

ACHA Guidelines

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

In this second year of the pandemic, institutions of higher education (IHEs) and their faculty, staff, and students are optimistic that the fall 2021 academic term will be far different than last fall, with a gradual return toward normalcy. Even with the resumption of research, academic, and co-curricular activities characteristic of a thriving campus, the unprecedented disruption to campus communities and the widespread financial, academic, social, emotional, and physical impacts resulting from the pandemic will require institutional attention, resources, and planning on multiple fronts for the foreseeable future.

Although COVID-19 vaccine is now widely available, not every eligible American will be vaccinated, making achievement of community (herd) immunity elusive. The emergence of more transmissible variant strains of SARS-CoV-2 may necessitate masking, hygiene, distancing, cleaning, and disinfection to some extent this fall, and perhaps beyond. The testing, contact tracing, quarantine, isolation, and remote monitoring systems established over the past year should also be retained to some extent, with modifications made in accordance with case prevalence and as vaccination uptake increases in the campus community.

In some respects, preparing for fall 2021 may be more complicated than it was for the two previous academic terms, as IHEs must maintain monitoring and surveillance processes, enforce masking and distancing, distinguish between a vaccinated and unvaccinated cohort, provide a rich and robust learning and living experience, and optimize the health and safety of a fully occupied campus. It is a tall order in the face of two key unknowns—the extent of variant strains of SARS CoV-2 and the level of vaccination of the campus community.

Since the December 2020 release of the [ACHA Guidelines: Considerations for Reopening Institutions of Higher Education for the Spring Semester 2021](#), three COVID-19 vaccines have received emergency use authorization (EUA) by the US. Food and Drug Administration (FDA). In addition, several vaccines have been authorized for emergency use by the World Health Organization (WHO). These vaccines have proven safe and highly effective in preventing COVID-19; [according to CDC](#), early data suggests the vaccines are also effective

in preventing transmission of the SARS-CoV-2 virus. The capability of COVID-19 vaccines to disrupt transmission and reduce disease incidence is the single most valuable lesson learned in the past four months. Shifting resources to vaccinate the campus community will have wide-ranging positive implications for higher education, the economy, the health of the public, and the health of individuals.

COVID-19 Vaccination

On April 29, 2021, the American College Health Association (ACHA) [published specific guidance on COVID-19 vaccination](#), stating that:

where state law and available resources allow, ACHA recommends COVID-19 vaccination requirements for all on-campus college and university students for fall semester 2021, in accordance with the IHE's normal exemption practices, including exemptions for medical contraindications. This recommendation applies to all students who live on campus and/or participate in on-campus classes, studies, research, or activities.

On a campus where COVID-19 vaccination is required, all faculty, staff, and students are fully immunized, except for those with medical or religious exemptions. In such a setting and where there is also low transmission in the off-campus community, it will be possible to relax testing requirements and other mitigation strategies, such as masking and physical distancing (see [CDC's guidance for people who are fully vaccinated](#)). Testing will be necessary on an as-needed basis for diagnostic purposes.

If vaccination requirements are established only for students, relaxation of testing and mitigation strategies for students is also possible. Existing CDC guidance states that fully vaccinated persons who are exposed to COVID-19 do not need to quarantine or, in most cases, be tested. With comprehensive vaccination, indoor classes, group sizes, residence hall occupancy, eating establishment operations, and sporting events may default to pre-pandemic guidance. Such an environment will be a new normal, but with continued need to seek local health department guidance and readiness to elevate COVID-19 precautions depending on campus or community transmission.

If a COVID-19 vaccine requirement is not implemented, it will be extremely important for IHEs to remain at heightened alert with their current oversight of population-based strategies to mitigate and contain the spread of COVID-19. Physical distancing, masking, control of group sizes, appropriate ventilation, advanced testing strategies, and rapid contact tracing would likely need to be continued. Communicating and reinforcing behavioral interventions will be particularly important as students arrive in the fall. New students may be unaware of the campus culture, rules, and procedures for COVID-19 containment, and they may be less likely to have previously been infected and therefore lack immunity. Fraternity and sorority rush; welcome events; the arrival of incoming students, including international students; bar patronage; congregate living, and various other group events may precipitate outbreaks when participants are not fully vaccinated.

Some colleges and universities may choose a plan of voluntary vaccinations but require a COVID-19 vaccine declination. The declination process serves to inform the individual of the benefits and risks of vaccination vs. non-vaccination and documents the individual's choice. Additionally, the document provides an estimate of community risk. Any declination process should be thoroughly reviewed by legal counsel and approved by the governing body. Similar processes for vaccine declination have been used with health care employees for many years (e.g., for hepatitis B vaccination) and on many campuses for students (e.g., meningococcal vaccination).

At this time, the need for COVID-19 vaccine boosters is not known. Variants may demonstrate resistance to vaccines and result in a need for boosters. Colleges and universities need to be well informed about booster recommendations and be prepared to advise and potentially provide booster doses or referral to a local resource.

Mass immunization involves distribution of vaccine to large groups of persons in the most efficient manner. These sites may be referred to as a "Point of Distribution" or "POD." Efficient vaccine PODs may deliver each shot in one to two minutes and have door-to-door experiences of 25 or 30 minutes. PODs may be drive-through or walk-through. Drive-through PODs offer advantages such as reduced mixing of persons getting vaccinated but require large spaces for car access, and accessing the site is difficult or impossible for those without a vehicle. Indoor PODs are more accessible for persons by foot and offer climate control for workers and patients. Careful attention

must be given to physical distancing, masking, airflow and filtering, and other infection prevention strategies.

PODs are usually classified as open or closed. Open PODs are, as the name implies, open to all persons. This would include campus members and non-campus members. Most state and federal vaccine sites have an open POD designation. Closed PODs are limited to a specific population, generally defined at a community level. College and university community definition would typically include all faculty, staff, and students. Spouses and household members may be included. A closed POD would not, however, include members outside of that community. Establishment of a Memorandum of Agreement with a local public health entity may be beneficial in defining the POD and planned use of vaccines.¹

As outlined by [ACHA's Mass Vaccination Clinic Guidance and Resources](#), COVID-19 mass vaccination events will require additional planning such as:

- Attention to the event site layout and flow patterns for efficient and safe events, as well as a registration process for the event.
- Access to vaccine doses.
- Security for vaccines and supplies.
- Appropriate cold-chain management of vaccines.
- Consideration for providing appropriate PPE for staff, masking requirements for patient participants, and easy access to hand sanitizer/hand hygiene.
- Strengthening of community partnerships (e.g., with local pharmacies, hospitals, health departments).
- Addressing the needs of vulnerable and special needs populations.
- Management of records, including connecting to state registries; sending reminders for additional doses as needed; and tracking of student immunization status.
- Encouraging use of CDC's [v-safe post vaccination health check tool](#) for COVID-19 vaccine symptom tracking and reporting.

In addition to the considerations included in [ACHA's recommendation for COVID-19 vaccination requirements for all on-campus students for fall 2021](#), campuses should:

- Develop strategies utilizing best practices to maximize acceptance of vaccination, including understanding and addressing vaccine hesitancy,

¹ The Center for Infectious Disease Research and Policy (CIDRAP) provides templates, checklists, and other [resources for planning a closed dispensing site](#).

communicating messages targeted to the appropriate audience, providing incentives for vaccinations, or implementing vaccine requirements for subgroups (such as those using campus housing, students in health professions, and athletes). ACHA's [Campus COVID-19 Vaccine \(CoVAC\) Initiative](#) will be providing tools and resources to help IHEs address vaccine hesitancy and promote vaccine uptake,

- Utilize established resources and toolkits such as the Association of Immunization Manager's [COVID-19 Vaccine Communication Resources](#) or CDC's [Vaccination Communication Toolkit](#) to optimize and tailor communications based on the audience .
- Stay up to date with [FDA guidance on vaccines](#). Attributes specific to the different COVID-19 vaccines, such as the requisite number of doses, storage requirements, and timing of doses, may influence vaccination strategies. Availability of vaccine and cold storage freezers may be primary determinants of vaccine choice.
- As vaccines become more widely available, college health centers should maintain an inventory of COVID-19 vaccines for routine administration. Student health programs should anticipate providing access to vaccines within their establishment or via other means, such as pop-up vaccination sites, and should be prepared to vaccinate or direct to local resources any students arriving to campus who are not adequately immunized.
- IHEs should determine the adequacy of immunization with vaccines not authorized by either FDA or by WHO in accordance with updated [CDC recommendations regarding people vaccinated outside the United States](#).
- Educate and train student-facing staff and faculty on vaccination benefits, venues, and other resources.
- Provide guidance on getting a second dose of vaccine. If the initial dose of a two-dose vaccine was received prior to arrival on campus in fall 2021, IHEs should share strategies with students for getting the second dose by the same manufacturer either on campus or in the local community.

COVID-19 Testing

COVID-19 testing remains a cornerstone for containment and mitigation of the pandemic. Even with a fully vaccinated campus, testing will still be required in some circumstances. It is crucial to have [a clear understanding](#) of the available tests; their uses, advantages, and limitations; and their place in the context of the larger

campus COVID-19 mitigation plan. Testing is used for diagnosis, screening, and surveillance. Viral testing with either a molecular test or antigen test is the mainstay of testing. Molecular tests identify genetic material from the virus and include the reverse transcription-polymerase chain reaction (RT-PCR) tests and nucleic acid amplification tests (NAATs). Molecular tests are highly sensitive and have high specificity. However, most of these tests need processing in a lab and have one to two days of turnaround time. Tests with a turnaround time of 15–45 minutes require specialized equipment and may be difficult to implement at large scale. RT-PCR testing may identify many post-infectious cases and therefore have diminished usefulness when used for screening.

Antigen tests identify specific proteins from the virus. Antigen tests provide convenient, low-cost testing with rapid results. However, they are less sensitive than molecular tests and may require RT-PCR confirmation. Their specificity is similar to that of molecular tests, and their [sensitivity correlates closely with the period of COVID-19 infectiousness](#).

Per CDC's [interim guidelines](#), antibody testing currently has limited utility. Its primary uses are with the diagnosis of multisystem inflammatory syndrome or other complications from COVID-19 and for epidemiologic studies. Currently, antibody tests are not to be used to assess immunity status after COVID-19 vaccination, nor are they to be used to determine the need for vaccination. In some countries, antibody tests are being considered to allow participation in international travel in lieu of a vaccine passport.

Home collection and at-home tests are becoming more common but are still relatively expensive for frequent or serial testing. If used for asymptomatic screening, these antigen tests are most accurate if used on day 0 and again on day 3. Those tests that require samples collected at home and sent away for testing may incur delays with results. Only those at-home testing products that have FDA authorization should be recommended to patients. Large retailers are now providing rapid at home tests directly to consumers without a provider prescription.

The data increasingly supports the frequency of testing, the speed of turnaround time and results notification, rapid containment of positive individuals, contact tracing efficiency and quarantine as more important than test sensitivity. How frequently to test asymptomatic individuals will vary depending on the level of immunity achieved on campus either through vaccination or recovery from natural disease, as well as the impact of susceptibility to variant strains and disease prevalence in the community.

Testing strategies on campuses have evolved significantly since the onset of the COVID-19 pandemic. Most have established well-defined systems independently or in collaboration with internal or external partners. Campus strategies now include an array of options such as diagnostic testing, move-in screening, random screening, pop-up testing, wastewater surveillance, or genomic surveillance. CDC provides interim guidance for SARS-CoV-2 testing and screening at IHEs [here](#).

- Diagnostic testing is usually considered testing of persons with symptoms or potential exposure. This may include testing persons with symptoms who are being evaluated by a healthcare provider, testing as part of contact tracing, testing unvaccinated persons exposed to COVID-19, or testing unvaccinated persons at an event attended by an individual with COVID-19. Whether fully vaccinated or unvaccinated, immunocompromised individuals, including those taking immunosuppressants should be evaluated for testing if symptomatic, exposed to COVID-19, or at an event attended by an individual with COVID-19. For most persons, testing is [not recommended for determination of resolution of infection](#).
- Screening tests may be used to test all students who move into campus-managed residential facilities at the beginning of the semester and may also include testing all competitive athletes on a frequent basis (see [NCAA's testing recommendation](#)). When community transmission of COVID-19 is moderate (10 or more cases per 100,000 persons each week) or higher, CDC advises serial screening of all campus members on at least a weekly basis. This testing is contingent on resources. In response to an outbreak, increased serial screening with contact tracing is likewise advised. Testing may take place with random selection of community members with molecular or antigen tests. To best function, results should be available as soon as possible and no longer than 48 hours.
- Pop-up testing is a means for providing testing on an as-needed basis in areas where individuals would most benefit. Depending on the patient's circumstance, this could be considered a diagnostic test or screening test.
- [Wastewater surveillance](#) is a newer public health strategy which complements but does not replace established surveillance methods. COVID-19 virus may be detected in wastewater [preceding a rise in case counts](#). Using wastewater surveillance results to estimate community prevalence is challenging unless

the community itself, wastewater flow, viral shedding in feces, etc. remain constant, but [trends may assist with forecasting and mitigation](#). Sampling wastewater is specialized and needs coordination with campus environmental health services and facilities. Testing of the samples may be provided by campus-based labs, state labs, or vendors.

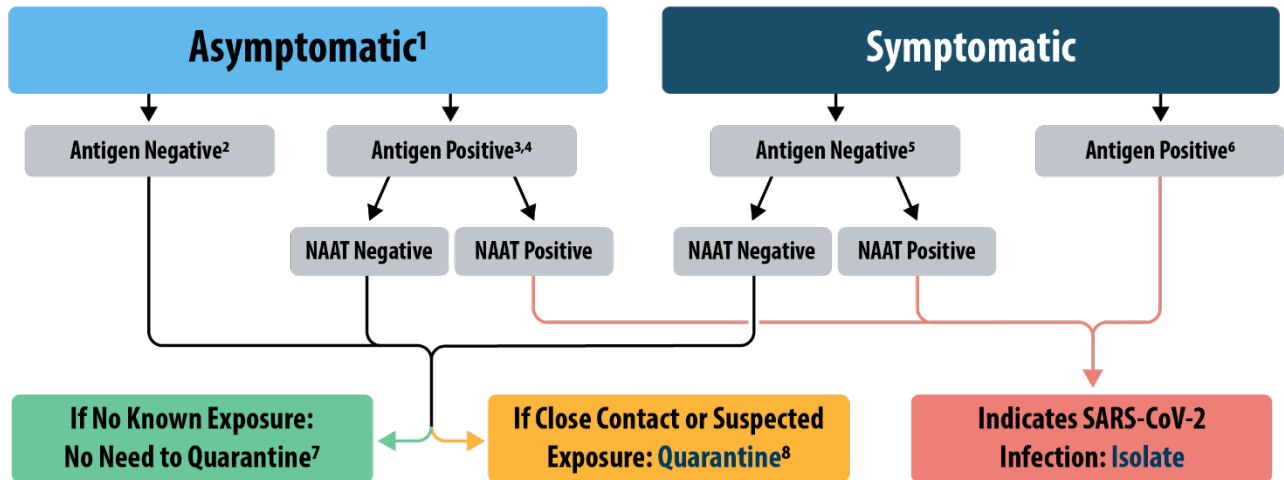
- [Genomic testing](#) can determine the presence of COVID-19 variants. Since November 2020, CDC has regularly been receiving samples for sequencing and evaluation from state and other public health agencies. They are also partnering with large commercial diagnostic labs and universities to scale up sequencing. This work has led to the development of the SARS-CoV-2 [Sequencing for Public Health Emergency Response, Epidemiology, and Surveillance](#) (SPHERES) consortium. Multiple public health and scientific organizations, including 53 academic institutions, participate in SPHERES to share genomic data. In addition to sequencing, which can be time consuming, labs could also re-test positive samples using PCR probes that are specific to the more commonly circulating variants.

Considerations:

- Entry testing remains a valuable strategy to reduce the spread of COVID-19. Some IHEs might opt to continue entry testing in order to identify breakthrough infections among vaccinated persons, particularly when students are coming from numerous points of origin. The IHE's plan must include the means to isolate and provide services and support for those who test positive.
- Those who have been fully vaccinated and those who have been diagnosed with COVID-19 within the past 90 days may be exempted from entry testing and surveillance testing. When designing campus testing programs, an individual or small select group should be assigned to monitor all the results in a systematic and regular basis. These results may give timely forewarning of an outbreak. An emerging challenge for institutions is assimilating multiple COVID-19 data sources in a meaningful fashion.
- Pooled sampling can be used to reduce costs and save time. It is a technique that is more beneficial when only a small number of positive results are expected. With pooled sampling, several patient samples are tested together. If the test is positive, individual samples must be tested. This may result in a need for resampling those persons.

- Diagnostic testing should remain available for symptomatic people and those who have been exposed to an individual who is positive for SARS-CoV-2.

- Refer to the [testing algorithm](#) published by CDC to assess when a confirmatory molecular test is necessary after a positive antigen test:



Source: U.S. Centers for Disease Control and Prevention, *Interim Guidance for Antigen Testing for SARS-CoV-2*

- Generally, weekly asymptomatic testing should focus on unvaccinated students, faculty, and staff, particularly those living in a congregate setting.
- Health equity remains an important principle and should be considered in testing plans. All students, faculty, and staff deserve equitable access to testing. Testing criteria must be transparent, simple, and consistent. Positive results should be accompanied by referrals to accessible care or resources. Race and ethnicity must be reported with test results to local health departments. See CDC’s health equity information and resources [here](#).
- CDC does not currently recommend routine surveillance testing on fully vaccinated individuals or those individuals within the 90-day window following infection, unless COVID-like symptoms occur.

Local health departments are responsible for leading case investigations, contact tracing, and outbreak investigation. However, during the pandemic, many student health services assumed contact tracing responsibilities on campus to improve timeliness. 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.

In addition to notification of exposure to an infected individual, contact tracers 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

Contact Tracing

Campuses should continue to offer testing, contact tracing, and isolation/quarantine of ill and exposed individuals on campus. This approach will require access to immediate testing for all students, faculty, and staff with symptoms. As case counts fall, the contact tracing workload should also decrease. The capacity to expand and contract the contact tracing workforce to meet demand will optimize efficiency and conserve tight resources.

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. The definition of a close contact is 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 two days prior to illness onset (or, for asymptomatic patients, two 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 local health department and institutional 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. However, as case numbers fall due to widespread vaccination, some IHEs may choose to offer quarantine and isolation accommodations to students who live off campus, particularly those with housing and food insecurity.

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:

- Deep understanding of the structure of the IHE, including names of residence halls, terms that are frequently used by students and employees, and activities that are common among campus community members.
- 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.
- The ability to gain the 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, vaccination status, infectious periods and interactions, and symptoms of COVID-19 for both pre-symptomatic and asymptomatic infection.
- Exceptional communication skills and cultural sensitivity.

Considerations for contact tracing:

- Partner with local, state, tribal, and territorial 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.

Masking and Physical Distancing

Masking and physical distancing continue to be two of the most effective means of combating the spread of COVID-19. By now, IHEs have well-established policies, procedures, and physical reminders to comply with mask mandates and distancing requirements. CDC's interim public health recommendations for [fully vaccinated](#) people required IHEs to accelerate a review of their current policies and procedures. Unless vaccination is required or vaccination status is known, the IHE must rely on the individual to demonstrate personal responsibility and comply with campus masking and physical distancing guidelines.

CDC's updated recommendations for fully vaccinated individuals includes discontinuation of masking and physical distancing requirements. IHEs must determine how to implement these new recommendations in consultation with public health authorities; in accordance with the governing body or local, state, territorial, or tribal regulations; and with consideration of rates of immunization, infection, hospitalization, and deaths in the campus and local community.

Therefore, implementation of masking and distancing guidelines could potentially include any of the following:

- Fully vaccinated students, faculty, and staff may resume pre-pandemic instructional, research, and co-curricular activities without physical distancing or masking. Those who are unvaccinated (including those who are not fully vaccinated) must continue to wear masks and maintain physical distance or attend class remotely. The IHE would need to designate a section of the space or a percentage of seats to accommodate unvaccinated individuals. Notably, without regulatory oversight or proof of vaccination, some may choose to disregard campus guidelines.
- Require face masks and physical distancing for all indoor public spaces, including classrooms, lecture halls, gyms, etc., and all large outdoor gatherings regardless of individuals' vaccination status.

- Establish a threshold of vaccination of the campus population before a blanket lifting of mask and physical distancing requirements.
- Develop a vaccine passport or other means to establish vaccine status to allow entry into classrooms or other public campus facilities.

CDC continues to recommend six feet of physical distancing if not fully vaccinated. A notable exception is the decrease in physical distancing standards from six feet to three feet for children in K-12 classrooms, with the caveats of concomitant universal mask wearing, meticulous hand hygiene, and optimal ventilation. See the most up-to-date CDC recommendations on [masking](#) and [physical distancing](#) for unvaccinated people; see also CDC recommendations for [fully vaccinated](#) people.

Considerations:

- IHEs should require unvaccinated individuals to continue to wear well-fitted masks and adhere to campus physical distancing guidelines.
- All campus transit riders, regardless of vaccination status, should be required to wear masks and physically distance.
- Masks should be required in health care facilities or locations providing health or counseling services.
- Local businesses and services may continue to require their patrons to wear masks. Local policies should be widely shared throughout the campus community.
- Campuses should encourage individuals to carry masks, even if they are outdoors, in case they encounter a situation in which physical distancing is not feasible.

Isolation and Quarantine

Most campuses have provided spaces for isolation and quarantine (e.g., designated residence halls or floors, contracted hotels, apartments) and have provided dining and support services for ill or exposed individuals. Generally, but not always, quarantine and isolation housing are reserved for students who live in on-campus housing. However, some IHEs may choose to offer quarantine and isolation accommodations to students who live off campus, particularly those with housing and food insecurity.

Current CDC guidance for quarantine and isolation are as follows:

Isolation (for those who have been diagnosed with COVID-19):

- A symptomatic individual diagnosed with COVID-19 should self-isolate for 10 days from the start of symptoms with resolution of fever for at least 24 hours

(without the use of fever reducing medications) and with improvement of other symptoms.

- An asymptomatic individual diagnosed with COVID-19 should self-isolate for 10 days from the date of testing.
- Individuals who have tested positive for COVID-19 with severe symptoms may need to extend self-isolation to 20 days.

Quarantine (for those who are not fully vaccinated and who have been in close contact with someone diagnosed with COVID-19):

Although CDC still recommends 14 days of quarantine for a close contact, they have provided other options.

- Unvaccinated individuals who have come in close contact (within 6 feet for more than 15 minutes) with someone diagnosed with COVID-19 could end quarantine without a test for SARS-CoV-2 on day 10.

OR

- Quarantine can be ended on day 7 with a negative SARS-CoV-2 test. The test must be performed no earlier than day 5. Individuals should continue to self-monitor for symptoms through day 14, wear a mask, maintain physical distancing, and avoid crowds. If symptoms develop, quarantine should resume and SHS or a private health care provider should be contacted.

Individuals who have been previously diagnosed with symptomatic COVID-19 and have recovered and remain asymptomatic should not repeat testing for 90 days. Those who develop new symptoms consistent with COVID-19 within three months may warrant retesting.

Individuals who have been fully vaccinated and are exposed to someone with COVID-19 do not need to quarantine or undergo testing for SARS-CoV-2 but should continue to monitor for symptoms. Unvaccinated individuals who are antibody-positive within 90 days of exposure to someone with suspected or confirmed COVID-19 do not have to quarantine if there is limited or no risk of exposure to persons at higher risk for severe illness with COVID-19. See the full CDC guidance on [isolation](#) and [quarantine](#).

Considerations for isolation and quarantine:

- Policies 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 during transit.
- 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.
- Ideally, 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 develop a “COVID Plan” prior to arrival to campus that includes a list of items (medications, clothing, academic supplies, etc.) to bring with them to a quarantine or isolation room. Plans should also identify individuals (i.e., family or friends) who will assist in securing and delivering needed items while in isolation.
- 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 entertainment 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 urgent personal needs (medication pickup, delivery of personal hygiene supplies, etc.).
- Policies and safeguards should be developed to avoid in-person socializing among students who are being housed in isolation and quarantine spaces.
- 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.

Campus Access for Visitors and the Public

In addition to students, faculty, and staff who access campus spaces in a more controllable fashion, campuses should also be prepared with policies and protocols regarding other persons who might need or wish to gain access to these spaces (e.g., official guests, informal visitors, and the general public). Such access might include brief visits for meetings and tours; informal visits for the purpose of casual interaction with specific students, faculty, or staff; participation in youth programs; and attendance at conferences, symposia, sporting events, performances, convocation, commencement, or other special events. Moreover, campuses might include spaces that were traditionally used by the general public (for example, restaurants, food courts, museums, parks/gardens, etc.).

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, financial donors, and tourists.

Campuses should assess multiple factors including the health of visitors and the overall health of the campus community to determine the level of access available to the public. When disease prevalence is increasing on campus or in the surrounding community, campuses should explore modified, lower risk alternatives such as virtual platforms, outdoor activities, and limited in-person capacity. Specific rules will vary from campus to campus based upon resources and local risks.

Questions and considerations when planning for the presence of visitors, guests, and the public:

- Decide which campus spaces are open to visitors and which are limited to official students, faculty, and staff.
- Determine the behavioral expectations of visitors while on campus (e.g., masking, distancing) and how will this be conveyed and enforced.
- Assess the origin of visitors and whether that influences the level of risk: are visitors from the local vicinity or more distant places? Are they arriving from higher risk countries?
- Determine whether any type of screening will be required upon entry (e.g., verbal symptom attestation).
- Whenever possible, rules for visitors should mirror those for students, faculty, and staff who use the same space.
- Determine the occupancy limits of each space in which visitors will be permitted and how the limits will be enforced.
- Decide whether viral testing will be required for certain visitors (e.g., for visitors participating in higher risk activities such as large gatherings, events with food and drink, or other mask-free interactions).
- Place masks and hand sanitizer at highly trafficked building entries.
- Decide which segments of the campus population will be permitted to have guests (e.g., undergraduates living in residence halls).
- Where feasible, maintain a registry of guests to facilitate contact tracing.
- Place increased signage at entrances to (and within) spaces used by the general public, as visitors will be less knowledgeable about campus rules and protocols.
- For performances, consider the safety of performers as well as audiences. Distancing between audiences and performers may need to be greater when performers are projecting their voices or blowing into instruments. Use masks and instrument bell covers to reduce droplet spread.

- Decide how restrictions might be modified based upon variations in the level of community risk (e.g., community infection rates, vaccination levels, etc.).
- Consider whether there will be age restrictions for some activities or spaces.
- Review local and state public health guidelines to ensure compliance with applicable regulations. Rules that are specific to the IHE may not apply when the spaces are also used by the general public.

Student Health Services

The role of student health services (SHS) has continued to expand during the COVID-19 pandemic, with SHS often adding testing, contact tracing, and case management to their responsibilities. As vaccines have become available, many SHS are also providing on site COVID-19 vaccinations. 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 continue to challenge the campus health system.

Patient Care Considerations

As campuses begin to reopen more fully to in-person learning, there will likely be an increased demand for health care services. Student health services should plan for and anticipate more requests for in-person visits. To be fully prepared, SHS should:

- Develop protocols for in-person visits. Consider designating providers for telemedicine and in-person visits on a daily basis. If possible, allocate a separate area of the clinic for acute illness.
- Continue the delivery of routine clinical preventive services when possible to prevent health consequences of delayed care.
- Continue to provide options for telemedicine or telephone consults when appropriate. Students with conditions placing them at higher risk for complications from COVID-19 and who have not been vaccinated should be encouraged to seek care via telemedicine when possible (some symptoms may require in-person clinical assessment).
- 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.) via the patient portal or utilize EHR templates.
 - Require all patients and clinic guests to wear well-fitted, multi-layer cloth face masks or provide patients with a medical procedure (surgical) mask.
 - Limit 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 when local conditions suggest ongoing risk.
 - Develop a plan for students with respiratory symptoms who need transportation to SHS, housing, or local hospitals. Ensure after-hours care options are included.
 - 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, and loss of sense of smell and taste (anosmia and dysgeusia).
 - Include a question about COVID-19 vaccination status on screening forms.
 - Establish protocols for managing patients with acute respiratory symptoms, including 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. Follow best practices to reduce risk when nebulizers are used (e.g., distancing, PPE, separation of patients who require nebulizer treatment behind closed doors, use disposable tubing and other supplies).
 - 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 possible, provide vaccinations at SHS and offer the vaccine to unvaccinated students at all routine visits. If this is not feasible, provide community resources and locations for vaccine appointments.
 - 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 provide updated messaging about COVID-19 protocols, policies, and services as well as the importance of COVID-19 vaccinations. 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 services, 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.
 - Consider embedding a mental health clinician within the SHS to provide easier access to mental health services and improve collaboration and coordination of care between health and counseling services.

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.
- If possible, segregate waiting areas for ill and well patient visits.
- Perform COVID-19 testing in a separate location of the clinic or outdoors when possible.
- Configure all waiting and other clinic areas to promote physical distancing.
- Ensure adequate amounts of alcohol-based (at least 60%) hand sanitizer, surgical masks for patients who do not bring their own mask, 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 of and responsibility for clinic cleaning and decontamination.
- Assess air exchange and filtration in care, treatment, and administrative spaces and determine time required between uses in the event of a known or suspected COVID-19 patient. Facilities may need to consider updating air handlers and

negative-pressure rooms/tents and conducting some visits outside. Portable HEPA filters may be necessary, but they should be placed so that airflow is not directed from one person to another person.

- 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. Establish Periodic Automatic Replacement (PAR) levels for PPE restocking, if such guidelines are not already in place.
- Maintain situational awareness of COVID-19 incidence and prevalence in the state and city and on campus.
- Require frontline SHS staff to be vaccinated for COVID-19.
- Consider a mandatory COVID-19 testing policy for all unvaccinated SHS 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 were 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 unvaccinated staff at higher risk of severe COVID-19.
- 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

The COVID-19 pandemic has significantly increased the mental health needs of our campus communities due to the consistent stress related to fear and uncertainty; burnout; and a sense of powerlessness, sorrow, and loss that has characterized life for so many. There is clear consensus that there will be a considerable psychological and psychiatric aftermath to this pandemic, resulting in high demand for counseling and psychiatric services when students return in the fall.

The pandemic's mental wellness impact was widely experienced but affected some more than others. Those who reported the poorest mental health were young adults and individuals with financial adversity or those unable to receive care for other medical conditions. [According to CDC](#), one in four young adults age 18–24 seriously considered suicide in spring 2020. The 18–24-year age group appears to be especially vulnerable, possibly due to many of the drastic transitions they were required to make and the isolation they experienced at what is typically a highly social stage of life. Factors such as inadequate sleep, exercise, or face-to-face socialization also increased the risk for poorer mental well-being. One of the most salient factors is not knowing when the pandemic and its consequences will end.

Other risk factors associated with poor mental well-being include:

- Having a pre-existing mental health condition or substance use disorder.
- Identifying as a sexual or gender minority, including transgender and nonbinary.
- Being a first-year college student or high school senior.
- Being a member of a marginalized population.
- Lacking social support.
- Having previously experienced trauma, having a childhood history of traumatic experiences.
- Experiencing poverty or lack of resources.
- Being a community college student and/or adult learner.
- Having a chronic illness, including long-term effects of COVID-19.

According to the Center for Collegiate Mental Health

(CCMH), students who perceived that their “mental health” was negatively impacted by COVID-19 and sought counseling treatment reported higher levels of mental-health distress in the following areas:

- Depression,
- Generalized anxiety,
- Academic distress, and
- General distress symptoms and overall wellness.

The data indicates that 85% of students seeking counseling services report that COVID-19 has negatively impacted at least one aspect of their life:

- Mental health (65%),
- Motivation or focus (61%),
- Loneliness or isolation (60%),
- Academics (59%), and
- Missed experiences and opportunities (54%).

Mental Health Strategic Planning

Now more than ever, a comprehensive public health approach is needed to address the looming mental health impact of the COVID-19 pandemic. Mental health must be viewed not just from an individual psychopathology level but from a public health standpoint. College counseling centers do not have the capacity to provide treatment to so many students on an individual level, nor should they. This is the time to engage and unite the campus in the goal of providing a safety net for students, faculty, and staff. There is an acute need to bolster resilience and create an environment of compassion and understanding. The campus should engage in strategic planning that is inclusive and considers not only the impact of COVID-19 but also proactively addresses the intersection of related academic, social, and institutional issues.

College and university leadership should prepare to address the continuous and future challenges encountered by the campus community caused by the pandemic. As students re-integrate into campus, leadership’s focus should include:

- Improving access to mental health care, improving students’ experience of mental health, integrating mental health issues and resources into class syllabi, and creating space for listening.
- Supporting resilience through consistent engagement with peers, leadership, and decision makers.
- Promoting healthy coping strategies through social norming.
- Fostering social connections and opportunities, especially for second-year students who may not have

anchored with the campus in their first year.

- Facilitating the diverse responses to the transition back toward pre-pandemic daily routines.
- Attending to the basics of food, shelter, and finances.
- Addressing academic worry, a key factor of reported distress as well as the anxiety related to the uncertainties surrounding the pandemic.
- Embracing resiliency programming that includes providing credit courses and implementing skill-based practices within student affairs and academic programs.

Counseling and Psychological Services

Since the onset of the pandemic, counseling services implemented new and expanded services and delivery methods including:

- Transitioning to digital and virtual platforms vs. in-person individual and group sessions.
- Expanding crisis services.
- Providing on-demand virtual psychoeducation, support, and therapy sessions.
- Providing training and education that help students at risk, including bystander intervention and gatekeeping suicide prevention programs.
- Enhancing partnerships with other departments to provide consultation and support.
- Enhancing web presence with digital offerings and self-help options.

Counseling services will likely retain or expand many of these offerings this fall.

Colleges and universities should anticipate the need for enhanced mental health services and develop plans to support the mental health needs of students returning to campus. This has been a year of distancing from social and interpersonal interactions and friendships. Students may have greater levels of anxiety upon return to a social campus environment and greater opportunity and access to alcohol and other drugs.

Considerations for counseling centers:

- Make an institutional commitment to providing more resources to college counseling centers.
- Provide clinician training and utilization of evidence-based trauma-informed practices specific to assessment and treatment (see appendix A).

- Provide clinician training about substance use disorders.
- Continue diversification of services by providing a menu of service options for students to include virtual, digital, and in-person options.
- Continue providing crisis management services; [SAMHSA](#) provides a comprehensive guide on best practices in providing mental health crisis services.
- Continue collaborations with campus partners.
- Focus on in-person and virtual same day appointments and “on demand” counseling options.
- Provide options for drop-in counseling.
- Create stepped care venues that provide the correct type and level of service based on the student’s presenting needs and functioning.
- Provide counseling services through remote service options, taking services to where the students are (residence halls, academic buildings, etc.). Collaborate with campus partners to ensure secure, private spaces for students to access remote care.
- Focus on normalizing and increasing help-seeking through consistent marketing, timely triage, and improving ease of access.
- Designate peer-based outreach and peer-based support groups provided virtually or in-person.
- Create service-learning opportunities on campus and in the community to encourage students to get involved as a part of the solution.
- Promote a work/life balance and a healing environment. Counseling staff are consistently addressing diverse and acute mental health needs of students while balancing their own personal stressors. Provision of therapy services through video can be more emotionally draining for mental health professionals. There is a need for acknowledgment and recognition for the important work that is done. The work climate must encourage and embrace self-care, collaboration, and focus on staff retention.
- Enhance gatekeeper strategies. Students will need a comprehensive approach to help maximize their strengths and engage in healthy habits such as finding social/academic balance, eating a nutritious diet, exercising, and developing healthy sleep patterns. It takes all campus stakeholders to encourage wellness, but also to identify those in distress. The need to cross-train all front line personnel to recognize and respond to trauma and identify risk factors needs to be a priority. The training should include students as well as

parents, faculty, and staff. The [Jed Foundation](#) and the [Suicide Prevention Resource Center](#) (SPRC) provide valuable resource options.

- Coordinate medical and counseling services. Collaboration between medical services and counseling and psychological services must be seamless, with a focus on eliminating barriers and promoting access to care. Since students often initially present to SHS, it should adopt a wellness assessment in addition to a depression inventory to proactively address the magnitude of physical, emotional, and spiritual effects resulting from the pandemic. Screenings need to embrace a trauma-informed approach with clear pathways for intervention and referral.
- Provide easy access to behavioral health providers. The practice of embedding behavioral health providers in primary care has had enormous success in both the private and public sector and allows for improved access to care, coordination, and a welcome warm hand-off.
- Provide opportunities for virtual telehealth sessions and consider safe in-person visits without masks, with adequate distancing, ventilation, and immunization; this acknowledges the value of facial expressions in providing accurate assessment, evaluation, and rapport building.

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 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 that effectively engages students in supporting healthy behaviors while 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 may need to adopt or maintain a variety of health promoting actions including:

- Trauma-informed adaptations to student services, including mental health services.
- Detailed infection control plans for in-person activities.
- Required COVID-19 vaccination for students and/or employees.
- Flexible attendance policies to support students in staying home when feeling sick.
- Flexible grading and course withdrawal policies to support students who are ill or working through other COVID-related life challenges.
- Enhanced outdoor venues for in-person activities (weather permitting).
- Provision of easily accessible SARS-CoV-2 testing.
- Provision of high-support isolation and quarantine facilities, either exclusively for on-campus residential students or for all students.
- Updated student codes of conduct to include behavioral expectations related to COVID-19.
- Changes to academic terms to reduce student travel and subsequent risks of transmitting SARS-CoV-2.
- Enhanced access to support services for food security, housing security, and temporary financial aid.
- Enhanced access to technology for ongoing distance education.

Pandemic response continues to be 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, including decisions regarding COVID-19 vaccination requirements, 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 pivoted to virtual programs, sparking broad conversation about translating evidence-based interventions designed for in-person implementation to the online environment. Health educators quickly gained

knowledge in effective use of online meeting software to maintain privacy, allow for actively engaged participation, and support accessibility.

The key consideration going forward is determining which technology-based or virtual health education should be maintained to best meet students' needs, and when it is appropriate to have face-to-face approaches. Many institutions have been able to implement programs in new ways that expanded reach and accessibility. Rather than simply returning to pre-pandemic program models, teams should review which adaptations to keep to best meet students' ongoing needs. Some programs or other health education activities may never return to in-person, or hybrid options may be used to reduce barriers.

In addition to transitioning standard programs, health educators continue to develop programs specific to COVID-19. These programs are designed to influence individual behavior and enhance motivation to prevent COVID-19 spread through vaccination and ongoing infection prevention and control. 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. The ACHA Higher Education COVID-19 Community of Practice (HECCOP) is [compiling examples](#) of COVID-19 risk mitigation programs and policies from a wide range of colleges and universities.

COVID-19 vaccine confidence and uptake should be a key focus on every campus. Whether vaccines are required or strongly encouraged, students will need access to accurate information and simple processes for obtaining a vaccine. Several theories and models (e.g., the Diffusion of Innovation Theory, the Health Belief Model, Stages of Change Model, Risk Perception models) help guide the approach to vaccine promotion. However, a basic approach to widespread vaccination should:

- Start with the early adopters—people who already want the vaccine. Ensure they can access the vaccine and that clear information and simple processes are in place for getting vaccinated, obtaining a second vaccine dose if required, and submitting verification as needed.
- Engage early adopters in spreading the word. They can create a sense of community around vaccination by sharing stories of why they chose vaccination, how easy it was to do it, and happiness with results. Consider the reasons why people may be hesitant to get vaccinated and engage early adopters in telling stories about overcoming real and perceived barriers.

- Develop a multi-pronged strategy to reach those who are contemplating vaccination but are not yet ready to do it. The strategy may include in-person and virtual activities along with communication campaigns. Consider offering incentives that are persuasive to your community. Be prepared to answer questions about safety, efficacy, and social justice, especially as COVID-19 vaccine requirements have not yet been normalized as many K-12 vaccination requirements have been. Students will need support in processing this change until it feels as standard as any other required vaccine.
- Know that some people cannot get vaccinated and/or will choose not to, regardless of public health efforts. Have clear exemption requirements and protocols in place and communicate broadly as needed.

IHEs can also utilize resources from ACHA's [Campus COVID-19 Vaccine \(CoVAC\) Initiative](#). CoVAC is providing ongoing guidance to build effective, equitable, and inclusive COVID-19 vaccination strategies to yield high vaccination uptake in students, staff, and faculty.

Harm reduction emerged early in the pandemic as 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. 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.

As students become more fatigued with physical distancing and mask guidelines, harm reduction may still play an important role in supporting and maintaining motivation to continue following COVID-related risk mitigation practices. Aspects of harm reduction can be incorporated into conversations about coping with trauma as well as preventing spread of SARS-CoV-2.

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 potential options for 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 meet standards or precisely follow guidelines while supporting these students in moving forward with doing what they can and are willing to do.

Health communication campaigns, often the result of collaboration between health promotion and communication professionals, including those in campus communications departments, remain a critical tool during the pandemic. Institutions have used multiple communication channels (e.g., social media, email, text messaging, etc.) to ensure all

students know physical distancing and masking guidelines and understand the facts of coronavirus transmission and to motivate students to follow guidelines.

Campaigns focused on factual repetition of public health guidelines are the easiest to implement, especially with the plethora of resources available from 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.

Every institution should be prepared to broadly communicate about COVID-19 vaccine safety and efficacy. A basic campaign would communicate vaccine information and the logistics of how to get vaccinated. Beyond that, a social norms or social marketing campaign could be used to address vaccine hesitancy.

Behavior pledges continue to be used with varying levels of success. Many institutions are using behavior pledges as an actual behavioral contract with clearly defined negative consequences if not followed. While [research](#) shows that broad behavioral pledges or contracts are not effective, behavioral pledges as a social contract, with efficacy coming from the aspects of social accountability, may be more useful in smaller groups with closer ties such as classrooms, fraternity and sorority housing, and residence halls.

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 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 physically distance from others).
- 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 individual 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.

With greater vaccination rates and higher confidence that COVID-19 will become less of a daily threat, students may feel a collective desire to make up for the losses that their social lives have suffered during the pandemic. Changes in use patterns of alcohol and other drugs may require a shift in strategies to adapt to changing risks and outcomes. This may also be true for sexually transmitted infections and sexual assault. College health professionals should maintain an awareness of the social drivers of behavior and consider anticipatory guidance and education to address shifts in behavior that could put students' health at risk. HECCOP, including its active [discussion forum](#), will evolve so that lessons learned from the response to the pandemic can be adapted to other college health challenges.

Health Inequity

The pandemic has highlighted the disparities in the delivery of care in the U.S. health system for marginalized populations. Data emerged that debunked the pandemic as "a great equalizer" but instead illuminated its contribution to poorer health outcomes for marginalized populations. College health centers should consider the state of physical and mental health of incoming students from these marginalized populations. Additionally, preparations should be made to honestly assess and address the impact of systemic and institutional racism in college health which may contribute to health disparities and the disproportionate burden of illness in marginalized student populations.

The pandemic's impact on the socioeconomic fabric of marginalized populations forced many individuals to make decisions between personal health and basic survival. College health professionals should be prepared to serve students who may have experienced food insecurity, homelessness, job loss, loss of loved ones, isolation, mental fatigue, and lack of access to care due to the pandemic. In addition to addressing the impact of the collapse of the economic foundation of many families, college health professionals should be prepared to address increased anxiety and stress due to social-political unrest that has occurred during the pandemic.

When preparing for the return of students, college health professionals should consider the following to help address the effects of health inequity in marginalized populations due to the pandemic:

- College health professionals should acknowledge the pandemic created additional barriers for vulnerable populations of students, many of whom became even more unwilling to seek help from health care professionals. College health programs should examine current operations and messaging to identify potential barriers to care. Hosting listening sessions that provide an opportunity for students to offer direct feedback will better inform changes that address barriers to care. For marginalized populations, college health programs provide a safety net for students. The effectiveness of these programs can be thwarted if programs fail to undertake a critical analysis of policies and infrastructures that may contribute to inequities in student health.
- Health communication tools and resources should be reviewed critically to identify any insensitive content that could create an additional barrier to care for marginalized populations. Marginalized populations' perception of health care institutions and practitioners has been impacted by the pandemic, causing greater distrust and less reliance upon traditional sources of authority in health care. Galvanizing movements such as Black Lives Matter and the increase in anti-Asian hate provide a platform to frame an in-depth analysis and critique of content in existing and new health education materials to identify any potential barriers to care for marginalized populations.
- Students may have missed critical preventative care visits due to a change in their family's economic status or lack of access to providers, causing poorer overall health or more severe illness. Additionally, strategies to overcome possible stigma related to pandemic-related changes in socioeconomic status should be explored. College health programs that have traditionally relied upon fee-for-service or insurance revenue should create opportunities or identify resources for students to offset the costs of additional care, treatment, or services. Sponsored wellness clinics and fairs provide opportunities to increase preventative care services.
- College health programs should consider enhanced modes of service delivery for marginalized student populations. Student input should be sought regarding service delivery, outreach, and marketing. Programs should consider taking services to the students to overcome possible student avoidance of traditional health seeking behavior. Examples include offering prevention or wellness visits in residence halls through walk-in clinics, pop-up clinics, mobile clinics, or telehealth.

- College health programs should acknowledge and address the mistrust of scientific information due to a pervasive culture of disinformation during the pandemic as well as the distrust of organized health care due to historical unethical research and practices performed on marginalized populations. New initiatives to restore students' trust and establish rapport with college health professionals must be developed.

Students with Disabilities

The pandemic disproportionately affected students with disabilities. According to the [Student Experience in the Research University \(SERU\) Consortium COVID-19 Survey](#), those with a physical, learning, neurodevelopmental, or cognitive disability were more likely to experience financial hardships (including unexpected increases in living expenses and technology spending), food and housing insecurity, depression, and anxiety. Accessibility to on-campus housing, COVID-19 vaccine, testing and the array of campus supports including counseling, health, disability, and student success services is critical to maximize their success.

In addition to the considerations to support students with disabilities noted in the August 2020 [ACHA Guidelines: Supporting Vulnerable Populations During the COVID-19 Pandemic](#):

- Ensure faculty and staff understand the available resources to support students with disabilities including testing, vaccination, housing, as well as clinical and mental health resources.
- Provide telemental health and telehealth services to ease access to care.
- Provide options for virtual instruction for those who cannot return safely to in-person classes.
- Ensure clinical and counseling staff are knowledgeable on the increased stressors experienced by students with disabilities.
- Assess patients for additional stressors and work closely and collaboratively with student support services including counseling, medical, and disability services and the office for student success.
- Establish a low threshold to refer students to counseling, health, academic, or disability services.

Combating Xenophobia

Over the past year, incidents of anti-Asian hostility, violence, and racism have created increasing distress in Asian, Asian American, Native Hawaiian, and Pacific Islander communities. In addition to social stigma,

microaggressions, and racialized depictions of the virus and the pandemic, these communities have also suffered from physical violence from persons who have blamed Asian people for the pandemic itself. News coverage about violent attacks against Asians in the U.S. has generated greater public awareness of this issue. Now more than ever, leaders of colleges and universities need to address the current fears and concerns of these affected communities. Strategies include:

- Delivering campus messaging that recognizes the impact of racism on Asian, Asian American, Native Hawaiian, and Pacific Islander communities, acknowledging contemporary concerns related to the pandemic as well as acknowledging the history of anti-Asian racism that predated COVID-19.
- Hosting community conversations to provide space for communities to voice their concerns about anti-Asian racism and its impact on the communities.
- Engaging with Asian, Asian American, Native Hawaiian, and Pacific Islander members of the campus community, including students, faculty, and staff.
- Leveraging resources including Asian affinity groups, campus Pan-Asian support offices, and academic departments that focus on Asian and Asian American communities.
- Encouraging the reporting of anti-Asian harassment and violence to campus authorities (public safety, campus ombudsperson, equal employment opportunity/affirmative action office, diversity office) and organizations like [StopAAPIHate.org](#).
- Reinforcing institutional shared values of mutual respect, equity, diversity, inclusion, and belonging.
- Promoting support groups and individual support through the campus counseling center and employee assistance program.
- Avoiding imagery that reinforces stereotypes about Asian people.
- Partnering with students to serve as advisory members to pertinent boards or committees to vet or contribute to policy and messaging.

Communications Plan

As IHEs approach the fall of 2021, a robust and coordinated communications plan about the “new normal” is critical. Whether continuing in-person instruction or reopening the campus after a prolonged period of remote instruction, the need for both strategic

and crisis communications will continue to be significant. Communications efforts will transition from crisis-oriented to normal operations. A special focus on employee and student well-being can support communities impacted by the many traumatic aspects of the pandemic.

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. Membership should include health promotion specialists as well as 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. The communications structure must support the need to send timely messages, and 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 IHEs have experience in crisis communications, and the basics of the approach will serve them well as they communicate about recovery.

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 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 as they reopen the campus.
- To share important safety measures.
- To communicate about COVID-related impacts such as budgetary reductions.
- To describe instructions for all or subsets of the campus population (e.g., requirements for COVID-19 vaccination).
- To address misinformation such as concerns about vaccination.
- To support community wellness and build resilience.

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 something that cannot be delivered.
- 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 departments, 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 plans for fall activities and health requirements 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. This is especially important for potentially controversial policies, such as a requirement for COVID vaccination.
- 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.
- Enlist students and employee ambassadors from representative backgrounds to share information and education about health-related topics, such as combatting vaccine misinformation.

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 vaccines performed) as well as key performance indicators (KPIs), a metric that is tied to a

specific goal or objective (such as quarantine space 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 dashboards(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 classroom retrofitting 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 employee sick time. KPIs should drive action, and performance should be easily seen on the dashboard. Consider using a simple system such as green, yellow, and red color codes to indicate if the campus is meeting its goal.
- Are there external benchmarks available? Comparing the 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).
- When will a given dashboard be archived? As campuses return to normal operations, an external

COVID dashboard may not be needed. Planning when and how to end this reporting can begin now.

- 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 include:

- Total number of cases by week, separated 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.
- Number of COVID vaccines administered.
- Number of fully vaccinated.
- Links to local (city or county) data.

Common metrics for internal dashboards include:

- Personal protective equipment availability.
- Employee absenteeism.
- Testing policy compliance.
- Employee behavioral violations.
- Testing capacity.
- Influenza vaccine compliance.
- COVID-19 vaccine compliance for students and employees.
- Quarantine space availability.
- Workplace outbreaks under investigation.
- Student outbreaks under investigation.
- Student public health conduct violations.

Instruction and Learning Environments

IHEs responded to the pandemic's disruption of the learning environment by transforming classrooms to safely deliver instruction in-person and/or adapting technology and pedagogical practices to provide classes virtually or in a hybrid format. Many IHEs have already announced their intent to resume a full in-person

learning experience for fall 2021. Planning for an in-person classroom for fall should include strategies guided by public health considerations while continuing to provide virtual options for those who cannot safely or logistically resume in-person classes, including those at higher risk of severe disease if infected with SARS CoV-2, those who won't or can't get a COVID-19 vaccination, and international students who can't reenter the U.S. **Returning to pre-pandemic classroom conditions should be contingent upon the level of campus vaccination.**

Though many states have eased physical distancing and capacity restrictions, it is important to develop and maintain plans for distancing, masking, and decreasing density within the classroom setting to decrease the risk of transmission of SARS-CoV-2, particularly when the rate of COVID-19 vaccination is unknown. Unless the vaccination status of each student is known, enforcement of masking and physical distancing for the unvaccinated classroom cohort is reliant on the honor system. If all classroom participants are known to be fully vaccinated, masking and physical distancing are unnecessary.

Options for campus implementation of masking and physical distancing in the classroom are outlined in the "Masking and Physical Distancing" section of these guidelines. Regardless of the option IHEs choose, classrooms, lecture halls, and labs should be optimally ventilated to reduce the risk of aerosol transmission. Ideally, ventilation occurs with clean outside air with at least 4-6 air changes per hour. In ventilation systems using recirculated air, the air should be filtered using a filter with a minimum efficiency reporting value (MERV) of 13 or higher or a high efficiency particulate (HEPA) filter.

Considerations:

- Prioritize in-person instruction for courses with academic outcomes that cannot be measured or achieved virtually, such as performance, laboratory, and clinical experiences.
- Implement a hybrid mode of instruction for the foreseeable future. Remote options should be planned for and available if a rebound in local infections necessitates continued physical distancing and to support vulnerable students and faculty/staff, students in quarantine or isolation, and students and faculty/staff who cannot physically return to campus.
- Limit the number of attendees for in-person courses/sections based on ventilation, air exchange, physical distancing measurements, and room capacity. Consider creating multiple sections/shifts to reduce numbers.

- Implement monitoring and tracking of in-person attendance and seating arrangements to facilitate contact tracing in the event of an exposure.
- Develop a physical distancing plan for each course. Physical distancing plans should be consistent with the most current CDC and health department guidance for IHE classroom settings and include:
 - number of students and faculty present in each session.
 - length of session.
 - nature of activities.
 - public health practices: masking, physical distancing, cough/sneeze etiquette, hand hygiene.
 - provisions for hand sanitizer and enhanced cleaning.
 - instructions to participants on the course-specific physical distancing protocol.
 - availability of remote options.
- Develop specialized plans for students who are at increased risk due to the occupational nature of their studies. Examples include health professional students and students engaged in out-of-classroom or community-based instruction. Ensure students are provided with adequate personal protective equipment (PPE), supervision, and other protections based on their risk.
- Develop specialized plans for courses and instruction that do not permit physical distancing, involve aerosol generation and/or involve other activities of higher risk. Examples include dance, theater, and performing arts.
- Develop attendance and excuse policies that acknowledge and support students who become ill without creating barriers. Encourage faculty-student communication regarding health status and any changes in the ability to complete coursework and academic responsibilities.
- Expand simulation experiences to create clinical scenarios for health professional students to practice technical, diagnostic, and exam skills.
- Identify resources for students with learning, physical, or mental disabilities or difficulties with remote learning platforms.
- Create a vaccination requirement for students, faculty, and staff who participate in education abroad, the health professions, dance, theater, performing arts, and all those whose classroom or service-learning activities do not permit physical distancing or place them at higher risk of infection.

The Workforce

Campuses will repopulate with faculty, staff, and students, but the fall 2021 semester will not be the same as pre-pandemic semesters. The rumored “new” normal will take several years to evolve. Even during fall 2021, there will likely be significant regional differences in disease prevalence and restrictions, which will affect campus operations, workforce availability, and workforce satisfaction.

Campus human resources (HR) leadership should continue to evaluate and modify policies and accommodations based on updated guidance from CDC and state, territorial, tribal, and local public health authorities. Faculty and staff, particularly those on the front line providing in-person services/instruction, must continue to have access to appropriate personal protective equipment (PPE), even where local restrictions have eased. 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. Opportunities for open dialogue must exist to reassure staff that their health and safety are paramount.

Considerations for the workforce:

- Plan an all-campus moment of reflection early in the fall to acknowledge the health and economic impact of the pandemic; community members and their loved ones whose lives were lost due to the disease; and the overlaying trauma of racial violence, racism, and political divisiveness.
- Update COVID-19 safety education and training materials to include new campus policies and safety guidelines.
- Have faculty, staff, and students review the updated education and training materials in a timely manner, ideally within the first two weeks of return to campus.
- Normalize voluntary use of well-fitted face masks, even where no longer required.
- Seek opportunities to leverage the expertise of student counseling staff to assist the entire campus workforce with a trauma-informed approach to working with each other and with students.
- Review and update HR policies and employee accommodations based on current CDC guidance.
- Develop plans for alternative or flexible work assignments for high-risk staff.

- Conduct meetings electronically, even when working on campus.
- 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 were exposed to COVID-19.
- Strongly encourage both flu vaccination and COVID-19 vaccination for faculty, staff, and contractors on campus. Consider implementing a requirement for active declination of either or both vaccines.
- Ensure employees receive adequate time off from work to get vaccinated.
- Host a mobile or on-site vaccine clinic.
- 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 instructional tools.
- Continue daily symptom checking and reinforce messages to stay home or leave work if sick.
- Continue to provide frequent, transparent communication to the workforce regarding disease prevalence on campus, ongoing or discontinued mitigation strategies, status of vaccination uptake in the community and opportunities to be vaccinated.

Off-Campus Students

During the 2020–2021 academic year, many student outbreaks were associated with students living in off-campus, non-university-controlled housing, including Greek Life-affiliated residences. At many universities, these private residences house much of the student population and are geographically contiguous to campus. The IHE may have limited ability to control conditions such as housing density, requirements for testing, and monitoring of social gatherings within these residences. Students living in university-controlled residences may visit these areas to socialize, increasing the risk to the on-campus student population. Strategies to address these residences include:

- Meet proactively with management companies and owners prior to student move-in to collaborate in setting behavioral expectations and communication.

- Request or, when possible, require Greek-affiliated housing to share housing rosters with campus contact tracing programs in advance in case of outbreaks.
- Extend university-provided quarantine/isolation housing to off-campus students.
- Extend campus testing programs to off-campus students.
- Recruit student ambassadors from Greek Life and off-campus residences to provide education and setting of community standards.
- Meet with local public health and local residences to discuss limits of enforcement and delineate responsibilities. Local public health and law enforcement may overestimate the IHE's level of access, control, and influence over student behavior in private off-campus residences.
- Review student judicial processes to determine options for behavioral enforcement off campus and clearly communicate these expectations to students.
- Communicate with families/guarantors in conjunction with private management companies.

Housing and Residence Life

Careful preparation remains the key to an organized, effective, safety-focused, and medically informed reopening and management of college and university housing in fall 2021. Reducing density to one student per room and/or providing individual bathrooms was deemed the lowest risk approach in both fall 2020 and spring 2021. However, many IHEs were unable to reduce the density of their residential facilities to this level. Consequently, students arriving from low incidence and high incidence communities and countries shared residential spaces. This was particularly challenging on smaller campuses that traditionally have high residential living requirements and/or those that are situated in more remote locations, including many private liberal arts colleges.

Therefore, in fall 2020 and spring 2021 semesters, many campuses chose to utilize early campus arrival (with modified quarantine), combined with rigorous SARS-CoV-2 testing programs (of either all students or a random sampling). Though resource intensive, the approach often succeeded in lowering numbers of active cases and reducing the need for isolation and quarantine space. Wastewater surveillance was also utilized on some campuses to provide early identification of SARS-CoV-2 in the residence halls.

Many campuses with apartment-style shared suites (which usually feature smaller bathroom facilities shared by fewer residents) were able to "cohort" these students. Some

campuses created cohorts by grouping more traditional residence hall two-person rooms into "pods" or "bubbles." This approach allowed IHEs to define quarantine groups more easily in the event of a COVID-19 case, and even "quarantine-in-place" in the cohort space. Although it is likely the numbers of COVID-19 cases in fall 2021 will be lower, particularly for those campuses with a COVID-19 vaccine requirement, these strategies may once again prove beneficial.

Virtually all campus residence halls and other on-campus housing required routine masking and physical distancing in common areas. In addition, students were repeatedly reminded (verbally and through posters, videos) to practice hand hygiene and cough and sneeze etiquette, and they were provided hand sanitizer and disinfectant wipes for use in common areas.

Implementing CDC's updated masking and physical distancing recommendations with indistinguishable cohorts of vaccinated and unvaccinated individuals will be challenging in a congregate living setting. Mandatory COVID-19 vaccination for those who wish to live in campus housing is a potential option to be considered in addition to those described in the "Masking and Physical Distancing" section of these guidelines.

Considerations for fall 2021 include:

- Residence life and housing staff should promote vaccination through all available communication venues including meetings, newsletters, posters, video monitors.
- On campuses with a fall 2021 COVID-19 vaccination requirement, residence life and housing staff will need to work with campus administration to enforce the requirement and obtain documentation of vaccination prior to fall 2021 move-in.
- Even in a situation in which the IHE does not require vaccination for all faculty and staff, serious consideration should be given to requiring COVID-19 vaccination for residence life staff living and working in on-campus housing facilities. These staff will remain at an increased risk of exposure to SARS-CoV-2 because they reside and work in a congregate setting.
- IHEs must decide upon an approach to on-campus housing for students who are unvaccinated, whether due to medical or religious exemptions on a campus with a vaccine requirement, or due to students choosing to forgo vaccination on a campus without a requirement. Questions to be answered include:

- Will unvaccinated students be allowed to reside in on-campus housing? If so, will these students be cohorted together, or will they be allowed to share rooms, cohort pods, and restroom facilities with vaccinated students?
- If restrictions are to be placed on the housing of unvaccinated students, including those with medical and religious exemptions, how will this be accomplished in ways to protect the rights, dignity, and privacy of these students, while limiting the risk presented by an unvaccinated cohort of students at the beginning of the semester and throughout the academic year?
- If it is determined (ideally by infectious diseases and public health experts) that community (herd) immunity exists on campus and/or in on-campus housing, will this allow for unrestricted housing status and access for unvaccinated students?
- Campuses should continue to 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 August 2020 [ACHA Guidelines: Supporting Vulnerable Campus Populations during the COVID-19 Pandemic](#).
- Even if an IHE has an improved incidence of active COVID-19 infection in fall 2021, it should ensure that custodial and residence life staff have ongoing access to sufficient and appropriate personal protective equipment (PPE). Staff should review PPE donning and doffing procedures prior to the start of fall 2021 semester.
- Surface transmission of COVID-19 is possible. High-touch surfaces should be cleaned and disinfected regularly, and all residents strongly encouraged to practice meticulous hand hygiene.
- Despite the likelihood of an improved COVID-19 risk situation in fall 2021, the professional and student staff living in the residence halls will remain susceptible to mental, emotional, and physical exhaustion. These staff will continue to need defined work schedules with time off as per institutional policies, regular exercise and break opportunities, and psychological/counseling support as needed.

These guidelines were developed in collaboration with the Association of College and University Housing Officers-

International (ACUHO-I). Please visit the [ACUHO-I website](#) for additional COVID-19 resources for residence life administrators and staff.

Dining Services

Prior to the COVID-19 pandemic, most campus dining services had students as well as faculty, staff and visitors queue up to enter indoor dining spaces, choose food options, and pay or swipe meal cards. Dining areas were often large and chaotic, with closely spaced tables and chairs and both sustained and episodic interpersonal interactions. As a result, significant changes were necessary in fall 2020 and spring 2021 to institute physical distancing and other infection prevention and control measures. Even on a campus with extensive or required COVID-19 vaccination in fall 2021, it will be advisable to continue many of the modifications made to campus dining.

Considerations for dining services:

- Require all dining facility staff to always wear face masks and gloves while working and interacting with the public.
- Require employees to follow infection prevention guidelines including:
 - Staying home when ill.
 - Practicing physical distancing whenever possible at work.
 - Washing hands often with soap and water for at least 20 seconds, especially after nose blowing, coughing, or sneezing. Covering coughs and sneezes with a tissue (or arm if not available).
 - If soap and water are not readily available, using hand sanitizer that contains at least 60% alcohol, covering all surfaces of hands and rubbing them together until they feel dry.
 - Avoiding touching the eyes, nose, and mouth with unwashed hands.
 - Cleaning and disinfecting frequently touched surfaces throughout the workday.
- Require all unvaccinated customers/diners to wear personal face masks while in the facility, other than when eating and drinking.
- Limit the number of individuals dining in an indoor facility at one time. The number should be chosen with the goal to achieve the capacity restrictions currently recommended by the local, state, territorial, or tribal public health authorities.

Successful approaches in fall 2020 and spring 2021 included:

- Access control: once the target number is reached, customers/diners are only allowed to enter when a diner/customer leaves the facility.
 - Cohort dining: having set dining times, with a cohort of customers/diners admitted, and no other entries until that dining period is completed.
 - Physically spaced (6-foot) floor markers for waiting lines outside and inside the facility.
 - Limiting the numbers of tables and appropriately spacing chairs per table.
- Work with campus services and physical plant personnel to maximize ventilation and air exchange in all indoor campus dining spaces.
 - Weather permitting, maximize covered and uncovered outdoor dining spaces.
 - Continue providing a bagged, take-out meal option at every meal, allowing students to eat outdoors, in their rooms or homes, or in other physically distanced locations. Consider offering take-out meals with kosher, vegetarian, vegan, and gluten-free options, as requested or appropriate to the student, faculty, staff, visitor customer base.
 - Arrange to deliver food to students in isolation or quarantine.
 - Provide custodial services with appropriate PPE (as per current [CDC guidelines](#)) for cleaning and disinfecting common, non-clinical spaces.

Athletics

After suspending most college athletic competitions in the fall, the spring saw the return of almost all sports, and fall, winter, and spring sports occurred simultaneously. This presented many challenges, such as coordination of travel, provision of appropriate medical coverage at all events, and complicated testing schedules for teams. With vaccinations becoming widely available, guidelines are changing to reflect the appearance of more fully vaccinated individuals. Many lessons regarding athletics were learned throughout this pandemic:

- Individual decisions about adherence to COVID-19 prevention protocols can profoundly impact the health and safety of the entire team and/or program.

- While there were many incidences of COVID-19 infection and exposure in athletic departments, proven transmission between teams *during* an athletic competition appears to have been rare, even in indoor and contact sports. Most exposure among athletic teams occurred due to social interactions outside of practices and competitions.²
- Testing, isolation, contact tracing, quarantine, and cancellation of athletic competition when necessary, appears to have been effective in reducing risk of transmission during sports competitions.
- CDC has continued to report that the primary mode of transmission of COVID-19 is aerosolization of the virus rather than fomites. Therefore, the sharing of equipment such as balls is not a significant 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.
- Testing prior to travel has been important for all sports because physical distancing can be difficult on flights, buses, and other means of transportation.

Many of the considerations included in ACHA's previous reopening guidelines continue to apply for upcoming intercollegiate athletics and sports medicine programs in fall 2021. Many of these recommendations were developed in collaboration with the [National Athletic Trainers Association Intercollegiate Council for Sports Medicine](#) (NATA-ICSM) and included guidance from [NCAA guidelines](#). Additional NCAA guidance is expected.

Considerations:

- 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.

² In this [January 8, 2021, CDC MMWR](#), data show that “despite the potential risk for transmission from frequent, close contact associated with athletic activities (4), more athletes reported exposure to COVID-19 at social gatherings (40.7%) and from roommates (31.7%) than they did from exposures associated with athletic activities (12.7%).”

- Testing, contact tracing, and quarantine recommendations continue to be in place for those student-athletes who are not yet fully vaccinated.
- Provide updated CDC recommendations about COVID-19 and infectious 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, changes regarding vaccinated people, 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 vaccination, physical distancing, and masking when appropriate.
- Update pre-participation screening, assess vaccination status, and screen student-athletes who have recovered from COVID-19. Although recent data suggest cardiac issues may be less common than initially thought, cardiac evaluation should follow a tiered approach:
 - For asymptomatic and mild illnesses, medical evaluation is recommended before returning to exercise. Any further cardiac testing should be based on clinical concern or institutional requirement.
 - For moderate to severe illnesses, electrocardiogram (ECG), echocardiogram, and troponin should be considered before returning 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, especially for athletes who may not have competed at all during the previous year.
- Review team practice considerations, including:
 - Requiring masks when needed based on vaccination status, practice location, and rate of community spread.
 - Modifying practice to limit the number of athletes affected if a team member tests positive for SARS CoV-2.
 - Utilizing outdoor spaces whenever possible.
- Ensure that vaccination, 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.
- Stay up to date on testing strategies, which continue to evolve.
- Review travel policies and remain current on local and state recommendations and requirements for arrival and return.
- Continue educating student athletes, coaches, and support staff about the importance, efficacy, and safety of the SARS CoV-2 vaccine. Assist student-athletes in accessing COVID-19 vaccination and be prepared to address concerns they may have.

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. Minimal transmission of the virus was seen in campus recreation centers that adhered to posted health and safety requirements.

Considerations:

- 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.

- Consider a phased return of sports and recreation programs based upon potential risk of transmission in each activity.
- Consider continuing to offer hybrid options that have been developed during this year as we begin to enter the “new” normal.
- Require the use of face masks when appropriate.
- Review and enforce physical distancing principles in indoor and outdoor 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.

International Travel

International travel guidelines continue to evolve as we enter the second year of the COVID-19 pandemic. U.S. authorities currently advise against most nonessential international travel. As of April 19, 2021, the U.S. Department of State has dramatically revised its Travel Advisory system to better reflect CDC Travel Warning Levels. This has resulted in approximately 80% of countries currently designated as “Travel Advisory Level 4: Do Not Travel” destinations, which carries very significant consequences on multiple levels. Consideration of universal risks of international travel in the COVID-19 era as well as consideration of risks at each specific destination continue to be crucial. Detailed information may be found at the [U.S. State Department International Travel website](#) and the [CDC International Travel During COVID-19 website](#).

The global COVID-19 landscape continues to evolve daily. Internationally, significant developments regarding multiple COVID-19 vaccines, rates of vaccine uptake, SARS-CoV-2 variants, testing options, and many other elements are important issues to consider when contemplating international travel complexities at this time.

Looking ahead to when international travel for IHE constituents resumes on a broader scale, protecting the health and safety 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.

- All IHEs should establish comprehensive institution-wide policies regarding international travel recommendations, restrictions, and requirements for both outbound and incoming travelers.

- The establishment of a standing group of key parties to assist in developing policies for IHE-related international travel is invaluable. The composition of the group will be unique for every college or university; participants may include representatives from student health services, office of international programs, administration including president, provost, and dean’s offices, safety and risk management, general counsel, faculty, university communications, residential life, diversity, equity and inclusion office, health promotion etc. Representatives from higher education commissions, board of regents, and others may be invited as well. Representatives from local, state, tribal, territorial health departments should be consulted and involved as appropriate.
- Policies should be created collaboratively with the IHE-wide international travel group as described above. Final decision-making authority must be defined and known to all involved.
- Policies should pertain to all students, faculty, and staff who are planning outbound or incoming IHE-affiliated international travel.
- 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.
- Frequent, detailed communication among all involved parties as indicated is essential.

Outbound IHE-Affiliated International Travel

- A travel registry should be established for all IHE-related international travel. Enrollment in the registry must be mandatory. This should include two emergency contacts. Plans for reliable intra-travel communication and ability to identify travelers’ locations are vitally important. These elements must be in place prior to travel.
- Specific guidance regarding the planning, submission, approval, and exception consideration process for any IHE-related international travel should be in place; modifications to reflect current COVID-19 travel guidelines and restrictions need to be clear. The potential for any travel to be canceled without warning needs to be clear to all parties.
- Detailed travel plans, purposes of travel, and destination contacts should be fully disclosed to appropriate IHE parties by travelers prior to departure.

- Current, reliable, relevant resources must be provided to travelers prior to departure, and their use encouraged. Emphasis on the need to remain current on this very changeable information is vital.
- Pre-travel orientations for all parties (students, faculty, and staff) are essential and should be mandatory. Orientations should contain robust current and relevant safety and health information, including emergency protocols as per usual. Relevant and thorough COVID-related education should be provided, including the following:
 - All travelers should bring adequate supplies of essentials in their carry-on, along with back up supplies if they have checked baggage. This should include but is not limited to:
 - Multiple appropriate masks: include disposable masks and washable face coverings. Consider at least one N-95 due to unknown risks during travel and at destination.
 - A generous supply of hand sanitizer and disinfectant wipes for travel as well as destination use.
 - A thermometer.
 - An antipyretic of choice (acetaminophen or NSAIDs).
 - Essentials unrelated to the COVID pandemic as per usual.
 - 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, including physical and mental health considerations.
 - COVID-19 vaccination, testing, quarantine, and isolation recommendations and requirements for all destinations, intermediate stopovers, and destinations as well as re-entry to the U.S.
 - The greater COVID-19 risks associated with travel, including transportation means and hubs (e.g., airports, train stations), crowds and close contact indoors, areas with high variant load, etc., and associated recommendations for enhanced personal protective measures such as using face coverings at appropriate times.
- Basic protective measures (appropriate face masks and their care, physical distancing, hand hygiene and appropriate sanitizers, etc.) and the importance of continuing these with international travel even if fully vaccinated.
- COVID-19 test types and availability.
- COVID-19 symptoms and appropriate actions to take if these develop.
- Appropriate care if ill, including red flags indicating critical illness and need to seek care.
- Isolation and quarantine guidelines and plans.
- Contingency plans in case of suspension of travel due to health issues.
- Arrival requirements at destination.
- Appropriate COVID-19 vaccination(s) should be administered prior to international travel, with the final dose given a minimum of two weeks prior to departure. COVID-19 vaccines and other vaccines may be [co-administered](#). Continue to monitor ACIP recommendations.
- Greater consideration should be given to pre-travel physical and mental health screenings due to increased health risks related to the COVID-19 pandemic, including questions of health care accessibility at the destination for all-cause needs due to strain on systems related to ongoing pandemic issues.
- Transportation logistics, especially air travel, must be evaluated and appropriate arrangements made. This is an extremely variable set of considerations. This might include requirements for negative NAAT/PCR testing and documentation within a specified period prior to travel, “Documentation of Recovery” (a copy of positive COVID-19 test within the last 90 days together with a letter from a health care provider stating that the isolation period has been completed and no COVID-related health concerns remain), evidence of COVID-19 vaccination(s) within a specified time frame prior to travel, or other documentation. Appropriate preparation must be undertaken well prior to any international travels.
- Appropriate and adequate health insurance for duration of travel 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 and exclusions due to U.S. Department of State Level 4 Travel Advisories. CFAR (Cancel For Any Reason) insurance may be considered.

Arrival on Campus from International Point of Origin

Many complex variables are currently at play for those arriving to campus following international travel including international students, faculty, scholars, and guests planning activities involving international travel. Domestic students, faculty, and staff arriving from international destinations after personal or IHE-related international travel must also have access to appropriate information regarding return to campus recommendations or requirements. For those arriving on campus, the following information should be considered. Excellent and clear communication is critical, as is easy access to support as questions or needs arise.

- It is crucial to inform everyone arriving on campus from an international destination of relevant, reliable, and current travel health and safety resources and to encourage the serious consideration of current recommendations in travel planning stages well in advance of travel. Travelers should be encouraged to access relevant information regularly as it frequently changes and may have significant consequences for their planned travels. The potential for major alterations in plans, including cancelation at any time, should be discussed.
- Every international student, faculty, and staff member is in a unique situation, which warrants individually tailored recommendations.
- All new or returning international travelers should prepare, with assistance from their host institution, for arrival at their U.S. destination. Resources and considerations to provide to travelers may include but are not limited to:
 - [CDC returning traveler guidance](#) and [U.S. Department of State guidance](#).
 - CDC's "[Travelers Prohibited from Entry to the U.S.](#)"
 - Local, state, territorial, or tribal and IHE guidance and requirements for arriving international travelers regardless of travel reasons.
 - Testing information: where, when, type, who pays, and documentation needed.

- Quarantine indications and arrangements: currently all unvaccinated travelers from international locations must quarantine for a minimum of seven days after arrival in the United States, although state, local, tribal, territorial, and IHE requirements may differ substantially from CDC recommendations. Specific quarantine arrangements regarding lodging, food, remote learning, and support for any physical or mental health concerns should be made well in advance.
 - Isolation indications and arrangements.
 - Notification of travel plans and updates by incoming persons to clearly identified host institution faculty or staff.
 - Vaccination information, including which COVID-19 vaccines are accepted by the IHE, valid forms of documentation/proof of vaccination, definition of fully vaccinated, where to get vaccinated after arrival, etc. Information regarding standard vaccinations required or recommended by the IHE (e.g., MMR, meningococcal vaccines) and TB testing should also be provided as necessary.
- IHE preparation for incoming international travelers should include detailed planning for accommodations made well in advance of arrival of international travelers and should include arrangements for lodging, food, and remote learning. The IHE should also provide the incoming traveler with:
 - Information regarding quarantine/isolation behavior guidelines.
 - A strong support framework during quarantine or isolation.
 - Clear information regarding health care (mental and physical) options and how to access services or assistance.
 - Easily available support and resources if experiences of xenophobia, isolation, or other issues arise and encouragement to utilize these resources.
 - COVID-related information as noted in the section on outbound travel.
 - Easy access to COVID-related supplies such as masks, hand sanitizer, etc.

International Students, Faculty, and Staff Present on Campus

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, staff, and students contemplating travel with subsequent return to the U.S. for IHE-related work or study 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. Travel interruption could significantly impact the traveler's IHE-related plans and responsibilities.

Those contemplating international travel 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).
- Testing, quarantine, and isolation requirements after return from international travel. This is described earlier in the section "Arrival on Campus from International Point of Origin."
- IHE and local, state, tribal, territorial, and national recommendations and requirements as appropriate. They should also be familiar with current CDC guidelines. At this time, recommendations vary significantly by location; all parties must know how to ascertain the current relevant requirements that pertain to them. Refer to directories of [local and tribal health departments](#) and [CDC returning traveler guidelines](#).

International travel is an evolving situation. Many IHEs in the U.S. have canceled or prohibited international travel for any university-affiliated reasons through Summer 2021. 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 unknowns 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—both outbound and incoming—should continue to monitor U.S. State Department and CDC websites, and discussions involving institutions and other relevant entities as previously described should be intentional, active, and ongoing. Excellent communication to include all involved parties is crucial as IHE-affiliated international travel gradually resumes.

Restoring and Sustaining the Mission

For 18 months, many IHEs have been operating in all-day, every-day pandemic mode. Planned initiatives were derailed. Many students, faculty, and staff may have seen their career trajectories altered. Projects and upgrades to facilities were postponed or cancelled, budgets were upended, and supplies and resources were exhausted. As we enter fall 2021, many institutions plan to have all students back on campus and expect relatively normal operations. This brings urgency to restore the institutional mission, especially as it pertains to supporting student health and wellness as part of overall student well-being, and the opportunity to emerge from the pandemic better and stronger.

- If not already in place, immediately seat a multidisciplinary "re-start" committee that includes or advises leadership about steps toward a fully functional fall.
- Reassess pre-pandemic projects and initiatives—what still matters? Which priorities have shifted? What new opportunities have become evident?
- If there have been layoffs or budget cuts, is there a path for stabilization to sustain core student health and wellness functions now that the campus is fully re-populated, and is there a path for strategic restoration?
- If accreditation or other forms of program review were put on hold, negotiate with senior administration to determine a path for moving forward.
- Resume quality assurance and quality improvement programs; for patient care or other programs compromised during the haste and drama of the pandemic, consider a process for lessons learned and future mitigation.

- As pandemic distractions and crises fade, resume participation on divisional and institutional committees.
- Leverage the new intra-institutional relationships necessitated by the pandemic to achieve political (e.g., budget advocacy and relationships with deans) and technical (e.g., data security for work-from-home or accessing Registrar data) gains.
- Leverage enhanced inter-university relationships (e.g., with public health authorities) to explore invigorated and new collaborations.
- Although new to many at the start of the pandemic, virtual services will be part of a new normal; step back now and commit to intentional trainings and standards around delivery of virtual services.
- Be thoughtful and intentional in determining and marketing a new blend of in-person and virtual services, not just clinical but also prevention and health promotion services, staff meetings, and so forth. Which activities will benefit from a blended platform (virtual and in-person) to become more inclusive (e.g., all-staff meetings that might now better accommodate staff with non-standard schedules [including ongoing work-from-home] and staff in multiple campus locations)? Distinguish between virtual and asynchronous options.
- Review if/how virtual and work-from-home arrangements have resulted in increased availability of physical spaces previously reserved for single-use private offices and creative uses for this new space.
- Recommit to professional development for all members of the health and wellness services staff, acknowledging that for budgetary and other reasons, there will be greatly increased reliance on remote and virtual content delivery for the foreseeable future.

Conclusion

Early in the pandemic, the scientific, medical, and public health community braced itself for a marathon, not a sprint. The past 18 months consumed the nation in a race to develop treatments and vaccinations; produce PPE, ventilators, and diagnostic tests; create surveillance systems and contact tracing programs; and transition to remote classrooms, exam rooms, and care sites. Vaccination has changed the course of the pandemic in this country, resulting in decreasing case counts, hospitalizations, and deaths and a new optimism that this chapter of COVID-19 is coming to a close.

These guidelines address how campuses can begin to resume core care, treatment, and services that were paused or limited as IHEs pivoted to crisis management. Now in the home stretch of the pandemic, the outcome of the race between vaccinations and variants will significantly influence campus reopening plans this fall. Planning must include the possibility that we might not reach sufficient community (herd) immunity on campus. With the finish line in sight, IHEs, in partnership with their campus health and wellness services, must continue to create opportunities, expand communication, enlist trusted messengers and partners, and advocate for a fully vaccinated campus and a healthy campus community.

Additional Resources

Higher Education COVID-19 Community of Practice (HECCOP)

ACHA's [Higher Education COVID-19 Community of Practice \(HECCOP\)](#) is a collaboration of diverse disciplines within higher education. HECCOP leverages the expertise and resources of its members to create and cultivate a community of practice for institutions of higher education (IHEs) on the topic of COVID-19 behavioral mitigation efforts. Through peer-to-peer collaborative activities, members of HECCOP come together virtually to share information, build knowledge, develop expertise, and solve problems aimed at reducing SARS-CoV-2.

HECCOP focuses on COVID-19 behavioral mitigation efforts, such as masking, handwashing, physical distancing, and testing. The community includes students and college health and wellness professionals as well as those in residence life, dining services, student affairs, athletics, recreation, facilities, and more.

Campus COVID-19 Vaccine Initiative (CoVAC)

ACHA's [Campus COVID-19 Vaccine Initiative \(CoVAC\)](#) will build vaccine confidence, increase vaccination visibility, and combat vaccine misinformation in college campus communities. This important project will include the development and dissemination of a vaccine confidence toolkit for faculty and staff, a social media toolkit, and a national student social media campaign.

ACHA seeks to build trust in students and other campus stakeholders by providing them with relevant, credible, accurate information on the importance of getting vaccinated, vaccine safety, and where to get vaccinated. The initiative will include student leaders, influencers, and other trusted sources, leveraging existing relationships to reach all those on campus who may be considering forgoing vaccination against COVID-19. This initiative is in the formative stages and will continue to grow as the needs of campus communities evolve.

The Higher Education COVID-19 Community of Practice (HECCOP) and the Campus COVID-19 Vaccine Initiative (CoVAC) are supported by the Centers for Disease Control and Prevention (CDC) Cooperative Agreement, CDC-RFA-CK20-2003. Program content is solely the responsibility of ACHA and does not necessarily reflect the official views of CDC.

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; Michael Deichen, MD, MPH, FACHA; Catherine Ebelke, PA-C, CTH, FACHA; Joy Himmel, PsyD, LCPC, NCC, RN, FACHA; Jessica Higgs, MD, FAAFP, FACHA; James Jacobs, MD, PhD; Michael Huey, MD, FACHA; Cheryl Hug-English, MD, MPH; Rachel Mack, BA; Tondra Moore, PhD, JD, MPH; Giang Nguyen, MD, MPH, MSCE, FAAFP; and Sarah Van Orman, MD, MMM, FACHA.



AMERICAN
COLLEGE
HEALTH
ASSOCIATION

Appendix A. Trauma-Informed Care

Providing trauma-informed or trauma-sensitive care requires a universal understanding and consistent approach to help students thrive as they return to campus. [According to the Trauma and Learning Policy Initiative \(TLPI\)](#), “a trauma-sensitive school is one in which all students feel safe, welcomed, and supported and where addressing trauma’s impact on learning on a school-wide basis is at the center of its educational mission. An ongoing inquiry-based process allows for the necessary teamwork, coordination, creativity, and sharing of responsibility for all students.”

Collective Trauma

In its 2014 publication “[Concept of Trauma and Guidance for a Trauma-Informed Approach](#),” the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) states that “individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being”. Additionally, SAMHSA (2014) describes the three “Es” of trauma: “event(s)”, the “experience of the event(s),” and the “effect of the event(s).” Events can be actual or the extreme threat of harm.

Collective trauma means that there is a shared experience of helplessness and negative emotional impact related to loss among a group of people. There is a shared identity, although we know that even given the same experiences, an individual’s perceived meaning-making will differ. This is why some individuals are affected much more severely than others.

There have been changes to the way an individual sees themselves, others, and the world around them and which has caused a sense of despair or anxiety. Stress transitions into trauma when resiliency is not sufficient.

Implementing a Trauma-Informed Organizational Framework

Trauma-informed care (TIC) has become a widely recognized paradigm for creating safe spaces and supporting engaged environments of care and compassion. It is an organizational framework that:

- realizes the widespread impact of trauma and understands potential paths for recovery,
- recognizes the signs and symptoms of trauma in students, faculty, and staff,
- responds by fully integrating knowledge about trauma into policies, procedures, and practices, and
- seeks to actively resist behaviors that re-traumatize.

Implementation of a trauma-informed organizational framework includes:

- **Assess the organization:** An organizational assessment will help determine which areas need improvement and which are already thriving. The prime focus areas include:
 - Leadership’s investment in the change process.
 - Development of policies with a trauma-informed approach.
 - Physical environment that promotes a sense of safety and collaboration.
 - Level of inclusiveness with input and feedback venues.
 - Interdepartmental and cross sector collaboration.
 - Screening, assessment, and treatment services-trained practitioners.
 - Training and workforce development- on-going training with incorporation of trauma-informed principles
- **Shift the paradigm:** The transition to a trauma-informed campus community must involve all levels of the organization. Establish a strength-based approach which provides an institutional reframe with a lens that filters all interactions, policies, practices, and procedures.

- **Focus on safety:** Reinforcing the importance of student, faculty and staff autonomy, choice, and empowerment. Trainings on organizational practices that promote safety and reduce the risk of re-traumatization. Training on self-care, recognizing the signs and symptoms of trauma, skill-based stress reduction, and self-soothing techniques is essential. Leadership must ensure that work environments and the campus culture at large are built on trust, fairness, and transparency.
- **Promote wellness:** Effective trauma informed campuses have systems in place to address the need for attention to self-care for students and employees.
- **Address cultural stereotypes and biases:** There is a need to enhance the responsiveness to the racial, ethnic, and cultural needs of individuals, recognizing historical trauma, and understanding its impact.
- **Commit to the change:** The entire organization must be committed to this approach. Leadership must fully embrace the framework and incorporate both formal and informal organizational culture shifts in this process. Faculty and staff should be trained in the TIC framework and incorporate changes into their daily tasks and into all interactions. Ultimately, the framework should be apparent with the very first contact with the campus community.

Student Engagement and Collective Trauma

A foundational tenet of health promotion is creating health *with* the people and community served. Intentional inclusion of students in the ongoing pandemic response and the healing of collective trauma is critical. Students need opportunities to collaborate in creating new directions for themselves and their communities. The trauma of COVID-19 may leave them feeling distrustful of institutions or government. They may be questioning their own identities and values. Institutions can address these needs by implementing trauma-informed services and including students in ongoing institutional response.

Students need opportunities to talk about and process how COVID-19 has affected their college experiences and their lives. They are re-negotiating who they are and where they fit in the world. Almost unlimited developmental and educational opportunities exist to help students make sense of their new world. Some examples include:

- Engaging students in identifying and maintaining positive changes that emerged from the pandemic.
- Student feedback sessions or questionnaires that both guide students through processing and inform institutional action.
- Classroom assignments exploring aspects of the pandemic.
- Planned events to recognize, grieve, and move forward from loss (e.g., loss of a family member or loved one and the loss of life events like an on-campus first year experience).

Additional Resources

ACEs Aware (California Department of Health Care Services): <https://www.acesaware.org/treat/principles-of-trauma-informed-care/>

National Council for Behavioral Health: <http://www.thenationalcouncil.org/topics/trauma-informed-care>

