware of signs and symptoms of influenza-like illness and specifically COVID-19. This also includes awareness of best practices and specific resources in event of their development of signs or symptoms or a high risk exposure to a person under investigation (PUI).
☐	☐	☐	Children, families and staff should be kept aware of the signs and symptoms of emotional stress, depression and suicidal ideation. This also includes awareness of best practices and specific resources in event of their development of signs or symptoms or observing the signs or symptoms in others.
☐	☐	☐	Provide access to mobile and web-based anonymous medical and behavioral self-screening applications based on best practices for families and staff.
☐	☐	☐	Provide access to 24/7 confidential medical services including access to urgent care and emergency care facilities in proximity to campus.
☐	☐	☐	Implement tools to identify and reach out to children, families and staff with atypical intervals of absence or lack of participation in child care activities and related events.
☐	☐	☐	Work closely with one or more clinical health center/clinic and community referral centers with expertise in the diagnosis and treatment of COVID-19 patients. Ensure confidential and ready access for all children and staff for clinical matters related to pandemic spread and recovery.
☐	☐	☐	Develop and widely distribute standard operating procedures (SOPs) that detail actions to be taken if a child, family member, staff member or visitor is symptomatic for COVID-19 and/or tests positive for COVID-19 or is exposed to an individual positive for COVID-19.
☐	☐	☐	Develop and communicate weekly wellness practices and policies to the campus community via established social/campus media channels.
☐	☐	☐	Ensure that children, families, and staff have access to 24/7 mental health and crisis support services via on campus and/or telecounseling resources.
☐	☐	☐	Communicate availability of established mental health support resources to families and staff via established media channels.
☐	☐	☐	For individuals experiencing housing insecurity, either develop/bolster an internal resource or ensure a process is in place to connect individuals to local/regional resources.
☐	☐	☐	For individuals experiencing food insecurity, either develop/bolster an internal food pantry and process or ensure a process is established to connect individuals to local/regional resources.
☐	☐	☐	Develop/bolster an internal and/or external hardship fund, committee, and application process to support individuals in crisis. Make information readily available to families and staff about how to apply for assistance for this or similar community funds.
☐	☐	☐	Develop and implement a "well check" outreach system for children that can be used to identify wellness-based concerns and issues.
☐	☐	☐	Ensure the child care center is equipped to manage or refer for both randomized and daily individual COVID testing for children and staff.
☐	☐	☐	Ensure children and staff complete age-specific mandatory safety education modules prior to the start of each session.The training modules must clearly cover all relevant age-specific COVID-19 health and safety policies and procedures (i.e. required masking, physical distancing, daily self-checking, etc.).

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