

ACHA Guidelines

Considerations for Reopening Institutions of Higher Education for the Spring Semester 2021

In seven months since the May 7, 2020, release of the ACHA Guidelines: [Considerations for Reopening Institutions of Higher Education in the COVID-19 Era](#), unprecedented research, diagnostic testing, vaccine, and treatment developments have advanced our approach to SARS-CoV-2, the novel coronavirus that causes COVID-19. For many campuses, the short-term goal upon entering the fall semester was to reach Thanksgiving break and provide a safe environment to carry out the institution's academic, research, and service missions; adhere to public health guidance; meet the expectations of students, faculty, and staff; and avoid fatalities. At the time of this writing, the nation is deep within a third wave of the pandemic and breaking daily records for confirmed cases, hospitalizations, and deaths. The emergency use authorization of two safe and effective COVID-19 vaccines is bringing new hope at the end of an arduous semester and calendar year.

After several months of experience, research, and practical applications, we know more, have learned from early missteps, and are better prepared for spring semester. For months, institutions of higher education (IHEs) have been in perpetual motion to retrofit facilities; acquire personal protective equipment (PPE) and cleaning supplies; educate and train the campus community; implement technology and testing programs; transition to telemedicine and telemental health services; and create new processes, systems, and partnerships to address the pandemic. This document serves to provide updated considerations and guidance for IHE presidents and chancellors, senior leaders, and college health professionals to inform their planning for the upcoming semester.

Lessons Learned

- Planning and preparation, including contingency plans are essential for an organized, effective, and timely response. The response must include strategies for recovery and future preparedness. Flexibility and quick adaptation to the changing environment are critical for success.

- United leadership is critical to a sustained and effective response. The leadership must have accurate and reliable data, a clear understanding of crisis management, and an in-depth knowledge of policies/procedures. They must leverage the research enterprise and campus and local experts and gain the trust and respect of the campus community through honesty, clear communication, transparency, and concern for the overall health and well-being of the campus and its surrounding community.
- Multilayered mitigation strategies with universal masking, physical distancing of 6 feet or more, and good hand hygiene accompanied by a coordinated public health strategy of robust testing, contact tracing, and expeditious isolation and quarantine processes are the most effective measures for decreasing the risk of transmission of SARS-CoV-2.
- Most campus outbreaks have been related to small and large gatherings without masking and without physical distancing that have occurred in bars, in on- and off-campus residences, and in Greek housing.
- Managing a campus outbreak requires a coordinated response and a close partnership among state and local public health authorities, community leaders and the IHE's COVID-19 emergency response team. Identifying key indicators and triggers to implement a change in campus operations should be established early, widely communicated, and continuously monitored. The health services director or designee should play an integral role in this effort.
- Students with COVID-19 are frequently asymptomatic. Preventing transmission by asymptomatic and presymptomatic individuals requires universal masking, physical distancing, swift identification through testing and contact tracing; and isolation and quarantine.

- SARS-CoV-2 is primarily transmitted via aerosols/droplets; therefore, proper physical distance among people in classrooms, along with appropriate ventilation and universal mask requirements will minimize transmission in instructional settings.
- There is little evidence to show secondary transmission is occurring either student-to-student or student-to-faculty member in instructional settings where everyone is wearing masks and proper physical distancing is maintained.
- Though fomites and surfaces pose a lesser threat, high touch areas must be cleaned and disinfected regularly, and all must practice meticulous hand hygiene and avoid self-contamination with unwashed hands.
- Student adherence to public health practices and the campus COVID-19 plan is essential for success.
- Students must be involved in planning, messaging, and the development of safer social activities.
- Fostering healthy behaviors requires a social norming approach and the use of all available channels of communication including social media, texts, and email.
- The frequency of testing and rapidity of turnaround time are more important than the sensitivity of the test. Surveillance, screening, and diagnostic testing strategies are all important in reducing the spread of COVID-19 on college campuses.
- Because of the numerous unknowns, the rapidly evolving nature of the pandemic, and the inability to predict student behavior, IHEs have established surveillance systems and thresholds to quickly change course. Planning must account for different scenarios and exit strategies.
- Herd immunity will only be achieved with delivery and widespread public acceptance of a safe and effective vaccine.
- Recognition of the mental health effects on the campus community cannot be minimized. The emotional impact of loss, uncertainty, isolation, and quarantine have been notable.
- The NCAA has continued to revise their recommended testing strategy for each sport. Testing is important in all intercollegiate sports, with the frequency and timing determined by the sport's risk level. Testing strategies should include, at a minimum, all "Tier 1" individuals, which includes student athletes, coaches, athletic trainers, medical

staff, physical therapists, equipment staff, and officials. In the "Appendix, Sport Transmission Risk, Sample Testing, and Masking Strategies" to its [Resocialization of Collegiate Sport: Developing Standards for Practice and Competition, Second Edition \(Updated\)](#), the NCAA provides details of testing recommendations.

The Work Force

Since the release of ACHA's Reopening Guidelines in May 2020, CDC has continued to update and expand the list of conditions that place individuals at increased risk of severe illness if infected with SARS-CoV-2 and has also developed a list of conditions that might place individuals at increased risk (see both lists here). Campus human resources (HR) leadership should continue to monitor these conditions and evaluate and modify policies and accommodations based on updated CDC guidance.

Faculty and staff, particularly those on the front line providing in-person services/instruction, must have ample and appropriate personal protective equipment (PPE) and cleaning and sanitizing materials available.

The pandemic-fueled economic downturn, social isolation, and "Zoom fatigue" have exacerbated stress levels, anxiety, and burnout, particularly in health, counseling, and health promotion staff and those faculty and staff who have shouldered the front-facing, day-to-day activities of the in-person campus. At a minimum, the IHE should ensure all faculty and staff have access to employee assistance programs and other wellness resources.

Considerations for the work force:

- Update COVID-19 safety educational and training materials to include new campus policies, new isolation/quarantine durations, revised definitions and reminders to wear masks, maintain physical distance, practice good hand hygiene, clean and sanitize, and to promote vaccine adherence to influenza and the COVID-19 vaccine.
- Have faculty, staff, and students review the updated educational and training materials in a timely manner, ideally within the first two weeks of return to campus.
- Review and update HR policies and employee accommodations based on current CDC guidance.
- Develop plans for alternative work assignments for high-risk staff.
- Develop employee health program protocols for management of exposed and ill staff members.

- Develop return to work protocols for staff who have become ill or exposed to COVID-19.
- Strongly encourage both flu vaccination and COVID-19 vaccination (when available). Consider implementing a requirement for active declination of both.
- Address faculty/staff mental wellness and provide resources such as employee assistance programs, financial literacy information, mindfulness teachings, and “care for the caregiver” programs.
- Provide coaches and mentors and/or workshops to assist faculty with technology and innovative instruction tools.
- Continue daily symptom checking and reinforce messages to stay home or leave work if sick.

Student Health Services (SHS)

The role of student health services was expanded during the pandemic, often with SHS staff adding testing, contact tracing, and case management to their responsibilities. Campuses will continue to look to student health services for medical and public health expertise, and SHS leadership should be poised to deliver current, sound, evidence-informed recommendations. Maintaining essential services to students while providing pandemic-related care and campus support have challenged and strained the campus health system.

Patient Care Considerations

In concert with the recommendations outlined in the May 2020 ACHA Guidelines: Considerations for Reopening Institutions of Higher Education in the COVID-19 Era, the SHS should:

- Advise patients to call before coming to the SHS for any type of visit.
 - If possible, utilize an online or telephone process for patient check-in.
 - Limit student contact with SHS computers/keypads. Have students complete and submit forms (health history, immunizations, consents, etc.) in the patient portal or utilize EMR templates.
 - Require all patients to wear face masks (or cloth face coverings if adequate face masks are not available).
 - Prohibit visitors, children, or accompanying guests who are not receiving care or services from entering the facility.
- Screen all patients and staff for COVID-19 symptoms before entering the clinic. Temperature checks may also be considered.
 - Develop a plan for students with respiratory symptoms who need transportation to SHS, housing, or local hospitals. Ensure after-hours care options are included.
 - Incorporate telehealth options as well as in-person visits into triage protocols.
 - Continue to utilize telemedicine visits and provide students with options for telemedicine or telephone consults when appropriate. Students with conditions placing them at higher risk for complications from COVID-19 should be encouraged to seek care via telemedicine.
 - Develop protocols for in-person visits. Consider designating and scheduling providers for telemedicine and in-person visits on a daily basis. Allocate a separate area of the clinic for acute illness.
 - Update screening forms to incorporate COVID-19 symptoms, including but not limited to: fever, cough, shortness of breath, chills, muscle pain, headache, sore throat, congestion, nausea, vomiting, diarrhea, anosmia, and dysgeusia.
 - Continue the delivery of routine clinical preventive services when at all possible to prevent health consequences of delayed care.
 - Ensure protocols for managing patients with acute respiratory symptoms include masking the patient, quickly rooming the patient, limiting and tracking the number of staff who enter the room, limiting the movement of the patient throughout the SHS, and cleaning of spaces where the patient was present.
 - Avoid use of nebulizers and peak flow measurements which can generate additional aerosols.
 - Ensure a COVID-19 testing plan is in place for students, faculty, and staff, either on- or off-site. Frequency and type of testing may vary depending on community and campus resources.
 - If dental operations are within the scope of services, review updated [CDC Guidance for Dental Settings](#).
 - Work closely with the marketing and communications department to continue to provide updated messaging about COVID-19 protocols, policies, and services. Use a variety of platforms

including websites, social media, and signage. Involve as many campus entities as possible in communicating these messages (housing, dining, recreation, etc.).

- Work closely with residential life staff to identify and manage students who require isolation or quarantine.
- Develop relationships and agreements with local emergency departments (ED) to accept ill patients requiring a higher level of care.

SHS Facility Considerations

- Design facility layout to provide in-person clinical services for needed preventative care and care for illnesses/injuries other than COVID-19 in the safest manner possible while minimizing transmission of COVID-19.
- Segregate waiting areas for ill and well patient visits. If separate waiting rooms are not available, consider placing a tent outside or identifying a satellite space for patients with respiratory symptoms. Deploy signage providing clear guidance on how to proceed.
- Perform COVID-19 testing outdoors when possible.
- Reconfigure all waiting and other clinic areas to promote physical distancing.
- Ensure adequate amounts of alcohol-based (at least 60%) hand sanitizer, face masks (or cloth coverings if masks are not available), tissues, and closed bins for disposal are available.
- Provide plexiglass/clear barriers between reception staff and waiting areas.
- Develop protocols for environmental management, including frequency and responsibility for clinic cleaning and decontamination.
- Assess air exchange of care, treatment, and administrative spaces and determine time required between uses in the event of a known or suspected COVID-19 patient.
- Ensure adequate IT network, wi-fi, hardware, and expertise to support telemedicine and telemental health visits.

SHS Administrative/Staff Considerations

- Utilize patient satisfaction surveys to obtain feedback about telemedicine or phone visits as well as clinic services. Develop a system to review the quality of care provided and incorporate into existing peer review processes.

- Ensure adequate PPE is available and that all staff are trained in its use. Monitor staff compliance with PPE use. Enough PPE supplies should be stocked to meet both patient care and testing needs.
- Maintain situational awareness of COVID-19 in the state, city, and on campus.
- Consider a mandatory COVID-19 testing policy for all staff.
- Implement effective patient-centered policies to safely meet the health and counseling needs of students.
- Develop employee health program protocols for management of exposed and ill staff members. Develop return to work protocols for staff who have become ill or exposed to COVID-19.
- Document all providers and support staff involved in the care of every patient so that exposures can be tracked.
- Ensure staff are knowledgeable about COVID-19 symptoms, transmission, relevant protocols, and updated CDC guidance.
- Develop plans for alternative work assignments for high-risk staff.-
- Continue to track costs and funding mechanisms for testing, contact tracing, and case management. Consider the financial impact of mass vaccination with COVID-19 vaccine.
- Develop plans for mass immunization with COVID-19 vaccine, including necessary personnel, supplies, and locations for vaccination administration and delivery.
- Identify appropriate charges (if indicated) for visits, telehealth services, testing, and supplies, including medications or vaccines. Identify correct billing codes to facilitate prompt, accurate reimbursement if billed to insurance.

Mental Health

Addressing the mental health and wellness needs of our students and campus community has proven to be a tall order for college health and counseling centers and campuses at large throughout the pandemic. Even before the pandemic, [college and university presidents placed student mental health needs at a high priority](#). College counseling centers moved quickly to develop new platforms for providing services, forge new campus and

community partnerships, and establish a diverse array of services using hybrid and fully virtual venues to support student mental health and wellness through these difficult times.

[JED's Comprehensive Approach](#) identifies key areas that colleges should address to support student mental health and to limit substance misuse and suicide. Within each strategic area, there are multiple activities and efforts that colleges can implement to support student mental health. The Jed Foundation emphasizes that a campus-wide systemic approach is integral in efforts to prioritize the mental health needs of students, especially at a time when students may have fewer interactions with peers, athletic coaches, and advisors and that faculty may have an even greater responsibility as gatekeepers.

The extreme academic, social, and economic pandemic-related disruptions, the transition to virtual environments, and constant uncertainty continue to take a toll on students' well-being. For many, the pandemic can be classified as a disaster with uncertainty being the main component; those with pre-existing mental health conditions, low frustration tolerance, and/or limited coping strategies have been heavily impacted. The American Psychological Association indicates that the [negative mental health effects of the pandemic](#) will be serious and long-lasting.

[ACHA and Healthy Minds survey data](#) collected early in the pandemic showed an increase in student incidence of depression and feelings of stress and anxiety. Student perceptions of loneliness and isolation have been cited as contributing factors. Some students report that mental health services have been more difficult to access since the pandemic. Early data suggesting increased incidences of stress and mental health symptoms are juxtaposed with data indicating improvements in student resiliency by 2.5% and decreased prevalence of risky drinking patterns.

Access to Care and Diversity of Services

The pandemic has accelerated the need for campuses to do "business differently". Now more than ever the need to provide a menu of mental health and wellness services is vitally important. Counseling centers are creating options other than the traditional in-person or virtual 50-minute psychotherapy session. Students often want "just in time" services that are timely, convenient, and accessible. To meet the need, counseling centers are offering "on demand" same day appointments, virtual walk-in clinics, mental health chat groups, and encouraging the use of self-directed skill building modules and apps.

Technology and Telemental Health

In spring 2020, most college health and counseling centers pivoted to virtual platforms, establishing eligibility and exclusion criteria and practice guidelines for the provision of telemental health services. Counseling centers will likely continue to refine, expand, and deliver their services in this manner throughout the upcoming spring semester. Widespread temporary state-by-state exemptions helped address legal barriers that prevented counseling across state lines. The sustainability of telemental health services will be based on evaluative outcome data, identified needs, and demand.

Ongoing Assessment and Evaluation

IHEs are encouraged to consistently assess the prevalence and acuity of student mental health symptoms on their campuses. It is important to collect data to support strategic planning, resource management, and service delivery models, including student satisfaction with telemental health services, as well as outcome data related to efficacy of care. Campuses are encouraged to identify how best to collect data without further burdening a virtual-weary population with additional electronic surveys.

Faculty and Staff Mental Health

[The ACHA and Healthy Minds data](#) indicate that there is a direct correlation between feeling valued and supported and a sense of wellness. A strong predictor of wellness is believing that your voice matters and feeling like you are a part of the decision making. For faculty and staff these tenets are equally important. Campus leadership must continue to recognize and validate efforts on a consistent basis and ensure that health, counseling, and health promotion staff as well as faculty and other staff continue to receive support, care, and resources on stress reduction, anxiety and depression management, and self-care.

Mental Health Considerations

- Ensure mental health providers continue to comply with current environmental, physical distancing, PPE, and public health infection control measures.
- Institute appropriate safeguards for in-person sessions, including symptom screening, physical distancing, and face masks for both client and provider.
- Develop and/or revise policies related to telemental health that are in line with accrediting bodies and best practice standards of care, including policies on education, training and credentialing of staff, and

processes for monitoring competence with telehealth protocols and practices according to local, state, and national requirements.

- Develop and/or revise policies that guide clinical practices and service provision, including policies on changes to the scope of services, patient confidentiality and privacy, informed consent, crisis management, risk management, clinical documentation, and system security.
- Outline steps required to offer services across state lines and communicate policies clearly to students.
- Encourage partnerships with faculty and other support departments such as financial aid and the registrar's office to promote connections and opportunities to reinforce training on how to appropriately identify, intervene, and refer students in distress.
- Add mental health questions to existing surveys, check-in processes, and functions to continuously take the wellness pulse of the campus population.
- For training facilities, ensure policies address how trainees' telemental health sessions will be supervised and whether sessions will be recorded for supervision.
- Address the issues of compassion fatigue with the health and counseling staff and promote venues for sharing and ongoing support. Identify wellness resources, including the employee assistance program.

Health Promotion

Health promotion is a process—a network of coordinated actions—that supports individuals' autonomy in creating health and well-being. Health promoting actions include implementing health-supporting public policy, developing healthy working and living environments, coordinating collaborative community action, providing health education, and working with health care systems to think beyond treatment to promoting health as an everyday resource.

Health promotion professionals are experienced in applying processes to multiple and varying focus areas. Health promotion processes can be applied to any health outcome of interest, and every institution selects focus areas for health promotion activities based on its unique contextual characteristics.

Senior health promotion professionals often have expertise in coordinating multi-layered, broad community action. They are uniquely skilled at developing and coordinating a

comprehensive framework for supporting student compliance across multiple campus operational units and utilizing best public health and prevention practices. Adapting policy and institutional operations to support health are core concepts of health promotion. The intent is to make healthy behaviors the easy choice through identification and removal of barriers to healthy action. In this area, institutions have adopted a variety of health promoting actions during the pandemic:

- Changes to grading and attendance policies to allow students greater flexibility.
- Changes to academic terms to reduce needed travel.
- Enhanced food security and aid for students in quarantine and isolation.
- Enhanced access to technology for distance education.
- Increased temporary aid for students in financial distress.
- Detailed infection control plans across the institution to provide structured, in-person opportunities to support well-being.

Student Engagement and Community Mobilization

Student engagement with institutional response to COVID-19 varies by campus, depending upon institutional values and structures and operational factors such as whether classes are remote or in person. Many institutions that have transitioned to a primarily online education model have seen a notable decrease in student engagement. Some institutions report lower student engagement across the board. Others report low student engagement generally, but consistent and sometimes increasing student involvement in health promoting activities, specifically those supporting mental and emotional health.

Students want opportunities to talk about and process how COVID-19 has affected their college experiences and their lives. They want support in understanding the constantly evolving information about the virus and mitigation efforts and applying these facts to everyday life. They want to know what they *can* do safely, as they are now well-versed in what they should not do. Students also are clear that the pandemic has only exacerbated the already widespread concerns about mental and emotional health.

A foundational tenet of health promotion is creating health *with* the people and community served. Because of this, health promotion professionals are experienced in using a

range of tools for community engagement and mobilization. As the pandemic evolved, health promotion professionals significantly expanded their use of technologies such as texting, social media, online meeting software, and apps. None of these tools are straightforward substitutes for in-person activities, and all require skill development for optimal implementation. However, many of these tools are working well and may continue to be utilized post-pandemic, advancing opportunities for community engagement.

Pandemic response is complex, multi-faceted work and an excellent learning opportunity for students in a wide range of disciplines. Inviting students to participate in institutional planning and response allows them to see that this type of work is not simple or one dimensional. They can observe and explore complex interactions of policy, organizations, and people. Additionally, students provide invaluable perspective on how to frame institutional decisions to best meet students' needs. Institutions that fully engage students in the pandemic response planning and implementation appear to have better results in reducing negative impacts.

Health Education and Behavioral Interventions

Many health education teams have pivoted to virtual programs, sparking broad conversation about translating evidence-based interventions designed for in-person implementation to the online environment. Health educators have quickly gained knowledge in effective use of online meeting software to maintain privacy, allow for actively engaged participation, and support accessibility. While sometimes difficult, the shift is also rapidly expanding knowledge in ways that may forever change the delivery of health education programs in higher education.

In addition to transitioning standard programs, health educators have developed programs specific to COVID-19. These programs are designed to influence individual behavior and enhance motivation to comply by increasing knowledge about physical distancing, mask wearing, and hand hygiene. It is important to note that none of these tools are effective as singular interventions but rather should be used in combination with complementary health promoting activities.

Harm reduction, an approach that focuses on providing non-judgmental, non-coercive resources to reduce transmission of COVID-19 while acknowledging that the disease can cause significant harm, appeared early in the pandemic response conversation. This approach allows opportunity for social justice, recognizing that many factors—including social inequities—affect peoples'

abilities to follow some public health guidance, such as physical distancing.

Harm reduction in application requires a belief that students can make positive choices. It includes the provision of non-judgmental information, with a variety of options for taking action. A principle of harm reduction is meeting people "where they are" and supporting autonomy in creating action plans. The overall goal is to recognize that some students can't comply with all physical distancing or mask guidelines while supporting them in moving forward with implementing the guidelines that they can and are willing to do.

The harm reduction approach is easier to practice in one-to-one conversations than in mass communication. Finding the balance between stating clear policy and encouraging harm reducing behavior can be delicate. People who have not previously practiced harm reduction may have a steep learning curve to determine how to implement this approach. Health promotion practitioners have been key collaborators in making this work.

Health communication campaigns, often the result of collaboration between health promotion and communication professionals, remain a critical tool during the pandemic. Institutions have used every communication channel (e.g., social media, email, text messaging, etc.) at their disposal to ensure all students know physical distancing and mask guidelines, understand the facts of coronavirus transmission, and to motivate students to follow guidelines. Specific tactics range from straightforward factual repetition of guidelines to social norms and social marketing campaigns.

Simple campaigns focused on factual repetition of public health guidelines are the most straightforward to implement, especially with the plethora of resources available from the CDC and other public health agencies. Effective social norms and social marketing campaigns are designed to enhance both motivation and factual knowledge and require more depth of theoretical knowledge, more detailed student information, and more resources for implementation to shape campaign messaging. Collaboration with the institution's COVID-19 planning and response committee, marketing and communications leadership, and the local community are critical for tailored, cohesive, branded, unified messaging.

Behavior pledges appeared as a widely used tool with varying levels of success. Some institutions used behavior pledges as an actual behavioral contract with clearly defined negative consequences if not followed. However, many institutions attempted to use the pledge as a social contract, with efficacy coming from the aspects of social accountability.

For the social contract approach of pledges to work, it is recommended that:

- Whenever possible, student representatives participate in the creation of their campus' behavior pledge.
- Students can personalize their own pledge, consistent with their values and views of self.
- Elements of the pledge be specific (e.g., I will wear a face covering when I ...) rather than general (e.g., I will social distance.).
- Reasons why pledging to the behavior be included, possibly even combined with a dedication to someone important to the individual (e.g., I'm doing this for _____ because _____).
- Pledges be in writing. If a written pledge is not possible, e-signing or initialing is more effective than a click or social media share.
- Pledges be made publicly, to combine private as well as group accountability.
- Reminders of the commitment be systematically shared for reflection on match to behavior.
- Students receive positive reinforcement when pledge behaviors are demonstrated.

Testing and Surveillance

Testing must be integrated with swift identification and containment of positive patients and contacts, physical distancing, face coverings, and hand hygiene practices to control the spread of COVID-19 on campus and within the community. COVID-19 diagnostic (PCR) testing for the virus allows for early identification, intervention, and effective contact tracing of COVID-19 cases. Testing results may also help the institution better understand and mitigate the spread of the virus.

A clearly defined comprehensive campus testing plan based upon available resources, current scientific evidence, and the needs of the campus community is vital. Diagnostic screening and surveillance testing strategies are both important in reducing the spread of COVID-19 on college campuses. Evidence continues to mount in favor of frequent testing of campus constituents on a recurring schedule. Campuses with limited resources should consult with their local public health authorities and/or local hospitals, labs, health care organizations, or other IHEs for assistance.

On-Campus Testing Procedures

To enhance the health, safety, and well-being of the campus and broader community, frequent testing is important and enables the institution to find asymptomatic or presymptomatic students and employees who may be unknowingly spreading SARS-CoV-2.

Until recently, CDC maintained its guidance to prioritize testing to symptomatic individuals and close contacts and briefly removed recommendations to test close contacts altogether. Cumulative research and data led to CDC's revised [tiered testing plan for IHEs](#).

Hierarchy for selection of persons for IHE-based testing depending on community resources can be as follows:

1. Persons with symptoms of COVID-19
2. Persons who have had close contact with someone with COVID-19
3. All students, faculty, and staff with possible exposure in the context of outbreak settings
4. Random sample of asymptomatic students, faculty, and staff to more rapidly detect increasing SARS-CoV-2 incidence, with consideration for incentivizing voluntary testing
5. All students, faculty, staff and members of their place of residence as part of a community-based testing strategy by health departments outside of outbreak settings

Diagnostic Testing

Diagnostic testing is performed when there is a reason to suspect that an individual may be infected with SARS-CoV-2. It is used to diagnose active infection in symptomatic individuals or those with recent exposure and is sometimes used to determine resolution of the infection. Daily health monitoring is an important adjunct to diagnostic testing. Health monitoring allows students and employees the opportunity to observe symptoms quickly so that diagnostic testing can be performed as early as possible. Examples of diagnostic testing are testing symptomatic individuals presenting to the health center and those who indicate that they were exposed to an individual with a confirmed or suspected case of COVID-19. Those with COVID-19 symptoms or deemed a close contact should immediately isolate/quarantine while awaiting test results.

Screening or Asymptomatic Testing

Testing an individual when there is no reason to suspect infection is known as screening. Screening is intended to identify infected individuals prior to the development of symptoms. Identifying asymptomatic positive cases of COVID-19 will allow campus officials to implement containment measures such as isolation/ quarantine to prevent wider transmission. Screening for COVID-19 may be beneficial for individuals where physical distancing is more difficult, such as first responders, emergency medical services staff, health care workers, those living in congregate housing, and workers in other essential campus departments/services, such as food services.

Pre-arrival testing is one example of screening. Some institutions required pre-arrival documentation of a negative test result before arrival to campus. The primary purpose of this testing is to identify individuals who test positive, immediately isolate them, initiate contact tracing, and prevent them from coming to campus while infectious.

Entry testing or on-arrival testing is another example of screening. This involves testing all students and employees returning to campus regardless of exposure, signs, or symptoms. The results are then used to determine what protective measures, such as quarantine or isolation, are needed on an individual basis.

Screening may also involve frequent recurring testing of individuals. More testing options, which are less invasive and conducive to point of care use, are becoming available. The advantage of less expensive antigen tests has been somewhat offset by their lesser sensitivity. However, increasing evidence points to testing frequency and rapid turnaround times as more important than the test sensitivity for ongoing screening. The availability of testing, as well as the funding and staff necessary to sustain frequent testing of students, faculty, and staff, are key considerations driving institutions' decisions to implement a screening program.

Surveillance Testing

Surveillance is very important to gain information about the population rather than the individual person. Surveillance testing for COVID-19 includes ongoing regularly scheduled testing and is helpful in determining the incidence and prevalence of COVID-19 on campus and/or in the campus community. Surveillance testing can provide an early warning system to identify hot spots within the residence halls, off-campus community, or the workplace and can help the campus understand if the campus population is practicing effective mitigation

strategies such as physical distancing, wearing face coverings, and avoiding large crowds.

True random selection of the appropriate percentage of the campus population can help the campus determine what percentage of the population may be infected with the virus. This is essential to planning, implementing, and evaluating public health practice on the campus. Typically, local, state, and federal authorities do not regulate surveillance testing; however, a sample of the campus population to test randomly and at regular intervals should be determined by the university using local infection rates and trends and other epidemiologic data. An example of surveillance testing is to select a percentage of a random sample of the campus population on an ongoing basis, such as every 30 days.

Wastewater Surveillance

The emergence of COVID-19 has resulted in an increased interest in wastewater surveillance. CDC considers wastewater surveillance to be a promising public health strategy as an early warning system for COVID-19 infection and initiated the [National Wastewater Surveillance System](#) (NWSS) which coordinates the assimilation of data from communities to health departments and CDC. Approximately 30 U.S. IHEs have implemented wastewater surveillance since students moved back to campus.

COVID-19 virus is shed in the stool by approximately 50 percent of infected persons. It is considered an early community surveillance indicator since positive stool samples may precede case data by four to six days. Stool can be positive in persons who are asymptomatic, presymptomatic, or symptomatic. Persons who become infected may shed the virus for weeks.

Although wastewater surveillance is an emerging public health surveillance tool for COVID-19, there are some limitations. A positive test merely indicates the presence of the virus and cannot be extrapolated to estimate the prevalence of the virus within a community. Positive tests also do not necessarily indicate the presence of infectious disease, since persons who are no longer infectious may continue to shed virus. In addition, the absence of viral biomarkers in wastewater samples does not necessarily indicate absence of infection from a group, since not all persons shed virus in their stool when infected. Nonetheless, wastewater surveillance provides a real benefit as an early indicator for the presence of the virus or trends within a tested community.

Various approaches can be used for establishing a wastewater surveillance system. Universities may focus on geographic areas on campus with elevated case rates,

or instead broadly assess samples from across campus. Sewage lines need to be mapped and access to specific building drainage is necessary. Samples are best collected at least bi-weekly via site sampling or on a continuous intermittent basis with an automated system. If testing is too infrequent, or is of inconsistent timing, the benefit is diminished.

Wastewater testing may be performed by various entities. These include commercial labs or vendors, state public health labs, and university labs. These testing entities will calibrate alert levels based upon their individual testing results. This data must be available to college health centers in a timely fashion. They may use the data to advance testing or other public health mitigation strategies in an affected area.

Testing and Surveillance Considerations

- Though CDC does not specifically recommend entry testing all students, faculty, and staff, it does [acknowledge its value](#), stating that “In an IHE setting, with frequent movement of faculty, staff and students between the IHE and the community, a strategy of entry screening combined with regular serial testing might prevent or reduce SARS-CoV-2 transmission.”
- Students, faculty, and staff with documented COVID-19 within the past 90 days should be exempted from the entry testing requirement.
- The campus community should be tested on a scheduled, recurring basis, with the ideal timing of twice weekly for students with test result turnaround times of <24-48 hours.
- Review CDC’s “[Developing a Wastewater Surveillance Sampling Strategy](#)” to determine whether this is a value-added approach for the campus.
- Wastewater surveillance is a supplement and not a substitute for a robust testing plan. Ensure the campus testing plan identifies it as such if sewage testing is undertaken.

Contact Tracing

Local health departments are responsible for leading case investigations, contact tracing, and outbreak investigation. Contact tracing follows case investigation and is a critical mitigation strategy to prevent the further spread of COVID-19. [According to CDC](#), contact tracing “involves identifying cases and their contacts then working with

them to interrupt disease transmission. This includes asking cases to isolate and contacts to quarantine at home voluntarily.”

Contact tracing is a confidential process that has been used for years to curb the spread of infectious diseases and avoid outbreaks. To be effective, tracers must connect with known patients to identify and quickly alert their close contacts of possible SARS-CoV-2 exposure. Therefore, many student health services assumed contact tracing of student cases to improve timeliness.

In addition to notification of exposure to an infected individual, contact tracers communicate extensively to provide disease and transmission education; gather information such as demographics, living arrangements, school and daily activities, and other pertinent data that will assist in slowing the spread of COVID-19; and manage the individual’s case. Contact tracers will also ask about signs/symptoms and underlying medical conditions and should have a system in place to direct those with symptoms to the appropriate health care or service provider. All contact tracers should complete a formal training to ensure consistent and quality information. The training may be provided by the local health department, CDC, or via a program such as the [Johns Hopkins University COVID-19 Contact Tracing](#) course.

All communications should be consistent with the institution’s protocols, and the definition of a close contact must be clearly understood. In October 2020, CDC refined [the definition of a close contact](#) as an individual who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period starting from 2 days prior to illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the infected person is isolated.

Contact tracers must be able to provide recommendations for quarantine and understand the institution’s policies for quarantine on and off campus. Many IHEs may not have the resources to offer quarantine and isolation accommodations for students who live off campus. Follow-up letters and/or communications must be timely and scheduled. Resourcefulness may be the greatest skill needed for a contact tracer on a college campus, since contacts may be difficult to reach or reluctant to engage in conversations.

Additional contact tracer skills include:

- Knowledge of the resources on campus and in the community, such as testing, medical and mental health care, academic support, financial aid, and food or meal delivery options for those in quarantine.

- Ability to gain trust of the contact to gather sensitive and accurate information.
- The ability to conduct interviews without violating patient confidentiality.
- Current knowledge of medical terms and principles of exposure, incubation, infectious periods and interactions, and symptoms of COVID-19 for both presymptomatic and asymptomatic infection.
- Exceptional communication skills and cultural sensitivity.

There are many different formulas or ratios that can be used to determine the number of contact tracers an institution must have in order to effectively manage the case load. The estimate will be affected by the number of cases over time, the percent positive rate, the responsiveness of the persons being traced, the skill level of the individual contact tracers, and the technology that is used to streamline the information.

Many public health experts estimate a minimum need of 30 contact tracers per 100,000 population during a pandemic. There are several contact tracing estimator calculators that can help campuses determine how many contract tracers are needed. [One example](#) is from the Fitzhugh Mullan Institute for Health Workforce Equity at George Washington University and is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). These estimator calculators will need to be adapted to the campus population.

Considerations for contract tracing:

- Partner with local and state health agencies to augment contact tracing efforts and optimize efficiency.
- Provide formal training and resources for campus contact tracers.
- Recruit students in health-related fields such as medical, nursing, and public health to augment contact tracing staff.
- Develop public service announcements and campaigns outlining the importance of contact tracing and cooperation with contact tracers.

Coordination with Local Public Health

Coordination of campus public health initiatives with local public health resources remains a vital component of college health. College health has had a longstanding campus public health responsibility to coordinate activity related to reportable diseases, vaccines, and infectious

disease outbreaks. With the emergence of COVID-19, the relationship between SHS and state, tribal, territorial, and local health departments has proven to be extraordinarily important. Various models of relationships between SHS and local public health entities have evolved. These may involve SHS reporting COVID-19 testing results, serving as a resource for testing and education, providing community COVID-19 telephone support, or assisting with contact tracing. More closely shared models often enhance the level of communication between the institution and the public health department with purposeful location of public health contact tracers on campus and university volunteers or employees providing contact tracing via the public health department.

Many public health jurisdictions have issued IHEs specific guidance requiring certain public health activities—for example, requiring the IHE to perform contact tracing on campus and provide community notifications, or to identify and report outbreaks. The SHS should be aware of these requirements and coordinate closely to ensure that these obligations are fulfilled.

Traditionally, community public health entities have provided hotlines or dedicated telephone numbers for community health questions. These COVID-19 hotlines have been an important resource for many colleges and universities. Some colleges and universities have implemented their own hotline and coordinated that resource with their local public health entity.

Bidirectional, timely, and frequent communication between the SHS and public health agencies is critical in the management of individual patients; early identification of outbreaks; or development of new tools, treatments, or messages. Communication ideally includes scheduled frequent meetings with the public health epidemiologist, public health officer, and SHS medical director or clinical leader.

Colleges and universities are a logical site for COVID-19 vaccine distribution. As vaccines become available, it will be important for SHS to plan with their local public health agency how best to rapidly vaccinate their students, faculty, and staff. Potentially, this collaboration could range from receiving vaccines from the public health program to distribution of the vaccine by the public health authority on campus. Each community is unique and therefore communication with the public health authority will best determine an approach that is practical and achievable.

Housing and Residence Life

Careful preparation remains the key to an organized, effective, safe, and medically informed reopening of campus housing in Spring 2021. Though deemed the lowest risk approach, many colleges and universities were unable to reduce on-campus housing to one student per room or provide students with individual bathrooms. This was particularly challenging on smaller campuses with a high residential population.

The following, in conjunction with two person per room assignments, may be viable alternate and supplemental approaches:

- Placement of physical barriers between beds such as shower curtains or Plexiglas
- Rearrangement of beds/placement head to foot for maximized distance
- Enhanced cleaning and sanitizing of high touch areas
- Universal masking requirements in common areas
- Early campus arrival with entry testing, modified quarantine, and rigorous recurring, scheduled SARS-CoV-2 testing programs (either all residential students or random sampling)
- Pods, cohorts, or bubble assignments for students who were then viewed as “family units”
- Decreased occupancy in community restrooms to accommodate physical distancing
- Wastewater surveillance was utilized on some campuses as an early warning system to effectively identify SARS-CoV-2 and implement targeted testing in the residence halls before widespread transmission occurred.

Considerations for housing and residence life:

- Campuses should consider their capability to isolate on-campus students from the larger community. Campuses with a high proportion of students living on campus may be more effective in limiting spread than campuses with larger off-campus populations who may be mixing with on-campus students socially.
- To maintain safe on-campus housing for students and residential staff, campuses must continue to offer widespread testing, contact tracing, and isolation/quarantine of ill and exposed individuals on campus. This approach will continue to require access to immediate testing for all students, faculty, and staff with symptoms.

- Campuses should continue to engage and meet the needs of vulnerable and marginalized campus residential populations, including (but not exclusive to) students at higher risk for complications from COVID-19 and students with disabilities. Such students may benefit from enhanced priority for single rooms if this can be accomplished without stereotyping, stigmatizing, or isolating the student. Additional recommendations can be found in the [ACHA Guidelines: Supporting Vulnerable Campus Populations during the COVID-19 Pandemic](#) (August 2020).
- Campuses should ensure that custodial and residence life staff have access to sufficient and appropriate personal protective equipment (PPE). Staff should review PPE donning and doffing procedures prior to the start of Spring 2021 semester.
- High-touch surfaces should be cleaned and disinfected regularly, and all residents strongly encouraged to practice meticulous hand hygiene.
- The professional and student staff living in the residence halls are particularly susceptible to mental, emotional, and physical exhaustion and are at an increased risk of exposure to SARS-CoV-2 as they reside and work in a congregate setting. These staff need defined work schedules with time off as per institutional policies, regular exercise and break opportunities, and psychological/counseling support as needed.
- Resident advisers, college health services staff, and “student ambassadors” should begin educating residential students about the importance, efficacy, and safety of the SARS CoV-2 vaccine. If possible, campuses should provide quick access to vaccination for residential students when their priority group is reached, expediting high-risk individuals.

Isolation and Quarantine

Most campuses provided spaces for isolation and quarantine (e.g., designated residence halls or floors, contracted hotels, apartments) and provided dining and support services for ill or exposed individuals. Generally, but not always, quarantine and isolation housing were reserved for students who lived in on-campus housing.

Campuses experienced varied utilization of their isolation and quarantine spaces as cases of COVID-19 spread throughout campuses. Many developed systems to provide wraparound services to support students in isolation or quarantine. These services were resource intense and required partnerships throughout campus to execute.

CDC made several significant changes to its [isolation and quarantine guidance](#) during the fall semester. In October 2020, CDC decreased the length of isolation to 10 days after symptom onset with resolution of fever for at least 24 hours (without the use of fever-reducing medication) and with improvement of other symptoms. For asymptomatic individuals, isolation could be discontinued 10 days after their initial positive RT-PCR test for SARS-CoV-2. Those individuals with severe illness may need isolation extended to 20 days. Individuals previously diagnosed with symptomatic COVID-19, who recover and remain asymptomatic, do not need retesting within three months after the date of original symptom onset. Those who develop new symptoms consistent with COVID-19 within three months after symptom onset of the original COVID-19 infection may warrant retesting if no other diagnosis is plausible.

Though 14 days of quarantine remains CDC's recommendation if deemed a close contact to a person with confirmed SARS-CoV-2 infection, CDC revised quarantine guidance in December 2020, providing [options for reduced time in quarantine](#). Potential options to release an individual from quarantine if permitted by local public health authorities are:

- After Day 10 without testing
- After Day 7 after receiving a negative test result (test must be performed on Day 5 or later)

If quarantine is reduced to less than 14 days using either option, the individual must:

- Continue to monitor for symptoms through Day 14 after exposure.
- Monitor health and immediately self-isolate and contact the SHS, private health care provider, or local public health authority if new symptoms develop.
- Wear a mask, maintain 6 feet physical distance from others, practice hand hygiene, and avoid crowds.

Considerations for isolation and quarantine:

- IHEs should discuss any changes in isolation/quarantine policies with their state, tribal, territorial, or local public health authority.
- Policy revisions should be coordinated and widely communicated so all members of the campus community have a clear understanding of the requirements.
- Protocols and procedures should be developed and made available to all individuals involved in the management of isolation and quarantine spaces.

- Campuses should be discouraged from sending students home to isolate or quarantine in order to help prevent further community spread.
- If adequate housing inventory exists, isolation and quarantine rooms should be physically separated from other residential student rooms. If possible, a specific residence hall or specific floors of a residence hall should be designated for quarantine or isolation.
- The rooms should have private bathroom facilities and be supplied with a thermometer, sanitizing wipes, tissues, soap, hand sanitizer, and toiletries.
- Rooms should be identified and labeled with appropriate signage and access restricted to essential personnel providing services to these students.
- The number of quarantine and isolation rooms needed will be dependent on factors such as campus size as well as the level of community spread of COVID-19. Preparation and planning must be made for the possibility of increased case numbers.
- Students should have a "COVID Plan" that include a list of items (medications, clothing, academic supplies, etc.) to bring with them to a quarantine or isolation room.
- Student health services and/or residential life staff, or their designees, should remotely monitor students daily (temperature checks and symptom screening). Plans should be developed for further clinical evaluation if symptoms progress or worsen or the patient requests.
- Dining services should arrange food delivery in collaboration with housing/residence life staff for students on the campus meal plan. Student affairs or campus life, in collaboration with housing/residence life staff, could arrange for the purchase of a campus meal plan or coordinate meal delivery for those students who have not purchased the campus meal plan. Consider food vouchers or gift cards for contact-free delivery.
- Counseling services and/or the office of spiritual and religious life should be available remotely to students in isolation or quarantine. Mental health care should be prioritized in recognition of the lack of physical and social contact during this time. Support teams could provide virtual wellness and entertaining activities to help decrease feelings of loneliness and isolation.

- Students in quarantine should have up to 60 minutes of scheduled time outdoors daily for physical activity, if possible. While outside, students should wear their masks and maintain physical distance from others.
- To the degree possible, students should continue academic activities remotely or be provided with note takers.
- A team of designated student affairs/campus life staff should be appropriately trained and on call to assist students with their personal needs (medication pickup, delivery of personal hygiene supplies, etc.).
- Plans should be developed for transportation to and from isolation or quarantine rooms as well as to and from medical appointments as needed.
- The IHE must provide appropriate PPE (as per [CDC guidelines](#)) and require custodial and maintenance staff and live-in professionals to wear that PPE when cleaning or entering isolation and quarantine spaces.

Athletics

While many college athletic competitions were suspended or cancelled during the fall season, most student athletes continued to practice in anticipation of a season later in the school year. Some student athletes were able to proceed with competitions. However, both practices and competitions continue to pose unique challenges to athletics teams' well-being, as well as the college community as a whole. Some of the lessons learned through intercollegiate athletics during the pandemic:

- While many teams attempted to “bubble” themselves as much as possible, student athletes, coaches, and support staff need to continue interacting with others on campus as well as their families. Individual decisions about adherence to COVID-19 prevention protocols can have a profound impact upon the health and safety of the entire team and/or program.
- Although there were many episodes of COVID-19 infection and exposure in athletic departments, proven transmission between teams *during* an athletic competition appears to have been rare, even in contact sports. Testing, isolating, contact tracing, quarantine, and cancellation of athletic competition appears to be effective in reducing risk of transmission during sports competitions.
- Most campus outbreaks among athletic teams occurred due to social interactions outside of practices and competitions.

- CDC has reported that the primary mode of transmission of COVID-19 is through close contact from person to person. Therefore, sharing of equipment such as balls should not be the main focus of concern.
- Indoor spaces are more risky than outdoor spaces. The [spread of COVID-19](#) is most likely with prolonged close contact in an indoor area with poor ventilation. These facts are important for both [indoor sports training and sport competition planning](#). Football and soccer have shown that on-field risk of infection is low for these outdoor sports even with close contact, allowing for a change in risk classification.
- Testing prior to travel is important in all sports because physical distancing can be difficult on flights, buses, and other means of transportation. Failure to receive results prior to departure can lead to late cancellation of events and unnecessary travel and exposure for participating student athletes, staff and spectators.

ACHA recommendations for spring 2021 intercollegiate athletics and sports medicine programs echo many, but not all, of the recommendations in the previous reopening guidelines; many of those recommendations for athletics were developed in collaboration with the [National Athletic Trainers Association Intercollegiate Council for Sports Medicine](#) (NATA-ICSM) In preparation for a partial or full continuation or resumption of intercollegiate activities in spring 2021, athletics and sports medicine programs should consider the following (for additional NCAA recommendations, see the [NCAA November 2020 reopening guidelines](#)):

- Continue to align department policies, procedures, and communication guidelines with institutional guidelines and CDC, federal, state, tribal, territorial, or local public health guidelines and requirements (see [CDC's guidance for colleges and universities](#)).
- Continue operations of the athletics COVID-19 action team, working committee, or task force, with input from college health and counseling services. Revised recommendations from CDC, NCAA, and other sports medicine professional organizations should be reviewed and any action plans should be updated accordingly.
- CDC has recently revised their [guidelines for quarantine](#), allowing quarantine of close contacts to end in as few as 7 days with a negative PCR test on Day 5 if permitted by local public health authorities. It is important to note that reduction in days results in

an increased risk of spread compared to the original 14-day recommendation. Close monitoring of symptom development is advised. This change may reduce the need for cancellation of competitions in Spring 2021 by increasing the availability of athletes.

- Provide updated COVID-19 and infection disease education for student athletes, athletic trainers, coaches, strength and conditioning professionals, administration, facilities management, and other departmental staff, including:
 - Changes to any recommendations or guidelines (e.g., quarantine length, situations of highest risk, etc.).
 - Responsibility for personal conduct, infection prevention, and safety practices.
 - Review of COVID-19 signs and symptoms and the need to immediately isolate and notify medical personnel in the event of illness.
 - Reinforcement of infection prevention and control concepts, including physical distancing and universal masking, which continue to be the most effective strategies for preventing COVID-19, and discussion of requirements for screening procedures and testing protocols for student athletes, coaches, and staff.
- Ensure adequate availability of personal protective equipment (PPE) for athletic trainers and custodial staff, including the monitoring of periodic automatic replenishment (PAR) levels. Review PPE donning and doffing procedures.
- Update pre-participation screening, confirming no high-risk exposure two weeks prior to returning to campus, absence of typical COVID-19 symptoms, and assessment of risk involved with travelling back to school. If the student athlete has had a confirmed COVID-19 infection in the last six months, [cardiac considerations are recommended](#) and follow a tiered approach:
 - For asymptomatic and mild illnesses, medical evaluation is recommended before returning to exercise and additional cardiac testing should be done based on clinical concern or institutional requirement.
 - For moderate to severe illnesses, ECG, echocardiogram, and troponin should be considered before return to exercise with referral to cardiology for further work-up if initial evaluation is abnormal.
- Review adherence to [NCAA governing body and sports medicine consensus recommendations](#) for transition and acclimatization to activity following extended inactivity periods, particularly for student athletes who did not participate in the fall 2020 semester.
- Review team practice considerations, including:
 - Requiring face coverings whenever possible, even during practice, unless strenuous activity is required, there is no contact to the head or face, and the mask does not become saturated.
 - Identifying functional units comprised of 2-10 individuals that always practice together to limit the number of athletes affected if there is a positive individual on the team.
 - Utilizing outdoor spaces whenever possible.
 - Conducting virtual team activities, when possible.
- Ensure that isolation and quarantine guidelines for athletes are consistent with campus and CDC guidelines and procedures and include approaches for onset of illness and/or exposure during athletics-related travel and competition.
- Review contingency plan for illness, isolation, or quarantine of athletic trainers, other sports medicine staff, and sports personnel such as coaches. Consider minimum staffing levels for safe continuation of team practice and competition activities.
- Stay up to date on testing strategies, which continue to evolve. CDC does not currently recommend repeat surveillance testing for infected individuals within [the 90-day window following infection](#). However, the NCAA is suggesting that athletic departments can wait 150 days before testing previously infected individuals. Individuals who develop symptoms between 90-150 days should be retested and isolated in accordance with established school protocols after the 90-day window has expired.
- Review travel policies, including testing prior to travel, assigned seating charts, reducing the need for overnight stays, and “grab and go” meals when possible. Provide additional buses to allow for 6 feet or more spacing between individuals during travel.
- Have policies in place regarding testing of symptomatic athletes or staff prior to competition. Policies should also be developed regarding contact of opposing school medical personnel if a positive case develops within 48 hours post-competition, so

appropriate contact tracing can occur. [NCAA's guidelines](#) state that proximity monitors and/or review of practice or game film may be helpful.

- Ensure all student athletes have received an influenza vaccine.
- Begin educating student athletes, coaches, and support staff about the importance, efficacy, and safety of the SARS CoV-2 vaccine. Plan for quick access to vaccination for each individual when his/her prior group is reached, particularly high-risk individuals.

Recreation Programs and Facilities, Including Club and Intramural Sports

Most campuses have recreation centers for students, faculty, and staff, and many include extensive indoor and outdoor facilities. In a typical year, many campuses have thousands of students participating in club and intramural sports, fitness classes, aquatics, and other opportunities for physical activity. As noted in the previous ACHA reopening guidelines, research has shown positive effects of exercise on the immune system and direct impacts on many chronic diseases that place individuals into higher risk groups for COVID-19 (including diabetes, obesity, and heart disease). There are also positive impacts on the psychological well-being of the exercising individual. However, these recreation centers and programs carry many of the same enhanced COVID-19 transmission risks that are potentially present in intercollegiate sports and local health clubs. Therefore, for the spring 2021 semester reopening, recreation programs and services should:

- Align recreation services policies, procedures, and communication guidelines with institutional guidelines and CDC, federal, state, tribal, territorial and/or local public health guidelines and requirements.
- Provide COVID-19 and infectious diseases education for recreation staff (professional and student), faculty, and instructors. As noted in the previous ACHA reopening guidelines, training should include:
 - Details of COVID-19 signs, symptoms, evaluation, testing, course of illness and transmission.
 - Infection prevention and control concepts and procedures.
 - Individual personal conduct and hygiene.

- Personal and institutional responsibility to protect the health and safety of all students, faculty, and staff, including maximizing efforts to protect recreation, intramural and club sport participants from COVID-19.
- Consider a phased return of sports and recreation programs based upon potential risk of transmission in each activity.
- Consider informing the campus community, including parents, about COVID-19 prevention steps being taken by the recreation department, while being sure to carefully craft and vet any communications going to all or part of the campus community.
- Require the use of face masks by coaches, instructors, recreation staff, and participants.
- Review and enforce physical distancing principles in indoor and outdoor recreation facilities.
- Consider starting or continuing to offer virtual recreation classes. Campuses could also consider maximizing one-on-one workouts with regular SARS-CoV-2 testing of both individual trainers and their students/clients.
- Feature signage (from CDC, SHS, or other sources) about COVID-19 prevention throughout the facilities.
- Increase the availability of hand sanitation stations (providing access to soap and water or 60% alcohol-based rub) throughout the facilities, especially in high touch areas (elevators, stair rails, turnstiles, etc.)
- Provide custodial services, athletic trainers, personal trainers, and fitness instructors with guidelines for appropriate techniques and PPE use (as per CDC guidelines) for cleaning and disinfecting common, non-clinical spaces, including recreation venues and equipment.

Many of these guidelines were developed in collaboration with National Intramural-Recreational Sports Association (NIRSA), Leaders in Collegiate Recreation. For more information about COVID-19 resources for recreational services professionals and their campus colleagues, visit the [NIRSA website](#).

Social Gatherings and Events

During the fall semester, students frequented numerous places on and off campus, including some of the highest risk areas: houses of worship, gyms, bars, and restaurants. Campus outbreaks were traced to large and small gatherings at on- and off-campus parties, bars, and social events without appropriate physical distancing and mask

wearing. This was particularly true for campuses with large numbers of off-campus students. Faculty and staff also spent a large portion of their time in off-campus settings. As a result, it was challenging to prevent introduction and repeated re-introduction of the SARS-CoV-2 virus into the campus community. Depending on state and local ordinances and guidelines and the current state of the pandemic, campuses should look for opportunities to deliberately and cautiously reintroduce on-campus events in spring 2021 and offer less risky venues for entertainment and socializing.

Considerations for social gatherings and events:

- Evaluate opportunities to reintroduce performing arts events, with scheduled recurring testing of performers, reduced audiences with physical distancing, required mask-wearing, and outdoor venues. This approach could be effective for theater, individual and group vocal performance, orchestral and chamber music performance, and others.
- Resuming larger on-campus events will require consultation from local public health authorities and additional information from CDC. It will still be necessary to continue physical distancing, face covering, diligent hand hygiene, and other mitigation measures already in place.
- Consider offering a mixture of in-person and remote social opportunities.
- Structure activities and events so attendees can participate in smaller groups.
- Evaluate all settings (indoors and outdoors) where students gather and strategically arrange furniture to maintain appropriate distance and limit occupancy.
- When weather permits, consider outdoor entertainment, wellness programs, and other physically distanced activities such as movies, mindfulness, yoga, cornhole, kickball, badminton, disc golf, or other yard games.
- Consider installing outdoor heaters.
- Consult with food services if planning to offer food during the event. Self-serve food or drink stations should be replaced with a server or boxed meals and individual sealed beverages.
- Hand sanitizer/alcohol-based hand rub or hand washing stations and covered trash receptacles should be strategically located throughout the venue.

Institutional Calendar

Limiting transitions that result in mass movement of students off campus to various destinations and then returning to campus in high volumes will reduce the potential of SARS-CoV-2 exposure to destination communities and conversely back to campus. In lieu of the traditional winter or spring break week, IHEs have opted for single days without academic instruction spread throughout the semester to provide brief respites for both faculty and students while discouraging widespread travel, including to traditional spring break destinations that promote congregating, drinking, or partying.

Considerations for the institutional calendar:

- Evaluate the academic calendar to eliminate lengthy break times and instead scatter single days without academic instruction throughout the semester.
- Clearly communicate changes to the academic calendar as far in advance as feasible.
- Discourage student travel during breaks in the academic calendar.

Visitors on Campus

The issue of visitors on campus is a surprisingly complex one. Visitors include family members, significant others, alumni, sports fans, students from other colleges and universities, vendors, contractors, opposing athletic teams (players, coaches, support staff), patients and families at academic medical centers, off-campus EMS crews and law enforcement officers, public health officials, and donors. The risks presented to both the visitors and the campus community vary based on the visitor group and the reasons for the campus visit.

Spring calendar activities such as recruitment, charitable/fund-raising events, and commencement, which bring large numbers of individuals from different areas with varying rates of SARS-CoV-2, should be reevaluated to incorporate modified, lower risk alternatives such as virtual platforms, outdoor activities, and limited in-person capacity.

Considerations for managing visitors on campus:

- Campuses should enforce the same COVID-19 public health safety practices required of students, faculty, and staff for all persons present on the campus, regardless of the reason for or duration of the visit. Expectations of behavior could be posted using outdoor signs, sidewalk markings, video boards, signs on entrances to buildings, etc.

- Employees could remind visitors of mask requirements but should never engage in heated confrontation. Training and education on mask policies and procedures and de-escalation techniques should be provided for employees like registration staff, security staff, cashiers, and ticket collectors who are in front-line positions and who may encounter visitors to campus.
- Place masks and hand sanitizer at highly trafficked building entries.
- Develop alternative, lower-risk options for traditional spring and summer gatherings.
- If an IHE is considering on-campus commencement events, traditional large commencement ceremonies should become a smaller, individual department or school event that is ideally outdoors with limited guests, physical distancing, and mask requirements.

Communications Plan

Regardless of size or reopening status, every IHE needs a robust, coordinated communications plan during the ongoing COVID-19 pandemic. Even for institutions with only remote instruction, strategic and crisis communications needs are significant. The IHE must provide frequent updates about future activities and reopening as well as urgent communications about topics such as cases in essential workers or community member deaths.

The campus COVID-19 planning and response committee, a communications sub-committee, or the central communication/public relations team should oversee all messages, including messaging from the SHS. Student health leadership should engage early and often with the communications oversight group, as well as senior campus leadership, as they develop health and wellness messaging. The communications groups may need specialized teams who have appropriate expertise in different areas including developing strategic communications, responding to urgent needs for crisis communications, and working with the media. The communications structure must support the need to send timely messages. Membership should also include those campus individuals responsible for Clery Act compliance to ensure obligations to notify the community about COVID-19 conditions are satisfied.

Communications must support the institution's brand identity, send a unified message, and align with the core mission and values of the IHE. Information must always be credible, trustworthy, timely, and up to date. Any document containing medical, science-based,

epidemiologic, and/or infection prevention and control messages should be reviewed by an individual with appropriate credentials or expertise. Information and recommendations will continue to evolve rapidly, and it is crucial to "get the science part right" in all communications.

Elements of Effective Messaging and Communication

Most or all IHE have experience in crisis communications, and the basics of the approach will serve them well as they communicate about partial or full reopening in the face of the COVID-19 crisis.

Effective crisis messaging:

- Has unified content.
- Is consistent and reflects brand identity.
- Addresses the intended audiences' needs and (if appropriate) is delivered in multiple languages.
- Is appropriate in tone to the urgency of the communication. Calmness, confidence, and compassion should be evident in the message.
- Is timely, transparent, and clear.
- Is updated frequently and dated to reflect this timing.
- Resides on a single, easily accessible landing page on the institution's website.
- Is delivered through multiple platforms (website, social media, email, etc.).
- References additional resources (e.g., website, hotlines, FAQs for additional information).
- Is assessed and adjusted as necessary.
- Is available in other languages consistent with the international student population.

While there are many issues to consider for communication pieces, it can be helpful to address these basic questions in all pieces:

Why is this message being sent?

Communications may serve several purposes including:

- To provide general updates about the situation.
- To delineate action steps the IHE is taking to progressively reopen the campus.
- To share important safety measures.
- To describe instructions for all or subsets of the campus population (e.g., get an influenza vaccination).
- To reassure the message's recipients.

What is the message?

- Define the main message. Limit to three or four main points per communication piece. Including too many key points into a single communication piece makes it overly complex and long, which risks reader fatigue, inattention, and loss of the message.
- Express authority but acknowledge uncertainty. Never over-assure or promise what you cannot deliver.
- Use non-technical, positive, and empathetic language.
- Each message should include contact information for email and phone follow-up. Ensure staff are prepared to respond to concerns in a timely manner.

Who is the targeted audience?

The most effective approach will vary significantly depending upon the target audience.

- All students or only a subset of students (e.g., only undergraduates, only health science students, only student athletes)?
- The entire campus community, including faculty and staff?
- Student families? The level of family concern about COVID-19 may be high and including them in key messaging is an excellent strategy to address their concerns and can be accomplished by inclusion in the main message or via a family-targeted version.
- Trustees?
- Alumni?
- Local hospitals, health department, urgent care clinics?
- Visitors to campus—visiting teams, prospective students, visiting scholars and faculty, vendors, conference attendees, etc.?
- Off-site partners, community service facilities, internship locations?
- Local and national media via a press release?

When should the message be sent?

- Communications regarding policies, procedures, and strategies should be planned and scheduled for release.
- The campus plan should include ongoing, regular communications about active cases as well as more immediate notification of audience(s) for a sudden resurgence of COVID-19 illnesses or the death of a student, faculty, or staff member from COVID-19.

- Urgent/important messages (e.g., a message in response to tragedy, such as the death of a community member) should be drafted in advance, so that the language can be crafted, appropriately vetted, and available for immediate use. To prevent delays in distribution, there should be a well-established procedure for approval of urgent messages including any needed approvals from university leadership.
- Important messages should not be sent in the late evening, at night, or on Friday afternoon. Typically, questions regarding the communication will arise, and it is important to have someone available to respond.

Where will this message be housed?

Whether the message is an email, video, or press release, it should be featured in a format and location most readily accessible to the target audience, such as the campus website or social media sites.

How will feedback and questions be addressed?

Some messages, particularly those delivered urgently, may create a flurry of responses from the community, parents, and the media. Campuses should ensure that adequate and appropriately trained staff are available to respond. Consider establishing a central email and hotline for COVID-related questions.

- Designate spokespersons in key areas to respond to media and individuals to answer phone and email inquiries using standardized and evidence-informed responses.
- Consider proactively engaging media (including campus, student, and local media), and prepare for contact from national press and communications organizations.
- Frequently asked questions (FAQs), or perhaps even recently asked questions (RAQs), can provide helpful, quickly accessible predetermined responses and should be posted prominently on the IHE's webpage.
- It is difficult to manage inaccurate information and rumors, particularly those circulating on social media. While some IHEs monitor key sites for misinformation and malicious content, many have concluded that the task is simply too big and social media is impossible to control. It is, however, worthy of discussion with the communications team.

- Consider hosting regular in-person or virtual leadership updates or town hall meetings. These updates could occur with greater frequency (weekly or bi-weekly) as conditions warrant. The president/chancellor, provost, or member of the COVID-19 response team could lead these sessions on emerging topics and continue to emphasize that the health and safety of the campus community is their highest priority.

Recovery Dashboards and Metrics

During the COVID-19 pandemic, campus recovery dashboards have become a common and key component of internal and external communications. A public recovery dashboard displays a set of metrics that the IHE will track, trend, and share with its community to inform about health guidelines and reopening decisions.

The metrics may include operational metrics (such as number of tests performed) as well as key performance indicators (KPI), a metric that is tied to a specific goal or objective (such as quarantine bed or personal protective equipment availability) that the IHE has set for recovery.

As an IHE develops dashboards, it should consider key questions:

- **What communication or operational need is the dashboard filling?** The dashboard should serve to inform and/or drive decision making and resource allocation.
- **Who is the audience for the dashboard(s) and what information does each audience need?** In addition to a public recovery dashboard, an IHE may have multiple other dashboards for internal and external audiences. While external dashboards may help to inform the general campus community about current campus and community health conditions, internal dashboards inform leaders about operational performance and identify areas in need of additional attention and resources. Individual departments may have dashboards; the student health service may track appointment availability, or an academic department may track zoom sessions completed. Internal dashboards may also be created for campus leadership; senior campus leadership may track workers compensation claims or COVID- related expenses.
- **Has the campus determined key performance indicators for these areas?** Key performance indicators should be established when appropriate, such as days on hand of personal protective equipment. KPIs should drive action, and

performance should be easily seen on the dashboard. Consider using a simple system such as green, yellow, and red to indicate if the campus is meeting its goal.

- **Are there external benchmarks available?** Comparing your campus to its peers can be valuable to campus leadership.
- **What data is available?** Be cautious in deciding to track metrics for which data is not readily available. Creating new data sources can require significant investment and should only be done for a compelling reason.
- **Is the data reliable and accessible?** Data integrity is important to ensure confidence among internal and external stakeholders.
- **Who will be responsible for maintaining and updating the data?** Make sure that there is redundancy in these positions and collection does not rely on a single individual.
- **How often will the data be updated?** The best dashboards are updated frequently (a minimum of one to two times a week).

The dashboard should display the information in a visually appealing and easy to read format, lead with key information, and allow the user to interact with the information.

Suggested Components of an External Recovery Dashboard

- Total number of cases by week: separate into employee and student cases
- Total numbers of tests performed by week: separate into employee and student
- Test positivity rates by week: separate into employee and student and if doing surveillance testing, by surveillance versus symptom/exposure testing
- Number of individuals in quarantine and isolation
- Links to local (city or county) data

Common Metrics for Internal Dashboards

- Personal protective equipment availability
- Employee absenteeism
- Testing policy compliance
- Employee behavioral violations
- Testing capacity

- Influenza vaccine compliance
- COVID-19 vaccine compliance (when available)
- Quarantine space availability
- Isolation space availability
- Workplace outbreaks under investigation
- Student outbreaks under investigation
- Student public health conduct violations.

Facilities

Due to the growing consensus that poor ventilation and aerosolization of SARS-CoV-2 poses a high risk for transmission, IHE facilities managers spent much of the fall semester evaluating air changes per hour (ACH) in residential, academic, and administrative campus buildings. In addition to increasing ACH, steps were taken to recirculate outside air, open windows, and utilize fans and HEPA filters to disperse aerosols in closed environments. Minimum Efficiency Reporting Value (MERV) 13 or higher filtration was optimally recommended for HVAC systems.

Outdoor spaces for instruction, social activities, dining, and recreation are deemed lower risk and encouraged. IHEs creatively utilized tents, canopies, and other outdoor structures and settings to gather yet remain protected during inclement weather.

With proper distancing, masking, cleaning, disinfection, and ventilation, risk of classroom transmission has been low. Continued adherence to physical distancing and evaluation of spaces to decrease density and increase distance remains critical. Numerous new processes developed over the last semester may have unintentionally created unexpected high traffic areas and bottlenecks. Reevaluation of these areas or the existing process itself should be undertaken.

Considerations for facilities:

- If unable to adequately ventilate a classroom or office space, avoid using it for instructional or meeting purposes. Consider adding portable HEPA filters to rooms.
- Evaluate signage to ensure that maximum occupancy, directions, and expectations to mask, maintain physical distance, and use hand hygiene are clearly noted.

- Evaluate opportunities for hands-free options including automatic door openers, wrist pulls, toe pulls, soap dispensers, paper towel dispensers, etc.
- Disable drinking fountains and replace with water bottle refill stations, if feasible.
- Disable restroom hand dryers to decrease risk of enhancing viral aerosolization.
- Ensure ongoing surveillance and monitoring of environmental and facilities infection control measures regarding the correct use of PPE, handwashing, and surface cleaning.
- Ensure IHE-provided PPE and hand sanitizing products meet FDA requirements.¹
- Evaluate high traffic and bottleneck areas and utilize signage, visual markers, or barriers to redirect, deflect, or eliminate flow.
- Consider relocating highly utilized services to main floors to decrease elevator utilization.

International Travel

Guidelines regarding international travel continue to advise to avoid all nonessential travel globally. Focus has shifted to consideration of universal risks of international travel in the COVID-19 era as well as consideration of risks at each specific destination. This is detailed on the [U.S. State Department website](#) and the [CDC website](#).

Significant changes regarding COVID-19 vaccination are on the near horizon. These are developing disparately on a global level and the landscape of international travel will undoubtedly be significantly affected by numerous factors. For example, there may be requirements for proof of specific vaccination(s) prior to air travel, obtaining visas, entering or departing countries, and many other unforeseen possibilities.

Looking ahead to that time when international travel for IHE constituents resumes on a broader scale, protecting the health of the individual traveler as well as campus and local communities is of paramount importance. The following elements should be considered for all students, faculty, and staff embarking on IHE-related international travel.

¹ In the early days of the pandemic, limited supplies of N95 masks in the U.S. compelled health care systems to purchase KN95 masks from China. Testing of these products over the summer revealed up to 70% did not meet the U.S. National Institute for Occupational Safety and Health (NIOSH) N95 standard. These KN95 products can still be used as surgical masks or procedure masks. The FDA has published [a list of PPE](#) that received emergency use authorization (EUA).

- All IHEs should establish comprehensive institution-wide policies regarding international travel recommendations, restrictions, and requirements for both outgoing and incoming travelers.
 - Policies should pertain to all IHE-related persons (students, faculty, and staff) who are planning international travel or returning from international travel.
 - Policies should be created collaboratively by appropriate parties (e.g., student health services, administration, office of international programs, risk management, and general counsel, as well as the state, tribal, territorial, or local health departments as appropriate).
 - Policies should be easily accessible, well-known to all affected parties, and enforceable.
 - Due to the variability of the global COVID-19 situation, policies should be reviewed regularly and revised as appropriate.
 - Due to the variability of the global COVID-19 situation, policies should be reviewed regularly and revised as appropriate.
 - Frequent, detailed communication among all involved parties is essential.
 - Detailed travel plans and purposes should be fully disclosed prior to travel.
 - Current, reliable, relevant resources must be provided to travelers prior to travel.
 - A travel registry must be established for all university-related international travel. Plans for reliable intra-travel communication and ability to identify travelers' locations are vitally important and must be in place prior to travel.
 - Pre-travel orientations are essential and should contain current and relevant safety and health information, including emergency protocols as per usual. In addition:
 - All travelers should have at minimum a basic understanding of COVID-19 and SARS-CoV-2, including, but not limited to:
 - Personal risk factors and effect on travel advisability
 - Detailed COVID-19 vaccination recommendations and requirements for all destinations, intermediate stopovers, and destinations as well as re-entry to the U.S.
- COVID-19 risks with travel including transportation means and hubs (e.g., airports, train stations)
 - Basic protective measures (appropriate face coverings and their care, physical distancing, hand hygiene and appropriate sanitizers, etc.)
 - COVID-19 symptoms
 - Test types and availability
 - Appropriate care if ill, including red flags indicating critical illness and need to seek care
 - Isolation and quarantine guidelines
- Greater consideration should be given to pre-travel health screenings due to health risks of the COVID-19 pandemic.
 - Appropriate health insurance should be mandatory for all travelers, including adequate evacuation coverage. Travelers and IHEs should carefully review the details of insurance policies to ensure adequate coverage for planned activities as well as an absence of pandemic exclusions.
- Students, faculty, or staff who have been traveling internationally and are planning to re-enter the campus environment:
- Should be encouraged or required to communicate their intentions with identified contacts at their institutions in order to receive relevant critical information well in advance of their anticipated return.
 - Must be familiar with and follow state, tribal, territorial, and local health department recommendations and requirements including regarding vaccination. At this time, recommendations vary significantly by location; all parties must know how to ascertain the requirements that pertain to them.
 - See [directories of local \(and tribal\) health departments](#)
 - See [CDC returning traveler guidelines](#)

International Students, Faculty (Including Visiting Faculty), and Staff Who Are Incoming to or Present on Campus

There are many complex variables at play for international students and colleagues planning travel in the evolving global COVID-19 situation.

- It is crucial to inform international students, scholars, researchers, and colleagues of relevant, reliable, and current travel health and safety resources and to encourage the serious consideration of current recommendations prior to travel.
- Every international student, faculty, and staff member is in a unique situation, which warrants individually tailored recommendations.
- All new or returning international travelers should refer to [CDC returning traveler guidelines](#) and review CDC's "[Travelers Prohibited from Entry to the U.S.](#)"
- Existing international students, faculty, and staff currently at an IHE in the U.S. who are considering travel to their home countries should review global travel restrictions as noted by the U.S. State Department and CDC. Relevant testing or vaccination requirements should be addressed well in advance of anticipated travel.
- Faculty and staff contemplating travel with subsequent return to the U.S. to continue IHE studies or work must seriously consider:
 - Current COVID-19 travel health risks and the possibility of significant unexpected changes in risks during their travels.
 - Detailed COVID-19 vaccination recommendations and requirements for destinations and re-entry to U.S.
 - Potential for abrupt disruption, cancellation, or other serious complications of planned return to the U.S. due to the COVID-19 pandemic.
 - Rapidly changeable re-entry restrictions (including at any intermediate points in itinerary).

International travel is an evolving situation. Most IHEs in the U.S. have canceled or prohibited international travel for any university-related reasons through May 2021. Summer and fall 2021 study abroad programs and other IHE-related travel are being scrutinized at an individual institutional level, and many have thus far postponed making definitive decisions. Incoming international students, faculty, and staff are faced with a multitude of uncertainties as well, and challenges and uncertainties

abound in both host and home institutions and countries. Considering the myriad of unknown factors involved with the COVID-19 pandemic, knowledge and resources to inform new international travel guidelines will continue to emerge in the coming months. Students, faculty, and staff considering international travel should continue to monitor U.S. State Department and CDC websites.

Vaccinations

As of this writing (December 29, 2020), the Pfizer BioNTech vaccine and the Moderna vaccine received emergency use authorization (EUA) from the FDA. Both are two-dose [mRNA vaccines](#). Allocation, distribution, and mass vaccination planning is currently in progress. EUA of additional vaccines from other companies is anticipated in the upcoming months.

CDC, individual state, territorial, or tribal health authorities will develop many of the policies and procedures governing distribution. Final plans may result in significantly different vaccine availability from state-to-state. The CDC Advisory Committee for Immunization Practices (ACIP) developed recommendations for priority recipients. Health care providers and residents of long-term care facilities represent the highest priority groups to receive COVID-19 vaccination when it becomes available.

At this time, healthy college students (those without conditions that would increase the risk of severe illness if infected with SARS-CoV-2) are in tier 3 and may not receive vaccine until late spring 2021. Given the risk of asymptomatic and presymptomatic students spreading COVID-19 to other cities, states, and countries during the "mass migration events" at the beginning and end of each semester, ACHA has requested ACIP to consider recommending students be vaccinated prior to the end of spring semester 2021.

Many challenging decisions loom and will undoubtedly involve extensive discussions at all IHEs, often with their respective local and state health authorities. Remaining informed on additional vaccination approvals and availability status, additional funding resources, and clinical information regarding the vaccines will be key moving forward.

There are currently many unknowns regarding COVID-19 vaccinations at IHEs. However, planning and preparation for administration of the COVID-19 vaccine should begin now. See ACHA's website for its "[Mass Vaccination Clinic Guidance and Resources](#)." This webpage includes additional resources and guidance for IHEs considering mass vaccination events.

Vaccine considerations:

- Support ACHA’s advocacy to provide students with access to vaccination prior to the end of spring semester 2021.
- Create a COVID-19 Vaccination Task Force to lead campus-wide efforts in preparing for COVID-19 vaccine availability. Consider reaching across departmental and divisional lines to include key individuals with the authority to deploy resources and those with relevant expertise to dispense, administer, document, or provide support services. Consider including representatives from:
 - Student health center staff, including:
 - Medical representative
 - Nursing representative
 - Pharmacy representative
 - Front desk/medical records representative
 - Billing/insurance representative
 - Health promotion representative
 - Counseling services/mental health representative
 - Travel clinic representative
 - University communications
 - Office of emergency preparedness
 - Senior administration
 - Facilities Safety and risk management
 - Legal counsel
 - Human resources
 - Finance and administration
 - Campus safety/police
 - Health professional schools within the IHE
 - Business schools/programs to assist with marketing plan and activities
 - Graphic design/art programs to design attractive attention-getting materials
 - Office of international programs
 - Student body, preferably one who can represent a broad constituency
 - Community partners, who may include:
 - Local, state, territorial, and tribal health authorities
 - Local health care providers (e.g., community clinics, hospitals)
 - Elected community representative or designee

Responsibilities of a COVID-19 vaccination task force include:

- Development of a plan to prioritize and vaccinate the campus community, including SHS personnel.
- Identification of appropriate vaccination site(s) with development of patient flow patterns to ensure smooth flow and proper physical distancing.
- Preparation and planning to receive, store, and administer COVID-19 vaccine, including recall reminders for 2nd doses.
- Development of policies and procedures to guide documentation, record keeping, monitoring, and follow-up vaccination appointments.
- Identification and ordering of supplies and equipment:
 - Storage for vaccine
 - Potential need for ultra-cold freezers
 - Additional standard vaccination refrigerators
 - Injection supplies
 - Alcohol wipes
 - Sharps disposal equipment
 - PPE
 - Cleaning and disinfectant products
- Development of marketing, promotional, messaging, and social media campaigns.
 - Provide accurate, clear, consistent, credible, current audience-appropriate communication from the outset. Misinformation or mistakes will be difficult to rectify.
 - Gather resources and consider widespread distribution via multiple platforms of easy-to-understand, clear, appealing materials regarding the approved vaccinations, how they work, efficacy, rationale, and current state of vaccine availability/distribution on campus. Communications should focus on unique aspects of this vaccine, including the need for two doses and the potential of post-vaccine systemic effects.
 - Maintain robust communication regarding the importance of continuing current public health measures (face coverings, physical distancing, hand hygiene, and cleaning high touch surfaces) regardless of vaccine availability or uptake.
 - Aim to be creative and innovative.
 - Involve all relevant entities as previously noted.

- Involve students at multiple levels (developing, executing, promoting).
- Consider leveraging multiple platforms.
 - Social media (Instagram, Facebook, Twitter, etc.): place adequate personnel in dedicated positions to develop and maintain fresh feeds and posts which should include showcasing student comments, appearances, and creations
 - Campus-wide emails to students, faculty, and staff providing links to resources and encouraging vaccination
 - Main IHE website: link multiple other pages to main information site, include FAQs, and offer a means to ask questions; consider allowing anonymous inquiries, and plan to monitor and respond to any submissions
 - Posters and digital screens around campus
 - Campus newspaper and campus and community radio and television stations: Develop public service announcements (PSAs) and distribute widely, offer accessible and clearly written material, and provide interviews with organizers, vaccine recipients, etc.
 - Short cameo appearances in classes (virtual or face-to-face) by organizers and vaccine recipients to highlight the program and importance of getting vaccinated.
 - Appropriately branded T-shirts, hats, buttons, stickers, masks, etc. to promote vaccine acceptance.
- Enlist the assistance of your school's mascot, create catchy mottos, and be creative!
- Utilize CDC resources. Many excellent materials are available for multiple marketing platforms
- Share ideas across institutions and via ACHA Connect and listservs.

Routine Immunizations

Over the first nine months of the COVID-19 pandemic, there has been an apparent decrease globally in standard immunization uptake. IHEs need to remain vigilant in continuing to adhere to all appropriate routine immunization recommendations and requirements. Immunizations of concern include but are not limited to:

- MMR X 2 at appropriate ages and with required interval observed between dosages
- HPV X 3
- Tdap
- Meningitis (MenACWY and MenB, as appropriate)
- Influenza

See the [ACHA Guidelines: Immunization Recommendations for College Students](#) for vaccines recommended to reduce outbreaks and other vaccines recommended for adults.

Conclusion

The global pandemic has caused widespread social and economic disruption, illness, and death. Colleges and universities responded quickly to make monumental changes and spent inordinate amounts to create a safer environment for students, faculty, and staff. Every aspect of campus living and learning has been affected, leading to this “new normal.” The arrival of safe and effective vaccines provides promise of an end to the pandemic, though resumption of pre-pandemic operations remains distant.

Preparing for COVID-19 vaccination is the next most pressing task, one that will require coordination and collaboration with campus and community partners. College health's tripartite medical, mental health, and health promotion services will continue to play a central role in this next phase of the pandemic response. These services have been an invaluable institutional resource, providing credible expertise, delivering care and treatment, and augmenting local public health, and they will require resources and ongoing institutional support to facilitate or implement a vaccination program and maintain sufficient surveillance, testing, contact tracing, and case management capability.

Resources and Additional Reading

Contact Tracing

- CDC: [Contact Tracer COVID-19 Response Job Description Template](#)

Coordination with Public Health

- CDC: [CDC-Funded Training for the COVID-19 Contact Tracing Workforce](#)
- CDC: [Interim Guidance for Case Investigation and Contact Tracing in Institutions of Higher Education \(IHEs\)](#)
- Johns Hopkins University: [Contact Tracing Course](#)
- University of Central Florida News: [UCF student contact tracers help limit COVID-19 on campus and in the community](#) (October 5, 2020)

Facilities

- CDC: [Cleaning and Disinfecting Your Facility](#)

Faculty/Staff

- CDC Information on People at Increased Risk: [People with Certain Medical Conditions](#)
- Inside Higher Ed: [Faculty Pandemic Stress Is Now Chronic](#) (November 19, 2020)

International Travel and COVID-19

- [CDC Travel Information](#)
- [U.S. State Department Travel Information](#)

Many additional travel health related resources in ACHA Connect Travel Health Forum library (members only).

Isolation/Quarantine

- CDC: [Duration of Isolation and Precautions for Adults with COVID-19](#)
- CDC: [When to Quarantine](#)

Mental Health

- American College Health Association COVID-19 Resources: [Mental Health](#)
- American Psychological Association: [Guidelines for the Practice of Telepsychology](#)
- American Telemedicine Association. Practice guidelines for video-based online mental health services. Washington, DC, USA. Best Practices in Videoconferencing-based Telemental Health. American Psychiatric Association and the American Telemedicine Association, April 2018
- CMS: [General Provider Telehealth and Telemedicine Toolkit](#)
- Higher Education Mental Health Alliance (HEMHA): [College Counseling from a Distance: Deciding Whether and When to Engage in Telemental Health Services](#)
- [The Jed Foundation \(JED\)](#)
- Substance Abuse and Mental Health Services Association: [Coronavirus Resources](#)

Testing

- CDC: [Testing, Screening, and Outbreak Response for Institutions of Higher Education \(IHEs\)](#)

Wastewater Surveillance

- CDC: [National Wastewater Surveillance System \(NWSS\)](#)—A new public health tool to understand COVID-19 spread in a community
- National Public Radio: [Colleges Turn To Wastewater Testing In An Effort To Flush Out The Coronavirus](#) (October 26, 2020)
- *Nature Biotechnology*: [Tracking COVID-19 with Wastewater](#) (September 21, 2020)
- *ScienceDirect*: [Wastewater and public health: the potential of wastewater surveillance for monitoring COVID-19](#) (October 2020)
- Water & Energy Sustainable Technology Center, University of Arizona: [Wastewater testing at UArizona stops coronavirus spread; garners national attention](#) (August 31, 2020)

COVID-19 Task Force: Reopening Guidelines Committee

These guidelines were developed by the Reopening Guidelines Committee, part of ACHA's COVID-19 Task Force. A special thanks to the committee members: Jean Chin, MD, MBA, FACP, FACHA (Committee Chair); Anita Barkin, DrPH, MSN, NP-C, FACHA, and Geraldine Taylor, MS, APRN-BC, FACHA (Task Force Chairs); Paula Adams, MA; Deborah Beck, MPA, EdD; Michael Deichen, MD, MPH; Catherine Ebelke, PA-C, CTH; Joy Himmel, PsyD, LCPC, NCC, RN, FACHA; Mike Huey, MD, FACHA; Cheryl Hug-English, MD, MPH; and Sarah Van Orman, MD, MMM.

