Resocialization of Collegiate Sport: Action Plan Considerations

This document serves as a follow-up to and assumes the premise of Core Principles of Resocialization of Collegiate Sport. The information in this document, which was developed in consultation with the NCAA COVID-19 Advisory Panel, is offered as guidance and is meant to be consistent with guidance published by the federal government and its corresponding health agencies and otherwise reflective of the best available scientific and medical information available at the time of print. These materials are not and should not be used as a substitute for medical or legal advice. Rather, they are intended as a resource for member schools to use in coordination with applicable government and related institutional policies and guidelines. They remain subject to further revision as available data and information in this space continues to emerge and evolve.

As the rates of infection and death from COVID-19 have recently declined or stabilized in some areas of the country, many states have established plans for resocialization, and there is an increasing dialogue about the need to balance the economic and other benefits of resocialization and reopening with the need to protect society from the public health consequences of the ongoing spread of COVID-19. Until a vaccine is in place, or until there is effective treatment, this type of balance analysis should continue, with an understanding that the most effective strategy to mitigate COVID-19 spread during resocialization includes the following:

- Personal.
  - Physical distancing.
  - Universal masking when physical distancing is not possible.
  - Hand hygiene, especially after touching frequently used items or surfaces.

    - Using a tissue, or the inside of your elbow, to sneeze or cough into.
    - Not touching your face.
    - Disinfecting frequently used items and surfaces as much as possible.
    - Staying home if you feel sick and following the advice of your health care provider.
- Local/institutional
    - Safe and efficient screening and testing sites for symptomatic individuals and trace contacts.
    - Surveillance, including contact tracing.
    - Isolation and quarantine for new infections or for high-risk exposure.

The decision to reopen college campuses and resume sport is part of this balance and is not binary in nature. Rather, it involves a complex combination of objectives that speak to decreasing harm, maximizing the number of lives saved, and improving overall quality of life for American citizens. A successful balancing of these objectives will most likely involve the development of targeted strategies that are based on emerging COVID-19 data and information, including the recently reported considerations described below:

- One-third of American deaths from COVID-19 have, to date, occurred in nursing homes and other long-term care facilities.
- The COVID-19 death rate among young healthy Americans is currently similar to the most recent death rates resulting from influenza.
- Asymptomatic infections have been common, especially in young healthy Americans.
- After infection with SARS-CoV-2, the virus that causes COVID-19, viral shedding is prominent in days two through five, and symptoms usually develop around day five.
- Certain individuals have been identified as being at higher risk for severe complications and death from COVID-19, and they include those with:
    - Age greater than or equal to 65.
    - Chronic lung disease, including moderate and severe asthma.
    - Serious heart conditions.
    - Immune system compromise.
    - Severe obesity with body mass index greater than or equal to 40.
    - Diabetes mellitus.
    - Chronic kidney disease with dialysis treatment.
    - Liver disease.
    - Sickle cell disease (not sickle cell trait).

While some stakeholders have embraced the idea of planning for the reopening of collegiate sports, others have questioned whether it would be better to simply wait until there is no longer a threat from COVID-19. The fact is that, at this time, we do not know how long COVID-19 will remain as a threat and, based on currently available data, it is conceivable that the SARS-CoV-2 virus will remain endemic with the number of new cases in society continuing to fluctuate over the next year or even longer. A resocialization plan that attempts to properly balance the public health considerations through the identification and implementation of appropriate safeguards provides an alternative to shutting down society and sport indefinitely.

Collegiate sport is intimately tied to college education. In other words, NCAA student-athletes are first and foremost students. While the structure of typical student life may evolve over time, and while student-athletes — like other students who are pursuing passions beyond the traditional classroom — invest intensely in the development of their unique skills, being a student is and will continue to be an essential function of being a student-athlete.

Within this context, these broad considerations relate to planning for the resocialization of collegiate sport.

Reopening Considerations

Before reopening athletics facilities for student-athletes, athletics departments and institutional leadership should consider whether and how the following may be incorporated into the broader campus action plan to facilitate identified health and safety objectives:

- A COVID-19 communication plan that connects athletics with the broader institution.
- A COVID-19 communication plan that connects the school, including athletics, with local and state facilities.
- A plan to protect and support higher-risk individuals.
- A plan to provide virtual alternatives as necessary and appropriate.
- Facility-specific health and safety plans that address, among other things, necessary resources, supplies and other applicable distancing and sanitation guidelines.
- The development of an athletics COVID-19 action team that may include these individuals among others:
    - Athletics director or designee.
    - Athletics health care administrator.
    - Head athletics trainer or designee.
    - Head team physician or designee.
    - Coach representative.
    - Strength and conditioning coach representative.
    - Student health services representative.
    - Counseling services representative.
    - Student-athlete representative.
    - Health care and emergency preparedness representative.
    - Faculty athletics representative.
    - Campus coordinator (dining hall, dormitory).
    - Compliance office representative.
    - Institutional legal counsel or risk management representative.
    - University relations and/or athletics communications representative.

Athletics Staff and Student-Athlete Return to Campus Considerations

Athletics department staff and student-athletes are part of the broader institutional population and any plan for their return to campus should align with broader institutional policy for return, which may or may not involve a COVID-19 testing protocol. However, student-athletes and athletics staff have

traditionally interacted with closer contact than the broader campus population such that there are additional risk and mitigation factors that should be considered within the athletics framework. Whereas new COVID-19 infections might be managed at a broad school level, it might be more difficult to manage any new infections and resulting potential for COVID-19 spread within athletics, and specifically within a team environment. Additional pre-return practices that may be considered for student-athletes and athletics staff may include, among others:

- Confirmation of no high-risk exposure to COVID-19 for at least two weeks before returning to campus.
- Absence of typical COVID-19 symptoms including, among others, respiratory issues, gastrointestinal problems, fever, headache, fatigue and muscle pain, for at least two weeks before returning to campus.
- If travel back to school involves physical distancing challenges (e.g., air or commuter bus travel), confirmation of local off-campus or campus-designated self-quarantine for at least seven days — or longer if advised by local or state governmental health officials — before returning to athletics.

Special consideration should be given to student-athletes and staff who are at higher risk of developing severe cases of COVID-19, including an individualized plan of safely returning to campus.

Post-Return Operational Considerations

Daily Self-Health Evaluations

Schools should consider asking all student-athletes and staff to practice at least daily self-health evaluations before participating in any aspect of in-person athletics activities. Encourage individuals who identify any of the following symptoms or signs during the self-health evaluation to contact the designated athletics health care representative by telephone or virtual visit before coming on campus or to any athletics facility:

- Shortness of breath or difficulty breathing.
- Cough or other respiratory symptoms.
- Headache.
- Chills.
- Muscle aches.
- Sore throat.
- Congestion or runny nose.
- New loss of taste or smell.
- Nausea, vomiting or diarrhea.
- Pain, redness, swelling or rash on toes or fingers (COVID-toes).
- New rash or other skin symptoms.
- High-risk exposure (e.g., new contact with an infected individual or prolonged contact with a crowd without physical distancing).
- Temperature of 100.4° Fahrenheit or above.

Preparticipation Physical Screening and Clearance

Institutions should prepare for the amount of time and resources that will be needed to complete adequate preparticipation health screening activities. Although some of these activities may be completed via telehealth or otherwise before return to campus, a thorough preparticipation exam is critical and may need to account for new and different COVID-specific symptoms and/or indications, including those pertaining to symptomatic and asymptomatic impact on pulmonary, respiratory and cardiac systems. Emerging information has revealed potential cardiac abnormalities in individuals who have developed COVID-19, but the incidence and impact on young adults is unknown.

In addition to these COVID-related medical complexities, which may require additional screening steps, basic COVID-specific distancing and sanitation recommendations likely will require more space for exam activities and more time between visits. While schools have great flexibility in terms of how they design the health screening and clearance process, it is critical that it be completed before preseason physical activities begin and that schools properly consider any related health and safety resource and scheduling needs.

Mental Health Considerations

An NCAA survey of student-athletes revealed that a majority of student-athletes surveyed reported experiencing high rates of mental distress since the outset of the COVID-19 pandemic. Over a third reported experiencing sleep difficulties, more than a quarter reported feeling sadness and a sense of loss, and 1 in 12 reported feeling so depressed it has been difficult to function, “constantly” or “most every day.” Mental health concerns were highest among respondents of color, those whose families are facing economic hardship and those living alone. Additionally, college seniors reported a sense of loss at 1.5 times the rate of underclassmen. In most instances, the rates of mental health concerns experienced within the last month were 150% to 250% higher than historically reported by NCAA student-athletes in the American College Health Association’s National College Health Assessment. For these reasons, considerations should be given to a focused mental health evaluation as part of pre-participation medical screenings, focusing on mental health symptoms and disorders that may have either developed or become exacerbated as a result of this pandemic.

Individual and Facility Health Hygiene Practices

Athletics departments should consider how best to promote and support appropriate adherence by student-athletes and athletics staff to applicable health hygiene recommendations including, among others, those described below:

- Hand hygiene.
- Physical distancing.
- Use of face masks/coverings where physical distancing isn't feasible.
- Proper cough and sneeze etiquette.
- Not touching the face
- Those feeling ill staying at home, or if they begin to feel ill once on site, avoiding contact with others, departing for home, and informing a physician and/or athletics health care provider.

In addition, athletics departments should give focused consideration to how staff and student-athletes might best align those practices with athletically related activities, especially those involving cardiovascular and group workouts.

Beyond individual hygiene practices, institutions should consider the development of protocols and techniques that speak to the serious risks related to the sharing of items like towels, water bottles and food and the importance of appropriate cleaning and disinfecting of shared equipment and spaces. Similarly, schools should evaluate how best to promote and support the same protocols to student-athletes, custodial and food services staff, medical personnel, coaches and other athletics department personnel.

Physical Distancing

As noted in the Core Principles document, resocialization of each sport begins as Phase One, and then progresses to Phases Two and Three in a manner consistent with established gating criteria. During Phases One and Two, strength and conditioning and other sport activities are conducted with the physical distancing guidance provided in the document. Although physical distancing is not possible during Phase Three practice and competition in high-contact risk sports (see below), institutions should consider how best to promote appropriate physical distancing practices outside of such organized sport/exercise activities, including in waiting and seating areas, entrances, exits and hallways in other high-volume common areas including, among others:

- Athletics training rooms and other sports medicine facilities.
- Athletics locker rooms.
- Strength and conditioning facilities.
- Team meeting rooms.
- Athletics academic areas.
- Athletics dining areas.

Similarly, departments should consider using virtual team meetings whenever appropriate and possible.

Infection Monitoring and Response Considerations

Infection Testing and Surveillance

Sports and activities vary with regard to potential contact with the SARS-CoV-2 virus. Accordingly, sports and activities may be divided into low contact risk (e.g., bowling, cross country, diving, golf, gymnastics, rifle, skiing, swimming and diving, tennis and track and field); medium contact risk (e.g., baseball, softball); and high contact risk (e.g., basketball, field hockey, football, ice hockey, lacrosse, rowing, soccer, volleyball, water polo, wrestling). Further, athletics staff may be divided into those with close contact ("inner bubble"), intermediate contact ("intermediate bubble") and limited or no contact ("outer bubble") with student-athletes. Surveillance and testing protocols should consider both the type of sport and the "bubble" of athletics personnel.

Each institution should proactively and carefully consider how it will monitor and respond to potential cases of COVID-19 within the athletics department. Surveillance and testing are considered by many to be the foundation of a successful COVID-19 monitoring and management plan. However, the infrastructure and details that underlie any surveillance and testing plan will likely depend on the unique nature of state, local and institutional guidelines and will vary from institution to institution.

Many different types of testing have been introduced and discussed by community health leaders since the onset of COVID-19.

Diagnostic Testing — Two distinct tests are included in diagnostic testing:

1. Polymerase chain reaction testing for viral particles. PCR testing assesses for the genetic information of the virus, that is present in an individual who is actively infected. PCR testing has traditionally relied on nasopharyngeal swabs and a specified reagent for completion of the test.
2. Antigen testing. Antigen testing assesses for proteins found on or within the virus. Antigen testing does not require the reagent and nasopharyngeal swabs that have been traditionally used for PCR testing. This allows antigen testing to be completed as a point-of-care test, meaning that the results are provided by a specific device on site and within minutes.

While for the most part PCR testing for viral particles is currently taking place in public or private laboratories, there has been a rapid evolution of point-of-care tests for PCR testing as well. Additionally, there is increasing progress in using more simple nasal swab tests or saliva samples for both types of diagnostic tests. This is important because nasopharyngal swab testing requires full personal protective equipment for the tester, as this procedure often induces a cough reflex.

Serological Testing — Serological testing assesses for antibody response to COVID-19 infection via a blood test. IgG antibody indicates a history of prior infection and hopefully correlates with future immunity, although data are not conclusive. IgM antibodies are an indicator of active infection. Sensitivity and specificity have not been well validated for serological testing, but such testing could be worthwhile once validation is secured.

Surveillance Testing — An important aspect of the mathematical modeling and epidemiological analysis of COVID-19, surveillance testing can be used to monitor virus movement, effect on certain groups of people and patterns of growth and decline. Such testing is still in its infancy. Any successful surveillance strategy will need to balance practicality and acceptable risk. There is not a no-risk option.

Testing Limitations and Future Methodologies

While diagnostic testing can be helpful and is currently the most accessible and accurate for purposes of large population use, it is important to understand that it currently only assesses for infection at the time that the test is taken. Negative diagnostic test results can, therefore, potentially provide a false sense of security, and athletics departments should consider the impact that testing frequency may have on the reliability of monitoring plans.

It's arguable that diagnostic testing becomes increasingly important in high-contact risk sports, especially after Phase Three practices and competition begin, because the risk of COVID-19 spread is greater where physical distancing and universal masking of athletes cannot occur, both of which are much less feasible in sports where student-athletes are regularly practicing and competing in very close proximity or while in physical contact. Some high-contact risk sport teams such as football also generate significantly high testing volumes in terms of the number of participants per team.

In light of these factors, athletics departments should consider the development and implementation of effective contact tracing protocols (e.g., "bubble" network identification process described above) that can be leveraged to efficiently and effectively ramp up and otherwise adjust testing protocols to address these heightened risks in the event a student-athlete becomes infected and has been participating in contact/collision sport practices or competitions.

If bulk batch testing and/or point-of-care viral and antigen tests become more widely accessible and reliable, this may help remove some of the inefficiency and cost currently associated with individualized laboratory testing processes. Regardless, athletics departments should consider the current and future availability and reliability of different kinds of testing, and any related budget, logistical and operation impacts, as they develop their broader institutional monitoring plans.

Contact Tracing

To efficiently and effectively respond to a new infection, athletics departments should evaluate how best to identify contact networks and trace contact interactions for staff and student-athletes. The identification of the participants in each "bubble" network can facilitate contact tracing if an individual becomes newly infected and can help the institution and applicable authorities prioritize the removal, isolation and quarantine of other at-risk individuals.

Response to New Symptoms/Diagnosis

If a student-athlete or a member of the athletics department staff develops COVID-19, the school, in conjunction with local health authorities, will need to evaluate how best to protect the others who may come in contact with that individual. Such a plan might include steps like immediate isolation from others and prompt contact with the primary athletics health care provider and required government authorities, as well as consideration of the following:

- A designated isolation room.
- Personal protective equipment for both the symptomatic individual and the treating clinician.
- Transportation to one of the following:
    - An on-campus facility with an isolation room.
    - Off-campus housing with isolation precautions.
    - Hospital or other medical facility (e.g., for individuals with shortness of breath or other evidence of cardiopulmonary compromise).
- Contact tracing of all exposed individuals.
- Return-to-activity protocol.

If the infection occurs during a period in which a competition takes place, the response and mitigation plan likely will need to take into account the safety of student-athletes and staff from the opposing team. Schools should consider the benefit of competition protocols that may include, among other precautions, daily self-health evaluations for all “inner-bubble” personnel, and campus access for only those with a demonstrated temperature of less than 100.4 degrees Fahrenheit and no new symptoms, and/or a negative result from a pre-competition diagnostic test. Testing strategies can also be employed but would not negate the benefit of daily self-health evaluations.

Based on the capabilities of currently available testing alternatives, existing standards of care suggest a quarantine period of approximately 14 days for all newly infected individuals and their high-risk (e.g., “inner-bubble”) contacts. However, emerging protocols are being developed that include an alternative to the 14-day quarantine; such protocols include daily, or every other day, or select day diagnostic testing over five to eight days, with action plans based on test results. Accordingly, if infection occurs after the commencement of team practice activities, this response plan could involve, among other things, temporarily or permanently ceasing in-person activities, or a diagnostic testing protocol that has been vetted by the institution and the local health authorities.

While the structure and details of response plans will vary from institution to institution, an athletics department should consider how its plan may impact the broader campus and community and how best to ensure its plan is appropriately aligned with applicable state, local and institutional requirements.