Pandemic & Preparedness Response Plan Writing Tips for Health & Wellness Units at American Universities

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Please note: your "final" manual will live as an annex within directives set forth in other documents or mandates at the university level (e.g., your Continuity of Operations Plan), the state or commonwealth level (e.g., physical distancing in restaurants, school closings, etc.), the national level (e.g., a *cordon sanitaire*), and even globally (e.g., a PHEIC* with clear case definitions from the WHO).

Early coordination and communication are the keys to the success of your pandemic response, as a campus moves:

1) from emergency de-densification (i.e., a partial or even complete evacuation)
2) to restricted re-densification (i.e., a less-populated re-opening), and finally
3) to reconstitution (i.e., a return to full, pre-pandemic operations and density).

Adherence to the procedures that you write into this living document has the potential not only to reduce a pandemic's physical impacts, but also to support quality care through the creative, emotional, environmental, financial, intellectual, occupational, social, solitary, and spiritual dimensions of wellness at your university. As you develop your manual, please consider the symbiotic nature of your town-gown relationship with your neighbors – literal and figurative – and let the spirit of the Okanagan Charter serve as your Muse. I must also underline the importance of universal, HIPAA- and FERPA-compliant contact notification, be it during non-pandemic standard care dealing with STIs or during pandemic situations; it is a mainstay of public health.

Pandemic response will differ greatly not only from University A to University B in the same city, but also at the same university from incident to incident based on: the inherent nature of the event or crisis† itself, staffing (and vacancies), infrastructure, time of academic year, financial restraints, student make-up (e.g., commuter, boarding, and on-line), lines of both communication and supply, the aptitude of a nation's pandemic response team, and evidence-informed national guidelines. "Ceteris paribus" does not apply in these situations – particularly in times of an epi- or pandemic, yet the policies and procedures that you create could serve as general guidelines for a second wave of the same contagion (e.g., when governments lift quarantines and *cordons sanitaires* prematurely, when herd immunity is not reached, when there is a latent genetic mutation of a current viral strain within an animal reservoir, when no vaccine exists, when seasons change, etc.) or for a different impending contagion altogether.

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* Public Health Emergency of International Concern (and PHEIC is pronounced "fake.")
† For this document, I define "crisis" as "the human reaction" versus "the event."

You can adapt your policy to specific pandemic planning assumptions, as it seeks to:

- contain and/or control propagation of the contagion, be it be emergent (e.g., reports of a deadly flu elsewhere), urgent (e.g., an active shooter on campus), or potentially assurgent (e.g., reporting a death by suicide);

- offer immediate care (medical and psychological) and postvention;

- reduce ineffective fear (which could lead to panic-buying which could lead to empty shelves which could lead to more ineffective fear, etc.);

- establish a strong RCCE response (Risk Communication/Community Engagement) to counter disinformation and misinformation;‡

- instill a campus-wide sense of community care, so that an individual may pursue self-care both shamelessly and completely;

- create fora to share your discoveries and insights with local, statewide, and national public health services, emergency medical services, and police; and

- provide the highest quality customer service and support to our faculty, staff, students, alumnx, families, donors, and surrounding communities.

Your final document will be anywhere from 100 to 500 pages in length, depending on whether it includes protocols for isolation, restricted re-densification, or both.

‡ During events such as the recent 2020 SARS-CoV-2 pandemic, I must emphasize the role of quality RCCE from your Public Health office (e.g., Health Promotion). The RC messaging goes to and then from the top of the communication chain (President and BoV), and the CE messaging goes to and then from the bottom up, e.g., peer educators, resident assistants, orientation aides, team captains, etc.]

Pandemic and Preparedness Plan for University Health Services

1. **Introduction** (this should be brief and can refer to other documents)

2. **Operative Definitions and Acronyms** (alphabetized; this section can be long)

3. **Purpose**

4. **Concept of Operations**

5. **Pandemic Planning Assumptions**
   5.1. WHO Assumptions

   5.2. Federal Assumptions
      5.2.1. Hand hygiene
         - Gloves (how to don and doff)
         - Sanitizer

      5.2.2. PPE use (how to don and doff)

      5.2.3. Mask use for patients and other visitors (how to don and doff)

      5.2.4. Respiratory hygiene, with cough/sneeze etiquette

      5.2.5. Patient placement within facility

      5.2.6. Physical distancing in facility
      [When designing a new facility, please consider waiting rooms for both "sick" and "well" patients according to general and/or case definitions]

      5.2.7. Isolation
         5.2.7.1. Within Medical Services, if such a room exists
         5.2.7.2. Within the rest of the facility

      5.2.8. Disinfection, Decontamination, and Safety
         - Blood and bodily fluids
         - Equipment (including prior to repairing or replacing)
         - Exam rooms, waiting rooms, break rooms, and corridors
         - Laundry and other textiles
         - Specimen handling, transportation, and disposal
         - Waste management

      5.2.9. Universal precautions with injections, IVs, and spinal taps (11 out of 10!)
      Related: provider safety when handling and disposing of sharps/needles

5.2.10. Transmission-Based Precautions
- **5.2.10.1.** Contact Precautions
- **5.2.10.2.** Droplet Precautions
- **5.2.10.3.** Airborne Precautions

[Please see those wonderful signs and posters included at the bottom of the above web page]

5.2.11. Communicable disease (perhaps HAI)
- **5.2.11.1.** Aseptic practices before, during, and after a patient's visit
- **5.2.11.2.** Vaccinations and immunizations (including storage and disposal)
- **5.2.11.3.** Veterinary public health concerns in campus-approved service animals, laboratory animals, and live mascots

5.2.12. Deceased patient in the clinic, when cause of death:
- Remains communicable
- Was by suicide

[Reporting death by suicide to control contagion]

5.3. ACHA Assumptions

5.4. State/Commonwealth Assumptions

5.5. University Assumptions

6. Continuity Planning

6.1. Orders of Succession within SOP

[Insert phone/email tree for the University's Contagion Control Team that includes department-focused addendum for Health & Wellness]

6.2. Sample Delegations of Authority within Health & Wellness

6.2.1. Associate Vice Provost for Health & Wellness often oversees:

6.2.1.1. Director, Campus Recreation
- Encourages online courses and advice, to maintain the health of the campus during a de-densification or closing
- Creates plan for restricted re-densification, especially when contagion can survive via fomites

6.2.1.2. Director, Counseling Services
- Conducts RAP (needs, resources, and any restrictions, e.g., HIPAA vs. emergency teletherapy)
- Directs clinical, psycho-pharmaceutical and -social support
  - Related to current epidemic/pandemic
  - Stigmatized populations
  - Pre-existing conditions

- Prepares for peri- and post-pandemic anxiety (including financial and occupational worries); shame from quarantining with others who don't support students' identities; guilt; and grief from human losses, loss of a semester, and loss of celebratory events – from Pride Festivals to graduation)
- Remains vigilant of needs resulting from concurrent events unrelated to pandemic, e.g., earthquake, plane crash, etc.

6.2.2. Director, Medical Services

- Develops SOPs and algorithms for this and other policies
- Trains all staff to identify basic symptoms of the infection according to WHO's/CDC's specific case definitions
- Identifies, treats, and transports any suspected cases (based on WHO/CDC/etc. case definitions)
- Relays findings to appropriate authorities
- Makes necessary "house calls" along with other providers
- Secures HIPAA-compliant telehealth platform
    - Trains staff
    - Shares with faculty, staff, students, and families
    - Contact Notification (be it by phone or app)

6.2.3. Director, Public Health (sometimes identified as "Health Promotion")

- Co-creates and coordinates de-densification, restricted re-densification, and reconstitution procedures
- Leads RCCE efforts
    - Communicates risks to all levels
    - Offsets ineffective fear by addressing observations during a pandemic
    - Organizes and educate community members
    - Address topics such as:
        - Navigating the pathogen
        - "Physically distant/mindfully close/socially just"
        - "Heal better vs. feel better"
        - Self-isolations
        - Closings
        - *Cordons sanitaires* for study abroad, international, and undocumented students
- Remains abreast of latest public health messages (WHO, CDC, state, and local authorities, etc.)

6.2.4. Director, Sexual Assault Response Services

- Recognizes and prepares for increased risks for SA/IPV during times of isolation
- Provides trauma-informed response, even if Title IX investigations are thwarted by a lockdown or closing

6.2.5. Director, Student Accessibility Services
- Supports students infected or directly affected by the pandemic
- Assists students with accessibility concerns during de-densification, re-densification, and reconstitution
- Liaises between students and faculty to support students with GAD, OCD, etc.
- May provide guidance to learners seeking Pass/Fail options

6.2.6. Director, Student EMS (e.g., NCEMSF chapter, ALS/BLS, etc.)
- Transports PUIs and known cases to hospital
- Takes vitals to assist student health staff
- Handles phone queries at campus based EMDs/PSAPs
- Can be a calming presence (passively or actively) during both de-densification and restricted re-densification phases

7. **Continuity of University Health Services' Facilities** (including telework, telemedicine, and teletherapy within and across state/commonwealth lines)

8. **Continuity Communications**

9. **EMR and Other Essential Records**

10. **Human Resources within Health & Wellness**
    10.1. Devolution of Control and Direction (outside of SOP)

11. **Testing, Training, and Drills** (these protocols must be "second nature")

12. **Restricted Re-Densification Protocols** (with baseline testing, if advised)

13. **Reconstitution Protocols** (including necessary criteria and monitoring)

14. **Conclusion**