

ACHA Guidelines

Considerations for Reopening Institutions of Higher Education in the COVID-19 Era

The COVID-19 pandemic continues to evolve rapidly, causing institutions of higher education (IHEs) to evaluate and plan for numerous “what if” scenarios. These guidelines are based on information about COVID-19 that is known today. They are purposely broad for universal use and written with the understanding that not all colleges will have the resources to implement everything written in this document. IHEs should view these guidelines and evaluate the feasibility of these recommendations in the light of their own campus environment, community resources, public health capacity, demographics, internal resources, and risk tolerance. As the pandemic continues, additional guidance will be forthcoming from ACHA.

Introduction

This sequel to the American College Health Association’s *Guidelines: Preparing for COVID-19* addresses administrative, medical, mental health, health promotion/well-being, and campus-wide considerations in reopening college/university campuses as the COVID-19 pandemic abates. Many public health experts and organizations have already developed models and projections using surveillance data, case counts, and infrastructure capability to identify when businesses, schools, campuses, and the country can safely reopen. Individual states in conjunction with public health entities and institutions of higher education (IHE) presidents/chancellors will ultimately determine when to reopen campuses. These ACHA guidelines provide considerations to minimize the risk of COVID-19 infection and a recurrent surge of infections as social distancing measures are relaxed on our campuses and in our communities and as we plan for the physical return of large numbers of students, faculty, and staff.

The risk of subsequent waves of infection remains until we achieve sufficient herd immunity through vaccination or actual infection and recovery. Clinical trials and vaccine development efforts have begun in earnest. However, to date, no vaccine or prophylactic pharmacologic exist. Our only tools are prevention through non-pharmacologic interventions, sound public health practices, and supportive therapy.

Therefore, the campus must be prepared on multiple fronts. Campus leadership should retain or develop an incident command structure, an effective surveillance system, and partnerships with local public health and health care organizations. The student health service (SHS) remains central to this public health effort and must have sufficient resources to address both COVID-19 surveillance and containment along with all other routine health and well-being needs of students. Even prior to the pandemic, the demand for mental health services often outstripped campus resources. Innovative approaches to stretch those resources further will be needed as this pandemic continues to take its toll on the mental health of students, faculty, and staff. The health promotion role in reinforcing public health’s infection prevention practices and influencing positive health behaviors are integral to the totality of student wellness and that of the campus in this phase of the pandemic.

Working in concert, these broad areas provide campus leadership with surveillance capability, a sound infection prevention and control strategy, and a means to quickly identify, isolate, treat, and refer individuals to mitigate a second wave of infection.

Key Concepts

- COVID-19, a novel coronavirus infection emerging in 2019, has led to an unprecedented infectious disease risk for all persons. The duration of this pandemic remains unclear, and the situation continues to evolve. COVID-19 will peak in different states at different times and will impact each IHE differently. Public health guidance, scientific knowledge, and clinical best practices will change, so these guidelines may require updates or risk quickly becoming obsolete. The single constant for each IHE is that the road to recovery will be long. We can anticipate restrictions and limitations in activities will be in place for the next 12–18 months, if not longer.
- Resumption of activities will be gradual and phased based on local public health conditions as well as institutional capacity. Return to an active on-campus environment will depend upon widespread testing,

contact tracing, and isolation/quarantine of ill and exposed individuals both on campus and in the community. Planners should prepare for the likelihood of a local rebound of infections that may result in a return to more restrictive mitigation measures and physical distancing for periods of time.

- The high touch, highly interactive, mobile, densely populated living and learning environment typical of most campuses is the exemplar of a congregate setting with multiple risk factors for ready transmission of COVID-19.
- Protecting our most vulnerable populations (medically susceptible, undocumented, students of color, uninsured or underinsured, non-traditional, older, DACA, and homeless students, faculty, and staff members) is a moral and ethical obligation. Some vulnerable individuals may need to observe ongoing physical distancing for a more prolonged period of time.
- Meticulous adherence to public health practices including hand hygiene, physical distancing, proper cough/sneeze etiquette, frequent disinfection of common and high traffic areas, symptom assessment, temperature checks, and face covering in public is the campus' new normal. This should be widely communicated to students, employees, and all campus visitors.
- The White House's "Opening Up America Again" plan identifies a phased approach to easing restrictions which will be dictated in large part by COVID-19 activity state to state. Campuses considering a similar approach should include community and campus triggers. Suggested criteria are located in Appendix A.
- Faculty, staff, and student immunity to COVID-19 will be essential for long term campus planning, management, and recovery.

Public Health Considerations

The overarching question is how to repopulate campuses in the safest way possible. The college/university must address the public health issues caused by the virus in a manner that permits easing physical distancing practices and the resumption of many of the activities and educational experiences of a vibrant campus.

Until a vaccine for COVID-19 is available and widely used or until an effective prophylactic treatment is discovered, physical distancing, viral testing, isolation, quarantine, and contact tracing are our best strategies to control the spread of this virus. Decisions to ease COVID-

19 distancing restrictions must be based on the best available scientific data and the rapid availability of testing. Campus experts, in collaboration with public health officials, are best positioned to inform and advise campus leadership on when to resume operations.

The campus must deploy primary public health controls to slow the transmission and reduce the mortality associated with COVID-19. These control measures include availability of appropriate personal protective equipment (PPE); environmental measures such as enhanced cleaning and disinfection, physical distancing, testing, and contact tracing; and the readiness of the campus and local health care systems and the campus infrastructure. Controls must be designed, implemented, and monitored to prevent and/or mitigate negative strategic, operational, financial, reputational, health, and safety impacts on the institution.

Containment and Surveillance Capabilities

Containment measures are multi-pronged and include surveillance, rapid identification of infection with immediate isolation, contact tracing, and quarantine. Currently available antibody (serologic) tests lack adequate evaluation of efficacy and reliability and are inadequate to determine whether a positive test conveys immunity. Antibody tests are currently best positioned to be used as part of research or public health surveillance efforts to determine estimates of population exposure. As antibody testing evolves, it may eventually play a role in diagnosis and determination of individuals at risk for infection.

Surveillance is the cornerstone of effective public health. Surveillance systems should detect the emergence and spread of infection within the general community and within specific campus populations. As the primary health resource for campus, SHS should take the lead in identifying at-risk groups such as SHS staff, first responders, on-campus residential students, athletes, Greek life members, medically vulnerable students, or other known student populations with frequent close contact. At some campuses, SHS may be asked to coordinate surveillance systems for non-student members of the campus community as well.

The SHS in collaboration with a partner health care organization and/or local public health department should develop the following capabilities for campus:

- Access to immediate viral testing for all students, faculty, or staff with symptoms.
- Contact tracing, identification, and quarantine of all persons exposed to COVID-19.

- Case management of all persons with COVID-19 symptoms and/or diagnosis and all persons under quarantine after exposure, including placement in isolation/quarantine housing, psychological support, support for basic needs, and ongoing monitoring while isolated.
- Syndromic surveillance utilizing EHR data, ongoing tracking of influenza-like illness (ILI) and COVID-19 symptoms, and, when possible, viral surveillance of asymptomatic students.
- Reliable, accurate antibody (serologic) testing, as appropriate based on emerging information.
- Future large-scale delivery of COVID-19 vaccines, when developed.

The Workforce

The college/university must build the necessary staffing capacity to resume not only their primary responsibilities but also the competency to understand their role in reducing transmission of COVID-19. Faculty and staff must be protected, trained, and adequately prepared.

Workforce protection and safety are critical to reopening, and measures must be taken to ensure the faculty, staff, students, and campus community have appropriate protective controls, plans, supplies, and guidance to safely return to work. Opportunities for open dialogue must exist to reassure faculty and staff that their health and safety are paramount.

To ensure faculty, staff, and students have access to the same basic information, formal education/training regarding COVID-19 should be offered. The campus COVID-19 planning and response committee in collaboration with IHE senior leaders would recommend the format and frequency of training and develop a system to monitor compliance (if the training is deemed mandatory). The training should offer the following minimum content:

- A general overview of COVID-19 including infection prevention and control measures (hand hygiene, respiratory etiquette, physical distancing, cleaning and disinfection), signs and symptoms, testing, transmission, and credible resources.
- Campus-specific policies and practices regarding infection prevention and control, campus health and safety resources, use of PPE including masks/face coverings, and actions if sick.

Employee Considerations

Employees should be given the following instructions for protecting their health and reducing transmission:

- Avoid office gatherings, break rooms, and unnecessary visitors in the workplace.
- Monitor for presence of COVID-19 symptoms (see <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>).
- Stay home (or leave the workplace) and notify the supervisor if symptoms develop.
- Wear masks or face coverings in all public spaces and spaces used by multiple people.
- Know where to find local information on COVID-19 and local trends of COVID-19 cases.

Supervisor Considerations

Supervisors should be given the following instructions for protecting the health of their employees and reducing transmission:

- Conduct meetings electronically, even when working on campus. If meetings cannot be conducted virtually, keep participation to fewer than 10 participants and enforce appropriate physical distancing and wearing of masks or face coverings.
- Encourage those with increased risk of severe illness or over the age of 65 to continue working remotely and avoid gatherings of greater than 10 or other situations of potential exposures, including travel.
- Consider phased return of employees to no more than 30% of the workforce at a time, staggering every 2–4 weeks for full return. Depending on the size and needs of the workforce, the percentage may vary. Numbers of employees are also dependent upon availability of PPE, support for increased environmental cleaning, and availability of employee health care.
- Stagger shifts to reduce the number of people in the workplace at the same time.
- Gauge employee willingness to volunteer to be the first to return and prioritize those with the greatest ability/desire to return, while paying attention to individual risk factors.
- Allow those who can work effectively from home to be the last to return and/or delay their return to the campus.
- Encourage single occupancy in work rooms.
- Procure sufficient disinfectant products and cleaning supplies so employees can frequently clean their own workspaces.

- Ensure that housekeeping is provided PPE and guidelines on appropriate techniques (as per CDC guidelines) for cleaning and disinfecting common, non-clinical spaces.
- Post and promote prevention strategies:
 - Wash hands frequently.
 - Maintain physical distance: stay 6 feet apart at all times.
 - Know the signs and symptoms of COVID-19 and what to do if symptomatic:
 - Stay home when you are sick (or leave work immediately) and notify your supervisor.
 - Call your health care provider's office in advance of a visit.
 - Limit movement in the community and wear a face covering in public.
 - Call your health care provider for instructions regarding return to work.

Facility Considerations

The following recommendations should be provided to those on campus responsible for maintaining facilities or ordering materials and supplies:

- Maintain at least 6 feet between workstations/workers. Place plexiglass or other barriers in workspaces where people must face each other or unable to be 6 feet apart.
- Consider installing plexiglass barriers at high-visited areas such as reception desks and check-in points.
- Place appropriate signage at entrances indicating how to proceed.
- Remove chairs and desks to ensure proper physical distancing in conference and waiting rooms. Identify allowable occupancy in order to control workflow and/or establish maximum attendance.
- Make face coverings available throughout campus (e.g., at the bookstore, pharmacy, etc.).
- Post maximum occupancy in common break areas and configure to accommodate appropriate physical distancing.
- Provide sanitizing supplies for individuals to clean their areas before and after use.
- Eliminate reusable kitchen items (flatware, dishes, and cups) and cleaning tools (sponges, brushes, towels) and replace with single use options.

- Replace shared appliances with single use or no-touch options (coffee makers, ice/water dispensers).
- Remove high-touch items such as magazines, common pens, etc.
- Provide hand sanitizer at all entrances and high-traffic areas.
- Identify frequently touched areas (doors, cabinets, etc.) and investigate options to implement no/reduced touch options such as door removal, card access, foot-operated door pulls/pedals, or sensor-triggered doors.
- Monitor and secure inventories of PPE, hand sanitizer, wipes, cleaning products, and hand soap.

Instruction and Learning Environments

Since the release on March 3, 2020, of the *ACHA Guidelines: Preparing for COVID-19*, almost all institutions of higher education transitioned to an online/virtual mode of instruction. While these efforts have allowed the teaching and learning missions of universities to continue, there are limitations to remote instruction. Planning should include strategies guided by public health considerations to resume in-person instruction.

General considerations should include:

- Prioritization of in-person instruction for courses with academic outcomes that cannot be measured or achieved virtually, such as performance, laboratory, and clinical experiences.
- Implementation of a hybrid mode of instruction for the foreseeable future. Remote options should be planned for and available in the event that a rebound in local infections necessitates continued physical distancing and to support vulnerable students and staff, students in quarantine or isolation, and students and staff who cannot physically return to campus.
- Limitation of the number of attendees for in-person courses/sections. In most cases, all in-person courses/sections should be limited to fewer than 30 participants and also utilize other physical distancing measures. Consider creating multiple sections/shifts to reduce numbers.
- Implementation of close monitoring and tracking of in-person attendance and seating arrangements to facilitate contact tracing in the event of an exposure

- Development of a physical distancing plan for each course that includes:
 - Number of students and faculty present in each session.
 - Length of session.
 - Nature of activities.
 - Mechanisms to conduct student and faculty symptom checks.
 - Public health practices: face coverings, 6 feet of 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.
- Development of 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 PPE, supervision, and other protections based on their risk.
- Expansion of simulation experiences to create clinical scenarios for health professional students to practice technical, diagnostic, and exam skills.
- Development of specialized plans for courses and instruction that do not permit physical distancing and/or involve activities of higher risk. Examples include dance, theater, and performing arts.
- Development of attendance and excuse policies that acknowledge and support students who become ill without creating barriers and without requiring unnecessary visits to health facilities for documentation of illness.
- Encourage faculty-student communication regarding health status and any changes in their ability to complete coursework and academic responsibilities.
- Identification of resources for students with learning disabilities or difficulties with remote learning platforms.

Student Health Services

Student health services (SHS) preparation should focus on maximizing its assets and capabilities before a large-scale physical return to campus. Strengthening campus and community partnerships; planning for containment; shoring up the supply chain; anticipating personal

protective equipment (PPE) and medical supplies for screening, mass vaccination, and treatment; reconfiguring the facility; updating policies and procedures; training staff; and addressing the budget are critical at this time. The campus will continue to look to the SHS for medical and public health expertise, and SHS leadership should be poised to deliver current, sound, evidence-informed recommendations.

Patient Care Considerations

SHS preparation for patient care was well-delineated in the *ACHA Guidelines: Preparing for COVID 19* (dated March 3, 2020). Since that document was released, most students have physically left campus. Many SHS have implemented telemedicine to provide access to care, protect staff, and conserve scarce PPE. Asymptomatic transmission of COVID-19 has been documented and presenting symptoms and the course of the disease have become clearer, though much remains unknown.

In concert with the recommendations outlined in the *ACHA Guidelines: Preparing for COVID-19*, the SHS should:

- Advise patients to make online appointments or call before coming to the SHS for nursing or provider visits.
- Develop processes to limit student contact with SHS computers/keypads. Have students complete and submit forms (health history, immunizations, consents, etc.) in the patient portal or utilize EMR templates.
- Continue to utilize telemedicine visits and provide students with options for telemedicine or telephone consults when appropriate. In particular, students with conditions placing them at higher risk for complications from COVID-19 should be encouraged to seek care via telemedicine.
- Develop an online or telephone process for patient check-in, if possible.
- Update triage protocols incorporating telehealth options.
- Update screening forms to include chills, repeated shaking with chills, muscle pain, headache, sore throat, anosmia, dysgeusia, and any other COVID-19 symptoms.
- Screen all patients and staff for respiratory symptoms and check temperature (ideally with infrared or laser devices) before entering the clinic.

- Develop protocols for managing patients with acute respiratory symptoms that include masking the patient, quickly rooming the patient, limiting and tracking the number of staff who enter the room, limiting the movement of the patient throughout the SHS, and cleaning of spaces where the patient was present.
- Avoid use of nebulizers and peak flow measurements which can generate additional aerosols.
- Require all patients to wear face masks (or cloth face coverings if adequate face masks are not available).
- Prohibit visitors, children, or accompanying guests who are not receiving care or services from entering the facility.
- Develop relationship and agreement with local emergency departments (ED) to accept ill patients requiring a higher level of care.
- Develop a plan for students with respiratory symptoms who need transportation to SHS, housing, or local hospitals.
- Develop a communications plan involving the campus communications office, outlining key messages such as how to access care and schedule appointments and which visits should be in person versus virtual. Use a variety of platforms including websites, social media, and signage. Involve as many campus entities as possible in communicating these messages (housing, dining, recreation, etc.).
- Dental operations pose additional risks due to the frequency of aerosol-generating procedures and the inability of patients to use facial coverings. SHS with dental services should consult with Environmental Health and Safety professionals with appropriate expertise before considering reopening these services.

SHS Facility Considerations

- Make all efforts to segregate waiting areas for ill and well patient visits. If separate waiting rooms are not available, consider placing a tent outside or identifying a satellite space for patients with respiratory symptoms. Deploy signage providing clear guidance on how to proceed.
- Reconfigure all waiting and other clinic areas to promote physical distancing.
- Implement signage throughout the SHS communicating reasons for physical distancing.
- Ensure adequate alcohol-based (at least 60%) hand

sanitizer, face masks (or coverings if masks are not available), tissues, and closed bins for disposal are available.

- Provide plexiglass/clear barriers between reception staff and waiting areas.
- Develop protocols for environmental management including clinic cleaning and decontamination. Assess air exchange for examination rooms and determine time required between uses in the event of a known or suspected COVID-19 patient.
- Ensure adequate IT network, wi-fi, hardware, and expertise to support telemedicine and telemental health visits.

SHS Administrative/Staff Considerations

- Add questions to satisfaction surveys to obtain feedback about telemedicine or phone visits.
- Ensure adequate PPE is available and that all staff are trained in its use. Monitor staff compliance with PPE use. Establish “par levels” (minimal acceptable PPE stores, also known as “safety stock”). PPE supplies should be stocked to meet both patient care and testing needs.
- Develop employee health program protocols for management of exposed and ill staff members. 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.
- Determine how SHS will handle work assignments for high-risk staff.
- Develop a financial model for campus leadership regarding potential costs and funding mechanisms for testing, contact tracing, and case management. Consider the future impact of antibody testing and mass vaccination.
- Develop plans for future mass immunization with influenza vaccine and COVID-19 vaccine, when available, including identifying supplies needed for both vaccines.
- 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.

Health Promotion

The role of health promotion in a healthy campus is multi-layered and founded in a prevention framework.

Assessment, environmental change strategies, social marketing, social norming, peer education training, and health education programs are just a few components. Health promotion may also house alcohol and other drug (AOD) services including the collegiate recovery community, interpersonal violence (IPV) prevention, sexual health and STI resources, and nutrition services including a teaching kitchen.

There may be a range of changing restrictions placed on in-person events based on local public health conditions, so health promotion staff should develop a range of delivery methods. Many health education programs and trainings are easily transferable to a virtual environment. However, the integrity of some aspects may not be conducive to virtual delivery. In those instances, there simply is no replacement for in-person, hands-on interaction to optimally engage and stimulate learning. Placing as much content as feasible online could allow capacity for more frequent but smaller peer trainings or programs that are not conducive to the virtual setting.

Health promotion offerings carry various levels of risk based on the size, physical proximity of participants, nature of the activity, and vulnerability of the population. Health promotion professionals can consult with their campus or public health experts to develop a risk assessment and plan for various types of activities. In general, programmers should limit attendees to 10, practice physical distancing, and begin each program with a brief instructional session reviewing hand hygiene, respiratory etiquette, symptoms of COVID-19, and staying home when sick. Attendees should continue to retain appropriate physical distancing and use face coverings during these onsite programs.

Individual visits for nutrition evaluations and counseling, AOD consultations, smoking cessation, health coaching, and sexual health education should be performed via telehealth until physical distancing restrictions are relaxed for the campus and local community. Case by case decisions on in-person interactions with students requesting IPV assistance or other sensitive discussions must weigh the needs of the student against the potential health impact on the staff. Any staff member with direct student encounters should be provided appropriate PPE and practice physical distancing.

In-person cooking classes have successfully been utilized in skill building and team building, as well as in branding and marketing. Until local public health conditions permit,

in-person cooking classes should be moved to a virtual format. The risk of many hands touching shared utensils in the close quarters of a food preparation and food sharing environment outweighs the educational and social benefits of these activities. An alternative hybrid approach is a live cooking demonstration broadcast via social media or Zoom (or similar video conferencing service), which will still permit opportunities for interactive chats with campus dietitians, meal planning and prep, nutrition counseling, and small group workshops.

Health promotion has the unique capability of developing cogent relatable messages that speak to the spectrum of individuals on campus. Health promotion professionals should collaborate with SHS and the broader campus leadership teams and campus specialists to plan and implement communications and marketing efforts. These may include media campaigns, public service announcements, email blasts, editorials, op-ed articles, flyers, posters, billboards, public transportation signage, and workshops; specific strategies should be based on the capabilities and interests of the campus. All communication efforts should reinforce sound public health practices, utilize multiple media channels, be pilot tested in efficient ways, and maintain consistency across approaches. These efforts should be designed to reach students as well as the university's key stakeholders; each of these audiences represent an ultimate audience as well as an intermediary audience (e.g., a faculty member who is made aware of best practices and ways these can be incorporated into classroom assignments as well as day-to-day activities). This collaboration should engage campus specialty offices (e.g., marketing and public relations) as well as faculty and academic departments (e.g., communication, marketing, public health). Collaboration may also extend to statewide or regional coalitions so cost-effective approaches can be developed and shared among campuses.

Frequently, assessment and evaluation activities are delegated to health promotion. Health promotion professionals are well-versed in assessment and evaluation methodology as well as the broader context of health issues associated with this pandemic. Their expertise is invaluable in the campus-wide effort to inform and guide health and well-being initiatives. While health promotion staff cannot lead all assessment and evaluation activities, they can provide leadership regarding the short- and long-term assessment of the campus environment and campus climate; student behavior, attitudes, knowledge, perceptions, needs, interests, and intentions; faculty and staff awareness, attitudes, and needs; social norms and messaging effectiveness; programming and training impact; and other population level issues. Incorporating

both quantitative and qualitative approaches is desirable. Engaging other specialists on campus (faculty and staff) will be helpful for garnering their expertise and providing opportunities for their students to gain experience.

Mental Health

Enormous efforts to establish physical distancing have resulted in both isolation and a change in routine for many persons. The emotional, social, and financial disruptions in combination with 24/7 media and fear and uncertainty surrounding this pandemic continue to take a toll on students' well-being, leading to concerns about increasing rates of depression, anxiety, substance use disorders, suicide, and domestic violence.

Many students are experiencing grief, disruption, and anxiety related to the changes. If students do not require psychotherapy, they may need an accessible, responsive venue for ongoing validation and support. Conversely, students with pre-existing depression, anxiety, and trauma are often more symptomatic during times of heightened stress and may require extra support in terms of more frequent contacts, sessions, and/or resources.

Telemental health has provided a path for mental health providers to continue providing services to students during the pandemic. In many college health settings, there has been a rapid and successful migration of counseling and mental health care to telemental health venues. Moving from telemental health back to in-person mental health services will be dependent on a variety of factors and for most operations will likely occur in stages. It is possible that mental health providers will never fully cease using effective telemental health programs established during the COVID-19 pandemic but will instead find an optimal balance between telemental health and in-person care.

As online enrollments are predicted to increase (due to health, disability accommodation, and/or financial needs of students and their families), campuses should make every effort to support telemental health care for enrolled students not physically present on campus. In addition, in order to fully serve all students who may need telemental health services, uniform standards and credentialing to practice across state lines will have to be established. The 2019 Higher Education Mental Health Alliance (HEMHA) *College Counseling From a Distance: Deciding Whether and When to Engage in Telemental Health Services* is an outstanding resource on telemental health in the higher education setting (see http://hemha.org/wp-content/uploads/2019/01/HEMHA-Distance-Counseling_FINAL2019.pdf).

Continued use of telemental health should be encouraged with the exception of those highly acute clients who meet exception criteria. In-person visits should be limited to those clients who would most benefit from such interactions. This could include crisis counseling, counseling for individuals unable to access telemental health, or other circumstances whereby the mental health professional believes an in-person visit carries significant benefit. Policies and procedures should clearly delineate which categories should receive an in-person vs. a telemental health appointment in order to facilitate appropriate scheduling. In order to maintain appropriate physical distance, waiting rooms may need to be modified or not allowed. If the size of the waiting room is an issue, services should be rendered by scheduled appointments only, no walk-ins allowed, or metered entrance to the clinic only at the appointment time. Integrated centers need to partner with health services for screening of all entrants to the clinic. Any staff member with direct student encounters should be provided appropriate PPE and practice physical distancing. Many of the patient and facilities considerations noted in the student health services section, such as limiting the use of high-touch areas or allowing online check-in, are applicable to mental health care as well.

Workshops, mindfulness, and other skill building programs could be placed in a virtual environment. Even group therapy visits could take place virtually. However, if the mental health provider deems the virtual environment to be subtherapeutic, the group could meet in person if there is space that allows for appropriate physical distancing. The staff should provide clear instructions on staying home if sick, respiratory etiquette, and hand hygiene well in advance of the group session. At this time, personal face coverings would also be recommended.

Developing mechanisms for virtual drop-in sessions may address some of the increased demand for services. Taking services to where the students are by establishing virtual "let's talk sessions" for students in specific divisional colleges/majors, residence halls, or groups allows for a sense of comradery and shared support. Students also would benefit from ongoing virtual support venues in which they have access to needed education, resources, and self-help tools. A virtual platform, facilitated by counseling staff, to share experiences, connect with others, and feel supported and heard can be useful.

The health and well-being of student health and counseling staff, particularly those with direct patient contact must be preserved and protected. Staff members working in crisis settings tend to work many hours under

pressure with risk of infection, morbidity, and mortality. Recognition of signs and symptoms of burnout and provision of support to mitigate the possible psychosocial consequences of work in these situations through employee assistance programs or stress debriefing meetings is the obligation and responsibility of senior leadership.

This is a critical time to provide training and resources to faculty, staff, and students on how to identify those in distress and how to effectively intervene and refer appropriately. Counseling services staff can provide virtual trainings and workshops to provide the needed education, skills, confidence, and competence required (see <https://www.sprc.org/comprehensive-approach/identify-assist>).

Other Key Campus Areas

Campus-wide preparation is the key to an organized, effective, safety-focused, and medically informed process of reopening. Although student health services will play an important role, this effort will require the ongoing engagement of executive leadership (president/chancellor, provost, vice president of student affairs/campus life, other senior leaders) and the oversight and coordination of the institution's COVID-19 planning and response committee described in the *ACHA Guidelines: Preparing for COVID-19*.

While all areas of the college/university will require adjustments upon resuming operations, several key areas outside the classroom, such as housing, dining, athletics, and recreational sports, will require additional consideration.

Housing

Depending upon the size of the college/university, its residential housing inventory, and on-campus residency requirements, thousands to tens of thousands of students may live and dine on campus during periods of full in-person instruction. Students congregate, study, and socialize in these on-campus residential settings. Students often reside with two or more individuals per living space, with roommates from different parts of the country and world. In such settings, there will frequently be a mixture of individuals from low COVID-19 transmission areas and high-transmission areas living in a single space.

Clearly, it is difficult to maintain full physical distancing in on-campus housing, and even modified guidelines may be difficult to achieve. Considerations to decrease the risk for exposure within traditional residence halls, campus apartments/suites, campus fraternity/sorority houses, and other on-campus housing arrangements, include:

- Single resident per room and ideally per bathroom (if possible). This may be feasible only if the college/university has a limited number of students on campus for in-person instruction. When shared bathrooms are used, define the type and frequency of cleaning.
- Requirement of personal face coverings in common areas.
- Frequent reminders of proper hand hygiene (verbally, posters, videos) with hand sanitizer widely available in common areas and rooms.
- Enhanced cleaning in all common areas and high-touch surfaces, consistent with enhanced cleaning practices of other non-residential areas such as academic buildings. Custodial workers should be provided appropriate PPE and training consistent with their duties. See CDC guidelines for cleaning and disinfecting facilities (available at <https://www.cdc.gov/coronavirus/2019-ncov/community/reopen-guidance.html>).
- Widely shared/posted information in common areas about COVID-19 prevention. CDC provides communications resources such as posters, videos, and more at <https://www.cdc.gov/coronavirus/2019-ncov/communication/index.html>. Posted information should be updated as appropriate or with significant changes.
- Training on public health measures and signs/symptoms of COVID-19 for all live-in professionals, graduate hall directors, residence advisors (RA), and others in similar roles.
- Restrictions on events and social activities as per current physical distancing guidance. Reconfiguring seating in common areas to ensure proper physical distancing. Establish allowable occupancy and develop plans to monitor and enforce.
- Restrictions on building access by non-residents, including outside guests, non-residential staff, and others. These restrictions may not apply to some people, such as personal care attendants for students with disabilities.

Students with medical conditions such as asthma, diabetes, immunosuppressive drug therapy including chronic systemic corticosteroid treatment, heart disease, HIV, and morbid obesity are at high risk for COVID-19 illness and complications. The IHE must address whether these high-risk individuals should return to residence halls and other on-campus housing in the early phases of reopening the campus or later.

Housing/residence life, custodial, and other support staff are frequently on-call and are often the first responders to the needs of residential students. They need access to PPE, appropriate exercise and break opportunities, defined work schedules with time off as appropriate, and access to psychological/counseling support.

Isolation and Quarantine

Inevitably, a residential student will contract or be exposed to COVID-19 and will require isolation or quarantine. Campuses must proactively identify appropriate residential spaces and reserve those spaces in the event of needed isolation or quarantine of a student(s). If on-campus housing is nonexistent, unavailable, or unfeasible, the college/university should identify off-campus options for the isolation and quarantine of residential students. It is unreasonable to expect IHEs to provide on-campus isolation and quarantine housing for students who live off campus, but it is recommended that the IHE develop a plan for fielding requests for isolation/quarantine housing for off-campus students.

Ideally:

- A protocol should be made available to all individuals involved in the management of isolation spaces and its procedures.
- The isolation and quarantine rooms should be physically separated from other residential student rooms.
- The rooms should have private bathroom facilities and be stocked with a thermometer, sanitizing wipes, tissues, soap, hand sanitizer, and toiletries.
- Spaces should be labeled externally with appropriate signage that states restricted access (e.g., “Private Quarters” or “Authorized Personnel Only”) but does not state the reason for the restricted access due to concerns about potential for stigma and FERPA/HIPAA violations. Any signage decisions should be reviewed with college/university general counsel. Minimally, a select group of individuals within housing/residence life, campus safety, and facilities should be aware of the rooms used for isolation.
- Adequate numbers of rooms should be pre-identified to accommodate an increase in need. CDC may later provide guidance on adequate numbers of rooms; if/when that guidance is released, these ACHA recommendations will be updated.
- Student health services staff should remotely monitor students on a daily basis (temperature checks and symptom screening) and transfer to an on- or off-

campus site for a clinical evaluation if symptoms advance or the patient requests.

- For students on the campus meal plan, dining services should arrange food delivery in collaboration with housing/residence life staff. 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.
- Counseling services and/or the office of spiritual and religious life should be available remotely to students in isolation or quarantine as needed.
- To the degree possible, students should continue academic activities remotely or be provided with note takers.
- A team of designated student affairs/campus life staff should be appropriately trained and on call to assist students with their personal needs (medication pickup, delivery of hygiene supplies, etc.).
- Transportation is made available to and from the location if medical care is needed.
- Custodial and maintenance staff and live-in professionals are provided with and required to wear appropriate PPE (as per CDC guidelines) when cleaning or entering isolation and quarantine spaces (available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html>).

All IHEs may not have the resources to meet each of these ideal recommendations but at a minimum should assess their capability to provide these accommodations for residential students in isolation or quarantine.

Many of these guidelines were developed in collaboration with the Association of College and University Housing Officers-International (ACUHO-I). Please visit the ACUHO-I website at <https://www.acuho-i.org/covid19> for additional COVID-19 resources for residence life administrators and staff.

Dining

On-campus dining services share many similarities with restaurants, but there are also a number of important differences that potentially impact the risk of COVID-19 transmission. In most campus dining services, students (faculty, staff, and visitors) queue up to enter, choose food options, and pay with cash, credit/debit cards or meal cards. Dining areas are often large and chaotic, with

closely spaced tables and chairs and both sustained and episodic interpersonal interactions. As a result, significant changes will likely be necessary to institute physical distancing and other infection prevention and control measures. If a campus chooses to partially or fully resume campus dining services, they should consider:

- Requiring all dining facility staff to wear face masks and gloves at all times while working and interacting with the public.
- Providing custodial services with appropriate PPE for cleaning and disinfecting common, non-clinical spaces as per CDC guidelines (available at: <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>).
- Requiring employees to follow infection prevention guidelines including:
 - Staying home when ill.
 - Practicing physical distancing whenever possible at work.
 - Practicing proper hand hygiene.
 - Avoiding touching the eyes, nose, and mouth with unwashed hands.
 - Cleaning and disinfecting frequently touched surfaces throughout the workday.
 - Undergoing temperature checks prior to shift.
- Requiring all customers/diners to wear face masks or coverings while in the facility. Since an individual cannot eat and drink while in a mask, masks should be worn during movement in the facility and can be removed when sitting and dining. This further emphasizes the need for physical distancing of patrons and additional discussions of providing only takeout options during the initial phases of re-opening.
- Limiting the number of individuals dining in a single facility at one time. The number should be chosen with the goal to achieve appropriate physical distancing of diners. Possible approaches include:
 - Access control: once the target number is reached, patrons are only allowed to enter when another customer leaves.
 - Cohort dining: established dining times admitting a specific group of customers/diners.
 - Physically spaced (6-foot) floor markers for waiting lines outside and inside the facility.
 - Appropriately spaced and limited numbers of tables and chairs per table.

- Eliminating buffet-style self-serve food or beverage stations and replacing with staff-served meal stations.
- Providing a bagged take-out meal option at every meal. Consider kosher, vegetarian, vegan, and gluten-free options, as requested or appropriate to the customer base.
- Arranging food delivery to students in isolation or quarantine.

Athletics

Many colleges/universities have hundreds of students participating in intercollegiate (varsity) sports. The novel COVID-19 virus presents a high risk of transmission in athletic settings due to frequent physical contact, potential for aerosolization during exercise, fomites (shared towels, water bottles, athletic equipment, balls/pucks), and the potential physical effects of over-training and dehydration on disease resistance.

Student athletes are first and foremost students. Athletics and sports medicine programs must ensure department policies, procedures, and communications regarding COVID-19 align with institutional, CDC, federal, state, tribal, territorial, or local public health guidelines and requirements.

In preparation for a partial or full resumption of intercollegiate athletics activities, including practice and competition, athletics and sports medicine programs should consider the following:

Creation of an Athletics COVID-19 Action Team:

Team members could include:

- Athletic director or designee.
- Head athletic trainer or designee.
- Head team physician or designee.
- Coaching representative.
- Strength and conditioning representative.
- Student health services representative.
- Counseling services representative.
- Student athlete.
- University crisis management/emergency preparedness representative.
- Health care system (academic medical center or local health care system) representative.

- Other potential ad hoc or advisory group representatives could include those from: recreation services, public health, facilities management, custodial services, compliance offices; equipment services; health promotion and well-being services, nutrition/dining services, housing, academics, human resources, campus safety, and athletic conference/governing bodies.

Creation of an Athletics and Sports Medicine COVID-19 Action Plan: This plan is a living document that is developed, reviewed, and updated by the Athletics COVID-19 Action Team and includes:

- Guidelines developed in conjunction with the campus COVID-19 planning and response committee regarding:
 - Personal protective equipment (PPE) and training for athletic trainers and custodial staff, including donning and doffing procedures.
 - Adequate availability of recommended PPE.
 - Recommended approach to Basic Life Support (BLS), resuscitation, and automated external defibrillator (AED) use in a student athlete/staff/spectator/patient with possible COVID-19.
- An assessment of the potential for COVID-19 transmission in each sport (e.g., individual vs. team sports; contact vs. non-contact sports; major spectator vs. limited spectator sports). Consider a phased return to athletics participation based on potential risk of transmission in each sport. Areas for consideration should include:
 - Sport-related impediments to personal distancing, which is unavoidable in many sports (e.g., wrestling, football, soccer, basketball, and other contact sports) and less common in others (e.g., golf, individual swimming events with appropriately spaced lanes, singles tennis).
 - Ball transfer during practice and competition (e.g., volleyball, basketball, soccer, baseball/softball, etc.).
 - Needs and feasibility of appropriate cleaning and disinfection in shared apparatus sports (e.g., gymnastics).
 - The difficulty/feasibility of “policing physical distancing” among spectators, even in a very small crowd and whether it is a task that athletics staff are able/willing to undertake.

- Pre-participation screening and evaluation of student athletes:
 - Consider addition of pre-participation questions regarding COVID-19 diagnosis, recent or current illness suggestive of COVID-19, exposure, current restrictions (isolation or quarantine), and/or current symptoms.
 - Carefully review each athlete for the presence of underlying health conditions that places the individual at higher risk for COVID-19.
 - Consider further evaluation of a student athlete based upon their questionnaire and recommendation of team physician or student health or primary care provider. Ensure onsite access to appropriate PPE in the event of a concerning student athlete questionnaire or screening.
 - Consider staggering pre-participation screening (rather than a single “mass screening event”), perhaps by team or by individual athlete appointments, to ensure physical distancing during waiting and examinations and allow cleaning of exam spaces between athletes.
 - Understand that scheduling changes could impact the immediate availability of individual athletes or teams upon return to campus.
 - At the time of publication of these guidelines, the question of COVID-19 testing of all intercollegiate athletes or other at-risk groups (noted on page 2) has not yet been settled. Given the current limitations of testing technology and interpretation of the results, it is clear that even a combination of testing for both infection (nucleic acid or antigen testing) and immunity (serologic or antibody testing) cannot provide a comprehensive picture of the safety of the student athlete “herd.” There will also be questions about the need for repeated testing and how often. IHEs and athletics programs are advised to continue carefully monitoring the recommendations of CDC, public health authorities, and professional organizations moving forward.
- Safe transition/acclimatization to athletic activity. Review adherence to NCAA governing body and sports medicine consensus recommendations for transition and acclimatization to activity following extended inactivity periods.

- Physical distancing principles in athletics. Consider recommendations for physical distancing in:
 - Athletics training room and other sports medicine health care facilities.
 - Athletics locker rooms.
 - Strength and conditioning facilities (including weight rooms). Will need to evaluate the spacing of equipment and use of a “sanitation station” at each equipment/exercise site so that cleaning can take place between each athlete, either by staff or the user.
 - Team meeting rooms.
 - Athletics academic areas.
 - Athletics dining areas.
 - High volume communal areas in athletics facilities, including spectator areas (“the stands,” arenas, and stadiums).
- Recommendations for virtual team activities (e.g., team meetings). Whenever possible, these virtual activities should include athletes, coaches, and staff currently separated due to high-risk conditions, illness, or travel restrictions.
- Recommendations on use of personal face coverings (or surgical masks) in the athletics setting (including training rooms and sports medicine settings) that are consistent with CDC guidelines.
- Recommendations for non-touch temperature check prior to practice, training, and competition.
- Recommended steps in the transport, assessment, and testing of student athletes or staff with potential COVID-19 illness.
- Isolation and quarantine guidelines for student athletes:
 - Guidelines should be consistent with campus and CDC guidelines and procedures (see Housing recommendations).
 - Many student athletes live together in groups (e.g., off-campus apartments and houses), which may present issues for isolation and quarantine of individuals and groups.
 - Include contingency plan for onset of illness and/or exposure during athletics-related travel and competition.
- CDC guidelines for disinfecting non-emergency vehicles in the event of transport of an individual with diagnosed COVID-19 or a person under investigation (PUI) (available at <https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/disinfecting-transport-vehicles.html>).
- Implementation of an athletics “shared responsibility” infection prevention plan, including:
 - Individual personal conduct consistent with prevention guidelines.
 - Signage about prevention based on CDC, campus, and other recommendations.
 - Hand sanitation stations (soap and water or 60% alcohol-based rub/hand sanitizer).
 - Annual prevention education and training for student athletes and staff.
- Guidelines for custodial services on appropriate techniques and PPE (as per CDC guidelines) for cleaning and disinfecting common, non-clinical spaces (available at: <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>).
- Guidelines for both athletic trainers and custodial services on appropriate techniques and PPE (as per CDC guidelines) for cleaning and disinfecting training room and sports medicine health care spaces, including terminal cleaning (available at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html>).
- Travel considerations: sports medicine staff should follow federal, state, local, and institutional public health recommendations related to screening and testing of student athletes and staff following team, work-related, and individual travel.
 - Considerations include travel to community or international “hot spots” and sports involved (contact vs. non-contact sports, team vs. individual sports).
 - Sports medicine staff should provide guidance regarding whether the proposed travel is appropriate given the current stage of the pandemic, potential isolation and quarantine measures that could arise as a result of the travel, and additional screening that may be required as a result of the travel.

- Contingency plans for illness, isolation, or quarantine of athletic trainers and other sports medicine staff. Consider minimum athletic trainer staffing levels for the safe continuation of team training and competition activities.

Provision of COVID-19 and infectious diseases education and training for athletics staff, including athletic trainers, coaches, strength and conditioning professionals, administration, facilities management, other departmental staff, and student athletes. The Athletics COVID-19 Action Team should recommend the timing (prior to return to campus) and continuing need throughout the academic year(s). The training should include:

- Details of COVID-19 signs, symptoms, evaluation, testing, course of illness, and transmission.
- Infection prevention and control concepts and procedures, including physical distancing, avoiding contact with ill individuals, and institutional screening procedures (if any).
- Individual personal conduct and hygiene.

Many of these guidelines were developed in collaboration with the National Athletic Trainers Association Intercollegiate Council for Sports Medicine (NATA-ICSM). For more college and university resources, visit the NATA website at <https://www.nata.org/professional-interests/job-settings/college-university/resources>.

Recreational Programs, Facilities, and Club/Intramural Sports

Most campuses have recreation centers for students, faculty, and staff, and many include multiple and/or extensive indoor and outdoor (e.g., fields) facilities. Thousands of students participate in club and intramural sports, fitness classes and activities, aquatics, and other opportunities for physical activity. Research has shown positive effects of exercise on the immune system and many chronic diseases (including diabetes, obesity, and heart disease) that place individuals into higher risk groups for COVID-19. Exercise also has positive impacts on psychological well-being. However, these recreation centers and programs carry many of the same enhanced COVID-19 transmission risks that are potentially present in varsity sports and local health clubs. Therefore, recreation programs and services should:

- Align recreation services policies, procedures, and communication guidelines with institutional guidelines and CDC, federal, state, tribal, territorial, or local public health guidelines and requirements.

- Provide COVID-19 and infectious diseases education for recreation staff (professional and student), faculty, and instructors. Training should include:
 - Details of COVID-19 signs, symptoms, evaluation, testing, course of illness, and transmission.
 - Infection prevention and control concepts and procedures.
 - Individual personal conduct and hygiene.
 - The important personal and institutional responsibility to protect the health and safety of all students, faculty and staff, including maximizing efforts to protect recreation, intramural, and club sport participants from COVID-19.
- Assess recreation and sports programs for their potential for COVID-19 transmission (e.g., individual vs. team sports; high intensity workouts with possible enhanced risk for aerosolization). Consider a phased return of sports and recreation programs based upon potential risk of transmission in a given activity.
- Consider informing the campus community, including parents, about COVID-19 prevention steps being taken by the recreation department. Be sure to carefully craft and vet any communications going to all or part of the campus community (see guidance under “Communications Plan”).
- Require the use of personal face masks by coaches, instructors, recreation staff, and participants.
- Employ physical distancing measures in:
 - Locker rooms
 - Strength and conditioning facilities (e.g., weight rooms, cardio areas). As with athletics, consider the use of a “sanitation station” at each equipment/exercise site so that cleaning can take place between each athlete, either by staff or the user.
 - Fitness and wellness classes.
 - Lounge areas.
 - Indoor and outdoor recreation facilities.
- Consider options to limit the maximum number of people in the facility with access control, use-by-appointment, or other measures.
- Consider starting or continuing to offer virtual recreation classes.

- Feature signage about COVID-19 prevention (based on CDC, campus, or other recommendations) throughout the facilities.
- Increase the availability of hand sanitation stations (soap and water or 60% alcohol-based rub/hand sanitizer) throughout the facilities, especially in high touch areas (elevators, stair rails, turnstiles).
- Provide custodial services, athletic trainers, personal trainers and fitness instructors with guidelines for appropriate techniques and PPE (as per CDC guidelines) for cleaning and disinfecting common, non-clinical spaces, including recreation venues and equipment (available at: <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>).

Many of these guidelines were developed in collaboration with National Intramural-Recreational Sports Association (NIRSA), *Leaders in Collegiate Recreation*. For more information about COVID-19 resources for recreational services professionals and their campus colleagues, visit the NIRSA website at <https://nirsa.net/nirsa/covid19/>.

Communications Plan

Regardless of size, a college/university must develop a communications plan when reopening the campus. Given the high stakes associated with reopening any IHE during the ongoing COVID-19 pandemic, it becomes vitally important to carefully craft and vet all communications to the campus community. Communications must convey the institution's confidence in the information, contain the institution's brand identity, send a unified message, and align with the core mission and values of the IHE.

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, counseling, and health promotion/well-being leadership should engage early and often with the communications oversight group, as well as senior campus leadership, as they develop health and wellness messaging.

Information must always be credible, trustworthy, and up to date. Ideally, 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 partial or full reopening in the face of the COVID-19 crisis.

Effective crisis messaging:

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

While there are many issues to consider for communication pieces, it can be helpful to address the basics of "Who, What, When, Where, Why, and How."

Who is the targeted 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?
- Students and parents?
- Trustees?
- Alumni?
- Local hospitals, health department, urgent care clinics?
- Visitors to campus—visiting teams, prospective students, visiting scholars and faculty, vendors, conference attendees, etc.?
- Off-site partners, community service facilities, internship locations?
- Local and national media via a press release?

The level of parental concern about COVID-19 will be extraordinarily high when the campus reopens. Including parents in key messaging is an excellent strategy to address their concerns and can be accomplished by inclusion in the main message or via a parent-targeted version. The most effective approach will vary significantly depending upon the target audience.

What is the purpose of the message?

- Define the main message. 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.
- Limit to three or four main messages per communication piece. For example, the key messages could be “We will continue to do in-person care, telehealth, and telemental health once the campus reopens;” “This is how to access care during and after office hours;” and “For questions, here is how you contact us.” If you also need to communicate about physical distancing in classrooms, residence halls and dining facilities, it is likely to be more effective in a separate message.
- Each message should include contact information for email and phone follow-up. Ensure staff are prepared to respond to concerns in a timely manner.

When should the message be sent?

- Some events will call for immediate notification of your audience(s), such as a sudden resurgence of COVID-19 illnesses on your campus.
- Urgent/important messages (e.g., a message in response to tragedy, such as the death of a community member) should be templated in advance, so that the language can be crafted, appropriately vetted, and available for immediate use.
 - The health services team should consider drafting key messages now for review and approval so they can be delivered to the campus in an orderly and timely manner.
 - The campus should consider developing a plan in advance for communicating about active cases as well as the death of a student, faculty, or staff member from COVID-19.
- Communications regarding policies, procedures, and strategies can be planned and scheduled for release more deliberately.

- 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.

Why is this message being sent?

Communications will serve several purposes including:

- To delineate action steps the IHE is taking to progressively reopen the campus.
- To share important safety measures.
- To describe specific approaches/instructions for subsets of the campus population (e.g., residential students, student athletes, health sciences students).
- To reassure the message’s recipients.

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

- As the campus reopens, consider hosting monthly 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.

International Travel

Currently, guidelines regarding international travel are very simple: **Avoid all nonessential travel globally.** This is detailed in the U.S. State Department's Level 4 Global Do Not Travel Advisory (<https://travel.state.gov/content/travel.html>) and the CDC Level 3 Global Travel Health Notice to avoid all nonessential travel (<https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>).

Looking ahead to that time when international travel for IHE constituents resumes on a broader scale, protecting the health of the individual traveler as well as campus and local communities is of paramount importance. The following elements should be considered for all travelers embarking on IHE-related international travel, including students, faculty, and staff. These recommendations are based on current information and will be updated as the global COVID-19 situation evolves.

- Frequent, detailed communication among all involved parties is essential.
- Detailed travel plans and purposes should be fully disclosed prior to travel.
- All IHEs should establish comprehensive institution-wide policies regarding international travel recommendations, restrictions, and requirements for both outgoing and incoming travelers.
 - Policies should pertain to all IHE-related persons (students, faculty, and staff) who are planning international travel or returning from international travel.
 - Policies should be created collaboratively by appropriate parties (e.g., student health services, administration, office of international programs, risk management, and general counsel, as well as the state, tribal, territorial, or local health departments as appropriate).

- Policies should be easily accessible, well-known to all affected parties, and enforceable.
- Due to the variability of the global COVID-19 situation, policies should be reviewed regularly and revised as appropriate.
- Current, reliable, relevant resources must be provided to travelers prior to travel.
- A travel registry must be established for all international travel.
- Plans for reliable intra-travel communication and ability to identify travelers' locations is vitally important and must be in place prior to travel.
- Pre-travel orientations are essential and should contain current and relevant safety and health information, including emergency procedures.
- Greater consideration should be given to pre-travel health screenings due to health risks of the COVID-19 pandemic.
- Appropriate health insurance should be mandatory for all travelers, including adequate evacuation coverage. IHEs should carefully review the details of insurance policies to ensure adequate coverage for planned activities as well as absence of pandemic exclusions.

Students, faculty, or staff who have been traveling internationally and are planning to re-enter the campus environment:

- Should be encouraged or required to communicate their intentions with identified contacts at their institutions in order to receive critical relevant information well in advance of their anticipated return.
- Must follow state, tribal, territorial, and local health department recommendations and requirements.
 - At this time, this includes quarantine at home for 14 days, checking temperature twice a day, monitoring for onset of symptoms of COVID-19, and maintaining contact with the appropriate health department as directed.
 - Directories of local (and tribal) health departments: <https://www.cdc.gov/publichealthgateway/healthdirectories/healthdepartments.html>
 - CDC returning traveler guidelines: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html>

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

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

- It is crucial to inform our international students and colleagues of relevant, reliable, and current travel health and safety resources and to encourage the serious consideration of current recommendations prior to travel.
- Every international student, faculty, and staff member is in a unique situation, which warrants individually tailored recommendations.
- All new or returning international travelers should refer to CDC returning travelers guidelines and review CDC's "Travelers Prohibited from Entry to the U.S." (available at <https://www.cdc.gov/coronavirus/2019-ncov/travelers/from-other-countries.html>).
- Existing international students, faculty, and staff currently at an IHE in the U.S. who are considering travel to their home countries should review global travel restrictions as noted by the U.S. State Department and CDC (see above and in Resources).
- Faculty and staff contemplating travel with subsequent return to the U.S. to continue IHE studies or work must seriously consider:
 - Current COVID-19 travel health risks and the possibility of significant unexpected changes in risks during their travels.
 - Potential for abrupt disruption, cancellation, or other serious complications of planned return to the U.S. due to the COVID-19 pandemic.
 - Rapidly changeable re-entry restrictions (including at any intermediate points in itinerary).

International travel is an evolving situation. Most IHEs in the U.S. have canceled or prohibited international travel for any university-related reasons through August 2020. Fall study abroad programs and research-based travel are being scrutinized at an individual institutional level, and many have thus far postponed making definitive decisions. Incoming international students, faculty, and staff are faced with a multitude of uncertainties as well, and challenges and uncertainties abound in both host and home institutions and countries. Considering the multitude of unknown factors involved with this pandemic,

knowledge and resources to inform new international travel guidelines will emerge in the coming months, and ACHA will offer updates as appropriate.

Conclusion

COVID-19 has changed the health and safety of our nation and our college campuses dramatically. Easing the mitigation and physical distancing restrictions too soon will offset the progress we are starting to see in the U.S. and may precipitate an increase in spread of the virus, cause unnecessary deaths, overwhelm health care facilities, and prolong the economic crisis. Until specific and effective therapies and vaccines are available and widely used, campuses may need to continue to loosen or reinstate public health control measures throughout the pandemic.

A careful risk assessment and staged approach is needed to balance the benefits and potential harms of adjusting these measures, so as not to trigger a resurgence of COVID-19 cases and jeopardize the health and safety of the campus community.

Colleges and universities should implement incremental steps based on testing, surveillance, contact tracing, and the health care and campus infrastructure ability to handle a surge in order to lessen physical distancing. Changes should be guided by local, state, and regional data for both the state in which the IHE resides and nationally.

Understanding and considering the preparedness levels of the community and the campus and marshaling the IHE's considerable teaching, research, and student development expertise and resources will be critical to the success of resuming campus operations and mitigating the potential spread of the virus.

Resources

White House Guidelines—Opening Up America Again: <https://www.whitehouse.gov/wp-content/uploads/2020/04/Guidelines-for-Opening-Up-America-Again.pdf>

IDSAs Policy and Public Health Recommendations for Easing COVID-19 Distancing Restrictions: https://www.idsociety.org/contentassets/9ba35522e0964d51a47ae3b22e59fb47/idsa-recommendations-for-reducing-covid-19-distancing_16apr2020_final-.pdf

American Psychological Association Practice Resources in Response to COVID-19: <https://www.apaservices.org/practice/clinic>

American Counseling Association, Counseling in a time of COVID-19: <https://www.counseling.org/knowledge-center/mental-health-resources/trauma-disaster/mental-health-professional-counseling-and-emergency-preparedness>

Substance Abuse and Mental Health Services Association: <https://www.samhsa.gov/coronavirus>

Mental Health America:
<https://mhanational.org/covid19#ForMentalHealthProviders>

American College Health Association:
<https://www.acha.org/COVID-19>

Higher Education Mental Health Alliance (HEMHA)
College Counseling from a Distance: Deciding Whether and When to Engage in Telemental Health Services:
http://hemha.org/wp-content/uploads/2019/01/HEMHA-Distance-Counseling_FINAL2019.pdf

International Travel and COVID-19:

CDC Travel : <https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>

U.S. State Department Travel:
<https://travel.state.gov/content/travel/en/international-travel.html>

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

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 (Task Force and Committee Chair); Deborah Beck, MPA, EdD; Michael Deichen, MD, MPH; Catherine Ebelke, PA-C, CTH; Mike Huey, MD, FACHA; Cheryl Hug-English, MD, MPH; and Sarah Van Orman, MD, MMM.



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Appendix A

Suggested Campus and Community Criteria in a Phased Opening Approach

Community

- Downward trajectory of ILI and COVID-19lik syndromic surveillance within a 14-day period.
- Downward trajectory of documented cases **or** percentage of positive tests (with flat or increasing volume of tests) for 14 days.
- Hospitals able to treat all patients without crisis care.
- Robust testing capacity in community including screening and contact tracing for symptomatic individuals.

Campus-Specific

- Downward trajectory of ILI and COVID-19 syndromic surveillance within a 14-day period.
- Downward trajectory of documented cases **or** percentage of positive tests (with flat or increasing volume of tests) for 14 days.
- Minimal cases of community transmission (no known source) in student population.
- Containment capabilities (See “SHS Preparation”).



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