



COVID-19

AND

**COMMUNICABLE
DISEASE GUIDE**

Association of
Camp Nursing

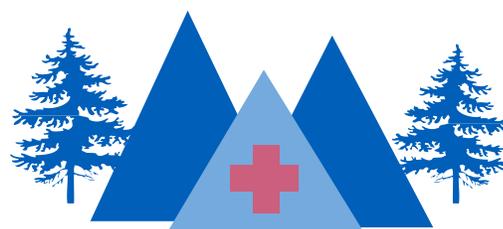


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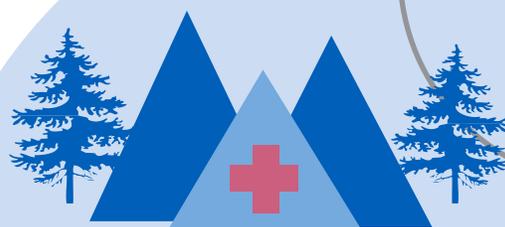
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Introduction

The *COVID-19 and Communicable Disease Guide for Camps* was developed to guide camp services and activities during communicable disease events. This information is intended to support camp leadership decision-making in creating their own guidelines. We wrote this resource from a nursing perspective. Therefore, the focus is on caring for clients and groups in response to illness in community-based environments. The goal of nursing care is health, which includes mental, emotional, and social health (MESH), as well as physical care needs. Consistent with that goal, this guide includes information about nonpharmaceutical interventions (NPIs) in addition to psychosocial interventions for staff and campers. This document also highlights the important role camp leadership plays in developing and operationalizing a communicable disease plan. We hope that information learned through this guide will promote a collaborative relationship between camp leadership and camp health service providers.

The guide uses as evidence research findings from surveys, interviews, and a review of health log entries collected from camp healthcare providers during the summer of 2020. This mixed-method design provided new and affirming information about ways to successfully manage camp during the COVID-19 pandemic. This guide also shares practical and creative interventions camps used within the structure and context of their operations. While we expect this guide to be particularly informative for camps operating in the summer of 2021, it is our hope that it will serve as an ongoing resource for many years to come and when future communicable illnesses impact our camp communities.

For camps or organizations that use this resource, the Association of Camp Nursing (ACN) is in no way responsible or liable for decisions made regarding healthcare practices and decisions at different camps and in different states. We can provide guidance and encourage each camp to understand unique variables that impact their ability to conduct different safety activities and response services. We hope you will dive in and use this information to promote a healthy camp community.

If you have questions, please feel free to reach out to ACN.

www.campnurse.org.

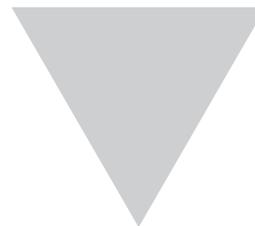
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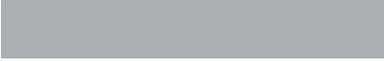
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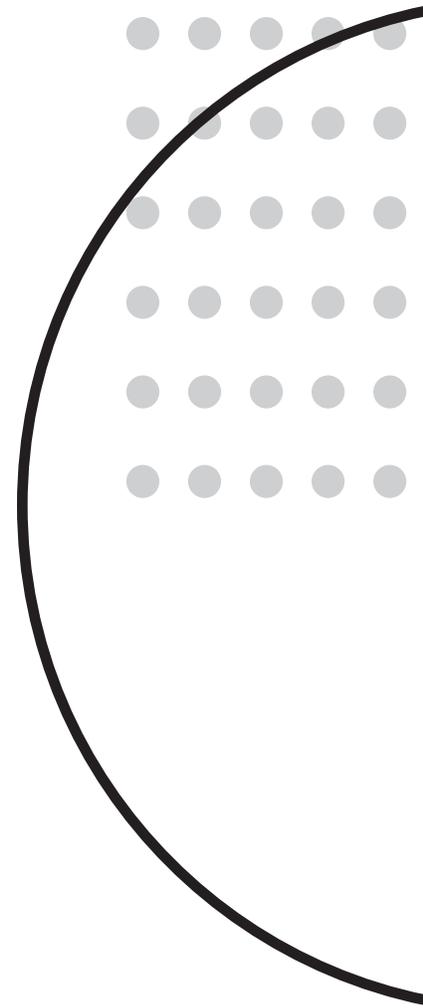
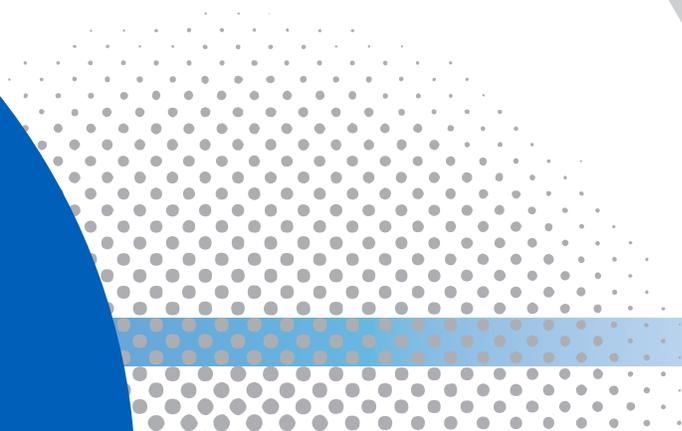
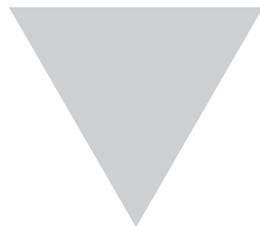
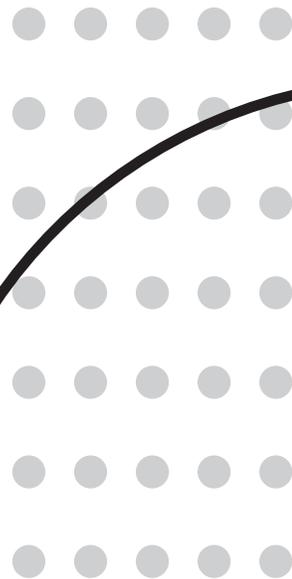


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COVID Research and Education



Camp Utilization of Nonpharmaceutical Interventions (NPIs) in the Summer of 2020 following the Onset of COVID-19

Barry A. Garst, PhD, and Tracey Gaslin, PhD, CPNP, FNP-BC, CRNI, RN-BC

What We Did

Background

In the summer of 2020, the Association of Camp Nursing (ACN) surveyed camp nurses and other camp healthcare providers to better understand camp healthcare within the context of the COVID-19 pandemic through a study approved by Clemson University's Institutional Review Board. A portion of the study examined nonpharmaceutical interventions (NPIs) that camps may have used in their response to the pandemic. This article summarizes findings associated with camp usage of NPIs, which are “actions, apart from getting vaccinated and taking medicine, that people and communities can take to help slow the spread of illnesses like pandemic influenza (flu)” (Centers for Disease Control and Prevention, 2020, para 1). Within camp contexts, NPIs are actions camp healthcare providers, camp leadership, and staff take to mitigate the spread of communicable diseases. The research questions were:

1. How many camps operated in-person sessions in the summer of 2020?
2. What NPIs were most common in camps?
3. What was the relation between confirmed cases of COVID-19 and NPIs?
4. What challenges did camps experience in implementing NPIs?

Methods

Out of 608 camp healthcare providers identified through ACN's membership, 181 providers completed an online questionnaire through Qualtrics (i.e., response rate = 29.7 percent). The questionnaire included several measures associated with NPIs.

1. Respondents were asked to evaluate how often their camp community used NPIs on a 1 (never) to 5 (always) scale. The nine-item scale was developed by the research team informed by the NPIs recommended for camp operation in the *Field Guide for Camps on Implementation of CDC Guidance* (Environmental Health & Engineering, Inc., 2020). These interventions included “promote healthy hygiene practices; intensify cleaning, disinfection, and ventilation; [and] ensure physical distancing” (p. 13).
2. Respondents were asked how many suspected or confirmed cases of COVID-19 were associated with their camp's operation, so these figures could be compared with NPI usage.
3. Respondents were given the opportunity to complete NPI-related, open-ended questions, including:

- a. “Which of the NPIs were the most and least difficult to implement in camp?”
- b. “Explain how your camp health services changed in order to use NPIs.”
- c. “Explain the difference in how well staff and campers followed your camp’s NPI guidelines.”

Following the survey, 22 camp nurses — a purposeful sample — were invited to participate in a follow-up interview, which elicited more information about the research questions. Interview participants were selected if they worked at a day or residential camp that operated in-person sessions during the summer of 2020. All selected members agreed to be interviewed for the study.

Descriptive statistics were calculated for quantitative items using SPSS version 24. Qualitative data (e.g., open-ended responses; interview responses) were analyzed using directed content analysis (Hsieh & Shannon, 2005).

What We Learned

Camps Operating In-Person Sessions in the Summer of 2020

NPI use was applicable in camps that operated in-person sessions. Out of the 181 respondents in this study, 55 operated in-person sessions during the summer of 2020 (30.4 percent). Of the 55 camps that operated in-person sessions, 27.8 percent represented day camps, 57.4 percent represented resident camps, and 14.8 percent offered both types of camp (Figure 1).

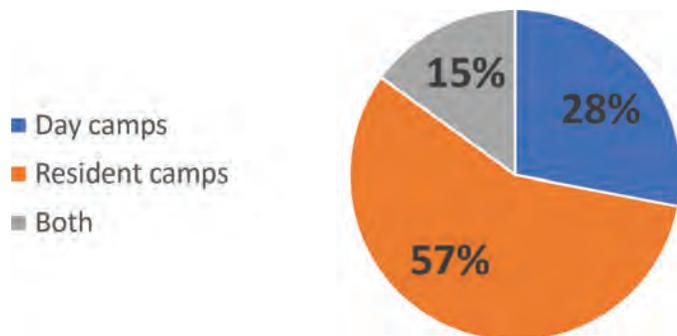


Figure 1: Percentage of In-person Camp Sessions Offered in the Summer of 2020 by Type (n=55)

Most Commonly Used NPIs

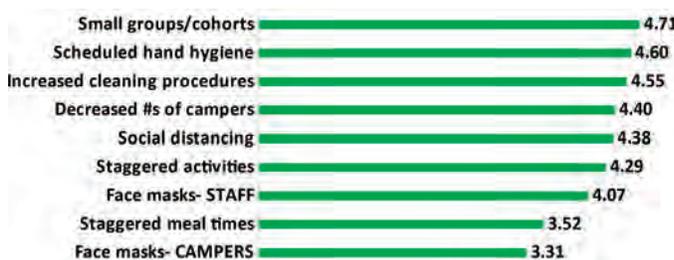


Figure 2: Frequency of Camp Use of Nonpharmaceutical Interventions in the Summer of 2020 (scale from 1[never] to 5 [always])

With ratings well above the 2.5 midpoint of the 1–5-point scale, all NPIs were used frequently (Figure 2). The most commonly employed NPIs were the use of small groups/cohorts (4.71), hand hygiene (4.60), and cleaning procedures (4.55). Less frequently used NPIs included face masks (for staff, 4.07; for campers, 3.31) and staggered mealtimes (3.52).

Relation Between Confirmed COVID-19 Cases and NPIs

The survey asked participants to report on their COVID-19 caseload. We asked for reports of COVID-19 suspects (anyone who presented with illness symptoms that could potentially represent COVID-19) and for the number of confirmed cases (individuals with positive results by testing) (CDC, 2020).

Of the 55 camps that offered in-person sessions, nineteen reported 49 suspected cases of COVID-19 among staff (one respondent reported 15 suspected cases at their camp) and 60 suspected cases of COVID-19 among campers (one respondent reported 10 suspected cases at their camp). Additionally, twelve respondents reported 17 confirmed cases of COVID-19 among staff (one respondent reported 6 confirmed cases at their camp) and seven respondents reported 20 confirmed cases of COVID-19 among campers (one respondent reported 10 confirmed cases at their camp). This distribution of cases helps us begin to understand that COVID-19 did not commonly present in camp settings, but when it was present, it could be transmitted. In the confirmed cases of COVID-19 among staff and campers, 33 percent of staff cases were in just one camp, and 50 percent of camper cases were in just one camp (see Figure 3).

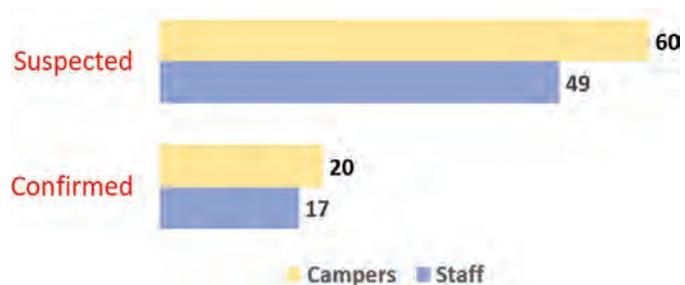


Figure 3: Suspected and Confirmed Cases of COVID-19 among Campers and Staff in the Summer of 2020

The distribution of COVID cases helped us understand that COVID-19 did not commonly present in camp settings.

Correlations between camps reporting confirmed COVID-19 cases and use of NPIs were examined. No statistically significant correlations between the use of any one specific NPI and confirmed COVID-19 cases were identified.

Least and Most Difficult NPIs to Implement

Respondents answered an open-ended question about least and most difficult NPIs to implement (Figure 4). The most difficult NPI to implement was social distancing (also known as physical distancing within the data), which was described as “almost impossible” and a “constant struggle.” Physical distancing was particularly challenging within cohorts, for specific populations (e.g., younger children, youth with special needs), and within certain activities such as swimming and basketball. The interview participants echoed the challenges of physical distancing.

Another difficult NPI to implement in camp was use of face coverings (also known as masks within the data). The wearing of masks was noted to be “difficult to police” and “inconsistent.” One camp healthcare staff shared, “camp administration did not feel

they were important and did not require them of staff except at check-in.” Both NPIs (i.e., social distancing and face coverings) became more difficult to implement in the later weeks of camp after camp participants became more familiar with one another. Several respondents noted challenges associated with staff wearing masks. This finding was consistent with findings from another question about differences between how well campers and staff followed the new NPIs, with 61 percent of respondents noting that campers followed NPIs better than staff. In some cases, camps had designated specific times when masks could be removed (i.e., eating, sleeping, water activities, exertional activities). In many camps, staff and campers could remove the face coverings when outdoors and maintaining a 6-foot distance.

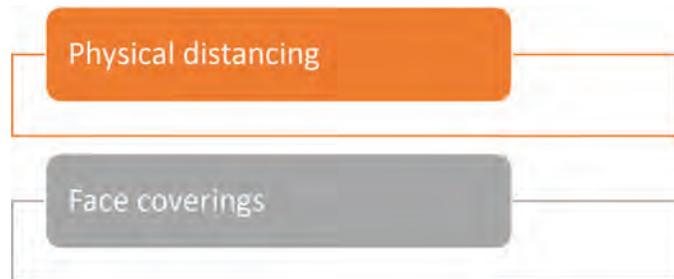


Figure 4: Most Common Challenges Associated with Implementing NPIs

Cohorting (i.e., organizing campers into small groups) was the easiest NPI to implement, based on the open-ended and interview responses. Handwashing and sanitizing practices were already common at camp and not shared as significant challenges to continue, even in a more robust way.

Changes Associated with NPI Use

Camp health services include activities such as medication management, documentation, screening, and other care processes. Approximately 64 percent of respondents identified that significant camp health services changes were needed to accommodate the required NPIs. Responses to the open-ended question, “Explain how your camp health services changed in order to use NPIs” produced the following key findings:

- Limits on number of individuals allowed in the camp health center at one time
- Participants with fevers could not remain in camp
- New distancing procedures for medication administration
- Resources directed to finding personal protective equipment (PPE), some of which were hard to find
- Nurse masking at all times, full PPE in suspected cases
- Plastic shielding installed at health center door entrance
- Outdoor health evaluation and treatment whenever possible
- Implementation of new daily temperature check procedures
- Daily monitoring of NPI usage and compliance
- New staggered meal procedures
- Identification of isolation/quarantining spaces and related procedures

In addition to these open-ended answers from the survey respondents, interview participants shared other changes associated with NPI use, including:

- Delivering nighttime medications to cabins instead of campers coming to the health center
- Asking campers screening questions when they came to the health center
- Moving health center operations to an outside location where ventilation was increased

Changes That Might Become Permanent

Changes for 2021 include an increased focus on education of staff, staff policies, managing staff contacts, and consideration for staff testing.

Interview respondents were asked what changes (in response to COVID-19) might become permanent. These “responses of permanence” reflected changes that worked so well in their healthcare facilities that respondents believed continued use could improve their model of care. Camp

healthcare services changes from summer 2020 that respondents believed could become permanent included:

- Having more activities outdoors when possible (e.g., camp check-in; food service; triaging campers and staff; mobile health services; drive-through check-in for campers),
- Emphasis on hand hygiene
- Increased cleaning

Themes associated with what respondents would do differently in the summer of 2021 if camps are still facing the COVID-19 pandemic included:

- Improve communication
- Plan and order supplies earlier
- Increase education and clarify policies for staff
- Hire more staff
- Require staff to stay on-site during camp
- Ensure staff are working and bunking together to decrease contacts
- Provide testing when staff and campers arrive at camp

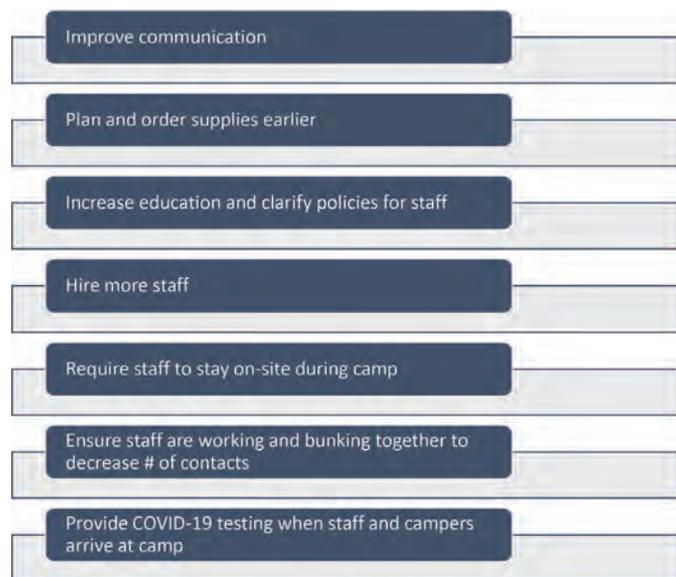


Figure 5: Permanent Change Considerations for Camp Health Services Following the Summer of 2020

Why It Matters

This study benchmarked camp healthcare practices associated with the use of NPIs in the summer of 2020. As NPI usage was a critical camp healthcare response to the COVID-19 pandemic, the study findings can inform ways camp healthcare providers can strengthen communicable disease response plans in future years.

This study did not evaluate the efficacy of specific NPIs, and the analyses did not uncover any correlations between specific NPI usage and confirmed COVID-19 cases. The findings suggest that most camps implemented NPIs in a comprehensive manner rather than selecting one or two that fit their situation, which is consistent with recommendations in the American Camp Association field guide that “no one NPI is sufficient” (Environmental Health & Engineering, 2020, p. 87). Importantly, NPI use began prior to camp (e.g., hand hygiene, screening, face masks, physical distancing) and then continued as camp sessions unfolded.

A key finding from summer 2020 was the need for a fully operational communicable disease plan (CDP) that outlines many of the components and activities identified in the research efforts. A CDP outlines a camp’s communicable disease prevention activities (i.e., NPIs); supplies and resources; outbreak management; and communication and debriefing plan.

One of the first prevention activities camps used was screening (Figure 6). Residential and day camps developed organized procedures for screening campers and staff prior to and during camp. Pre-screening was an activity that required individuals to self-monitor their health status. Individuals were asked to monitor temperature, signs and symptoms of COVID-19, recent travel, recent exposure, and quarantine status for 7–14 days prior to arrival at camp. The intent of health screening was to encourage individuals

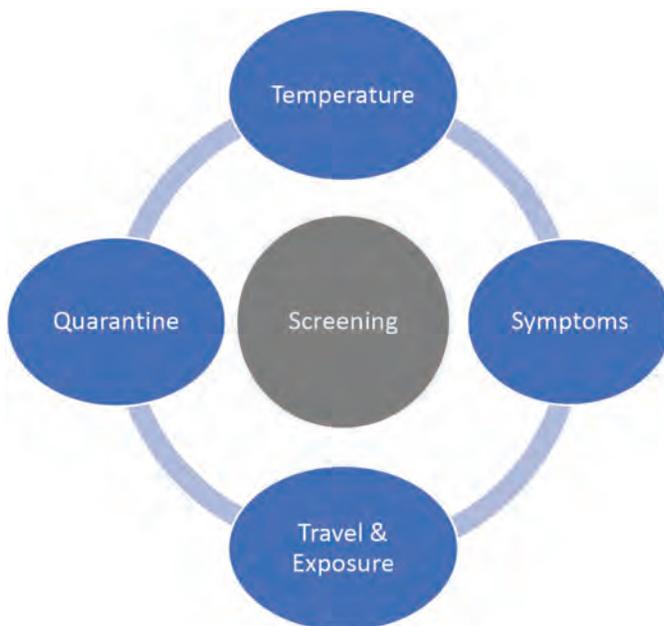


Figure 6: Elements of Screening for COVID-19 in Camps

to arrive at camp in a healthy state. Daily self-monitoring allowed for heightened awareness of health status and responding to potential health alterations before arriving at camp.

Screening then continued at camp on the day of arrival (initial screening), when staff and campers were asked many of the same questions and received similar screening to what was being done in the pre-screening period. After initial screening, day camps continued the same screening process daily (ongoing screening), because campers and staff returned home every evening and had an

increased risk of exposure. Residential camps did ongoing screening but used a variety of methods to conduct this activity. Some residential camps took temperatures daily, others asked screening questions, and others did a combination of activities as their ongoing approach to screening. Some camps took an additional step of conducting post-screening. Camps conducting post-screening asked parents to report any COVID-19 signs and symptoms in their children within two weeks of returning home.

Camps created small groups (cohorts), enforced wearing of face masks at appropriate times, and promoted frequent and thorough hand hygiene through the camp experiences. These techniques were used in both day and residential camp settings. Small groups have been a mechanism to limit exposure and improve contact tracing if needed. Face masks were most often used when individuals could not maintain a 6-foot distance and when indoors with more restrictive ventilation. Camper face masks were often removed at designated times:

- Eating
- Sleeping
- Participating in water activities
- Doing exertional activities
- When there was no risk of interacting with individuals in other groups

Camps adjusted activity schedules to allow adequate and thorough hand hygiene to minimize illness transmission.

Staff had opportunities to remove face masks at some of the same points in time as campers, but more restrictions were imposed when staff were off duty because of the potential of interacting with one another or others in a different group.

Creative handwashing opportunities were created using canoes, portable stations, water fountains, and other sources of water. In addition, camps adjusted their schedules (fewer activities, more time for hand hygiene) to allow time and attention to handwashing or use of hand sanitizer strategically placed throughout camp.

Sanitizing and ventilation are two additional NPIs that were used during summer camp 2020. Sanitizing occurred in two particular ways: frequently and in high-touch areas. Many camps considered “frequently” as daily cleaning, others conducted sanitizing twice a day, and some included cleaning of activity areas between uses by each group. Camps conducting sanitizing of high-touch areas cleaned tables (dining hall, activity), bathrooms, and doorknobs/handles. The intent of sanitizing was to help minimize fomite transmission.

As the summer progressed, camps learned more about the impact of ventilation in minimizing transmission of illness. Promotion of air movement helps decrease circulating viral particles in the air (Centers for Disease Control and Prevention, 2020). Some camps moved all their operations outdoors, including activities, food service, and healthcare. For these camps, they had no cases of confirmed COVID-19. Camps evaluated their

healthcare services and also adjusted to prevent congregation at the health center. This included activities such as setting up a healthcare tent with open sides that provided excellent ventilation and more opportunity for distancing. Some camps created mobile health services (healthcare golf cart and a health supplies triage bag) that traveled to activity areas and provided care to individuals while keeping them in their small groups. These strategies by healthcare teams reinforced many of the other NPIs (e.g., cohorting, physical distancing, ventilation, face masks, hand hygiene) and therefore promoted a healthier camp community.

What We Still Need to Know

There is more to learn from this pandemic experience. While the camp healthcare community understands the full spectrum of NPIs was effective in preventing transmission of communicable diseases, future studies of COVID-19 in camp could be designed to evaluate specific NPIs and their influence on COVID-19 spread.

This effort calls for more research on NPI usage to “determine which may be most efficacious for reducing communicable disease spread within camp settings” (Garst, Dubin, Gaslin, Schultz, & Rodrigues, In Press). Camps that reported the most cases of COVID (both suspect and confirmed) experienced some inconsistent NPI use with cohorting and face masks. One camp did not require cohorting for everyone and allowed some participants to continue to follow an individualized schedule that promoted crossover between different camper groups. Another camp did not consistently use or enforce face mask use in campers or staff when individuals were within 6 feet of one another.

Future research should also examine how the onset of the COVID-19 pandemic impacted campers, seasonal staff, and health center staff mental, emotional, and social health (MESH). Staff were reported by several camps to be more “relaxed” and less adherent to NPIs, especially during times of socialization, when NPI use was more critical. A finding from summer 2020 included elevated levels of anxiety in staff, while campers were reported to be more “resilient” and demonstrated little emotional concerns related to potential exposures. More research is needed regarding the best education and preparation methodologies for staff to better manage MESH issues while encouraging performance of NPIs for camp safety.

Ventilation as an NPI was discussed early in the summer camp planning process, but at that time the camp community did not yet fully understand the potential impact of circulating air on respiratory particles. The CDC (2020) identified that risk for transmission is greatest when there is an accumulation in respiratory particles related to poor ventilation and air handling (CDC, 2020). Camps, therefore, moved activities and services outside to help promote circulating air. More research is needed regarding the role of ventilation (e.g., fans, outdoors, screens) on disease transmission and how camps can continue to use this NPI in more effective and organized ways.

For camps that operated in the summer of 2020, only 85 percent had an established communicable disease plan (CDP). Those camps that did not have an established CDP may have utilized many of the preventative activities and had an idea about what actions to take in an outbreak, but they missed the value of having a more comprehensive plan of care. Additional research is needed regarding CDP use and development at camps in an effort to provide thorough and comprehensive camp health services.

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Creative Implementation of Nonpharmaceutical Interventions (NPIs) in Camp

Beth Schultz, PhD, DNP, RN; Tracey Gaslin, PhD, CPNP, FNP-BC, CRNI, RN-BC; and Barry Garst, PhD

Preventing the Spread of Disease

The nursing profession is often attributed to Florence Nightingale. Not only did she elevate the nursing profession, but she implemented and promoted infection control principles in healthcare (Gilbert, 2020). For example, she is credited with promoting handwashing, providing regular sanitation and cleaning, advocating for fresh, “clean” air, and making sure adequate space was left between patients in hospital wards to prevent the spread of infection (Gilbert, 2020). All the measures Florence Nightingale implemented are still applicable today as we strive to decrease the transmission of communicable diseases — including coronavirus (COVID-19).

The best way to prevent the spread of a virus is by minimizing exposure (Mahajan et al., 2020). However, we, as relational beings, cannot stay separated from one another. We are meant to be in community and to collaborate as part of the process of living. We are designed to use all our senses, with an emphasis on touch, as part of relationship building and maturation. In the current COVID-19 pandemic we are pushed to consider a variety of ways to help control the communicability of illness while allowing us to share community-based experiences. During the summer of 2020, camps used a variety of nonpharmaceutical interventions (NPIs) to mitigate transmission risk, and they found creative ways to do so (Garst et al., 2021).

This article highlights information identified through post-camp research about camps’ experiences with NPIs (Garst et al., 2021). (If you haven’t already read the article, “Camp Utilization of Nonpharmaceutical Interventions [NPIs] in the Summer of 2020 following the Onset of COVID-19” in this guide, you may want to do so to familiarize yourself with the findings regarding how camps used NPIs last summer.) The intent of this article is to provide insight regarding camp operations focusing on creative use of NPIs to meet the needs of

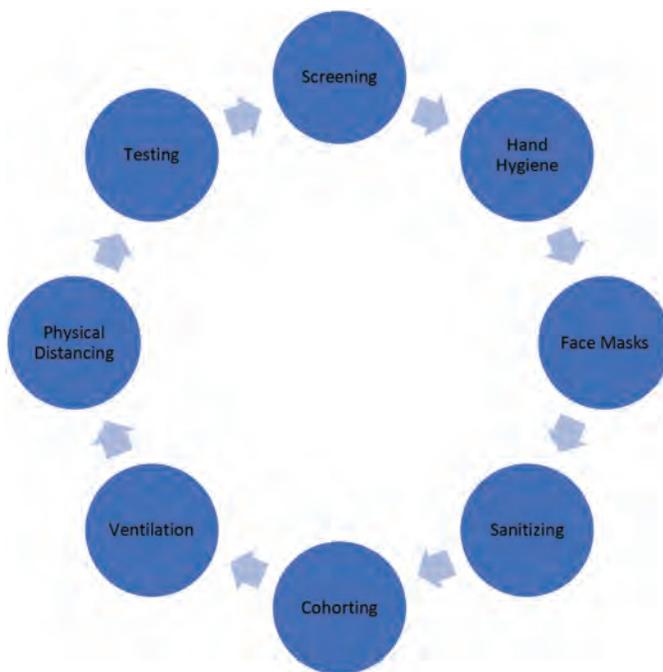


Figure 1: Nonpharmaceutical Interventions

the populations. During the summer of 2020, a variety of NPIs were recommended to decrease the risk of illness transmission. Those NPIs included screening, hand hygiene, face masks, sanitizing, cohorting, ventilation, physical distancing, and testing (see Figure 1).

These NPIs were critical to providing a safe camp experience and can be useful for future potential communicable events. Camps instituted these interventions through a variety of techniques and strategic planning. The following sections describe each of the NPIs and share creative ways camps implemented the NPIs to promote health, minimize risk of transmission, and support families wanting their children to have a camp experience.

Screening Strategies

Pre-screening

Camps implemented screening strategies for campers and staff prior to, during, and after camp. Screening usually occurred for 7–14 days just prior to camp arrival. During that time, individuals self-monitored for illness symptoms and performed daily temperature checks. These screening events helped in several ways:

- Encouraged campers and staff to arrive at camp in a healthy state.
- Promoted daily awareness of health status, allowing for expedient intervention if someone was ill.
- Provided a sense of security that all families were doing the same screening to support the health of the camp community.

In many cases, screening was done with a “pen and paper” method using tools from the Association of Camp Nursing (ACN) website (see Figure 2: Pre-Screening Tool). Families and staff completed these forms daily and provided them to camp during check-in.

Some camps took it a step farther and used web-based applications (i.e., apps) for the screening process.

Camper Name: _____ Session: _____

Pre-Camp Health Screening

Dear Camp families,

In an effort to minimize illness at camp we ask that you check on the health of your camper daily beginning 14 days prior to camp. The best camp sessions start with healthy campers and this begins at home. Please bring this completed form to camp on opening day.

Please indicate if your camper has any of the following symptoms prior to camp and record a temperature daily. If any temperature or symptoms are present, please have your camper evaluated by a licensed provider and contact camp for further guidance.

Symptoms (symp):

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Muscle Pain
- Sore throat
- New loss of taste or smell
- Nausea
- Vomiting
- Diarrhea

Please initial

1. My child has not been around anyone with any of the listed symptoms or diagnosis of COVID19 in the 14 days before the start of camp. Initial _____
2. No one in our household has been sick in the 14 days prior to camp. Initial _____
3. My child has not traveled by air or traveled out of state in the 14 days prior to camp. Initial _____
4. My child has adhered to our state's guidelines regarding COVID19. Initial _____

	Day:	14	13	12	11	10	9	8
	Temp/ symp							
	Day:	7	6	5	4	3	2	1
	Temp/ symp							

Start date of temperature/symptom screening: _____

Our signature indicates that we completed this health screening daily for 14 days prior to camp and to the best of our ability. We understand that arriving to camp healthy is vital to a healthy camp for all campers.

Parent Signature: _____ Date: _____
 Camper Signature: _____ Date: _____

Created by Eesnor Matthews RN

Figure 2: Pre-Screening Tool

This creative approach provided some additional benefits. First, individuals completing the questions via an app could send that information directly to the camp. Two apps used previously were the ProCare App and the AirTable app. Each app approached screening from a different view. ProCare is a childcare app used by camp program providers in their programs, while AirTable is an app used by camp nurses to create surveys and data trackers.

A new technology-driven screening app is the Health Champion app (<https://myhealthchampion.com/covid19-app/>). This tool is intended for employees, but others could use it as well. This app is HIPAA-compliant; it protects personal health information while allowing employers (i.e., camp providers) to view individual health screenings on a daily basis.

Initial Screening and Arrival at Camp



Figure 3: Example of “Drive-Through Check-In” System

Advantages of Drive-Through Check-In
Updated health information gathered prior to arrival
Efficient and organized
Transitioned quickly
Enabled counselors extended engagement with campers
Allowed health services preparation time

After completing pre-screening, staff and/or campers arrived on site. Both residential and day camps felt the need to implement safer check-in procedures and take proactive steps before allowing campers into the camp setting. The hope was to prevent the introduction of unwanted illness (i.e., fever, cough, vomiting) or bugs (i.e., lice), as well as to identify the health status of participants on opening day (i.e., bruising, arrival with injury, noticeable behavioral concerns). Historically, arrival day was a frantic, busy day with many tasks and interactions with families and children brought to camp. The summer of 2020 created a need for camps to develop a “drive-through” check-in system (see Figure 3). The process utilized many NPIs (e.g., ventilation, face masks, screening, cohorting, distancing) to create a

system for quick and healthy arrivals. Parents drove into camp, camper temperatures were taken, and if campers were temperature free (afebrile), they exited the vehicle and completed the check-in process with camp staff as their parents left camp without entering the camp building(s). This new process was well-liked and is being considered as a standard for many camps moving forward.

Hand Hygiene

The CDC recommends frequent handwashing with soap and water for at least 20 seconds (US Centers for Disease Control and Prevention, 2020). Soap and water are preferred, but if not available, cleaning hands with a hand sanitizer that contains at least 60 percent alcohol is acceptable, if appropriate for the age and ability of campers.

Common methods camps employed that helped campers and staff wash their hands for at least 20 seconds were singing a camp song or playing a 20-second music clip. In addition, signs and other visual reminders were placed around camp to encourage campers and staff to comply with handwashing practices, especially prior to eating, after using the toilet, after coughing or sneezing, and after camp activities (US Centers for Disease Control and Prevention, 2020a; see Figure 4). Planning for and initiating intentional handwashing breaks throughout the camp day reinforced proper hand hygiene.

To make handwashing fun, camps developed creative handwashing stations (see Figure 5). These stations were built, borrowed, and developed through thoughtful (and often inexpensive) planning. We learned that the more convenient the location of the handwashing station, the more likely the campers and staff would be compliant with frequent handwashing. Therefore, camps provided some type of handwashing station at multiple locations in camp. Examples of such stations included changing water fountains to handwashing stations, using supplies to create a tabletop and sink that could be



Figure 4: Handwashing Protocol



Figure 5: Camp Handwashing Stations

connected to a water hose, and procuring portable stations that operated through pedal pumping the water through the system.

Sanitization

Sanitizing is an important step in the prevention of fomite transmission. Fomites are surfaces that may be contaminated with microorganisms that could possibly cause illness to individuals touching those surfaces. High-touch surfaces at camp included tables, door handles/knobs, and bathrooms. To help address potential fomite transmission, camps found ways to sanitize those surfaces “frequently” (*Field Guide for Camps on Implementation of CDC Guidance, 2020*; US Centers for Disease Control and Prevention, 2020a). With limited staffing, camps had to think creatively about how they might conduct their cleaning activities. Although some camps were able to hire additional staff to conduct frequent cleaning (one to two times per day), most camps had to consider ways to make it part of the community-building process.

This community-building process through helping one another with the camp chores was a great way to promote the joy of giving — and then to encourage campers who were being served to verbalize their gratitude for the service. Campers embraced the opportunity to do their part and have ownership in making the camp function and safer for everyone. Camps used simple tools like sign-up days, pats on the back, “peer before person” turn-taking, and positive affirmation to promote service to others as a leadership skill. The COVID-19 pandemic, with all its challenges, has also allowed for some amazing growth and appreciation at camp. Other than purchasing the sanitizing supplies, the labor, cleaning, and sanitizing were part of the camp experience — and one that may also strengthen a camp’s culture moving forward.



Figure 6: Face Mask Usage in Camps
(Permission from mouselovespig.com)

Face Masks

As COVID-19 continued to be transmitted across the US and other countries, wearing a face mask became second nature. It became uncommon to see someone without a face mask over time. Interestingly, early feedback was that it would be difficult to keep face masks on children during the camp experience. However, data so far has found just the opposite. Campers demonstrated resilience in wearing their face masks and adhered to camp rules to be with their peers (see Figure 6).

Knowing face masks were going to be part of the camp experience, some camps decided to make it fun. Camps taught campers how to make double-layer cloth face masks with fun material. Some camps had cool art projects to decorate masks, and other camps provided opportunities for campers and staff to create masks for individuals in need. Face masks were another creative and engaging art project that not only had physical health benefits, but also allowed for much-needed socialization and mental health promotion during the isolation of the pandemic.

Cohorting/Physical Distancing

Cohorting is the process of maintaining small groups with little to no interaction with others. The intent is to help contain viral transmission if someone begins to exhibit symptoms of illness. In addition, cohorting provides an organized method for contact tracing (see Figure 7). Most camps did not use the term cohort; instead, they used terms like groups, families, pods, or villages.

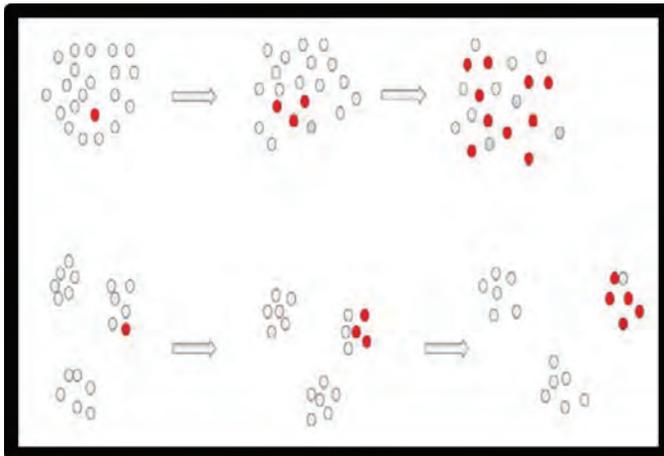


Figure 7: Visual Model Representing Cohorting as a Strategy for Communicable Disease Transmission, Prevention, and Contact Tracing (NOTE: Top portion of the figure represents disease spread in large groups compared to the same spread using cohorting in the lower portion of the figure.)

To encourage individuals to stay within their cohorts, visual reminders and verbal support became important and helpful aids. Camps used simple tools such as spray painting the grass with designated areas for each cohort, applying duct tape to demonstrate off-limit areas, and staggering activities to prevent cohorts from crossing paths in activities.

Many of these cohorting measures also support physical distancing at camp. The cohorting process encouraged physical distancing by spacing out activity areas and adhering to duct-taped limitations. Creative meal-time services also promoted physical distancing. Instead of congregating

in a crowded dining hall, camps moved all their food services outside, providing daily picnics, staggered mealtimes, or allowing different groups to eat in the dining hall each day. Since masks have to be removed for meals (while eating, but not necessarily within dining facilities), it is important to consider creative ways to promote other NPI use to minimize risk. In these new scenarios, camps offered handwashing, physical distancing, ventilation, cohorting, and sanitizing to offset the inability to use a mask while eating.

For overnight camps, the CDC recommends positioning beds so that campers and staff sleep head to toe at least 6 feet apart (US Centers for Disease Control and

Prevention, 2020b). Camps posted signs to remind campers and staff of the head-to-toe rule (see Figure 8). Camps posted footprint signs on the end of the beds where they wanted campers to put their feet. Simple visuals such as these prevented staff from having to constantly remind campers to sleep according to an established protocol.



Figure 8: Head-to-Toe Sleeping (Permission from Kidobunk.com)

Ventilation

Ventilation is the process of creating air movement to decrease the volume of circulating respiratory particles. Therefore, activities in areas of increased ventilation decrease the risk of viral transmission (US Centers for Disease Control and Prevention, 2020). Camps organized an array of creative mechanisms to increase airflow. Changes included:

1. Opening windows and doors for outdoor air
2. Adding fans to circulate outdoor air through cabins and activity buildings
3. Moving all activities and services (including food) outside
4. Providing all health services outside (i.e., triage, treatments, medications)
5. Intake screening conducted outdoors via drive-through
6. Lowering windows 2–3 inches during bus/van transportation

Healthcare providers continue to learn that ventilation plays an important role in minimizing risk of illness from respiratory droplets. Therefore, whether combating COVID-19 or other respiratory illnesses, consider ventilation a partner in promoting a healthy camp community.

Health Services

Health services are a critical component of a camp community. Healthcare staff must provide services in an organized and effective way. Historically, many health services have been provided in the health center. However, during an illness that requires separation and respiratory precautions, congregating individuals from different cohorts in the health center is not ideal, and a variety of camp health services must be adjusted. With these adjustments, services still need to be provided in a timely and organized way to promote health and prevent errors. Camps made changes to several important healthcare services:

1. Medication management. Most camps historically have had campers come to a medication window or health center location to pick up medications. In summer 2020, camps decided that their healthcare providers would take medications to individuals in their cohorts, cabins, or the dining hall instead

of having campers line up at the health center. This procedural change allowed for the maintenance of the small groups while still attending to individual camper needs. Camp nurses shared that they liked the opportunity to engage with campers on-site through these procedure changes. It did require some additional time, but the more individualized approach to care was valued.

2. Many camps moved all their services outside under an open tent. For some camps, this was initially a decision to provide space in the health center for isolation needs. Once camp nurses were outside under a tent with a breeze available, they voiced excitement about this change. Camp nurses reported they could provide almost all needed care outside (i.e., medications, injury care, nebulizer treatments, care procedures). Some camps organized a second tent as a quarantine or isolation area separate from the general camp population. This was another change secondary to COVID-19 that may be a lasting and helpful update.
3. Several camps created mobile health services. They received a golf cart, placed a medical logo on the cart (see Figure 9), and traveled to campers in activity areas for minor injuries and illness. This change in the process of delivering care continued to promote the use of several NPIs, which helped to minimize disease transmission.



Figure 9: Logo Signifying Camp Health Services

Testing

Testing for COVID-19 was not possible for most camps in summer 2020, as such testing did not become readily available in many communities until later in the year. However, some camps did ask that staff and/or campers have at least one negative test prior to camp arrival or, if available, to have a test done on arrival day. Testing is another NPI and should not be considered a fail-proof alternative. If someone has a negative polymerase chain reaction (PCR) or antigen test, it just means the test is negative at that moment. The timing of a test can impact the results. If tested too early after exposure, the test could be negative, and if tested too late, the test could be negative. In addition, many individuals are asymptomatic or mildly symptomatic, making the decision regarding testing even more challenging (Binnicker, 2020).

For the few camps that tested for COVID-19, they developed a specific testing pattern. Some camps tested only on day of arrival; other camps tested on day 7 of quarantine and then again on arrival day (day 14); some camps tested throughout the camp experience, with some individuals getting tested 5–7 times during the summer season. An even smaller number of camps tested as part of the screening process, prior

to or upon arrival, and to diagnose when someone presented with COVID-19 symptoms.

As of the publication of this guide, more testing is becoming available, and the first at-home test has been approved (i.e., December of 2020). Companies may also be available to provide COVID-19 testing and education for camps. Vaccine dissemination is now in progress, but it is unlikely that many campers (and maybe staff) will have access before the 2021 summer camp season. Therefore, identifying a testing plan will be helpful for camps in preparation for summer 2021.

Conclusion

Many camps were able to successfully implement NPIs needed to provide a safe and enjoyable camp experience, an important part of the lives of many children, teens, and staff. ACN's research into the use of NPIs in camps during the summer of 2020 indicated that the implementation of NPIs resulted in fewer visits to health centers and a decreased number of sick campers when compared to previous camp seasons. Overall, NPIs helped to minimize COVID-19 transmission as well as the transmission of other childhood illnesses (i.e., common cold, gastroenteritis). This data affirms that, even in the absence of a global illness, NPIs, when implemented with fortitude, can deter illness in community-based environments. Access to these many creative strategies can be used in future camp experiences and hopefully provide guidance for dealing with a variety of potential communicable illnesses. Health and safety are the goals for staff and campers, and through these NPIs, we feel confident that many illnesses can be reduced in day and residential camp settings in the years ahead.

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Steps in Developing a Communicable Disease Plan

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Introduction to Communicable Diseases in Camp

Communicable diseases (CDs) are conditions that may spread from one individual to another and are sometimes called “infectious” or “transmittable.” The most common are bacteria, viruses, fungi, and protists. These elements infiltrate the human body via different routes causing a variety of symptoms that can then be passed to other individuals if not controlled (Edemekong & Huang, 2020).

Camps historically have had to manage an array of CDs, including H1N1, measles, pertussis (whooping cough), influenza, and others (Copeland et al., 2010; Fankem et al., 2014; Schaffzin et al., 2007). Even through these experiences, camps may continue to have challenges in knowing what steps to take for prevention, intervention, and recovery activities for campers and staff.

While research has identified strategies camps can use to reduce injuries and illnesses among campers and staff (Garst et al., 2013), other studies suggest the need for ongoing education within the camp community on communicable disease prevention (Garst et al., In Press). This article outlines steps for developing a communicable disease plan that can be used for a variety of CDs. Our hope is that camps can use this guide to direct essential services, safeguard communities, and minimize transmission risk at camp.

This document is supported by a variety of important and useful resources. Please be sure to access the resources provided at the end of the document for more reading and education.

As we begin to outline the key components of the communicable disease plan (CDP), there are a few important considerations:

1. Everyone at camp needs to be on board with the CDP process and procedures, including leadership, staff, and campers. If we want individuals to use prevention activities proficiently and consistently, the camp will need a process that provides reinforcement and encouragement when individuals are not practicing health and wellness interventions. Public health promotion requires that we appreciate the value of keeping our “neighbors” healthy while limiting the potential introduction and spread of illness within camp.
2. Multiple interventions used at the same time generally produce improved outcomes. For example, the camp community’s experience with the COVID-19 pandemic in the summer of 2020 provided evidence that outlined how multiple nonpharmaceutical interventions (NPIs) were used successfully. Camps created a multilayered approach to NPI usage to marginalize risk, which we

A multilayer approach is essential to marginalize transmission risk.

- will discuss in this planning.
- Health, wellness, and preventive care activities among camp participants and visitors (i.e., handwashing, sanitizing, physical distancing) tend to diminish over time, requiring that we utilize encouragement strategies to maintain a high level of compliance.

We will discuss the different components of a communicable disease plan. Each camp will arrange the elements in a way that works best for their camp structure, operations, and populations served.

Components of a Communicable Disease Plan

A CDP is comprised of four components: (a) Prevention Activities, (b) Supplies and Resources, (c) Outbreak Management, and (d) Communication and Debriefing. When developing a CDP, a camp may decide to outline these elements in different ways. Some camps create the CDP using a chronologic approach from pre-camp requirements through post-camp considerations. Other camps may separate this information categorically, keeping each element in separate categories with less emphasis on time.

Table 1

Methods to Organize a Camp-Based Communicable Disease Plan		
Example 1 (Categorical)	Example 2 (Chronologic)	Example 3 (Mixed Method)
Prevention Strategies	Pre-Camp	Prevention
Supplies and Resources	During Camp	Intervention
Outbreak Management	Post-Camp	Recovery/Mitigation
Communication/Debriefing		

Table 2

Template One Example (Categorical)

Prevention		
	Pre-Camp	
		Strategy One Strategy Two, etc.
	During Camp	
		Strategy One Strategy Two, etc.
Supplies		
	Pre-Camp Collection	
		Supply List/Companies/Cost
	During Camp Usage	
		Supply List/Reorder

Resources		
	Pre-Camp	
		Identification/connection with Resources
		Onsite & External
	During Camp	
		Communication with Resources
Outbreak Management		
	Pre-Camp	
		P&P Development/Review
		Rehearse Procedures
	During Camp	
		Triage/Care/Documentation/Testing
		Transmission Potential/Response
Communication		
	Pre-Camp	Staff Training
	During Camp	Documentation of Care/Media Reports/Collaborating with CD
	Post-Camp	Debriefing Impacted Staff/Campers

The CDP format is an important consideration, as staff training and engagement must follow a logical pattern of operations — and everyone involved must have a solid understanding of steps to take for health promotion. As you establish a plan, identify what procedure seems most appropriate for you and your camp, organize your CDP accordingly, and then train staff on their roles in supporting and implementing the CDP.

I. Prevention Efforts

Prevention activities are those used to help minimize risk of spreading infectious (i.e., communicable) conditions. These activities may vary depending on what the communicable condition may be and how it is transmitted between individuals. Therefore, NPIs may be important to establish and use prior to camp arrival *and* during camp participation. During the COVID-19 pandemic in 2020, camps used an array of activities to help mitigate transmission risk (American Camp Association, 2020).

Seeing an array of prevention strategies in Table 3, we have to consider which of these should be a consistent feature at camp and which might be implemented when public health communications suggest an infectious illness is eminent. What was your camp doing prior to COVID-19? Were you effectively using some of the listed strategies to prevent a variety of communicable illnesses?

Table 3

Nonpharmaceutical Interventions		Pre-Camp	During Camp
1.	Handwashing: Frequent; 20 seconds duration; soap and water or sanitizer with 60 percent or more alcohol	X	X
2.	Sanitizing: Cleaning high-contact surfaces (tables, bathrooms, doorknobs/handles) with appropriate agent that kills infectious agent		X
3.	Cohorting: Maintaining small groups (8–15 people); navigating camp as small group; limiting mixing with other cohorts		X
4.	Ventilation: Moving activities and services outdoors; use of screens, fans, windows open; create circulating air as appropriate		X
5.	Face Masks: Worn when appropriate and if infectious agent is spread by sharing of respiratory secretions	X	X
6.	Screening: Process to monitor individual health status; may be conducted prior to camp, during camp, and post-camp	X	X
7.	Physical Distancing: Process of encouraging spacing of 6 feet or greater between individuals if appropriate for the infectious agent	X	X
8.	Testing: Conduct testing prior to and during camp as a screening and/or diagnostic tool if testing options are available	X	X
9.	Vaccination: Up-to-date immunizations for all staff and campers when possible.	X	
10.	Communicable Disease Team: Educate a preselected team of individuals who would have a critical role in an outbreak should it occur (i.e. healthcare staff, camp director, food service, facilities staff, cleaning staff, media communications)	X	

(Erceg, 2020b; Gaslin, 2020)

Each camp will make decisions about ongoing prevention activities, but we do encourage *handwashing, sanitizing, ventilation, screening, and vaccinations* for all camps at *all times* when possible and appropriate. Each of these elements will help individuals arrive to camp healthy and hopefully remain healthy during the camp experience. In situations where a communicable disease may be developing, incorporating more stringent activities (e.g., cohorting, face masks, physical distancing, testing) may be helpful for prevention.

II. Supplies and Resources

A second important consideration is to identify your resources and procure supplies you might need for a communicable disease situation. Supplies include items that help to

minimize bacterial, viral, or fungal transmission or growth on surfaces. As with COVID-19, the Centers for Disease Control and Prevention (CDC; [cdc.gov](https://www.cdc.gov)) and the Environmental Protection Agency (EPA; [epa.gov](https://www.epa.gov)) provide information about the most effective agents to use in killing microorganisms that may cause illness. Different communicable illnesses may call for different sanitizing agents. Therefore, we should look for resources from these two agencies for each communicable illness to appropriately clean camp facilities. Best practices for using sanitizing agents include the following:

1. When possible, clean a surface with soap and water first. Removing dirt and grime from surfaces will allow better penetration of the sanitizing agent afterwards.
2. Apply sanitizer and allow it to remain on the surface (i.e., tables, bathrooms, sinks) as recommended by the product manufacturer. In many cases, the sanitizer works better by having extended contact with the surface.
3. Make sure there is adequate ventilation with some cleaning agents to avoid potentially harmful fumes. Follow the product manufacturer recommendations.
4. A cleaning and sanitizing schedule is often determined by the frequency of use. The more frequently areas of camp or supplies are used, the higher the risk for transmission between individuals, because everyone is touching the same elements. An increased cleaning schedule is encouraged for high-touch areas identified by each camp. These usually include items like dining hall tables, door handles, and bathrooms. Cleaning in activity areas between uses by each group should be considered as well.

Cleaning and sanitizing should be done frequently and in high-touch areas.

In addition to sanitizing agents, other supplies are needed to prevent disease transmission. The camp should establish a supply list and monitor volume/usage for future planning. Consider the need for gloves, face masks, gowns, and goggles (or other eye protection) for individual protection. Paper products (i.e. paper towels, cleaning towels) become important supplies with increased cleaning. Be sure to include these helpful products in your supply list.



Figure 1: Sanitizing Products and Protection Supplies

III. Internal and External Supports

A second preparatory activity is to identify and arrange resources for the care of campers and staff. During stressful experiences like a communicable disease outbreak, individuals may need additional education and support. Camps may identify on-site resources, however, external resources can provide additional services as needed. In particular, individuals may need mental, emotional, or social health (MESH) intervention. If a camp decides to have additional resources available on site, there are important steps to consider.

1. Identify on-site support services that might be essential:
 - a. Mental health or behavioral health support
 - b. Additional healthcare staff
 - c. Mentoring staff
 - d. Cleaning support
2. Create a job description for each role that clearly outlines the responsibilities of the position.
3. Create a written orientation plan for each role and have the trainer and trainee sign the orientation plan when completed to verify all training topics were covered. This document is often overlooked as an important step in creating a successful role transition. Unless you establish written goals of the position (job description), it is challenging to hold individuals accountable and determine if they met the expectations of the role.
4. Have a plan for camp leadership to conduct frequent checks on individuals filling the new role and provide coaching (i.e., reinforcement and/or re-education of the role) to ensure successful performance.

In addition to potential on-site resources, a camp should consider having a well-established link to external support systems. A helpful tool is to have a resource manual (hard copy or digital) that can be accessed for use in times of need. For many external organizations, it is best to connect with these resources prior to needing their assistance.

External resources to consider include:

- Suicide Prevention Hotline
- Crisis Intervention Hotline
- Public Health Department/Public Health Officials
- Local Urgent Care Center
- Emergency Room
- Communicable Disease Testing Sites
- Local Pharmacy
- Local Mental Health Services (Psychiatrist/Psychologist/Counselors)

**National Suicide/
Crisis Hotline**
800-273-8255

**American Camp
Association Hotline**
800-573-9019

**Association of Camp
Nursing Health Hotline**
502-830-8393

- American Camp Association Camp Crisis Hotline
- Association of Camp Nursing Health Hotline

Other than the national hotline numbers, it is helpful to take a proactive approach in developing a relationship with external resources. Contact these resources prior to the start of camp and share information about the camp and what your potential needs might be.

Example: *Hello, Dr. Pediatrician. I am Camp Nurse Nancy at Camp Joy, and I am calling to share that we will be having camp in your area on the dates of _____. We sometimes have children who become ill, and we may need to connect with you for evaluation and treatment. Is this a possibility? What will you need from us as a camp in order to receive care or medication for an individual staying with us at camp? Our phone number is XXX-XXX-XXXX, and our address is _____. We appreciate your time and hope that if a camper experiences an injury or illness, we can partner with you to provide appropriate care.*

Supplies and resources are critical elements for managing communicable diseases. Document these processes in your CDP. Identify suppliers, their websites, phone numbers, and process for ordering needed sanitizer and paper products. The same is also important for resources. Identify potential resources, including name, website (if applicable), email, and phone numbers for ease of access. The middle of an emergency is *not* the time to try and locate external support services.

Collaboration is the process of partnering with others to produce outcomes that are mutually beneficial. Collaboration is the responsibility of both parties – the camp and the supplier/resource. We must do our part to provide education and information to potential partners if we desire their support in a potential camp crisis.

Table 4

CDP supplies

Product	Supplier(s)	Phone	Website	Process/Notes/ Expense

Table 5

External Resources

Resource	Phone	Email	Website

Managing Illness and Outbreaks

The crux of communicable disease planning is outbreak management. Our greatest concern is that we know what to do in the event multiple camp participants demonstrate illness symptoms of a similar nature. We need to respond in a way that we provide adequate and appropriate care while also preventing others from becoming ill.

At camp we live in tight quarters, eat closely together, spend extended hours with one another, and often share bathroom facilities. A camp is a community-based experience that requires us to care for not only the individual, but also the population at large. Therefore, we must consider each of these encounters and how we might conduct prevention activities while concurrently intervening with those who are ill. We discussed potential prevention activities earlier that can help minimize transmission of illness, and these prevention strategies are also *part of outbreak management*.

Let's begin with the one child who presents with "illness symptoms." A variety of symptoms can be contagious — cough, sore throat, congestion, skin rashes, nausea/vomiting, diarrhea, and others. Many general illness symptoms can be caused by a communicable illness, so it is better to isolate a person with questionable symptoms than potentially expose the camp population (Erceg, 2020a). Follow these steps:

1. Camper Sally presents with cough and congestion. She is placed in isolation and becomes the "index case."
2. Conduct a thorough nursing assessment of the individual and close contacts of the ill individual (cabinmates, counselors). If any close contacts have similar symptoms, consider isolating them as well. Check everyone's immunization status.
3. If a camp has several individuals exhibiting similar symptoms, activate your communicable disease team and outbreak plan.
4. *This is the step where camps take different paths.* The path chosen is based on



Figure 2: Outbreak Plan #1

the capacity of the facility. For a camp that has robust health services, they may be able to maintain and manage ill individuals on site. For camps that operate a more lean experience, ill individuals may be sent home for evaluation and care. Develop an algorithm that guides the camp's steps in managing an outbreak.

Once camps arrive at Step 4 (launching the CDP), a variety of activities need to be initiated. These events typically occur simultaneously. They include:

1. Confirm that the CDP team understands their responsibilities and roles. The team should include camp leadership, facilities staff, food service staff, and healthcare staff. At this point, any external resources that you have conferred

with prior to the start of camp (public health, urgent care, ER, mental health support) should be put on alert and given notification of the camp's illness status as appropriate.

2. Confirm that you have isolation space for all ill individuals or how you are going to make additional space (i.e. put up tent, use empty cabin). It is best if these individuals have their own bathroom facilities.
3. Does the camp nurse or other healthcare staff need help? Who will that be? Do counselors become healthcare support staff, or do you have support from external sources "on call" for assistance?

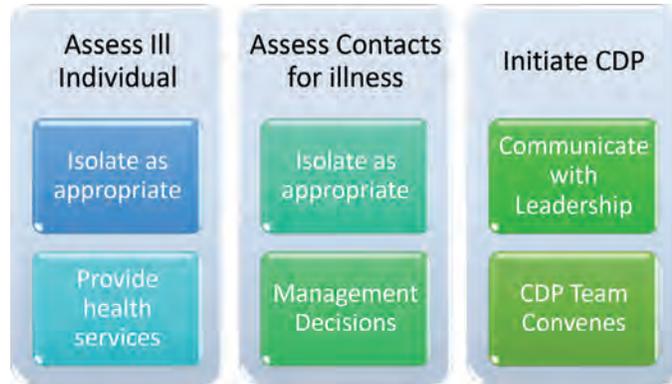


Figure 3: Outbreak Plan #2



Figure 4: Outbreak Plan #3

4. Assign a person(s) to assist with documentation. There will be much required documenting of activities, care, services, and communication, and the healthcare staff will not be able to do it all. Sometimes assigning someone to be a scribe is a great help to the nurse and other healthcare providers who may not have the time to document during the event(s).
5. How will ill campers and health staff get fed? What is the plan for food to be delivered to these individuals without increasing the risk of transmission?

Creating documentation practices that save time and promote organization will be key in an outbreak.

6. What is the process for washing linens and sheets? Do the facilities staff need to take extra precautions when handling the laundry for the isolation areas or health center? What is the plan for cleaning the isolation areas or health center?

7. Designate your communications person for media and families. Make sure this individual has good public relations skills, and that any media statements and communications are carefully crafted and agreed upon by camp leadership.
8. Don't forget about the unaffected individuals still participating in camp. The show must go on for the well individuals wanting a fun camp experience. Consider dividing staff in a way to keep some with the well campers and others

serving in support roles with the ill individuals. Avoid crossover between these staff to minimize any transmissible illness (Erceg, 2020b).

The CDP team may look something like the organizational chart shown in Figure 5.

Once the CDP activities are in operation, communicating frequently and in an organized manner will be helpful to make sure the needs of individuals are being met. The camp director will play a critical role in making sure the CDP team is working in a coordinated manner.

Communication and Debriefing Following a Communicable Disease Event

Communication becomes the link to a successful operation. When individuals become part of a significant team effort, they want to do their best. The primary mechanism of goal achievement is through a consistent feedback loop. If we are doing good work, hearing affirmation of our efforts helps encourage us to continue. If our actions are not achieving the desired results, constructive feedback can help us refocus and take a different approach to our services. This communication and interaction loop is most often led by the camp director. As the leader, the camp director must consciously and consistently ask questions, inquire about processes, and determine where we can continue to improve.

Whoever is filling the leadership/coordinator role should carry paper and pen, write down responses from staff, and identify areas of weakness and/or growth that can make a

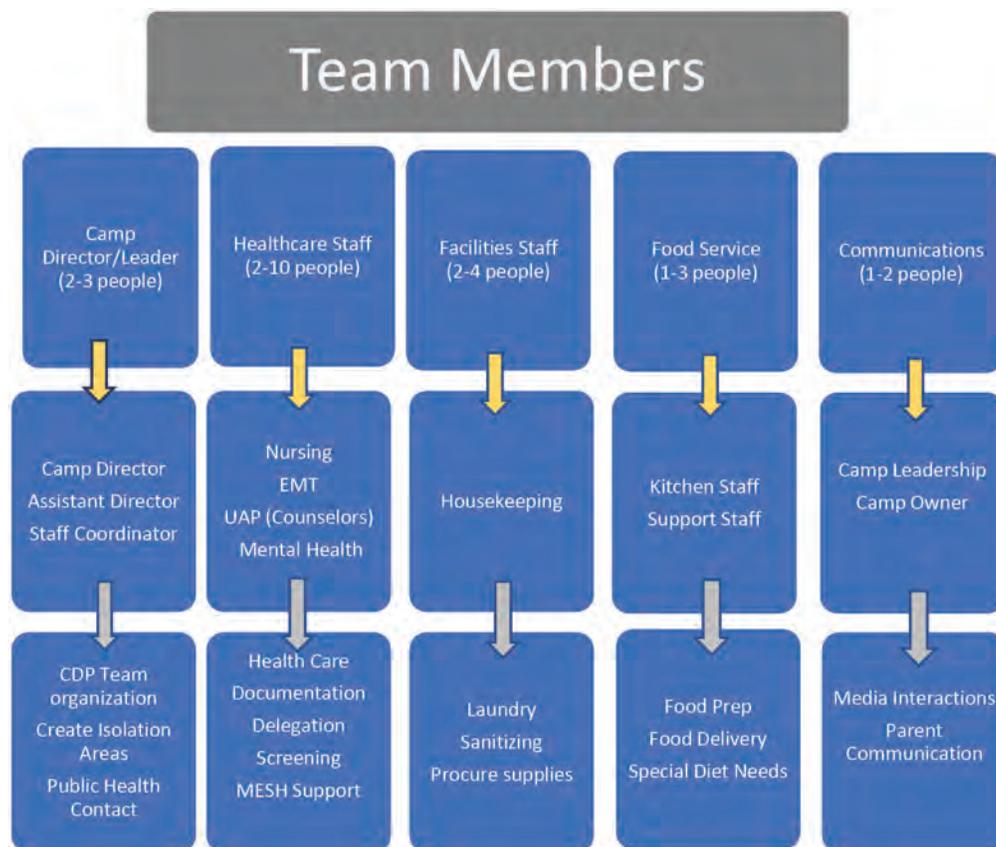


Figure 5: CDP Team

difference for everyone at camp. It is important to not only address the needs of the ill individuals and staff caring for them, but also of the well campers and staff who will continue to need guidance and support. They need to see the camp director on site, as this instills confidence in their efforts to promote a positive experience.

As you work through a communicable disease event, debriefing becomes an important activity for everyone impacted. The camp director and/or mental health support (if available on site) can begin to conduct debriefing sessions. Debriefing after a significant health event is considered trauma debriefing or critical incident debriefing. These communications are aimed at dealing with the psychological impact of critical events. The debriefing allows individuals to process the event and reflect on its personal impact (Davis, 2013).

Critical events can impact individuals in different ways. How the event is internalized often drives the emotional response or concerns that arise. To be therapeutic and meet the needs of individuals at camp, debriefing should occur on site or nearby and encourage the sharing of emotions or thoughts related to the communicable disease event. Debriefing should begin as soon as possible after the CDP is operational — and hopefully within 72 hours of the initiation of the event (Davis, 2013). Ideally, the camp should work through difficult emotions in a helpful and organized way instead of having individuals share their experiences via social media, with friends, or with others who should not have access to sensitive information.

Conclusion

Creating a CDP requires time and intention. Proactive consideration is the first, and maybe most important, step to having a well-constructed plan to provide care to ill individuals in a camp environment. Each camp's CDP will be unique, because each camp has different facilities, capacities, staffing, and access to internal and external supports. When developing your CDP, consider what you are able to accommodate. Some camps may have limited space and time, and their plan could be to send individuals home. Other camps operating robust programs with large numbers of campers may have the capacity, staff, and housing to provide on-site communicable disease care. Regardless of camp size, scope, or capacity, each camp can and should establish a CDP that works for them.

Once the CDP is in place, share the plan with your public health officials, parents and guardians, and other external sources who may be able to provide feedback about how they can best support your on-site care efforts. Communication and coordination produce excellence in care. Here is your chance to make a real difference.

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Testing Considerations for SARS-CoV-2 in Summer Camp Settings

Laura Blaisdell, MD, MPH, FAAP

A major challenge of the COVID-19 pandemic has and continues to be our ability to effectively, efficiently, and economically test for the presence of SARS-CoV-2 in both symptomatic and asymptomatic individuals. The marketplace for testing has exploded, with companies having taken the initiative to develop new and advanced testing options. These testing tools give us the opportunity to better identify individuals who may be an infectious risk to others, especially in community-based environments. This article outlines helpful information about communicable disease testing, in particular, testing for COVID-19. This information will provide guidance for summer camp 2021 and will be a great resource in the event future communicable illnesses must be addressed in camp settings.

Types of Testing: Why We Test for COVID-19

When we think about COVID-19 testing, most people consider testing as a means to arrive at a diagnosis. However, in the public health realm there are many reasons why we test an individual or populations. Diagnostic testing is done when an individual has symptoms and we want to determine if the symptoms are correlated with a communicable illness like COVID-19.

There are other reasons for testing.

- **Mitigation testing** is conducted on an as-needed basis on potential cases to contain transmission. By testing anyone who is either symptomatic or asymptomatic, but had a close, prolonged contact with a confirmed or suspected case, we may be able to prevent a disease from being shared with other individuals.
- **Screening testing** is done for individuals without symptoms or without known exposures, who either work or live in environments that put them at higher risk for the contraction or transmission of illness. Examples of screening environments include nursing homes, elective operations facilities, schools, or summer camps.
- **Surveillance testing** is a newer, population-based testing development in that COVID-19 pandemic samples are periodically or regularly taken from a percentage of the population or segments of a population to look for the presence of illness.

Types of COVID-19 Tests

The number and type of available tests and criteria for use continue to evolve due to a rapid review process by the US Food and Drug Administration (FDA) under their Emergency Use Authorization (EUA) program. While a range of testing options become

Table 13.1 Adapted from the US Food and Drug Administration Coronavirus Testing Basics Fact Sheet

	Molecular Test	Antigen Test	Antibody Test
Synonyms	PCR, RT-PCR diagnostic test, viral test, NAAT, LAMP	Rapid diagnostic test	Serological test, blood test, serology test
Sample collection	Nasal or throat swab Saliva	Nasal or throat swab	Finger stick or blood draw
Time for results	Same day (some locations) or up to a week	One hour or less	Same day (many locations) or 1 to 3 days
Follow-up testing	Not usually	Without symptoms: Positive requires PCR Negative – none With symptoms: Positive – varies by state may require PCR Negative – requires PCR	Most states require positive antibody tests be followed up with PCR to rule out current infection. Sometimes a second antibody test is needed for accurate results.
Test results	Active coronavirus infection. Past infection as much as 3 months ago.	Active coronavirus infection.	Infected by SARS- CoV-2 in the past.
Test does NOT	Show past SARS- CoV-2 infection.	Detect low viral loads which may occur during early stages of infection.	Diagnose active SARS-CoV-2 infection Cannot confirm that you did or did not have SARS-CoV-2
Note	Tests can remain positive weeks after infection due to continued shedding of viral RNA.	Test approved by FDA generally are for use on symptomatic people, who likely have high viral loads. Use on asymptomatic people as a screening tool is essentially an “off label” application of the test.	Does not diagnose infection.

Examples of tests	Lab Corp Quest Diagnostics National health services tests Lucira (at home test)	Abbott IDNow Quidel Sofia 2 BD Veritor Ellume (at home test)	Thermo Fisher OmniPATH COVID-19 Total Antibody ELISA Test
FDA	US Food and Drug Administration		
PCR	polymerase chain reaction		
RT-PCR	reverse transcription polymerase chain reaction		
NAAT	nucleic acid amplification test		
LAMP	loop mediated isothermal amplification		

Environmental Health & Engineering, 2020.

available, a limitation of these tests is a lack of rigorous review before being allowed into the marketplace. Tests that have limited evidence to support their performance (sensitivity and specificity) complicate the ability to interpret the test results.

At the time of writing, there are three general types of tests for COVID-19: molecular, antigen, and antibody. Table 13.1 of the American Camp Association (ACA)'s *Field Guide for Camps on Implementation of CDC Guidance* lists factors related to the use of molecular, antigen, and antibody tests for camp attendees.

Molecular Tests

Molecular tests for SARS-CoV-2 are rapidly increasing. When the COVID-19 pandemic began, reverse transcriptase PCR (RT-PCR) tests were the first molecular tests to be developed and widely deployed. They remain the primary tool for diagnosis, mitigation, and screening. The numbers and types of available SARS-CoV-2 nucleic acid detection tests (NAAT) are rapidly increasing and now include, in addition to laboratory-based RT-PCR, rapid RT-PCR and RT-LAMP. These rapid tests have been developed for use in nonlaboratory settings.

The Infectious Disease Society of America (IDSA) currently recommends NAAT (specifically RT-PCR) for testing of all symptomatic individuals suspected of having COVID-19. Additionally, the US Centers for Disease Control and Prevention (CDC) and state public health agencies generally require RT-PCR-based testing, including as confirmation following antigen, antibody, or other screening methods.

Molecular tests are typically collected using a swab sample from the back of the nasal passage or back of the throat (e.g., nasopharyngeal, oropharyngeal, or nasal mid-turbinate). Saliva samples are also used for some tests, but nasal swabs are far more commonly used.

Considerations in use of standard RT-PCR include:

- Testing results are indicative of exposures three to five days prior to the testing day.

- False negative results can be obtained due to improperly collected sample, post-testing exposure, or testing too soon after exposure.
- Discomfort with collection samples; typically, nasopharyngeal is the most uncomfortable.
- Time from collection to results is highly variable, ranging from two to seven days depending on the laboratory.
- Cost of testing can be high, and it's not always covered by insurance.
- Supply chain shortages have been known to occur.
- Test must be conducted under the supervision of a qualified healthcare professional. Self-swabbing is increasing and home testing is increasing.
- The first at-home molecular test (Lucira) has received emergency use authorization (EUA) for molecular COVID-19 testing at home.

Antigen Tests

Because molecular RT-PCR often requires specialized materials, equipment, personnel, and transportation to a centralized laboratory, interest in rapid antigen tests for SARS, CoV-2 has been high since the beginning of the pandemic. The rapid antigen tests are most often a test for the SARS-CoV-2 N protein, are relatively inexpensive and can be used at the point of care. Most rapid antigen tests are swab samples taken from nasopharyngeal or mid-turbinate samples.

A RT-PCR test may be necessary to confirm an antigen test result.

Post-market studies of rapid antigen tests have shown variable testing characteristics. Antigen tests are generally less sensitive than RT-PCR or other NAATs for detecting the presence of viral nucleic acid. The clinical performance of antigen tests largely depends on

the circumstances in which they are used. The “gold standard” for clinical diagnostic detection of SARS-CoV-2 remains NAATs, such as RT-PCR. Thus, it may be necessary to confirm an antigen test result with a NAAT, especially if the result of the antigen test is inconsistent with the clinical context. An antigen test was just released through EUA for at-home testing (Ellume). If this test returns positive, the recommendation may be for repeat testing with RT-PCR to confirm the results.

Table 1. Summary of Some Differences between Nucleic Acid Amplification Tests and Antigen Tests Interim Guidance for Antigen SARS-CoV-2 | CDC | cdc.gov

	Nucleic Acid Amplification Tests	Antigen Tests
Intended Use	Detect current infection	Detect current infection
Analyte Detected	Viral Ribonucleic Acid (RNA)	Viral Antigens
Specimen Type(s)	Nasal, Nasopharyngeal, Sputum, Saliva	Nasal, Nasopharyngeal
Sensitivity	Varies by test, but generally high	Moderate
Specificity	High	High
Test Complexity	Varies by Test	Relatively Easy to Use
Authorized for Use at the Point-of-Care	Most are not, some are	Most are, some are not
Turnaround Time	Ranges from 15 minutes to >2 days	Ranges from 15 minutes to >2 days
Cost/Test	Moderate (~\$100/test)	Low (~\$5-50/test)

A summary of the differences between NAATs and antigen tests can be found at www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html. Analytic performance may differ from overall performance when considering issues of test availability, quality of specimen collection and transport, and turnaround times of results.

The sensitivity of antigen tests varies but is generally lower than most NAATs. The antigen level in specimens collected either before symptom onset or late in the course of infection may be below the test's limit of detection of virus. This may cause a negative antigen test result, while a more sensitive test, such as most NAATs, may return a positive result.

The specificity of antigen tests is generally as high as most NAATs, which means that false positive test results are unlikely when an antigen test is used according to the manufacturer's instructions. Despite the high specificity of antigen tests, false positive results will occur, *especially when used in communities where the prevalence of infection is low* — a circumstance that is true for all in vitro diagnostic tests. CDC considers low prevalence to be when NAAT positivity over the last 14 days is less than 5 percent or when there are fewer than 20 new cases of COVID-19 per 100,000 persons within the last 14 days, which is likely in the camp setting. In general, the lower the prevalence of infection in the community, the higher the rate of false positive test results.

Clinicians and public health practitioners should understand test performance characteristics to recognize potentially false negative or false positive test results and guide additional confirmatory testing and patient management. Laboratory and testing professionals who perform antigen tests should understand the factors that affect the accuracy of antigen testing. Clinicians, laboratory and testing professionals, and public health practitioners should also understand the differences among diagnostic, mitigation, screening, and surveillance testing.

Antibody Tests

Serology, or antibody testing, for SARS-CoV-2 is conducted by collecting a blood sample from a small finger prick to see if a person's immune system demonstrates a response to the virus. Currently, it is unknown whether a positive antibody test can affirm that a person has immunity and will be protected from infection or reinfection with COVID-19. Other unknowns include how long antibodies to SARS-CoV-2 remain in the body, what level of detected antibody determines immunity, and how long immunity might last. The antibody test alone is not useful as a screening tool to determine potentially infective people, or those who have long-term immunity. The application of antibody testing in camp settings is not recommended. Antibody testing can be effective in certain clinical settings and in wide-scale population studies, but not for screening to identify potentially infectious cases (Environmental Health & Engineering, 2020).

Location of Testing

Camps have options for where the laboratory services and testing can be conducted. COVID-19 testing services are expanding and can include centralized testing sites, provider offices, urgent care centers, and other community locations. Camps may send testing out to a laboratory (either local or mail-away), hire a testing service to come to camp, or personally conduct on-site rapid testing. This last option requires a camp to apply for a Clinical Laboratory Improvement Amendment (CLIA) Certificate of Waiver to perform FDA-waived tests in the nonlaboratory setting. If using a laboratory or a testing service, those facilities should have their own testing certificate, and a camp should consider asking about their level of certification.

For more information about the CLIA Certificate of Waiver, see <https://www.cms.gov/regulations-and-guidance/legislation/clia/downloads/howobtaincertificateofwaiver.pdf>.

Who Pays for Testing

Payment for COVID-19 testing depends on the situation for testing (diagnostic vs. screening); testing availability and type; federal and state regulations; and individual insurer policies, among other factors. Under Families First and the CARES Act, plans and insurers must cover FDA EUA COVID-19 tests without cost-sharing. The federal government reasons that Section 6001 of the CARES Act requires the coverage of items and services only for “diagnostic purposes.” Diagnostic purposes extend to those with symptoms of COVID-19 as well as asymptomatic people who have been exposed. In these instances, a healthcare provider would still have to determine that a diagnostic test was medically appropriate.

The federal government draws a line at “testing conducted to screen” for workplace health and safety (like an employee return-to-work program), for public health surveillance, or for any purpose not primarily intended for individualized diagnosis or treatment. The guidance documents note that these tests fall beyond the scope of Section 6001 at this time. It is unclear what changes may be supported in upcoming legislation. Therefore, the camp testing plan should investigate if the expense of testing can be shouldered by attendee insurers, be a shared expense between families and camp, or if the camp needs to shoulder the full cost of testing alone.

Day Camp Considerations

The day camp environment is more likely to reflect local rates of COVID-19, and as such, screening and surveillance testing may have a lesser role than diagnostic and mitigation testing. Like day schools or workplaces, all attendees commute and return home each day, making testing representative only of the current status at the time the test is carried out. Diagnostic and mitigation testing can be coordinated with local public health officials and healthcare providers. Screening and surveillance plans for day camp populations are under debate. Decisions regarding testing may be influenced by the community rates of COVID-19 (see ACA’s *Field Guide for Camps on Implementation of CDC Guidance* for more information).

Testing Strategies for Overnight Camps

As outlined in the ACA's *Field Guide for Camps on Implementation of CDC Guidance*, testing scenarios are relevant to camp programs:

1. Pre-screening testing carried out within seven days (or preferably 72 hours) prior to arrival at camp
2. On-site screening/testing conducted upon arrival at residential camps or prior to day camp arrival

Pre-screening Testing

Pre-screening test results should be reported to the camp Health Center.

Testing prior to camp is considered “pre-screening” testing. If pre-screening testing is conducted, results should be reported to the camp health center or administration before the first day of camp to allow for confirmation of test type and negative result. Tests must be scheduled with sufficient turnaround time to allow for

results to be assessed prior to travel (note that some test results can be delayed by several days). Pre-camp testing of all campers and staff is strongly recommended for overnight camps. When available and results can be obtained quickly (i.e., less than 72 hours), RT-PCR tests are considered the most sensitive for identifying cases early in infection and are generally used in most screening programs. The at-home Lucira test would be a good option in this case, as it is an RT-PCR test and you receive results within 30 minutes. This test still requires a prescription, so a camp must logistically determine how to get prescriptions for individuals they wish to test.

- Good practice: Campers and staff are tested at home within seven days of travel to residential camp. Low-risk behaviors are advised after testing and prior to camp.
- Better practice: Campers and staff are tested within 72 hours of arrival at camp, where available. Low-risk behaviors are advised after testing and prior to camp.
- Best practice: Campers and staff are tested within 72 hours to seven days of arrival at camp, where available. Low-risk behaviors are advised after testing and prior to camp. After arrival at camp, campers and staff are retested after three to five days to capture potential travel-related exposures.

Note: Some states may require a 14-day post travel quarantine period based on several factors, including the community transmission rate of the traveler's home area.

On-site Screening and Diagnosis

Testing upon arrival at camp is considered on-site screening and is recommended for overnight camps if resources allow. Camps may then use the same on-site equipment and processes for diagnostic testing of symptomatic attendees. Camps may be able to obtain testing supplies and laboratory relationships that make on-site RT-PCR and/

For More Information

See CDC's Overview of Testing for SARS-CoV-2 at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html>

Testing Strategies for SARS-CoV-2, at <https://www.cdc.gov/coronavirus/2019-ncov/lab/faqs.html>

FDA's FAQs on Testing for SARS-CoV-2 at <https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/faqs-testing-sars-cov-2>

or rapid antigen testing feasible. Camps may also be able to use the at-home testing options at camp to achieve quick results and financially be able to screen every staff and camper upon arrival and when needed.

Camps performing on-site testing should understand test performance characteristics in screening and diagnosis to recognize potentially false negative or false positive test results and to guide additional confirmatory testing and patient management.

If camps develop capacities for testing, the following best practices may be achieved:

- For overnight camps lasting more than three days, campers and staff could undergo RT-PCR testing on site after approximately three to five days to allow for identification of potential travel-related exposures.
- For overnight camps lasting more than three days, campers and staff could undergo rapid on-site screen testing, such as antigen tests (Ellume), or using mail-in samples after approximately three days to allow for evaluation of campers and staff with symptoms that could be consistent with COVID-19.
- Staff at overnight programs who leave camp for weekend trips or other off-facility activities should be tested after three to five days upon arriving back at camp.

It should be noted that all campers and staff must wear face coverings while waiting to be tested, keep physically distanced from all individuals, and adhere to the strictest and most diligent NPIs until testing status can be obtained. For more information about mitigation and surveillance screening, see the *Field Guide for Camps on Implementation of CDC Guidance*.

Testing is an important and helpful tool to identify and potentially isolate infectious risks. At present, screening and diagnostic testing are considered another nonpharmaceutical intervention (NPI) and should be used in conjunction with the full array of other NPIs. It would be helpful to determine your camp's capacity for testing and include your testing plan as part of your communicable disease plan. Communicable diseases will continue to be a challenge for camps and other community-based experiences. Understanding the role of testing will help us broaden our prevention efforts and promote a healthy camp environment.

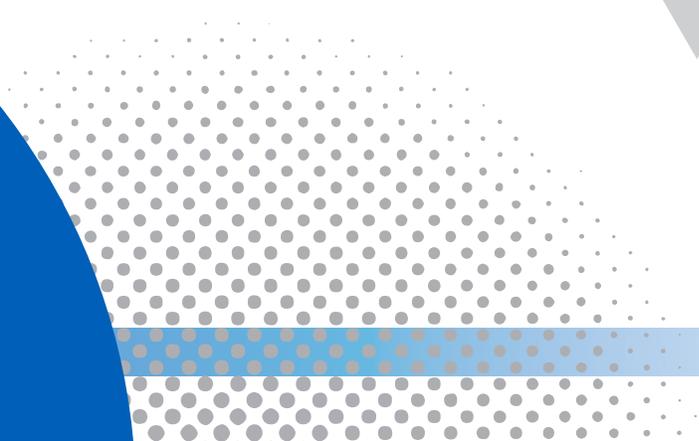
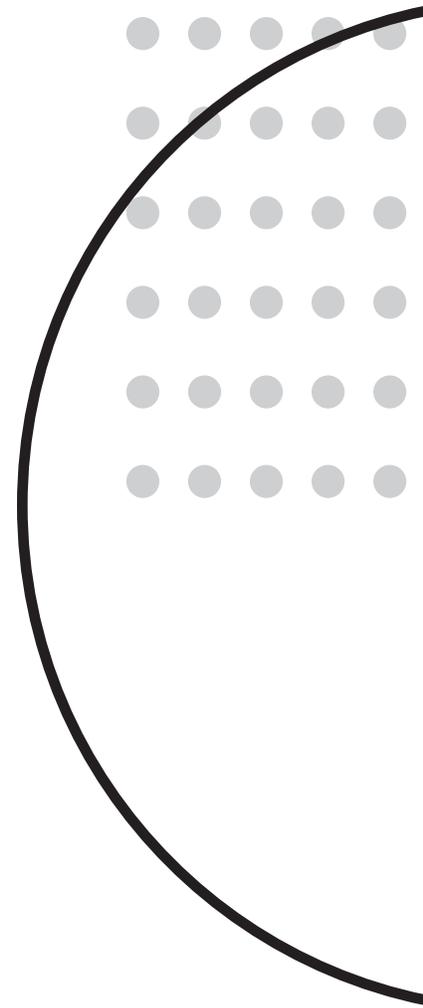
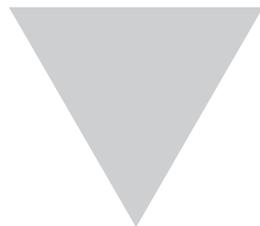
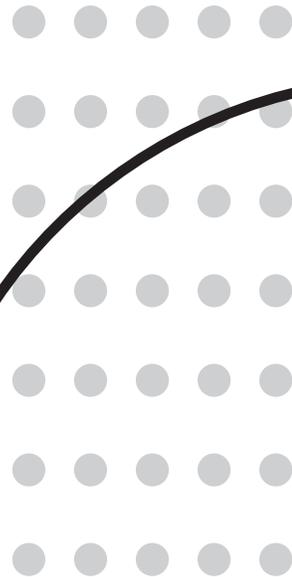
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Mental, Emotional, and Social Health Guidance



The Age of Trauma: Finding Hope and Healing at Camp

John Hamilton, MA

Throughout my childhood, I spent hours, summer after summer, jumping off the white wooden dock on the shores of Swanzey Lake in New Hampshire. My mind is filled with memories of splashing water, smiling faces, and friends encouraging each other. These thoughts provide me with an emotional rush of gratitude.

When I was 12, these memories were threatened as emotions stretched to new heights. Four days into a two-week camp, I woke up in my bunk and saw spots all over my stomach and legs.

One of my cabin mates asked, “What’s the matter with you?”

My counselor quickly encouraged me to see Nurse Emma to find out what was wrong. While everyone else went to breakfast, I remember sitting quietly outside her office. After distributing all the morning medications, she walked up the granite steps and through the wooden screen door, which slammed behind her. She took my temperature and scanned my skin. Then she looked me in the eye and said, “This isn’t chickenpox, but I don’t know what’s wrong with you.”

I’ll never forget the curiosity and pain from that simple statement.

Both my parents are nurses. I was a wild child — played hard — and had countless injuries that occurred while at camp. I was even rushed to the hospital in an ambulance after splitting my head open on the tailpipe of a bus — but that’s a story for another time. The physical pain I felt and the scars that remain from many of these physical injuries pale in comparison to the mental and emotional scars from the summer of 1994.

After giving me a dose of diphenhydramine, Nurse Emma said she would check back in with me before dinner to find out more about what was wrong. I repeated her words countless times during the day as fellow campers, friends, and counselors asked, “Does the nurse know what’s the matter with you?” By the time our all-camp night game commenced, I was at Cheshire Medical Center’s urgent care due to fear of the unknown.

What is not visible leaves a different kind of wound.

In her defense, Nurse Emma couldn’t have known what was wrong. Many of you are currently scrolling ahead in the article for the diagnosis — part of my point. It took my primary care physician, a dermatologist, and one persistent allergist to find out over the next six months that I had cold urticaria. But my question is, what was Nurse Emma looking for? What was she considering? How might her approach have helped her offer the true care she longed to provide to a hurting child? Rightfully so, what was visible was the focus. But what was not visible left a different kind of wound — an emotional scar from social and emotional stress similar to what many of the children we long to care for are facing today.

The human body is designed to handle some stress. Tolerable stress, such as the first day of kindergarten or climbing a high ropes course, can be positive and help youth develop resilience. Resilience means being able to adapt and cope with stress in a way that helps you get better at bouncing back from challenging and stressful moments (Burke Harris, 2018). However, without the presence of kind-hearted support, a child's stress responses can be detrimental to their overall well-being. When children experience a stressful situation or are exposed to an ongoing stressful environment, the body's natural way of dealing with stress (a fight, flight, or freeze response) can become harmful (Van Der Kolk, 2014). When this happens, something we call "toxic stress" occurs — which can lead to behavioral challenges, sickness, and mental health issues. The same can be true for adults.

Dr. Nancy Liberman, director of child trauma at the UCSF Child Trauma Research Center, validated this when she said, "COVID would be a new adverse childhood experience (ACE) for all of us." ACEs are a term used to describe all types of abuse, neglect, and other potentially traumatic events experienced by individuals under the age of 18 — making the pandemic one of the most complex forms of collective trauma our world has faced.

We can define things by what they mean to us or how we are connected to them. Both matter. The American Psychiatric Association defines trauma as an event, a series of events, or a set of experiential circumstances — from exposure to actual or threatened death, serious injury, or sexual violence (DSM-5, 2013). Trauma has lasting adverse effects on an individual's mental, physical, social, emotional, or spiritual well-being, long-term health ramifications, and can even impact brain development (Perry, 2007; Burke Harris, 2018). These lasting effects leave those of us longing to provide care or aid asking the question, "How do I proceed with care under the current circumstances?"

Trauma-informed care broadly refers to a set of principles that provide the lens through which we see the impact of severe harm on youths' mental, physical, and emotional health. Few spaces reflect the primary care for the basic physiological and psychological needs the way camp does. Having a kind-hearted, caring approach encourages support and treatment for the whole person, rather than focusing solely on treating visible symptoms or specific behaviors. We must think beyond the basic needs of Maslow's Hierarchy and move toward self-actualization with hope.

This is exactly what Camp HOPE America — the first local, state, and national camping and mentoring initiative in the United States to focus on children exposed to domestic violence and adverse stress-related events — is doing. The vision for Camp HOPE America is to break the generational cycle of family violence by creating pathways to hope and healing for children who have witnessed family violence and other forms of complex trauma. Since its inception, Camp HOPE America has used the camping model to rebuild lost hope and increase resiliency in the children it serves. Relationships forged in the camp setting play a crucial role in enhancing protective factors and giving children

exposed to trauma the willpower to avoid repeating the vicious cycle of violence and abuse they have experienced (Gwinn, 2015).

“Hope is not wishful thinking; hope is the single greatest predictor for a life well lived.”

Hope refers to the positive expectation children have toward the attainment of a future-oriented goal. Snyder (2000) described hope as a cognitive-based motivational theory in which children learn to create strategies as a means to attain their desired goals. Hope theory has two fundamental cognitive processes termed “pathways” and “agency.” Dr. Chan Hellman says, “Hope is not wishful

thinking; hope is the single greatest predictor for a life well lived.”

Heading into the summer of 2020, many faced questions about how to proceed and which risks were worth taking. I was honored to witness peers at Camp Hope navigate complexities and put on a COVID-19-safe camp. They utilized nonpharmaceutical

Leaning In To Care

One camper, Mya, faced profound challenges during her week of camp. Not one of them related to the physical ramifications from COVID-19. Many resulted from the compounded trauma in her own life, mixed with the stress we’re all facing as a result of the uncertainties this pandemic has brought about.

When Mya ascended the power pole at the High Adventure course, chants of her name echoed off the surrounding canopy of trees. The ease in which she traversed the first part of the line was astounding. Then in a moment, with a gasp of air, all became quiet. You could hear leaves rustling with the breeze and birds chirping as Mya took a seat, all her weight upon the line. She was held by two of the staff attempting to belay her.

Mya was frozen. The usual coaxing didn’t seem to work. Mya’s body was in a full-blown stress response. It was almost as if there an irregular production of neurotransmitters, dopamine, and serotonin were producing instantaneous catatonia.

Mya let out a scream. Many nearby campers and a couple of counselors were concerned there had been a significant injury, thinking she had hurt her legs. The onsite therapist and licensed clinical social worker were on the scene. Ten minutes later she was on the ground and off the line. Twenty minutes later she was regulated and had gained control of her behavior, emotions, and thoughts in the pursuit of long-term goals. With the encouragement of her counselors, she walked to the golf cart, which transported her to the health center, where she worked with the nurse and clinician to better understand what was really happening underneath the surface.

The following morning, Mya was limping around camp, walking that afternoon, and playing the all-camp game by evening. What seemed to be a major injury was actually a traumatic-stress response.

interventions (NPIs), personal protective equipment (PPE), and *a lot of hope* to create a healthy communal experience. They were prepared to take the necessary precautions for the physical needs on the surface while adjusting to meet the campers' mental, emotional, and social health (MESH) needs beneath. Children thrived — and relationships were nurtured through meaningful, face-to-face connections.

I recently had the privilege of seeing Mya again during a virtual activity. It was evident her hope and resilience had increased from her time at camp. Sure enough, the data from the Hope Research Center's report aligned with our outcome. Despite the traumatic experience and intensity of the incident, with the right care and guidance, Mya's belief in herself, others, and her dreams increased as a result of her time at camp.

As we navigate the current context of ACEs, trauma, stress, and a realization that hope plays a significant role in health and healing, here are a few considerations when caring for individuals (children and adults) at camp:

1. Well-being is always the desired outcome of hope. The more we know about the science of hope, the greater our responsibility to nurture an individual's goals to live a healthy life.
2. Although the camp setting is therapeutic in nature, support is essential. Belief immunizes children from adversity by giving them manageable amounts of choice to mitigate stress and mobilize self-actualization.
3. Be a guide along the "greater" path to healing by helping individuals identify goals, find pathways to achieve their goals, and increase willpower by discerning their motivation.
4. Assess an individual's response to an injury or illness using a holistic biopsychosocial lens that looks beyond the behavior, illness, or injury on the surface.
5. If possible, we highly recommend the support of licensed clinical social workers and certified counselors onsite to provide effective MESH care. They will have the appropriate skill set to debrief with others and promote positive outcomes.
6. Self-care matters. You cannot validate, educate, empower, and support an individual with hope and healing-centered engagement unless you offer this to yourself as well.

Belief in another person is an immunization for adversity.

Given the current reality of our world, we all need to understand the science of hope. Hopeful individuals (children and adults), are able to exert mental energy to their pathways and persevere by self-regulating their thoughts, emotions, and behaviors in pursuit of their desired goal.

Martin Luther King once said, "Everything that is done in the world is done by hope." In an age of trauma, we need to believe in a new path of care. We must consider what lies beneath the surface, the response on the surface, and the holistic being — regardless of what's visible. It's essential to the services we long to provide, vital to the future of those we're serving, and the type of care we desire for ourselves.

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Working with the Mental, Emotional, and Social Health Issues of Campers in the Age of the Coronavirus Pandemic

Bob Ditter, M Ed, LCSW

Some Thoughts Before You Begin

If this pandemic has reminded us of anything, it is that virtual connections, including those made via social media, leave something vital out of the way we as human beings communicate. The pandemic has made it abundantly clear that we listen with more than just our ears, and we talk with more than just our mouths. The way we touch, our physical presence, the look in our eyes, our facial expressions, and the way we hold ourselves communicate with a subtle, yet essential richness we don't miss until we don't have it. This applies equally to children, who need the social stimulation of other kids; the attention of interesting, appropriate, and caring adults; and the sense of belonging that comes from being immersed in a supportive community — all of which is what a positive camp experience provides.

As I think about all the children and teens I've seen at camps across the country in the last 40-plus years and in my psychotherapy practice, I realize that we have it wrong. Most people think of school as essential and camp as elective. What I have come to understand is that *camp gives kids that deep drink of connection, creativity, and inspiration that grounds them and fortifies them for the demands of the school year.* Socialization and deep relationships are not frivolous add-ons for kids. They are the essential core ingredients for building and maintaining a foundation for the growth and maturation young people experience throughout the rest of the year.

Keep in mind that most children will not have had the benefits of being in a socially and emotionally uplifting and connected environment for more than 15 months by the time they come to camp. This is the starting place when it comes to thinking about how best to work with campers: they have lost more than a full year of being in the kind of stimulating, socially rich, growth-inducing experiences both camp and school provide.

Overview

- Normalizing. It is important to remember and to point out to your campers and staff that nothing about this pandemic is or has been normal. *The only thing normal about it is the way it makes us feel* (sad, frustrated, frightened, angry, lonely, etc.).
- One Size Does Not Fit All. The specific kinds and severity of the losses that campers and their families have experienced as a result of the pandemic will vary widely. The impacts of those losses will be uneven and unequal.
- Camp as a Mirror of Society. The pandemic has laid bare the tremendous disparities in food security, housing security, job security, emotional stability,

and overall financial security. It will come as no surprise, then, that different camper populations are going to mirror the rest of society. The more resources and security your particular camper families have had access to, the more likely they will have been able to weather the adverse impacts of the pandemic. The scarcer the resources a given camper's family has had access to, the more likely they will have suffered greater losses and psychological hardship as a result of the pandemic.

- Having a second home in a less-populated area is a very different vantage point for riding out the pandemic than living in a crowded apartment with multigenerational family members sharing one bathroom and with little or no outdoor space to retreat to. Being able to work from home and maintain one's level of income is a very different experience from being a frontline worker who has to face the risk of infection every day — or being suddenly unemployed and fearing the loss of one's home or not being able to feed one's family.
- Get Good Information. You need to get some idea of just how the pandemic has impacted your particular camper population. Having this information will arm counseling and healthcare staff with ways to connect with campers on a deeper level. A sample parent questionnaire is provided in Appendix A.

Common Denominators

1. Universal Loss

Even though the impacts of the pandemic on the mental, emotional, and social health (MESH) of children are uneven, depending on their individual circumstances, *every camper and staff member has lost and will have lost something by the time they arrive at camp*. That loss may be catastrophic — like the loss of a parent, sibling, close relative, or family friend to COVID-19 — or something more subtle, like a loss of innocence or sense of well-being. Indeed, the pandemic has been an unkind reminder of our mortality, and even your campers have been listening to the daily reports of new cases, second waves, and deaths from COVID-19.

2. Universal Helplessness and Loneliness

The pandemic has created an environment of universal uncertainty. Will:

- I get sick?
- Someone in my family get sick or die?
- We have school?
- I be able to see my friends?
- I be able to play sports or my musical instrument or do ballet or just hang out?
- I be able to graduate (from high school or college)?
- I ever get my friend group back again?
- This ever end?

- There be camp, and if there is camp, will it be so different that it won't *feel* like camp?

All this uncertainty has made people feel out of control of their own lives. We have all been experiencing different degrees of *helplessness*, which is one of the two most difficult emotions for human beings to bear. As if that weren't enough, because of the social distancing we've had to practice and the closure of schools, restaurants, and other places of communal gathering, we've also been feeling varying degrees of the *second most difficult human emotion to tolerate* — loneliness. This is the one-two emotional gut punch of the pandemic.

3. Universal Grief

One way to think about the increased social and emotional distress and uncertainty the pandemic has caused is to think about loss and grief. When we lose something that is essential to us, like contact with our friends, the support and closeness of our communities (schools, college campuses, neighborhoods, friend groups), or financial security, we have emotional reactions that are best described as fear and grief.

Grief has many stages, or states, and campers and staff members might be in any one of those stages when they come to camp. (An outline of the various stages of grief appears in Appendix B). Furthermore, campers (and some staff) may not *know* what they are feeling. Given the length of the shutdown and the helplessness and loneliness it has engendered, campers and staff may have become either numb to those feelings or highly anxious (which creates a numbness of its own sort). Either of these reactions — numbness or anxiety — is simply the brain's *attempt to adapt to a threat it cannot see, and a sense of loss and lack of control it cannot tolerate*.

4. Possible Conditions of Campers

We can't predict the exact behaviors or MESH issues that any given camper will present with. However, we do know with a high degree of certainty the conditions that many campers have been living under during the pandemic, and some of the physical states and behaviors that may occur as a result. A sample follows:

- **Low muscle tone.** Campers who have been stuck inside their homes and have not been exercising may have muscle tone deterioration. We can expect campers who have lost muscle tone to also experience a loss of endurance.
- **Overweight.** Because of inactivity and not being able to participate in sports or play outside, some campers will have put on weight.
- **Low emotional "muscle tone."** Because of social distancing, quarantining, and virtual school, many campers will not be used to being in groups of other kids. While most campers will adapt to being back in groups quickly (kids are often more resilient than we give them credit for), some will be noticeably out of practice. Those campers may have trouble:
 - Sharing.

- Respecting others' personal space.
- Being patient with others.
- Tolerating the needs of other campers that compete with their own.
- Listening to others.
- Sharing attention with their counselors or other campers.
- Cooperating and collaborating.
- **“Bored and lonely.”** This is how many children have described themselves during the pandemic.
 - “One day is like another. Sometimes I don’t even know what day it is.”
 - “There’s nothing to look forward to.”
 - “Online school is exhausting! It’s so hard not to get distracted.”
 - “Even in-person school is not like real school. You can’t hang out, and you can’t see people’s faces or reactions.”
 - “I’m not able to get into trouble in school with my friends anymore!”
- **Soaring screen time.** Going hand in hand with less outdoor time and physical activity is the soaring amount of time children and teens have been spending on their devices. The added dimension to screen time is the withdrawal factor. A recent article in *The New York Times* put it well:

“There will be a period of epic withdrawal,” said Keith Humphreys, a professor of psychology at Stanford University, an addiction expert and a former senior adviser to President Barack Obama on drug policy. It will, he said, require young people to “sustain attention in normal interactions without getting a reward hit every few seconds” (Richtel, 2021).

If camp is one of the first out-in-the-world events in a camper’s life, that withdrawal may present as irritability alternating with a need for constant attention and, at times, even listlessness.
- **More deeply connected to home.** As a result of sheltering in place, many campers have had much more time at home with their siblings, parents, and/or grandparents. This can either be a hidden benefit of the pandemic or a stressor. We know there are many cases of unreported abuse because of the rise in tensions in homes where parents may be out of work, some people are sick, someone in the household has a mental illness, or there is simply no outlet for the emotional stress in the family. Getting good information about the campers will help you anticipate what burdens they are carrying to camp and how they might behave once they get there.
- **Separation anxiety.** For many campers, the transition out of their homes where they have been sequestered for more than a year will come with relief and great exuberance, especially initially. For others, it may come with anxiety and trepidation, resulting in some cases of more pronounced homesickness. Remember, too, that a record number of families have adopted a dog or other

pet during the pandemic, which may make leaving the safe space of home even more challenging.

Tips and Skills That Support Camper MESH

Tip 1: Take Time to Connect

If anything, taking the time to establish a relationship with each camper will be even more critical than before the pandemic. *Campers won't listen to you if they don't feel you are truly interested in them and their well-being.* And you can't support your campers and advocate for them if you don't know what influences their world or what their reality has been.

There are many ways to initiate and strengthen your connection to your campers. Listening to them and showing curiosity about their world is central. Do they have a pet at home? (Talking about pets is a great and quick way into the hearts of most children.) What's it been like for them during this pandemic? After all, if we have one thing in common no matter what, it is that we've all been through the same thing — even if our particular experiences may have been different. What have they missed the most?

Playing with your campers is another essential way to deepen your connection. Getting lost in a fun activity with them creates connections quickly. Appendix C is something I call “Keys to Campers,” which is a kind of checklist that helps you track how you are spending time with and getting to know the kids.

Tip 2: Connect Before Your Redirect

Before you correct a camper or request that they stop doing something they shouldn't be doing or start doing something they aren't doing, try to connect with them in some small but personal way. Example: “Hey, buddy? What's up? That looks like a great game you're playing! But right now we are all cleaning up, so I need your help, OK?” There are many ways to validate a camper or appeal to them through your relationship. Doing so helps strengthen the trust between the two of you. Obviously, at times when a camper is engaging in a behavior that is potentially harmful or dangerous, you simply take charge and redirect that child right away.

Tip 3: Name it to Tame it

You can help campers put into words the emotions they may be feeling and *normalize them*. The declarative sentence that appears in the Overview section bears repeating to campers when the time is right: “Nothing about the pandemic is normal. The *only* thing that is normal about this is the way you feel about what's happened to you. It sounds like you are (sad, angry, frustrated, frightened, in disbelief) about (then state the specific loss that camper may have experienced). Why wouldn't you be? I'd be concerned if you *didn't feel that way*, because it would mean something wasn't working right.”

As I've said, a lot of campers will not have identified what they're feeling, and given the universality of the pandemic and its impact on us all, it is a safe bet that many

campers will exhibit behaviors related to those feelings. As they say, “*Name it to tame it!*” If children can’t say what they are feeling, they act those feelings out.

Tip 4: Use the Grief Model

Connecting behavior to feelings can be very helpful for most campers. The more you know about their individual backgrounds and how the pandemic may have impacted them, the more you can help them make sense out of their feelings and the behavior their feelings may be driving. The grief model (Appendix B) can help with this.

Tip 5: Know When to Play and When to Rest

Because of the lack of exercise and social connection most campers will have had, they will all benefit from the activities at camp. That said, many of them will tire more quickly than usual. This will be especially true if they have gained weight or have had less physical exercise during the pandemic. The fatigue will not just be physical, however. Many muscles — physical *and* social-emotional ones — won’t have been used for some time. So, while getting kids into what I call *flow experiences* — where you play with abandon and have so much fun that you forget about the time — you will have to anticipate that your campers will need downtime their first summer back from the pandemic.

Tip 6: Know When to Go “Off Script” and Take a Break from the Program.

Remember that your kids have not had the opportunity to just hang out together for over a year and a half. If your campers are talking and relating and having fun together, maybe that’s not the time to force them to play soccer or take that tennis lesson. Obviously, there is a balance here, but erring on the side of allowing your campers to enjoy one another and savor their time together is a good thing for MESH.

Tip 7: Be on the Lookout for Overstimulated Behaviors

Again, because your campers won’t have had the opportunity to let loose in group play, just being together will be extremely stimulating for some. Be prepared for some silliness or rambunctious behavior. You may even find some campers challenging your authority because they just can’t settle down. This may be particularly true of some kids diagnosed with attention deficit hyper-active disorder (ADHD). Find ways to get them active and give them a safe outlet for their energy, but be careful that they don’t get overtired. When children with ADHD get overtired, they tend to have a much harder time self-regulating.

Tip 8: Sing with Your Campers

Singing is a great way for kids to feel part of a larger group and to get into *flow experience*. It also has a calming effect on kids and adds to the overall spirit of camp. Even if you have to socially distance yourself from one another while in a larger group, singing is a great way to help campers feel like they belong. *Make sure everyone knows the words to the songs!*

Tip 9: Encourage Campers to Support One Another

Since everyone has been through a challenging time with the pandemic, use that common denominator to your advantage. We have probably never had something that has both challenged as well as connected us to such an extent. Acknowledging that the pandemic has been harder for some kids than others is a way of helping them help one another. It is a way to help campers develop empathy and understand what support is.

Appendix D, “NAME It,” provides you with the language to use to acknowledge when your campers support their peers or help or encourage one another — all good character traits!

Tip 10: Have Time for Reflection at the End of Each Day in Small Groups

We don’t give children enough time to reflect on their day or to put into words how they have felt about what they have done. Doing so can increase their individual awareness, strengthen the sense of cohesion in the overall group, and have a calming effect. Some camp counselors call this “roses and thorns” (the good and not-so-good aspects of the day), or “share and care,” and they do it during what they call “flashlight time.” Here are some typical nighttime reflection prompts:

- “What was a highlight of your day?”
- “What’s something new you did at camp today?”
- “Name something you’ve learned about yourself or a skill you’ve gotten better at.”
- “What’s something you would like to do tomorrow?”
- “Tell us about a new friend you’ve made.”

Tip 11: Provide Hope

As it comes time to leave camp, many campers get sad or anxious because they don’t want to leave the safety and comfort of their friends. The present reality means some campers will also feel nervous about heading back to life at home during the pandemic (virtual school, being distant from friends, fearful of being infected, etc.). We can’t predict exactly when things will go back to “normal,” but it is clear that won’t happen for some time, even after people get vaccinated. So it is important to give the campers hope. The truth is, it *won’t* always be this way. We *will* get through this. A little reminder can be helpful.

Tip 12: Celebrate!

Find ways to celebrate the opportunity you have all had at camp. Not only does celebrating mark the fun, accomplishments, friendships, and relief of camp, but it makes those experiences *more memorable* — which makes it easier for your campers to *hold onto those experiences and take them home*.

Underlying Camper Vulnerabilities and “Breakthrough Behaviors”

Many children have underlying MESH conditions, such as anxiety, depression, obsessive-compulsive traits, attention deficit disorder, hyperactivity, or autistic features. With the right support, guidance, and structure, these youngsters are able to manage their vulnerabilities and function at a fairly high level most of the time. The pandemic has created conditions where many of those children may have lost that support, guidance, and/or structure. Perhaps they have not been able to attend class, get therapy, exercise, be in play groups, or get various other kinds of support. As a result, some of those children will not be coping as well. They may have what we call “breakthroughs.” That is, their MESH issues overwhelm their coping strategies, and they experience an upwelling of symptomatic behavior.

Again, getting good information about your campers will help anticipate which ones may be at risk for having an outbreak of more troubling or challenging behavior. Use the tools provided in the appendices to guide your actions and support as we move into summer 2021 and beyond.

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Appendix A

Parent Survey: COVID-19 Impacts on Campers

Camp is a fun, fast-paced, richly social, hands-on growth experience that can have a tremendous positive impact on children. The more information you can give us about how the pandemic has affected your family and your child, the better able we will be to support them while they're here. As always, anything you share with us will be held in strict confidence.

1. What losses or significant changes has your child experienced during the COVID-19 pandemic? (Such as death of a relative/friend, parental job or business loss, loss of school or sports season, cancellation of other travel plans, etc.)
2. How has your child handled being out of school, away from friends, and sheltered-in-place with your family? (Examples would be irritable, cranky, anxious, calm, focused, withdrawn, etc. Please share as complete a picture as you can.)
3. What has been your child's reaction when they knew they were coming to camp in spite of the pandemic? (Please give a full mix of the reactions: excited, relieved, nervous-anxious (about what), eager, hesitant, etc.)
4. Is there anything else about your child's behavior during the pandemic that you think will help us help them take full advantage of their time with us?
5. If your child has a preexisting condition or diagnosis (ADHD, autistic features, anxiety, depression, obsessive-compulsive disorder, etc.), how did the pandemic affect your child's ability to cope?

Appendix B

Five States or Stages of Grief

Your staff and your campers have all been experiencing various degrees of GRIEF as a result of the losses they have experienced during the pandemic. While those losses will vary in degree and severity, everyone will have lost something in this crisis, even if it the sense of having control over one's own life and well-being.

The specific grief reactions of your campers and staff will differ. That said, grief in your campers and staff will be universal, if sometimes subtle. Note that different campers are going to be in different states of grief. They are also not always going to be aware of exactly what they are feeling. (One of the things we as adults do for children is help them put into words what it is they are feeling. "Name it to tame it!")

In addition, just because the grief model lays out a series of emotions in a kind of order, beginning with shock and/or denial and leading all the way to acceptance, there is no "right" order or progression of these feelings. Different people go through them in different orders; they may even go back and forth between two or three of them in a given time period.

The Five Stages



Shock/Disbelief/Denial/Numbness



Anger! (Agitation, Frustration, Restlessness, Irritability, Impatience)



Bargaining/Deal-making: "Do we really have to wear masks...?" "Why can't we...?" Deal-making has an element of denial in it — a refusal to accept reality. It may also be tinged with anger.



Sadness: Staff for what they've lost; campers for what they've lost. Sadness, while not a pleasant emotion, has a kind of richness about it: in order to be sad, you must have had something meaningful in your life to be sad about. Sadness differs from **depression**, which is a kind of emptiness.



Acceptance: In the case of camp, this means taking advantage of the opportunity we have to be together and to take from it what we can while we can.

Appendix C

“Keys” to Your Campers

Group/Cabin Counselor _____ Cabin/Group _____

Campers don't listen to you just because you are their counselor (or friendly camp nurse). They listen to you when they sense that you are truly interested in them and have spent time playing with and relating to them. This form will help you see who you know well and who you might need to get to know a little better. Have you sat next to them at a meal? Have you walked and talked with them from one activity to another? Have they made eye contact with you? What are some “keys” to each of your campers? This is the way you create “money in the bank” with them. Money in the bank gives you “currency” (trust and credibility) with your campers.

Camper Name “Keys” to this Camper A favorite camp activity, camp friend, hobby, pet at home, food, sports team, or other interest. Something the camper gets excited by, is afraid of, wants to try out at camp. Write one such fact over each key below each camper's name.

	<input type="checkbox"/> Made eye contact with me <input type="checkbox"/> Walked and talked with me	<input type="checkbox"/> Sat next to at a meal <input type="checkbox"/> Sought me out	<input type="checkbox"/> Pet? Name? <input type="checkbox"/> Played with
	<input type="checkbox"/> Made eye contact with me <input type="checkbox"/> Walked and talked with me	<input type="checkbox"/> Sat next to at a meal <input type="checkbox"/> Sought me out	<input type="checkbox"/> Pet? Name? <input type="checkbox"/> Played with
	<input type="checkbox"/> Made eye contact with me <input type="checkbox"/> Walked and talked with me	<input type="checkbox"/> Sat next to at a meal <input type="checkbox"/> Sought me out	<input type="checkbox"/> Pet? Name? <input type="checkbox"/> Played with
	<input type="checkbox"/> Made eye contact with me <input type="checkbox"/> Walked and talked with me	<input type="checkbox"/> Sat next to at a meal <input type="checkbox"/> Sought me out	<input type="checkbox"/> Pet? Name? <input type="checkbox"/> Played with

Appendix D

NAME It

A method for cultivating positive character traits and values in campers and staff.

Name the behavior you see.

- “Wow! You were really trying! You really gave it your all!”
- “I noticed you stayed behind to help J find his/her/their tennis racket.”
- “I could see you were working really hard not to lose your temper.”
- “Even though you’ve been homesick, you keep going to activities and making friends.”

Affirm the camper for that behavior.

- “I am very impressed! You should be proud of yourself!”
- “That was really helpful and so kind of you!”
- “You did a fantastic job in a tough situation!”
- “I really admire you for that!”

Make the connection between the behavior and the character trait it exemplifies.

- “That’s what we call GRIT!”
- “That was showing a lot of kindness on your part!”
- “You were showing great self-control!”
- “You have been working hard to keep a positive attitude!”

Encourage others to strive for those traits.

- “Let’s see . . .”
- “. . .how hard we can all try!”
- “. . .how kind we can all be to one another!”
- “. . .how much we can all keep a positive outlook!”

Supporting Staff Mental, Emotional, and Social Health (MESH) at Youth Summer Camps

Christopher A. Thurber, PhD

Staff do their best work when they are happy, healthy, and connected. Therefore, the camp's leadership — directors, senior staff, and healthcare providers — must support their staff's mental, emotional, and social health (MESH). Taking care of the young adults who are taking care of children is a perennial duty that is both rewarding and essential. Whereas a cabin leader, group counselor, or activity head with unstable or poor MESH is a liability, one with solid, resilient MESH is an enormous asset.

Stressors Galore

The COVID-19 pandemic that began overseas in late 2019 resulted in quarantined conditions for most people in the world in the early months of 2020. These conditions — such as sheltering at home, attending work and school online, and dramatically reducing face-to-face social contacts — took an enormous physical and emotional toll on broad swaths of the world's population. Of 90 million cases worldwide, about 50 million people recovered, 38 million live with symptoms or complications, and 2 million have died. Whether infected or not, almost everyone in quarantine felt the anxiety associated with increased uncertainty about their future, the depression associated with social isolation, and the irritability associated with more screen time and less exercise and time outdoors — not to mention much more time with family than most of us are used to.

For camp professionals, 2020 was the most stressful year of their careers. There was more uncertainty, more emergency planning, more communication, and more frustration than ever. Some programs ran on site successfully, with many health precautions and program alterations in effect; most ran online programs with equal measures of creativity and optimism. All are to be congratulated for doing their best to make the wisest choice for their staff, campers, and families — given their facility, budget, location, and the information they had at the time. And although everyone involved in camping grieved the loss of normalcy, those staff and campers who had looked forward to camp but did not have it were especially stricken.

The pandemic had strong positive elements for many people as well. For example, much of that increased family time strengthened important relationships. Many people learned what they could live without and felt an increased sense of gratitude for their circumstances. Coincidentally, 2019 and 2020 were also the most active civil rights years in the United States since the 1960s. Many people gained a better understanding of the combination of prejudice and power that continues to fuel racism in this country.

Trauma-Informed

Given the diversity of your staff's experiences, it is impossible to say whether the pandemic, the social justice movement, and other life events qualify as traumatic. If we

define trauma as “an event, series of events, or set of circumstances that is experienced as physically or emotionally harmful or life-threatening, overwhelms the person’s ability to cope, and has lasting adverse effects on the person’s mental, physical, social, emotional, or spiritual well-being” (Trauma-Sensitive Schools, n.d.), then we have a place to start. Yet we may know little about how a particular staff member experienced recent events; even less about any adverse childhood events (ACEs) that our staff have endured. Nevertheless, our executive leadership and staff management can be trauma-informed.

Lest we get too caught up in diagnostic labels, we should remember that “Emotional connection is crucial to healing. In fact, trauma experts overwhelmingly agree that the best predictor of the impact of any trauma is not the severity of the event, but whether we can seek and take comfort from others” (Johnson, 2008) Therefore, I advocate that camp directors, senior staff, and healthcare providers focus less on gathering detailed personal histories for the incoming staff and much more on assembling supports that will provide comfort before, during, and after the season.

Best Selves

To be their best selves, frontline camp staff (those who have hours of daily interactions with campers) need the following (ACN, 2021):

1. Clarity

As staff are hired or rehired, directors must provide a detailed and accurate job description. Healthcare providers should review these descriptions and offer feedback to directors to ensure they accurately describe the physical and mental stamina required for frontline staff to excel. Whenever possible, one of the camp’s healthcare providers should be among the senior staff who interview each candidate. During the interview, share the MESH supports that camp offers and specify those it does not. Although you cannot ask about a person’s mental health history, you can ask, “Given the demands of the job and the supports I’ve described, how confident are you feeling about maintaining top performance over the course of nine or ten weeks?”

All job descriptions should include staff responsibilities both while on duty and during scheduled time off (which is essential for recharging). Be sure to describe what staff usually do when they need to take a break, as well as how to ask for support when needed. Even if you think you know the person you are interviewing, and even if *they* think they know what the job entails, be sure to review their responsibilities and schedule in detail. Not only will the clarity in expectations provide comfort (by reducing unknowns to a manageable minimum), but it will also help you and the prospective staff member make a wise choice about whether they can handle all aspects of the job in their current MESH state.

2. Predictability

The past year and a half had more unpredictability than most people could comfortably handle. The world is slowly becoming a bit more predictable for some of us, but much still remains difficult to foresee — and that kindles many anxious feelings. You cannot create predictability where there is none, but you can give staff lots to count on. For example, you can give them a rough timeline of the summer, share your contingency plans if the pandemic worsens, describe how you and your team support frontline staff, and outline the program of pre-season and on-site training you plan to provide.

In addition, healthcare staff can provide suggested pre-screening activities that reinforce the importance of all staff arriving in healthy mental and physical condition. Everyone needs to be emotionally ready to face the differences from last season and the season before that. Better still, staff need to celebrate and gamify otherwise mundane or tiresome tasks, such as washing hands and wearing masks.

Once on site, the camp nurse can provide reassuring instructions for the steps a staff member should take if they develop symptoms of COVID-19 or any other illness. Healthcare providers are also the most important asset for encouraging consistent adherence to nonpharmaceutical interventions (NPIs), such as physical distancing or coughing in one's elbow. Expressing a positive attitude, providing the medical rationale for healthy practices, and setting a good example are leadership traits that buoy frontline staff. By contrast, poor role-modeling from the healthcare staff need only happen a couple of times for all the other staff to forsake healthy practices. *If the nurse isn't doing it, why should I?* is not a question you want staff to be asking.

3. Training

Competence feels good. Flailing and failing feel bad. The most reliable way to support your staff's mental health is by giving them the tools they need to do their jobs well. Staff who lack the leadership, youth development, behavior management, safety, and supervisory skills to do an excellent job will quickly feel overwhelmed. And overwhelmed staff cope by withdrawing and eventually quitting.

Just as all campers and caregivers should prevent intense homesickness (Thurber, 2005) by watching the Prep4Camp video, *Summer Camp Success*, frontline staff should prepare for their own separation from home. As a way to reduce risk and boost the staff's MESH quotient, I recommend that camps provide a combination of pre-season, online training and professional on-site training that emphasizes role-plays, realistic simulations, and skills practice, rather than lectures. Of course, the health center staff must also provide explicit training on the protocols they want staff to follow in the event that someone in the bunk, cabin, tent, or group becomes ill. Ultimately, the goal is for staff to feel confident in their ability to mitigate risks and respond supportively to novel challenges. As opening day nears, remind staff that they are all part of a team. No one does their camp job alone.

4. Time Off

If the director has hired staff thoughtfully, with your participation, then the frontline staff will all be responsible adults. They should know how to relax and recharge their batteries when they have hours, evenings, or days off. They should understand the principle of returning from time off feeling better than when they left. Not returning to duty exhausted, hungover, preoccupied, or all three, is their responsibility, just as providing guidance about the best local attractions, hikes, and scenic venues is the director's.

In cases where staff are not permitted to leave camp property during their nights and days off, it is the director's responsibility to ensure staff have a cloistered and peaceful on-site retreat. At day camps, it is the director's responsibility, with your guidance, to advise staff on the best practices for healthy off-site behavior each night.

Unfortunately, the spontaneous nature of summer camp colludes with the devotion we have to our jobs. The result is that we sometimes skip breaks and time off. In an emergency, that's fine, but as a regular practice, it's unwise. Set a good example by taking your own allotted time off and avoid asking staff to donate theirs.

5. Regularly Scheduled, On-Site Supports

If you stand before the staff this summer and pronounce that you know how stressful (and fun!) working at camp can be, and then remind staff that your door is always open, you can expect exactly 1 percent of the staff to avail themselves of you. "Get help if you need it" is a statement most of the staff will hear as a challenge. It's tantamount to saying, "If the dining hall catches on fire, the extinguishers are near the doors."

Instead of relying on staff to swallow their pride and seek support from their direct supervisor or from a member of your leadership team, protect some time in every staff member's schedule when they can check in with some of their peers and their direct report. Normalize the stresses of the job and frame these comforting check-ins as a proactive method of treating small problems before they grow.

If, in your professional judgment, a staff member gets to the point where they cannot perform the essential functions of their job, healthcare providers need to step in and offer a firm but sensitive MESH appraisal. For example, speaking to the camp director about such a circumstance might sound like, "Bennie has many strengths, including her artistic creativity and lifeguarding skills. However, it seems to me that her mood fluctuations make community living difficult for the girls in her cabin. In my professional opinion, she needs a couple of days out of her position of leadership and responsibility. I'm not confident that she can adequately care for other people's children at this time. But some rest and time at the health center will be enough for Bennie and the rest of us determine whether or not she should continue in her current role."

6. An On-Call Professional

All youth programs should have an established relationship with a mental health professional. This could be a psychologist or clinical social worker on your staff

or a clinician whose practice is near the camp. You might also have a consultative relationship with a clinician who can provide virtual services from a distance. Whatever the arrangement, this professional should be someone who is available to meet promptly with a staff member who appears to be struggling.

True, we would not hire staff who appeared unfit for the job. However, people sometimes have unforeseen MESH conditions or crises that render them unfit for the job (at least temporarily) or that need professional intervention. The camp's contracted mental health professional is both an excellent node in the web of MESH supports that you can help provide to the staff, *and* is the person you want to perform the kind of assessment that will help you determine a staff member's MESH fitness for the job.

7. Trauma-Informed Supervisors

Camp staff deserve supervisors who both serve as mentors — through their wise advice and sterling example — and who view staff behavior through trauma-informed lenses. That means supervisors need to bear in mind that markers of underperformance, such as forgetfulness, irritability, resistance to change, and low motivation, can be consequences of trauma, not willful neglect or malice. Underperformance or misbehavior is not always a result of having endured an adverse event, but one must consider that possibility before rushing to judgment.

For example, a counselor's reluctance to help blow up balloons for a lip-synch dance party at camp could reflect avoidance of loud noises that is the anxious vestige of having witnessed gun violence. If a few balloons have popped early in the process of party preparations, it might have generated uncomfortable waves of anxiety. That staff member might quietly withdraw as an act of self-care. How a supervisor responds when they see the staff member standing alone and not helping depends on whether the supervisor is considering a *range* of possibilities. The counselor could be lonely, hungover, or anxious — or a hundred other things. No one expects the supervisor to read minds or know every supervisee's childhood history. But you should expect every supervisor to inquire sensitively before assuming that the counselor is lazy and chastising them. Trauma-informed care would sound more like, "Hey, friend, is everything OK? There are other ways to help if you want" than "Hey, pal, get off your duff and help us blow up balloons!"

8. Healthy Food and Drink

As the expression goes: "Garbage in, garbage out." On the other hand, providing healthy food and drink, including after-hours snacks, goes a long way toward helping every staff member be their best self. In my clinical practice, one of the first questions I ask people with complaints of general malaise is how they are sleeping, exercising, and eating. We all need time to rest, exercise, and rejuvenate.

Nurses and other healthcare providers at camp can encourage good health through their own sterling example of nutritious eating and regular exercise. They can also meet

pre-season with the dining services team to review the menu and discuss upgrades. Introducing more whole, raw, unprocessed foods is a great place to start.

9. Recognition

All staff, at every level of experience, appreciate a simple thumbs-up, pat on the back, or word of praise for a job well done. Sure, they will be happy to take home a modest paycheck and the end of the season, but the real reward is knowing that their efforts made a difference. Beware of slipping into the mindset of *I don't have to praise them for just doing their jobs*. Sure you do, because it feels good and those good feelings are quite motivating. Plus, if you and the other members of the camp's leadership team dole out more praise than criticism, the staff will respond better to the criticism. They'll be confident that the senior staff notice all the good things they do, not just the missteps. This season especially, remember to praise staff for taking good care of themselves and for supporting others. And refrain from praising staff who are not demonstrating good wellness practices. Some staff may have pulled an all-nighter finishing the set for the upcoming play, but announcing that fact and asking for the whole camp to give them a round of applause sends the message that staying up all night is something you value.

10. Self-Determination

Finally, let the staff have a say in how they manage stress and care for themselves. This is not tacit permission to regress and unleash their inner party animal. It's a way of returning some agency and control to a younger adult who has had some of their self-determination stripped over the past year and a half. Asking staff, "What do you need to do your job well?" and "How can I support you?" and "What feels most comforting in those tough moments?" helps reposition them into their MESH driver's seat. You are there to provide some guardrails, of course, but ask staff what feels supportive when the going gets tough. (And it will, a bit, for everyone.)

One last reminder: Do not coddle the staff. We want staff who are healthy and self-reliant. We have all been through lots in our lives — especially recently — and some of us have survived traumas and overcome severe hardship. However, pampering or indulging staff by being permissive is unhealthy for them, risky for the campers, and contrary to camp's mission. Unless you are running a residential treatment program for adults with mental illnesses, it is not ethical to keep a suffering or underperforming staff member on duty. If it helps clarify your thinking about a staff member's fitness for the job, ask yourself, "Would I want this person caring for my own child right now?" Remind yourself that you are helping to run a top-tier summer youth program staffed by kind, adventurous leaders who shine brightest when your standards are as high as your compassion.

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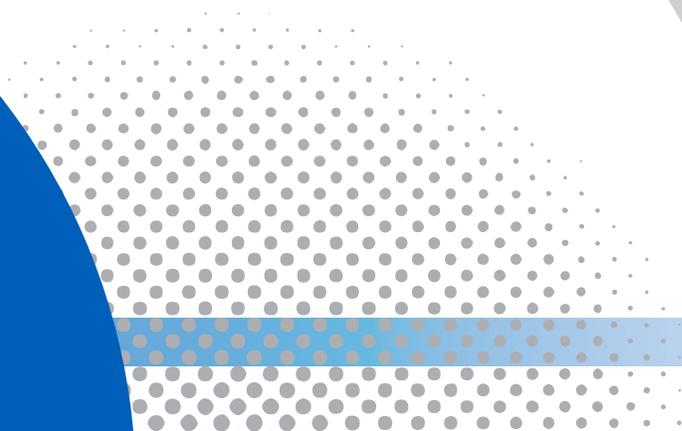
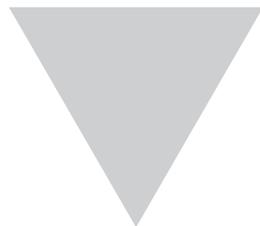
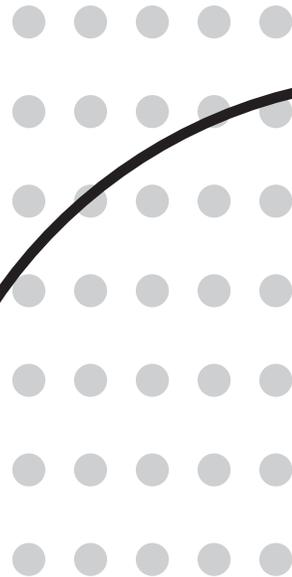
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Christopher Thurber, PhD, is a thought leader in education and youth development. He has dedicated his professional life to promoting social and emotional adjustment for young people who are spending time away from home at boarding schools, summer camps, and hospitals. Most recently, he co-founded Prep4Camp and Prep4School to share homesickness prevention techniques and academic success strategies with the world. Dr. Thurber is the co-author of The Unlikely Art of Parental Pressure: A Positive Approach to Pushing Your Child to Be Their Best Self. Learn more, download resources, and subscribe to fresh content by visiting DrChrisThurber.com.





Communicable Disease Resources and Supplies



Health Services Activities, Tools, and Equipment

Paula Lauer, RN, BAN

Knowing how to manage equipment, supplies, and activities during a healthcare event is a challenge. We can easily care for individuals when we have everything needed to provide health services, so we need to identify essential supplies and activities to help prevent illness and/or effectively screen and diagnose health conditions. Provided here is information regarding health services activities and supplies potentially needed during a communicable disease event. Review the following guidance and consider the appropriateness of each item within the context of your camp structure and operations.

Cleaning, Disinfecting, and Sanitizing

COVID-19 has encouraged us to revisit our policies and processes around cleaning and sanitizing our camp facilities. We may historically have performed organized cleaning activities, but time tends to lead to shortcuts and delays in cleaning. When we learn that a serious communicable illness may be transmitted through high-touch areas, we find a need to reinvigorate our cleaning and sanitizing efforts to promote health and wellness.

- Cleaning – involves the removal of dirt and debris from a surface. Usually this occurs by wiping the “butter and jelly” off the dining hall tables. A counter can be totally free of visible dirt but still be a breeding ground for germs.
- Disinfecting – involves killing germs. This activity reduces the number of germs on a surface by 99.9 percent or more. Be sure to use a disinfectant appropriate for the microorganism of concern.
- Sanitizing – involves killing more germs. Sanitizing is the dual process of cleaning and disinfecting surfaces to help prevent fomite transmission.

6 Steps for Safe & Effective Disinfectant Use



Step 1: Check that your product is EPA-approved
Find the EPA registration number on the product. Then, check to see if it is on EPA's list of approved disinfectants at: epa.gov/listn



Step 2: Read the directions
Follow the product's directions. Check "use sites" and "surface types" to see where you can use the product. Read the "precautionary statements."

Step 3: Pre-clean the surface
Make sure to wash the surface with soap and water if the directions mention pre-cleaning or if the surface is visibly dirty.

Step 4: Follow the contact time
You can find the contact time in the directions. The surface should remain wet the whole time to ensure the product is effective.

Step 5: Wear gloves and wash your hands
For disposable gloves, discard them after each cleaning. For reusable gloves, dedicate a pair to disinfecting COVID-19. Wash your hands after removing the gloves.



Step 6: Lock it up
Keep lids tightly closed and store out of reach of children.



coronavirus.gov

- If equipment or surfaces are thought to be contaminated and can be cleaned, follow the CDC cleaning and disinfection recommendations. Remember, you can't disinfect dirt!

A sanitizing process for a nonporous surface might include:

1. Clean with warm, soapy water.
2. Rinse with clean water.
3. Mix 1 teaspoon bleach to 1 gallon water and wipe/spray surface (for COVID). Bleach/water solutions need to be remade after 24 hours. There are other sanitizing solutions for different organisms — follow CDC and EPA recommendations for choice of agent (Wisconsin Dept of Health Services, 2020; Environmental Protection Agency, 2020a).
4. Allow to air dry.

For porous surfaces: If surfaces or equipment are thought to be contaminated and cannot be cleaned, they can be isolated. Isolate porous surfaces for a minimum of 24 hours before handling. After 24 hours, remove the soft material from the area and clean the hard (nonporous) surface per the recommendations. Isolate hard surfaces that cannot be cleaned and disinfected for a minimum of seven days before handling. Follow CDC and EPA recommendations (Centers for Disease Control and Prevention, 2021; Environmental Protection Agency, 2020a).

- See Appendix A for a Cleaning and Sanitizing Schedule Example.

Ventilation

Ventilation involves the process of reducing the concentration of viral particles in the air. This occurs through circulating air, so we find it helpful when activities and services are moved outside. Consider using one or more of a variety of available supplies to assist with air movement and filtration to promote ventilation — especially when the communicable illness is thought to be spread by respiratory droplets (Centers for Disease Control and Prevention, 2020f).

- Filters
 - Perform an assessment of HVAC systems to see if they are able to handle a higher-rated air filter. Not all HVAC systems can handle increasing the Minimum Efficiency Reporting Value (MERV) rating, which pushes more air through smaller holes.
 - Air filters have MERV ratings. The higher the number, the smaller the particles it can trap.
 - MERV-13 or higher air filters are able to trap smaller particles, including viruses (Environmental Protection Agency, 2020b).
 - HEPA is a type of pleated mechanical air filter. HEPA filters



can theoretically remove 99.97 percent of dust, pollen, mold, bacteria, and any airborne particles with a size of 0.3 microns (μm) (Environmental Protection Agency, 2020c).

- Portable HEPA filters in high-traffic areas may be used when MERV-13 air filters are unable to be used. Consider using HEPA air cleaners in the Health Center or residential areas with isolated individuals.



Portable HEPA Filter



- Move all activities and services (food service, health service, program areas) outside. Use open-air tents and cross ventilation to help mitigate risks for COVID and other potential respiratory conditions.
- Increase ventilation by opening windows if unable to move outdoors.
- Turn on ceiling fans or add box fans to areas to promote cross ventilation.

Hand Sanitizer

CDC recommends washing hands with soap and water whenever possible, because it reduces the amount of many types of germs and chemicals on our hands. When soap and water are not available at camp, use hand sanitizer with at least 60-percent alcohol content (often listed on the label as ethanol, ethyl alcohol, isopropanol, or 2-propanol).

- How to use:
 - Properly apply alcohol-based sanitizer by rubbing the gel over all surfaces of your hands and fingers until your hands are dry.
 - Follow label directions for use.
- Be careful around fire when hand sanitizer has been recently used.
- Using hand sanitizer does not take the place of handwashing if your hands are physically dirty. Remember, you cannot sanitize dirt (Centers for Disease Control and Prevention, 2020c, 2020d)!

Handwashing

In an effort to provide easy access for handwashing during summer 2020, camps created a variety of simple, inexpensive handwashing stations. These stations were located in areas where handwashing may not have been available before. In most cases, all that was needed was a water source (i.e., water hose), and individuals were able to wash hands as an integral part of the camping experience. Going forward, a buddy system to promote accountability for handwashing could prove successful in promoting

adherence.

Create reminders of handwashing on camper/staff schedules. Sing a fun camp song or create a camp slogan to encourage campers and staff to scrub their hands for a minimum of 20 seconds.



Personal Protective Equipment (PPE)

Personal protective equipment for health staff and others is only effective if used within the proper guidelines. Individuals who could encounter a potentially infectious

Sample of camp schedule showing handwashing.

Schedule	Monday	Tuesday	Wednesday	Thursday	Friday
7:00 a.m.	Arise – Wash Hands				
8:00 a.m.	Breakfast – Wash Hands				
9:00 a.m. Activity					
10:00 a.m. Activity					
	Handwashing Break				
11:00 a.m.					
12:00 p.m.	Lunch – Handwashing				
1:00 p.m. Activity					
2:00 p.m. Activity					
	Handwashing Break				
3:30 p.m. Activity					
5:00 p.m. Activity					
6:00 p.m.	Dinner – Handwashing				
7:00 p.m.					
8:00 p.m.	Bedtime Snack – Handwashing				

During the pandemic, U.S. adults were more likely to remember to wash their hands after coughing, sneezing, or blowing their noses than in 2019*

Despite this increase, about 1 out of every 4 people don't wash hands after these actions

Always wash your hands

-  **After** using the bathroom
-  **Before** and **after** preparing or eating food
-  **After** coughing, sneezing, or blowing your nose

*ConsumerStyles data collected in October 2019 and June 2020 (by Porter Novelli Public Services)

During the pandemic, you should also wash hands

-  **Before** and **after** touching your eyes, nose, or mouth
-  **After** going to a public place and touching a frequently touched surface
-  **Before** and **after** touching your mask

CDC.GOV

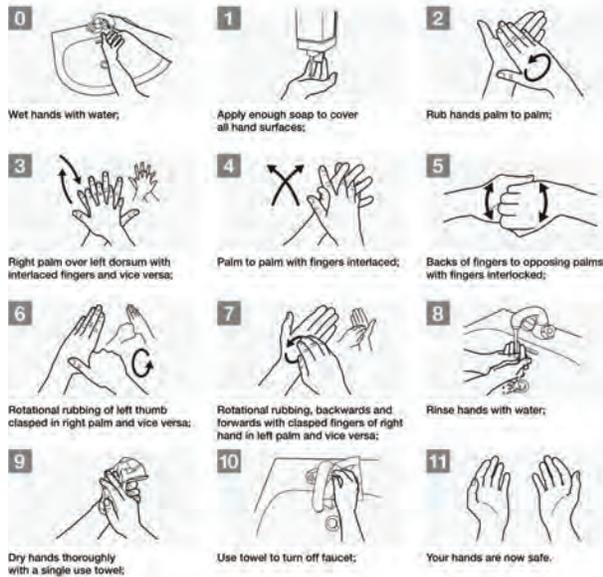
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MMWR

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB.

 **Duration of the entire procedure: 40-60 seconds**



- 0** Wet hands with water;
- 1** Apply enough soap to cover all hand surfaces;
- 2** Rub hands palm to palm;
- 3** Right palm over left dorsum with interlaced fingers and vice versa;
- 4** Palm to palm with fingers interlaced;
- 5** Backs of fingers to opposing palms with fingers interlocked;
- 6** Rotational rubbing of left thumb clasped in right palm and vice versa;
- 7** Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;
- 8** Rinse hands with water;
- 9** Dry hands thoroughly with a single use towel;
- 10** Use towel to turn off faucet;
- 11** Your hands are now safe.



Patient Safety
A World Ahead of Your Health Care

SAVE LIVES
Clean Your Hands

HANDWASHING

Accessible version: https://www.cdc.gov/coronavirus/2019-ncov/globel_covid-19/handwashing.html

Wash hands with soap and water for at least 20 seconds. Use the cleanest water possible, for example from an improved source.* Use an alcohol-based hand rub that contains 60% alcohol if soap and water are not available.



- 1** Wet hands with water.
- 2** Apply enough soap to cover all hand surfaces.
- 3** Rub hands together and scrub everywhere.
- 4** Wash the front and back of your hands, in between your fingers, and under your nails.
- 5** Rinse hands with water.
- 6** Dry hands completely using a single-use towel or air dry.

WHEN TO WASH HANDS TO PREVENT COVID-19:

- **After** blowing your nose, coughing, or sneezing
- **After** being in a public place
- **Before** and **after** caring for someone who is sick

Remember to wash your hands after each of these activities to stay healthy:

- **Before, during, and after** preparing food
- **Before** eating food
- **After** changing diapers or cleaning up a child who has used the toilet
- **After** using the toilet or latrine
- **After** touching an animal, animal feed, or animal waste
- **After** touching garbage

*Water should be from an improved or protected water source. Learn more at <https://washdata.org>.



cdc.gov/coronavirus

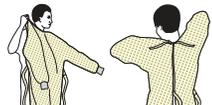
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individual may need to use different types of PPE (masks, gloves, gown, face shields) to protect both the individual and the care provider. While nurses are trained in the use of PPE, health center support staff may have never used these supplies and will need education and support.

- Determining the volume of PPE needed will be dependent on several variables (i.e., size of population served, number of healthcare providers/healthcare aides, communicable disease plan).
- Good hand hygiene should be practiced in conjunction with and before and after use of PPE.
- As part of your communicable disease plan, develop a relationship with a medical supply provider in the event the camp needs additional PPE and a quick response time.

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

- 1. GOWN**
 - Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
 - Fasten in back of neck and waist
- 2. MASK OR RESPIRATOR**
 - Secure ties or elastic bands at middle of head and neck
 - Fit flexible band to nose bridge
 - Fit snug to face and below chin
 - Fit-check respirator
- 3. GOGGLES OR FACE SHIELD**
 - Place over face and eyes and adjust to fit
- 4. GLOVES**
 - Extend to cover wrist of isolation gown

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

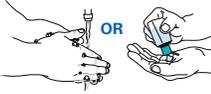
- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene



Donning PPE (Putting on in correct order)

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

- 1. GLOVES**
 - Outside of gloves are contaminated!
 - If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
 - Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
 - Hold removed glove in gloved hand
 - Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
 - Discard gloves in a waste container
- 2. GOGGLES OR FACE SHIELD**
 - Outside of goggles or face shield are contaminated!
 - If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
 - Remove goggles or face shield from the back by lifting head band or ear pieces
 - If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container
- 3. GOWN**
 - Gown front and sleeves are contaminated!
 - If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
 - Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
 - Pull gown away from neck and shoulders, touching inside of gown only
 - Turn gown inside out
 - Fold or roll into a bundle and discard in a waste container
- 4. MASK OR RESPIRATOR**
 - Front of mask/respirator is contaminated — DO NOT TOUCH!
 - If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
 - Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
 - Discard in a waste container
- 5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE**


PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE



Doffing PPE (Removing in correct order)

Screening

Prescreening camper and staff prior to their arrival at camp is a critical part in recognizing illness early and preventing it from entering camp. Screening can be completed by the parent/guardian, the camper, or the staff member. Prescreening could be helpful for many different communicable illnesses (as well as COVID-19) as a tool to raise awareness of one's health status. Once individuals complete the prescreening period of 7–14 days, their self-monitoring logs can be brought to camp on arrival day



COVID-19 Prescreening Tool

This tool is to be used by campers and/or staff 14 days immediately before arrival at camp. The intent is to create potential symptoms. Campers and staff are encouraged to bring this document home during the initial health s

Screening Element	Day 1	Day 2	Day 3	Day 4
Temperature? (Take Temp)				
Cough? (Y/N)				
Headache? (Y/N)				
Shortness of breath or difficulty breathing? (Y/N)				
Fever (>100.4)? (Y/N)				
Chills? (Y/N)				
Muscle aches? (Y/N)				
New loss of taste or smell? (Y/N)				
Nausea, vomiting, or diarrhea? (Y/N)				
Quarantined for at least 2 weeks directly prior to camp? (Y/N)				
Exposed to someone ill or someone who has had COVID-19? (Y/N)				
National or International travel in the last month? (Y/N)				

Y = Yes; N = No

Pre-Camp Health Screening

Dear Camp families,

In an effort to minimize illness at camp we ask that you check on the health of your camper daily beginning 14 days prior to camp. The best camp sessions start with healthy campers and this begins at home. Please bring this completed form to camp on opening day.

Please indicate if your camper has any of the following symptoms prior to camp and record a temperature daily. If any temperature or symptoms are present, please have your camper evaluated by a licensed provider and contact camp for further guidance.

Symptoms (symp):

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Muscle Pain
- Sore throat
- New loss of taste or smell
- Nausea
- Vomiting
- Diarrhea

Please Initial	
1. My child has not been around anyone with any of the listed symptoms or diagnosis of COVID19 in the 14 days before the start of camp.	Initial _____
2. No one in our household has been sick in the 14 days prior to camp.	Initial _____
3. My child has not traveled by air or traveled out of state in the 14 days prior to camp.	Initial _____
4. My child has adhered to our state's guidelines regarding COVID19.	Initial _____

Start date of temperature/symptom screening:	Day: 14	13	12	11	10	9	8
Temp/symp							
Day: 7	6	5	4	3	2	1	
Temp/symp							

Our signature indicates that we completed this health screening daily for 14 days prior to camp and to the best of our ability. We understand that arriving to camp healthy is vital to a healthy camp for all campers.

Parent Signature: _____ Date: _____
 Camper Signature: _____ Date: _____

created by Eleanor Matthews, RN 2020

(see examples that follow). Once at camp, on-site illness monitoring and/or temperature evaluation are tools to evaluate the ongoing health status of the community.

- Many of the questions used in prescreening can also be used for the initial on-site camp screening (on arrival) and as ongoing screening throughout the camp experience. For day camps, the initial and ongoing screenings become the same event—as campers and staff have been screened daily during COVID-19
- If managing a paper prescreening form is difficult, you might consider using an app for prescreening. Apps used during summer 2020 included Procure and Airtable, however, there are likely many apps that could be used for prescreening campers and staff.
- Using an app allows the camper/staff to enter daily screening results that are then transmitted to the camp the same day. This allows for a timelier review of symptoms and responding to any health alterations before campers or staff arrive on site.

Thermometer Options

Thermometers are needed for almost every communicable disease. Infectious illnesses often cause an increase in temperature, and having the ability to accurately measure temperatures will be key. It will be important to know if an individual is febrile

(with fever) or afebrile (without fever) through the monitoring period. Considerations related to thermometers:

- Thermometers should be cleaned and sanitized between users.
- When using any thermometer, remember the environment in which it is being used. It is crucial to ensure the person and the environment are in the best possible condition.
- Consider the following:
 - If a person is sweating or shivering, the thermometer may not give an accurate reading.
 - If you are in an environment that is outside the recommended temperature range of the thermometer, you may also be given a false reading. Thermometer may need to be calibrated.

 **Thermometer Comparison & Analysis**

Thermometer		Cost	Accuracy	FDA Approved	Features
Tympanic Thermometer (checks temp of tympanic membrane)		\$30.00-\$45.00	0.2 to 0.4 degrees off rectal Ear wax or small ear canal may interfere with accuracy	Yes for most all brands	Quick - Temp in 1-3 seconds Easy to clean
Digital Thermometer (oral)		\$8.00-\$15.00	Within 0.1 degree of rectal	Yes for most – check brand	Accurate Requires more time
Temporal Artery Thermometer (checks temp of temporal artery)		\$40.00 - \$90.00	0.5 to 1.0 degree lower than oral	Most are approved – check brand	Accurate – closest to rectal if done appropriately
No Touch Thermometers (Infrared - forehead)		\$60.00 - \$90.00	May not be as accurate as it takes skin temp.	Check brand Less expensive brands lack accuracy	Only check skin temp Quick but can be inaccurate with poor technique Need good training for more accuracy

<https://www.mayoclinic.org/diseases-conditions/fever/in-depth/thermometers/art-20046737>
<https://www.ncbi.nlm.nih.gov/books/NBK263242/>
<https://conductscience.com/thermometers-a-complete-guide/>

Testing Considerations

Please see the attached table in Appendix B as guidance for testing considerations for campers and staff.

References

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- Environmental Protection Agency (2020a). List N: Disinfectants for Coronavirus. Retrieved from <https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19>
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- Wisconsin Department of Health Services (2020). Cleaning and Sanitizing with Bleach after an Emergency. Retrieved from <https://www.dhs.wisconsin.gov/flood/sanitizing.htm>
- World Health Organization (2009). How to Handwash. Retrieved from https://www.who.int/gpsc/5may/How_To_HandWash_Poster.pdf

Appendix A

Cleaning & Sanitizing Schedule Example

Areas	Before Each Use	After Each Use	Daily	Weekly	Monthly	Comments
FOOD SERVICE						
Food Prep Surfaces	Clean Sanitize	Clean Sanitize				
Dishes & Utensils		Clean Sanitize				
Tables		Clean Sanitize				
Countertops		Clean	Clean Sanitize			
Mixed Use Tables	Clean, Sanitize					Before serving food
Refrigerator					Clean	
ACTIVITY AREAS						
Door Handles			Clean Sanitize			
Floors			Clean			
Dress up costumes		Launder				Launder
Activity Areas			Clean	Deep Clean		Air dry if needed
Drinking Fountains			Clean Sanitize			
Computer keyboards			Clean	Clean Sanitize		
Phone Receivers			Clean	Clean Sanitize		
BATHROOMS						
Sinks & Faucets			Clean Sanitize			
Countertops			Clean Sanitize			

Toilets			Clean Sanitize			
Floors			Clean			
SLEEP AREAS						
Sheets/ Pillow Cases		Laundry				
Blankets		Laundry				
Mattresses		Clean Sanitize				

Appendix B

Potential COVID Testing Patterns for Summer Camp Consideration (2021)*

(As of February 2021)

Camp Type	Camper (C) Duration of Stay	Staff (S) Duration of Stay	Testing Considerations	Testing Pre-Camp ¹ C=camper; S= staff	On Arrival C=camper; S= staff	Development of Symptoms	Exposure Testing ^{1,2} (Use Guidance from Public Health)
Day Camp	Return Daily	Return Daily	Test at Start of camp season and weekly thereafter as best practice 14-day Pre-Screen	PCR within 1 week prior to start of camp season		Isolate & PCR test (Antigen ³ test with clinical guidance)	Quarantine & PCR or Antigen at day 4-5 post-exposure
Residential	7 days or less	Full Season	14-day Pre-Screen	(C, S) PCR or Antigen test day before arrival OR	(C, S) PCR or Antigen test 5 days after arrival	Isolate & PCR test (Antigen test with clinical guidance)	Quarantine: C-test when return home; S- PCR or antigen test 4-5 days post-exposure
Residential	Greater than 1 week	Full Season	14-day Pre-screen	(C, S) Test with PCR or Antigen on day 7 of pre-screen	(C, S) PCR or Antigen test 5 days after arrival	Isolate & PCR test (Antigen test with clinical guidance)	Quarantine & PCR or Antigen at day 4-5 post-exposure
Rental Group (Not Families)	7 days or less	7 days or less	14-day Pre-screen	(C, S) PCR or Antigen test 3-5 days before arrival		Isolate & PCR test (Antigen test with clinical guidance)	Quarantine; test when return home
Family Camps	7 days or less	Full Season	14-day Pre-screen for staff	PCR or antigen for each family member within 5 days of arrival		Isolate & PCR test (Antigen test with clinical guidance)	Quarantine; C- test when return home; Staff: PCR or Antigen at day 4-5 post-exposure
						If antigen test is negative, follow with a PCR test	If antigen test negative, follow with a PCR test for exposure testing

* These testing considerations are provided with the idea that camps will also be using all available nonpharmaceutical interventions at camp to mitigate risk and that camps are following the guidelines of their state public health officials.

1. Take into account the amount of time it will require to receive results from testing.
2. Exposure is defined as people who have had close contact (within 6 feet for a total of 15 minutes or more) with someone with confirmed COVID-19 (CDC.gov).
3. Antigen testing may be affected by local rates of COVID-19 transmission. If antigen testing is being used, work in collaboration with knowledgeable health care provider(s).

For individuals who have received the full vaccination for COVID-19:

- These individuals do not need to be tested prior to camp; only if symptoms develop or if exposed at camp.

- These individuals do not need to quarantine if exposed to COVID-19 if the following criteria are met (New – CDC Feb 2021):
 - a. It has been at least two weeks since second vaccine dose (if given a two-injection vaccine).
 - b. It has not been longer than 90 days since vaccination. After 90 days, individuals would need to quarantine again if exposed.
- These individuals should not test positive on a PCR or antigen test but should have positive antibodies on an antibody test.
- Vaccinated individuals should continue to use the full slate of NPIs at camp, as we currently do not have information about potential transmission risk to others after being vaccinated.
- Contact your state public health officials if you have questions regarding testing and vaccinations as they apply to camp in your state.

CDC.gov: <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/summer-camps.html>

CDC.gov: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html>

FDA.gov: <https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/faqs-testing-sars-cov-2>

Campnurse.org: <https://campnurse.org/education-and-resources/covid-19-considerations-for-camp/cdc-recommendations-for-camps-covid-19>

COVID-19 Frequently Asked Questions (FAQs)

Lynne Rodrigues, RN

Camp Preparation & Education

1. What type of questions should we ask on a screening tool?

The purpose of screening is to help individuals arrive to camp in a healthy state. The screening process is to help identify if an individual has concerning symptoms or experiences that might prevent entrance into camp. The questions more helpful to include would be symptoms of the potential condition, potential exposures (i.e., group activities, travel), and steps taken to prevent exposure to illness (i.e., quarantine, activity limitations).

2. What is the appropriate number of people to have in a cohort/group?

There is no exact number for cohorting, however, understanding that the purpose of cohorting is to prevent spread of an illness if it does enter camp, smaller cohort sizes are preferable. Data from summer 2020 and the COVID-19 experience suggests an average of 8–15 people in a single cohort. In addition to having small numbers in a cohort, other infection control efforts included limited mixing of cohorts and limited large-group activities. In the event of



an outbreak, having smaller groups promotes more effective surveillance and contact tracing within the close contacts of one group instead of the entire camp community.

3. How did you make handwashing a successful activity at camp?

Handwashing can itself be a fun camp event. Instead of making handwashing a rule, make it a fun, engaging activity by adding music, establishing mentors, and having games that demonstrate the importance of washing (i.e., GloGerm and UV light). Hand hygiene can be accomplished by soap and water and hand sanitizer (at least 60-percent alcohol). Camps can consider decreasing the number of activities to allow more time for handwashing between events. Therefore, it is not a requirement but another engaging activity with peers.

4. How frequently should we clean areas at camp and what areas need more attention?

Sanitizing is the process of cleaning and disinfecting. Cleaning and disinfecting should be done together. Clean an area with soap and water and then apply a disinfectant that maintains contact with the surface according to product directions. The frequency of these activities varies but generally should be done at minimum once each day. The best practice is dependent on the infectious agent (COVID-19 or other microorganism) and often includes cleaning high-touch areas (tables, bathrooms, doorknobs, door handles) between individual and group use.

5. What types of masks should we use at camp – cloth or disposable?

Face masks protect both the wearer and others from expelled respiratory droplets. A face mask is primarily intended to catch droplets from the wearer, preventing them from contaminating others in the area. Additionally, wearing a face mask can protect the wearer from inhaling droplets in the environment and minimize risk of becoming ill. Recommendations include: the mask should have at least two layers of tightly woven but breathable fabric (light should not pass through the material), should cover both the mouth and nose, and should fit closely to the face without gaps or flaps. Camps might consider using face coverings that meet these CDC recommendations for communicable respiratory illnesses. If using cloth masks, they should be washed daily in a general cycle and dried in a hot dryer. If using a traditional single-use mask, it can be disposed of each night and replaced with a new mask each day.

Face masks should have two layers of tightly woven breathable fabric.

Lindsley, W.G., Blachere, F.M., Law, B.F., Beezhold, D.H., Noti, J.D. (2020) Efficacy of face masks, neck gaiters and face shields for reducing the expulsion of simulated cough-generated aerosols. Retrieved from <https://doi.org/10.1101/2020.10.05.20207241>external icon.

6. What are some ways to increase air movement (ventilation at camp)?

Ventilation becomes an important factor for minimizing transmission of COVID-19.



Viral particles spread between people more readily indoors than outdoors. When outdoors, the concentration of viral particles rapidly reduces with the wind, even a very light wind. The lower the concentration of viral particles, the less likely some of those particles can be inhaled into your lungs; contact your eyes, nose, and mouth; or accumulate on surfaces (CDC, 2020). Ways to increase air movement include: move

activities and services outdoors, open windows/doors, add fans to increase effectiveness of open windows, and increase air filtration in indoor areas that cannot be moved outside. When using fans, employ thoughtful care and aim fans to move air away from people and toward windows and exits.

7. What are some helpful hints for supporting emotional and social health of staff and campers?

Consider a space for staff to relax outside.

Staff members are typically young, social beings who often learn and grow by connections with their peers. Therefore, it can be helpful to create safe opportunities for these individuals to interact with one another. Consider offering an outdoor staff lounge, tools for processing the camp experience (i.e., journaling, access to a social worker or behavioral health support, debriefing opportunities), and fun experiences where they can “play,” such as staff time for activities (i.e., horseback riding, hiking, outdoor swimming). Also consider a quiet space for staff to relax and “chill out” outside where they can use their phones, computers, read, or have some time alone.

8. What are three key informational pieces we should provide to parents when they are considering sending their child to camp (during COVID)?

Anytime a camp experience may look for feel different than the traditional experience, we must prepare parents and families to help campers adjust to the new environment. Some simple ways to reframe the camp experience:

1. Share a typical camp day schedule with updates and changes from past practice.
2. Give parents key points on new procedures to share with children prior to arrival at camp (i.e., sleeping arrangements, food service, new/different activities, individual responsibilities, health/wellness services).
3. Provide pictures of camp changes to help families visualize how camp will look.

Residential

1. What are some options for keeping residential staff healthy on site?

Health is promoted by activity, nutrition, and mental rest. Seek opportunities to do these things for staff. Consider an afternoon hike or opportunity to use the pool; have supplies to make an afternoon smoothie or shake; prepare a treat, such as fresh cookies or warm brownies, as a thank-you for staff; find quiet places where staff may be alone to think, read, and meditate. Find creative and simple ways for individuals to have some space to respond to emails, use their phones, or do laundry. Taking care of staff does not require huge expense, but it does require concern and caring for their well-being.

2. In a residential setting, what are some tips for promoting health and safety in the sleeping areas?

During communicable disease events, creating separation is a helpful tool, especially when wearing a mask is not an option (i.e., during sleeping and eating). Arrange sleeping quarters with the greatest space between individuals, including sleeping head to toe when in bunk beds. Encourage each camper to only touch their luggage, clothing, and supplies — and not to share with others — as a “kindness” to friends. Sharing promotes cross contamination and increases risk for illness.



3. What are some tips for feeding large groups of campers in one dining hall?

Feeding large community groups is a great opportunity for creative service. Camps have learned how to have daily picnics, stagger mealtimes to minimize the number in the dining hall, create cookout options where food is cooked and eaten outside, and place snack tents strategically around camp. There are many alternatives to traditional dining hall meals.

4. What are some options for screening campers on arrival day?

Screening is a process to identify if an individual has characteristics that make them high risk for transmitting illness to others. To screen campers, consider ways to use nonpharmaceutical interventions (NPIs) in the process. Last summer, many camps did a drive-through check-in process where one adult guardian/parent brought the child to camp, the camper was screened in the vehicle (symptom check, temperature), and if no concerning findings presented, the camper entered the facility and the guardian drove away. This process promoted NPIs such as physical distancing, ventilation, screening, face masks, and handwashing to create a safety net of prevention.

“Drive-Through Check-In was a great tool and timesaver allowing us to better serve campers safely.”

Day Camp

1. What instructions should we give to day camp staff to try and keep them healthy for the summer?

The greatest risk for day camp staff is returning home each night and potentially being exposed to another individual with illness. Encourage day camp staff to try and

quarantine each night by not attending social events, limiting visitors and encounters outside of family, and self-screening for symptoms of illness. Encouraging day camp staff to get adequate rest and nutrition will aid in keeping folks healthy. Remind staff that careful handwashing and face mask use during their off hours will be beneficial for prevention of illness for all.

2. If we need to do daily screening, how do we do that? Who can do the screening?

Screening ideally should be done at the point campers are separating from family. This may be at the bus stop, at the pickup location, or at the facility itself. Camp staff can ask about signs and symptoms of illness and conduct a temperature screen if appropriate for the illness of concern. Individuals trained on the task of screening can conduct these activities. If a camper does not pass screening, they can return home with the parent before entering the camp and interacting with others. The camp should consider the same screening procedures with day camp staff.

3. What are some nonpharmaceutical interventions (NPIs) options for pre-camp care and/or after-camp care (when campers have historically been mixed together)?

Many day camps offer pre-camp and after-camp care. Often, early and late camp hours are provided and serve campers from all cohorts within the camp community in one larger group. Consider ways to keep campers in their regular cohorts for the care periods outside of usual operating hours. Maintaining cohort groups at all times will help minimize transmission of



communicable diseases. Nonpharmaceutical interventions (NPIs) — such as masking, handwashing, and social distancing — will be a solid foundation here. Camps can explore other simple options such as using duct tape or movable fencing to define areas in which you want individuals to remain, encouraging small-group interactions, offering small-group snack, developing team names, and/or developing a cohesive cohort team.

Staff

1. Is it helpful to bring staff to camp for an extended period of time prior to campers arriving? How long?

For several reasons, it can be helpful to bring staff together prior to campers arriving on site. In the case of COVID-19 (during summer 2020), many camps brought staff to camp 7–14 days prior to camper arrival. This allowed time for the camp to identify any staff who developed illness symptoms, conduct testing as part of their health protocols,

and determine how mixing and cohorting of staff would occur during the summer. Prescreening prior to staff arrival also promotes bringing healthy individuals to camp without impacting the camper population.

2. What are some tips for getting staff to buy in to use of the nonpharmaceutical interventions (NPIs)? Are there tips to encourage staff to be good role models for campers?

Recent research identified that counseling staff have more challenges than campers with adherence to nonpharmaceutical interventions (NPIs) throughout the summer. Young staff (18- to 22-year-olds) often have a sense of invincibility related to COVID-19 and feel that, even if they are exposed to the condition, they will not become very ill. The key is to help staff understand that a communicable illness could be transmitted to individuals they do not know. This pertains to COVID-19 as well as many other infectious illnesses.

Understanding one's staff is key to knowing how to support and encourage **wanted** behaviors. For some staff verbal affirmation is critical. For others, peer recognition is key. Take a proactive approach to positive encouragement to hopefully prevent reactive corrections of staff behavior. Can you create a staff game that promotes positive feedback for adherence? Can you identify ways to help individuals value community health over self-desire? The key is the Golden Rule (Love Your Neighbor as Yourself). Education and support during staff orientation and training will be crucial to setting a tone aimed at community.

Understanding one's staff is key to achieving wanted behaviors.

3. If I have been vaccinated, do I still need to quarantine if I am exposed to COVID?

Research in the medical and scientific communities continues to expand knowledge of the SARS-CoV-2 virus and the illness COVID-19. As this knowledge grows, recommendations change frequently. On February 10, 2021, the CDC announced fully vaccinated individuals are no longer required to quarantine after exposure to another COVID-positive person. "Fully vaccinated" is currently defined as having received both doses of either the Pfizer or Moderna COVID vaccine. Additionally, to meet criteria to be exempted from quarantine, at least two weeks must have passed since the second dose was administered, as it takes two weeks to build immunity. The CDC clarified — because it is still unclear how long the vaccine's immunity lasts — if it has been 90 days or more since the second vaccine dose was administered, an individual must resume quarantine restrictions after a known exposure. Finally, any vaccinated individual must still quarantine if they have symptoms consistent with SARS-CoV-2 infection. These recommendations for vaccinated individuals now align with individuals who have natural immunity after recovery from a COVID-19 infection.

4. If I have been vaccinated, do I still need to wear a mask?

Yes, all individuals, including vaccinated individuals and those with natural immunity, must continue to mask and follow all CDC health guidelines, as it is unknown if vaccinated individuals are still able to transmit the virus to others. CDC health guidelines include but are not limited to:

- Social distancing
- Avoiding large gatherings
- Frequent handwashing
- Following travel recommendations as they are issued
- Avoiding poorly ventilated spaces
- Covering coughs and sneezes
- Following guidelines from your workplace or school



5. If I have had COVID-19, do I still need to quarantine?

No, maybe not. If an individual can provide documentation of a positive COVID test within the last 90 days, they can be excused from quarantine. They must be able to provide supporting documentation to be excused. Currently, if 90 days have passed since the positive test, an individual must resume quarantine precautions after exposure.

Transportation

1. What are the most important considerations related to buses or other types of group transportation?

As with many other activities, the key to safe transportation is to use as many nonpharmaceutical interventions (NPIs) as possible in a layered effect to mitigate risk. For transportation, consider doing screening and then using handwashing, face masks, ventilation, and spacing to minimize transmission. Screen individuals before they board the bus, then perform hand hygiene, confirm face masks are in place, and have defined seats for everyone on the bus. Before departure, make sure the bus windows are lowered a couple of inches to allow adequate ventilation throughout the trip.

2. What should we be considering related to campers who arrive by airplane?



The same requirements used for bus transportation should be considered for air travel. The benefit here is that airlines have requirements in place to limit transmission and have excellent filtration systems on planes. Therefore, when you add prescreening and handwashing (to the airlines' requirements of spacing, ventilation, and face masks), you support risk mitigation.

Health Services

1. What were some of the most common changes to health services related to COVID prevention?

Many camps collaborated with key camp stakeholders to develop a working Communicable Disease Plan (CDP). Camps utilized the CDP to guide staff in the response and management of health concerns. Having a working CDP offers families and staff insight and preparation for how health concerns will be addressed. If camp administration chooses, a working CDP, or excerpts from the CDP, can be distributed to camp families. Sharing this information with parents and guardians can be reassuring and valuable to parents. It increases their confidence to know the organization has planned for management of health concerns during camp programming.

One of the most common changes implemented by many camps was moving delivery of many healthcare services outdoors. Camps did this by utilizing sheltered porches, tents, or other temporary structures adjacent to the usual camp health center. Another practice many camps found helpful was sending healthcare to the camper or staff member out in the activity areas. Using this practice, delivery of healthcare services remained outdoors and individuals were cared for in their cohort, limiting risk by not mixing with others. Additionally, campers and staff were often able to continue participating in an activity until healthcare personnel arrived.



Camps that previously delivered camper medications in large group settings worked to adjust that practice as well. Some camps established a plan to distribute medications to only one cohort at a time, and some performed medication distribution outside. Other camps found ways to completely change previous medication delivery practices while working to use as many nonpharmaceutical interventions (NPIs) as possible during care. Several camps found hiring more staff helped them adjust and respond to necessary changes to previous health service routines.

2. What types of personal protective equipment (PPE) should healthcare staff use when providing care?



PPE use is dependent on the illness being addressed. In the context of COVID-19, a face mask and gloves are adequate for simple triage. If conducting a procedure that produces aerosolized particles (i.e., nebulizer treatment), consider adding eye protection, such as a face shield, and a gown. It is helpful to understand how the communicable illness is transmitted and then respond with appropriate PPE use. *The Control of Communicable Diseases Manual* (David L. Heymann, MD) is a helpful resource for information about infectious illnesses and can be a useful reference in the camp health center.

3. What are some options if an individual presents to the camp health center with illness?

Although there are many ways to conduct these steps at a camp, here are the primary processes to consider if someone presents with illness.

1. Triage the individual outside if possible.
2. Isolate the individual if there is concern for communicable illness.
3. Monitor the individual for improvement or deterioration.
4. Arrange COVID testing or other testing (i.e., strep testing) for the individual if warranted.
5. Transfer the individual to higher-level care (urgent care, ER) if symptoms/condition warrant.

4. Should testing of staff and/or campers be part of a camp's Communicable Disease Plan (CDP)?

Testing can be another nonpharmaceutical intervention (NPI) included in a camp's CDP. Testing should not be considered a replacement for the other NPIs, but rather an addition to the NPIs a camp has already implemented. If testing will be incorporated, have a well-defined plan around testing times, testing frequency, and accessing results. Camps will need to investigate testing sites and requirements, as the availability of routine testing can vary widely across the country. If a camp is considering hiring a company to perform on-site testing, it will be important to ask for the company's Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver. If a camp is planning to do its own on-site testing, the camp must have a CLIA Waiver. Here are two resources for additional information on CLIA regulations:

1. <https://www.cdc.gov/labquality/waived-tests.html>
2. <https://www.acponline.org/practice-resources/business-resources/laboratory-proficiency-testing-program/cli-waived-testing>

5. Can two campers in isolation share an isolation space?

Two campers who present with similar symptoms can most likely be isolated in the same space. The isolation site should be well ventilated and offer space to position individuals at least 6 feet apart. Encourage good hand hygiene and provide frequent sanitation to high-touch areas in the isolation space. These recommendations are for COVID-19. Be certain to consider the suspected communicable illness in question and plan delivery of care based on recommendations from medical evidence, public health guidelines, and state requirements for the suspected illness.

6. What are some options for quarantining a group of campers after exposure or potential exposure?

Quarantining can be done as a group; these individuals are not demonstrating symptoms but have been exposed to someone with illness symptoms. Camps may consider creating a shadow camp where quarantined campers can continue to do

activities separately from others. Quarantining should employ use of nonpharmaceutical interventions (NPIs) in addition to the separation of affected campers from the larger camp group.

Enhanced use of NPIs becomes more important to prevent transmission within the group being monitored.

Good handwashing, face mask use, physical distancing, and sanitizing become more important in this transitory phase of quarantine to help prevent potential transmission within the group being monitored. A camp may decide to quarantine a group in their own cabin, but ideally they should have access to their own bathroom facilities. Quarantine for COVID-19 allows us to monitor a small group of exposed individuals and then consider testing about three to five days after initial exposure to identify any additional positive cases. Subsequent contact tracing can be done within this structure to minimize transmission.

Many questions could be asked regarding communicable disease management. We hope these answers provide a starting point, and we encourage you to reach out to ACN for additional support and guidance as we plan for summer 2021 and beyond!

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Resources

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